

*Turning Challenge into Opportunity:
What Home Care Needs to Know About
Medicare Advantage*



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INTRODUCTION

The growth of Medicare Advantage as a payment source for an increasing percentage of the Medicare population has resulted in a myriad of challenges for the home health industry. Among these are confusing paperwork, low payments, issues with bad debt, restrictive practices regarding visits and plans of care, higher billing and collection costs and slow payment. In light of these challenges, it's critical that home health providers are armed with:

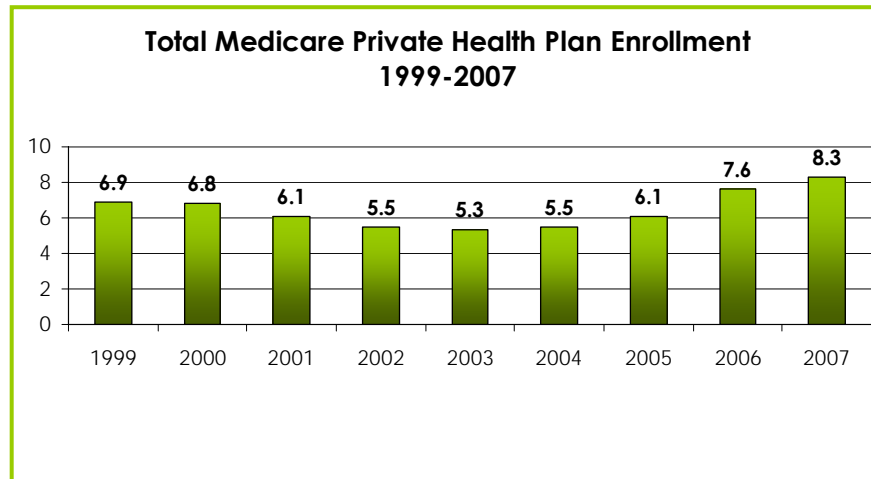
- Knowledge about history of Medicare Advantage plans and how they view risk
- Understanding of the risk associated with the growing percentage of Medicare beneficiaries enrolling in Medicare Advantage plans
- Insight into the trends in case mix, utilization, and outcomes of the Medicare Advantage patient population receiving home health services
- Tools to demonstrate to Medicare Advantage plans how the evolving risk associated with their enrollees can be mitigated by more fully utilizing home health services under improved contract terms and less restrictive practices

Medicare Advantage — An Overview

Inception. In 1982, TEFRA legislation authorized Medicare HMOs—which became operational in 1985. At that time, the program was intended to manage care for Medicare beneficiaries more effectively and to save Medicare money. The programs were modified through the years—adjusting payment methods and introducing more choice for seniors. In 2003, the Medicare Modernization Act (MMA) significantly boosted payments to private managed care providers, resulting in significant growth of the program.

Growth. Participation and enrollment in these Medicare managed care plans—now called Medicare Advantage (MA)—have fluctuated over the past decade. As depicted in the chart below, over the past several years, the program has seen a rapid rise in both the number of plans and the number of enrollees. Though most of the elderly and disabled people on Medicare still have their health bills paid by the traditional fee-for-service program; 18 percent now get their Medicare benefits through MA plans. This market penetration varies regionally, with some states experiencing a MA enrollment of 30 percent or more among their Medicare population, compared to as low as 3 percent in other states. Medicare enrollees in these private health plans increased from 5.3 million in 2003 to 8.3 million as of June 2007.

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Note: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, Cost contracts, Demonstrations, HCPP, and PACE contracts.

Source: Mathematica Policy Research, Inc. "Tracking Medicare Health and Prescription Drug Plans Monthly Report" December 1999-2006. CMS Monthly Summary Report, February 2007.

Challenges. Medicare Advantage plans are funded by Medicare but the design and administration are carried out by private-sector insurers. An Advantage plan must offer at least the same benefits to the beneficiary as traditional Medicare but may offer better benefits as well. However, though the plans are reimbursed by Medicare, they have great freedom with regard to the way in which they can and do contract with health care providers. Thus, few home health providers are paid for 60-day episodes of care through MA Plans—though this is the payment mechanism for traditional Medicare. From a provider's perspective, another major difference between MA and traditional Medicare is that traditional Medicare offers uniform reimbursement, benefits, payment processes, and paperwork regardless of beneficiary residence or provider location. In contrast, MA programs have extreme variation both within and across markets with regard to these aspects of coverage.

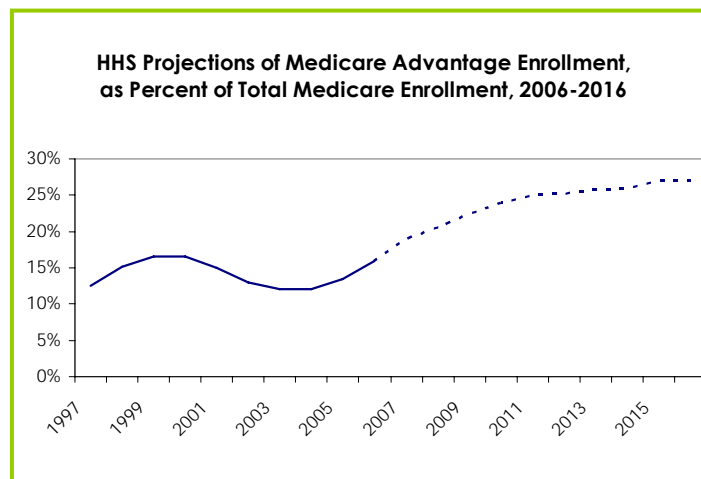
For example, recent data from the Kaiser Family Foundation illustrated differences between MA plans in one zip code in Oakland, California. Analysis of 22 different MA plans serving that area showed premiums for MA plans that ranged from \$0 to \$99 per month. Coverage for inpatient care varied widely, as did skilled nursing facility coverage. Of concern to home health providers is that some of the plans included up to 10 percent co-pays for home health.

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Aside from working with multiple payors with different rules, paperwork and payment models, the other challenge for home health providers is that MA plans typically focus time and attention on the providers associated with the highest costs—generally hospitals and physicians. Little attention has historically been paid to the home health provider market. Without an understanding of the positive impact of home health on overall beneficiary outcomes and cost, MA plans employ cost containment measures and operational practices that create challenges for home health providers developing an overall treatment plan for a patient’s episode of care.

■ Evolving Patient Mix Carries Risk for Medicare Advantage Plans

There is little doubt that the number of Medicare beneficiaries will dramatically increase over the next decade as baby-boomers age. Projections from the U.S. Department of Health and Human Services (HHS) and from the Congressional Budget Office (CBO) also suggest that we will see a substantial increase in the percent of Medicare beneficiaries enrolled in Medicare Advantage plans by 2013, with estimates ranging from 20 percent to 30 percent.



Source: Centers for Medicare and Medicaid Services, 2007 Medicare Trustees Report Table IV.B6

Chronic Conditions. Current data makes clear that this growing population will have multiple chronic conditions and will therefore constitute a huge risk for the plans in terms of health care utilization and expense. According to analysis of the Medicare Current Beneficiary Survey (MCBS), nearly 90 percent of Medicare beneficiaries reported having one or more

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chronic conditions. Underscoring the risk associated with caring for a population with chronic conditions, Medicare benefit payments were \$295 billion in 2004—accounting for almost one-fifth of the \$1.4 trillion in national personal health care expenditures.

These elderly, chronically ill patients will represent challenges for MA Plans—many of which had previously focused on younger, employed populations. Plans will need to identify and employ strategies to help beneficiaries manage their chronic conditions and avoid unnecessary (and costly) hospitalizations and emergent care.

Lapses in Quality. At the same time, recent studies have raised questions about the quality of the Medicare Advantage Plans that have recently entered the market. At a November 9, 2007 Medicare Payment Advisory Commission meeting, officials expressed concern about recently released quality data showing differences among the newer Medicare Advantage plans.

Trends Among Medicare Advantage Patient Population in Home Health

Despite issues and challenges with the recently-announced changes to the prospective payment system (PPS), traditional Medicare does ensure continuous home health care for a 60-day episode of care. Those episodic payments allow providers to create and follow evidence-based best practices for chronic care management, medication management and other aspects of patient care. In contrast, MA plans typically authorize a few visits at a time—a practice frustrating to homecare providers offering ongoing care.

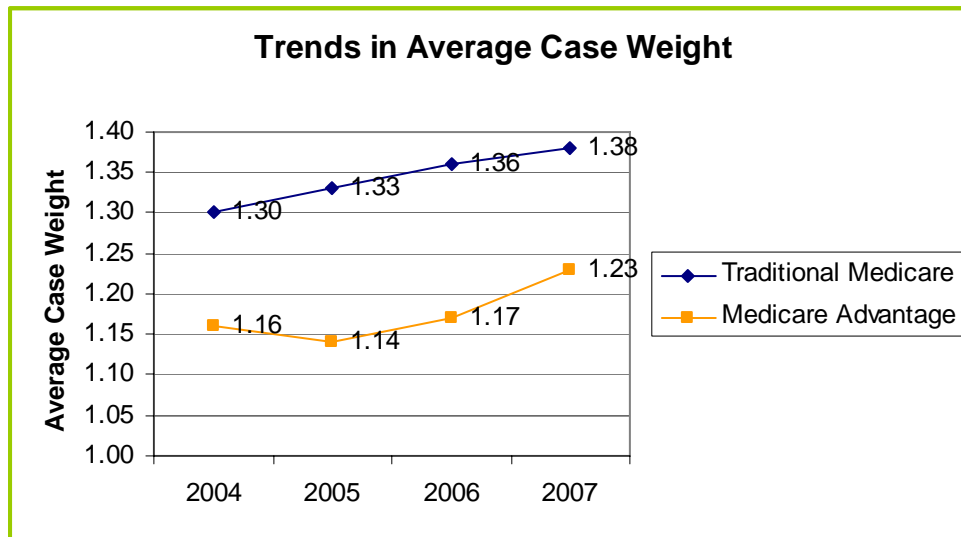
Literature searches show little academic research around Medicare Advantage in the home health market. Studies within home care from the mid to late 1990s offer conflicting evidence on whether Medicare Advantage coverage is associated with lower utilization, lower costs, and lower quality outcomes among enrollees as compared to enrollees covered by traditional Medicare.

There is data, however, on recent trends in Medicare Advantage as compared to traditional Medicare. An analysis of over 3.4 million patient episodes from OCS' proprietary home health data warehouse provides insight into the underlying patient populations and utilization patterns.

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Case Mix. In the first half of 2007, MA patients accounted for 15.4 percent of all episodes in the OCS data warehouse, up from 12 percent in 2004; mirroring the growth in MA plans seen across health care settings during this time. Following a steady increase in the percentage of minority MA beneficiaries receiving home care, the demographics of the MA and traditional Medicare patient populations now look fairly similar with regard to average patient age, gender, ethnicity and risk factors.

Since 2004, similar to traditional Medicare patients, there has been a consistent increase in the percentage of MA patients experiencing a number of troubling characteristics: poor overall prognosis, guarded rehab prognosis, life expectancy 6 months or fewer, and conditions prior to medical or treatment change. These trends coupled with a consistent increase in average case weight experienced by both traditional Medicare patients and MA patients suggest a creep in elevated risk for poor outcomes and increased spending among Medicare beneficiaries.

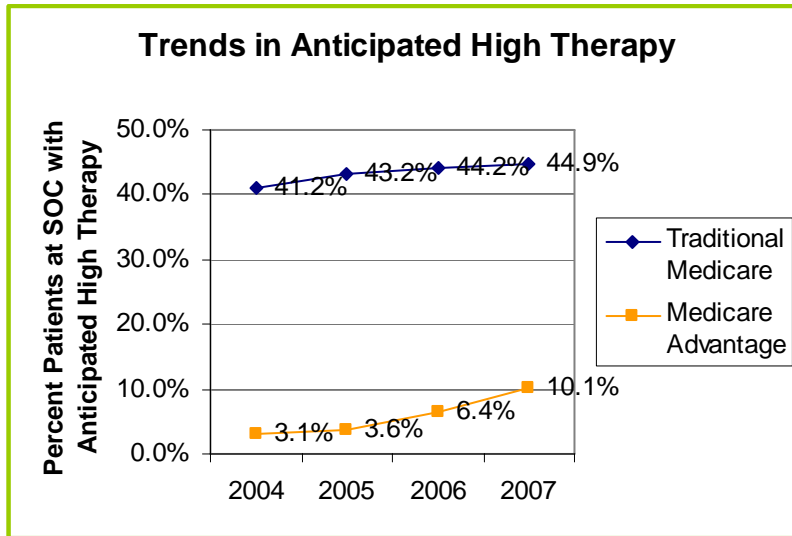


Source: OCS, Inc. Home Health Proprietary Data Base 2004-2007

Although increase in case weight has been experienced by both traditional Medicare patients and MA patients, it must be noted that the average case weight value for MA patients has been consistently lower. In 2007 it was, 1.23 compared to 1.38 for traditional Medicare patients. This difference may, in part, be explained by the dramatic difference between the groups regarding the anticipated need for 10+ therapy visits at start of care

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(SOC)—a key driver in the current PPS case weight calculation. In 2007, the percentage of patients projected to need 10+ therapy visits was 10.1 percent for MA patients compared to 44.9 percent for traditional Medicare.

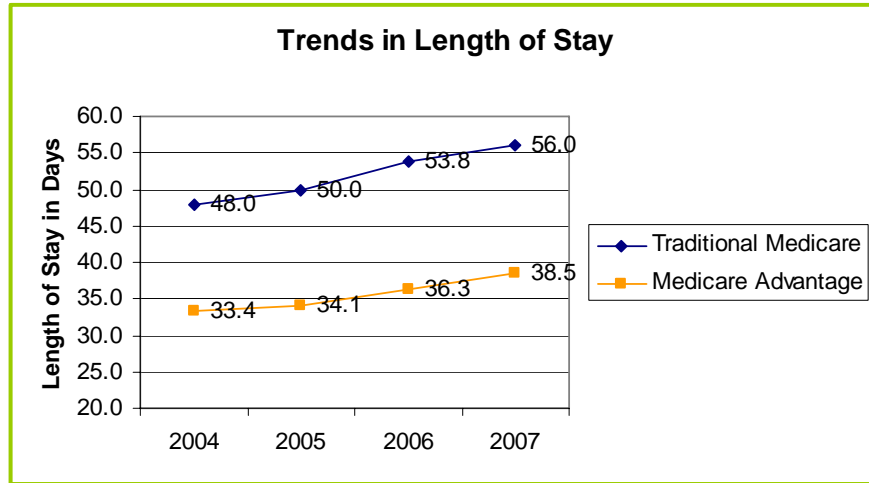


Source: OCS, Inc. Home Health Proprietary Data Base 2004-2007

What remains less clear is to what degree the difference in anticipated therapy between the two groups reflects—an actual difference in case mix resource needs or if it more closely reflects the reality faced by home health providers in grappling with MA plans restrictive practices regarding visits.

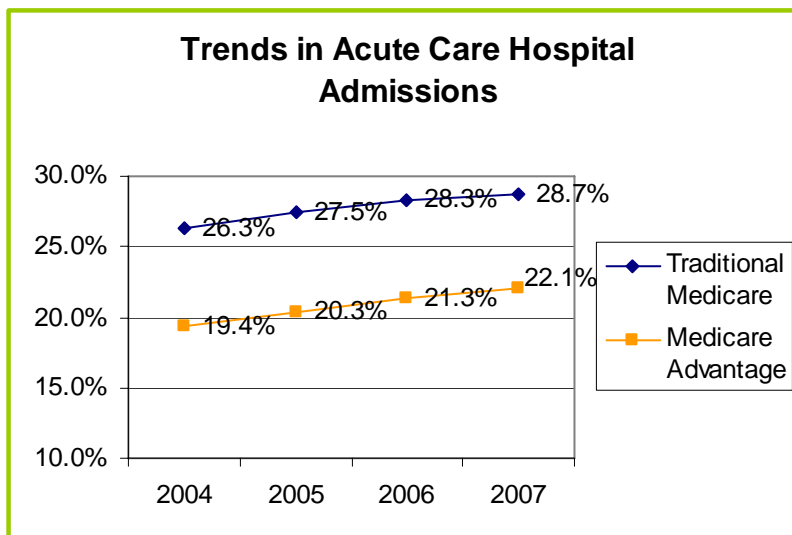
Utilization In terms of utilization, during the last three years, there has been a steady increase among the MA patient population in terms of length of stay and acute care hospitalization—an increase also experienced by traditional Medicare patients. For example, the chart below illustrates the trends and differences in home health length of stay. Both groups experienced consistent increases in average home health length of stay from 2004 through the first half of 2007. However the traditional Medicare length of stay was 45 percent higher than MA.

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Source: OCS, Inc. Home Health Proprietary Data Base 2004-2007

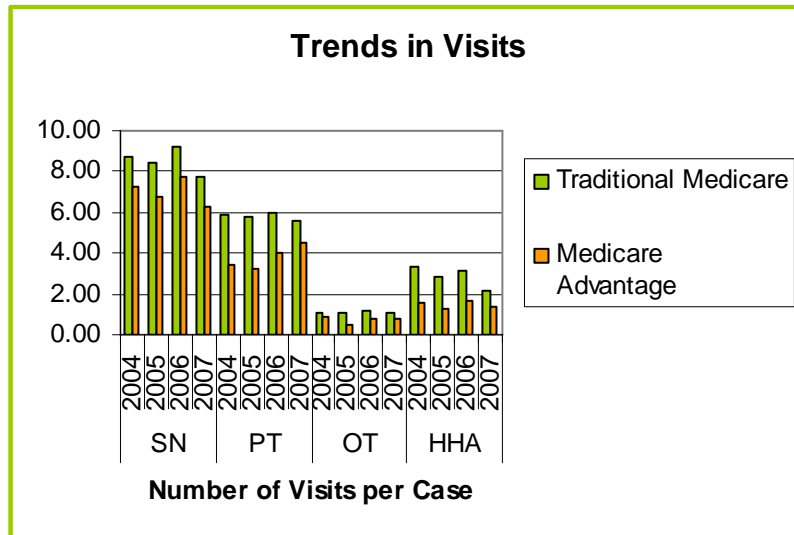
Trends in the rate of acute care hospital admissions are also similar between the two groups. While there has been a consistent increase in the average rate from 2004 to the first half of 2007, the traditional Medicare rate has remained consistently higher.



Source: OCS, Inc. Home Health Proprietary Data Base 2004-2007

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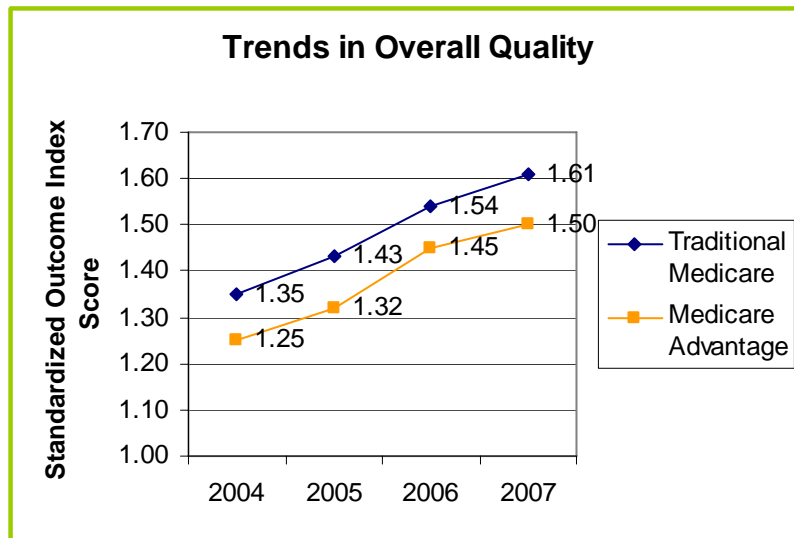
When evaluating trends in utilization by number of visits provided by home health providers, there has been a decrease in number of skilled nursing visits received by MA patients, an increase in the number of physical therapy visits and little to no variation in the visits provided by other types of clinicians. Traditional Medicare patients during this time frame, in contrast, experienced a decrease in both skilled nursing and home health aid visits and little or no variation in visits provided by therapist or other clinicians.



Source: OCS, Inc. Home Health Proprietary Data Base 2004-2007

Outcomes. Despite the evolving risk of the MA population reflected by the trends in case mix and increased utilization, trends in quality outcomes for MA patients, as measured by a composite measure of quality outcomes and depicted in the graph below, have simultaneously increased year over year.

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Source: OCS, Inc. Home Health Proprietary Data Base 2004-2007

A closer inspection of trends in individual outcome measures also show that with the exception of improvement in status of surgical wound and improvement in urinary incontinence, MA patients have achieved higher and higher rates of improvement in clinical outcomes and in outcomes related to activities of daily living since 2004.

However, despite gains in outcomes over the past 4 years, it is important to note that MA patients have consistently experienced lower overall outcomes than traditional Medicare patients during the same time frames.

Tools Needed to Demonstrate The Value of Home Care to Managed Care Plans

MA plans and the challenges they present to home health providers are not going away any time soon. Rather, as the Medicare population is growing, so is the percentage of individuals that are choosing to enroll in MA plans and the number of plans they have to choose from.

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A look at the trends in case mix, utilization, outcomes since 2004 of home health patients covered by MA plans suggest a consistent creep in case weight, length of stay, acute care hospital admission rates, and overall outcomes, similar to that experienced by traditional Medicare patients. Although an increase in overall quality over the years at first blush appears good news, it is important to note that MA patients have consistently achieved a lower overall quality outcome compared to traditional Medicare patients. In light of the concern recently voiced by MedPAC over a lapse in quality delivered by newer MA plans in the market, this gap warrants attention and monitoring. Furthermore, extreme differences between percent LUPA episodes and anticipated high therapy at start of care suggest some of the challenges in how home health providers must approach developing care plans for MA patients due to practice restriction regarding visit authorization.

Rather than arguing about whether MA plans or traditional Medicare coverage is better for patients or the national health economy, assuming that Medicare Advantage will continue to grow as predicted—covering more than 50 percent of Medicare beneficiaries in many markets, home health providers would be wise to accept the reality of MA plans and to seek out tools and strategies to reduce the challenges they present. In particular, home health providers would benefit from tools that help them educate MA plans about the value of more fully utilizing the home health care setting to offset costs in other higher cost healthcare settings, such as hospitals—and the skill to use these tools to negotiate improved contract terms with less restrictive practices.

Objective research to discern the impact of home health on overall Medicare spending, outcomes and patient satisfaction—especially findings that suggest increased home health utilization reduces overall spending—would go a long way toward offering home health providers evidence by which to negotiate contracts with improved rates and less restriction. Such evidence would underscore for MA plans that there's no financial benefit to ratcheting down home health care, but that home care can serve as a means of addressing the MA plan's most pressing problem of cost containment as they grapple with our nation's chronic and elderly population.

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Biographies

Amanda Twiss

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With more than 20 years of experience in medical information software and outcomes analysis, Amanda Twiss became President of OCS in 1997. Prior to joining OCS, Amanda was a founder of another successful Washington-based healthcare technology organization—HBSI. During her tenure as the Senior Vice President, HBSI grew from a start-up company to a successful hospital information company with more than 700 customers and 200+ employees.

Amanda has also served as the Director of Strategic Planning at Health Northeast, Inc.; Senior Planner for Long Term Care at the Central MA Health Systems Agency; and Government Relations Liaison with the Massachusetts Hospital Association. Amanda is a frequent speaker at national conferences in the areas of outcome information, provider profiling and benchmarking. She holds a degree in Health Administration and Planning from the University of New Hampshire.

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Tina Schwien is a registered nurse with 15 years experience that includes staff nursing, clinical trial coordination and health policy research for the U.S. Government Accounting Office (GAO). She completed undergraduate work at Whitman College where she earned a BA in Sociology and at the Johns Hopkins University where she earned a BSN in Nursing. Her graduate degrees include both MN and MPH degrees from the University of Washington.

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