

The home health payment system

Presentation to Senate Committee on Finance staff

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Presented by: Sharon Bee Cheng

Key points

- Home health spending and use have changed over the past ten years
- The payment system has also changed
- How the current payment system works
- Issues
 - Changes in the base rate, add-on
 - Changes in use of the benefit

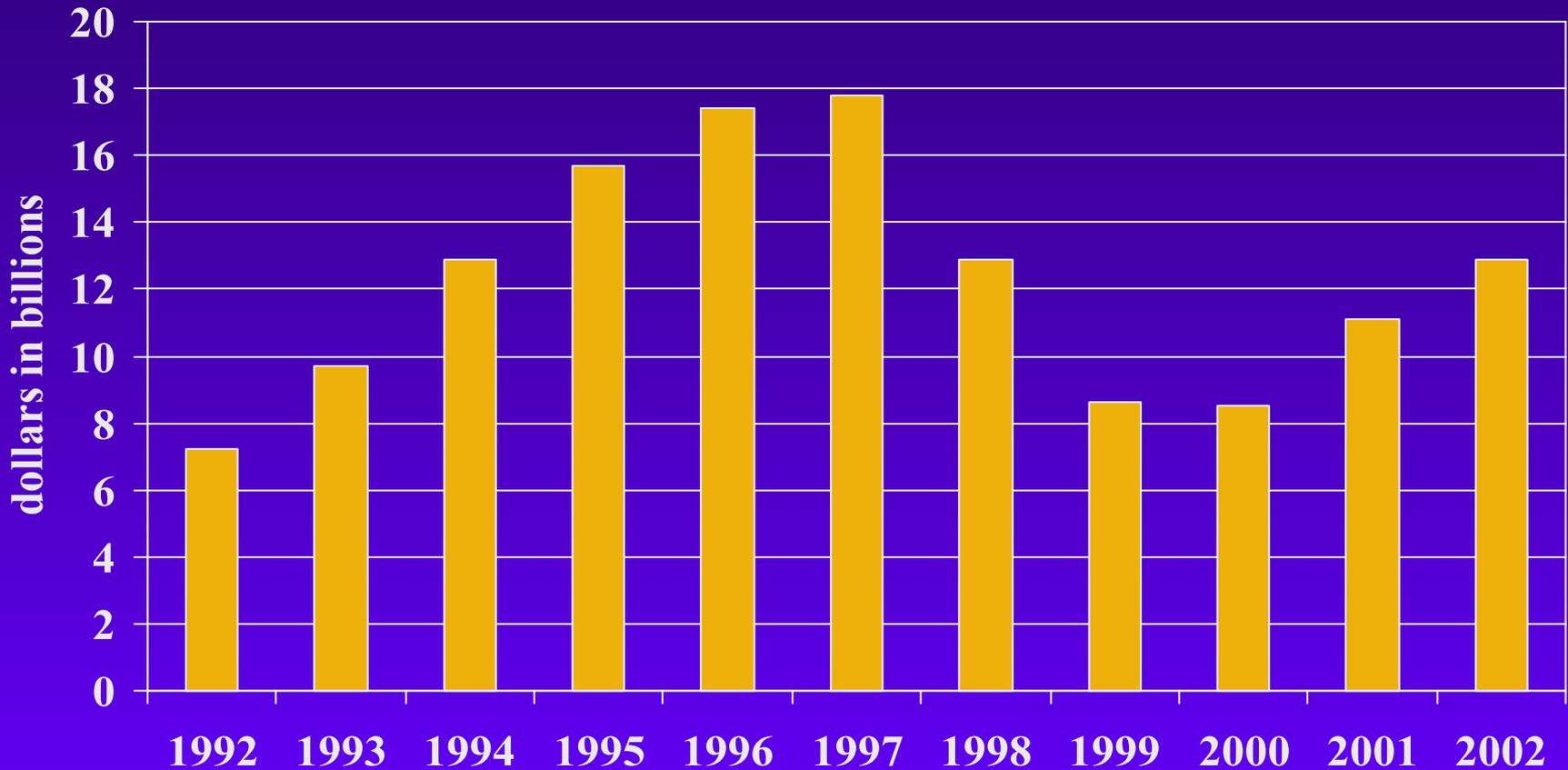
Overview of sector in 2001

- 2.2 million beneficiaries served
- Program spending of \$10 billion
 - (5% of Medicare total)

Home health agencies

- Currently 7,000 certified agencies
- Wide range of sizes
- Types: voluntary, for-profit, and government

Trends in spending



Explaining changes in spending

- Three phases
 - Rapid growth from 1990 to 1997
 - Rapid decline 1997 to 2001
 - Moderate growth following 2001
- Three payment systems
 - Cost-based before 1997
 - Interim payment system 1997 to 2000
 - Prospective payment system after 2000
- Changes in use

Explaining changes in use

- Incentives of the payment systems
- Eligibility for the benefit
- Enforcement of standards

Changes in the product

	Pre-PPS	Post-PPS	Change
Visits per episode	36	21	-42%
Length of stay	106	41	-61%
Percent of visits for therapy	9%	23%	+155%

Home health sector services

Eligibility:

- Homebound
 - Leaving home requires considerable, taxing effort
 - Absences are infrequent
- Medical necessity for skilled care
 - Diagnosis or treatment requires a nurse or therapist
- Part-time or intermittent frequency

How Medicare pays for home health

Service is measured in episodes.

Amount of payment for an episode is the national base rate, adjusted for case-mix and for prices in the area where the patient resides.

Home health episodes

- 60-day periods
- Contain at least five visits
- Beneficiaries may receive as many episodes as they need as long as they remain eligible

Base payment

- Base payment covers the costs of visits and routine supplies
- Based upon a model with 1997 costs
- Updated annually using home health market basket

Adjusting payment for case-mix

- Home health resource groups (HHRGs)
- Based upon the OASIS assessment
- HHRGs classify patients based upon
 - clinical severity of their medical condition
 - functional limitations
 - service use
- 80 HHRGs have relative weights to reflect the anticipated costliness of care

Calculation of home health payment (Mr. X , Philadelphia)

- Base rate x HHRG weight
 $\$2,160 \times 1.85 = \$4,000$
- Adjust labor portion for local wages
 $\$3,000 \times 1.12 = \$3,500$
- Total payment
 $\$3,500 + \$1,000 = \$4,500$

Other adjustments to payment

- Add-on for services provided to beneficiaries in rural areas
- Low utilization, high utilization (outlier), partial episode, significant change in condition

Key issues in home health

- Decrease in the base payment for FY2003
- Expiration of the rural add-on
- Tension between post-acute benefit and long-term care
- Changes in the use of the benefit
- Technical refinements of the system

Changes in use

From 1996 to 2001

- Episode length fell in each setting
- High-cost states had the greatest declines
- Post-discharge care fell most for patients with low probability of use
- Community-referred home health fell most for individuals with lowest probability of use