

# Is This as Good as It Gets?

## *The False Promise of Risk-Based Medicare and For-Profit Dominance of Care*

by William D. Cabin, PhD, JD, MPH, MSW

Up until 1980, home-health agencies were excluded from receiving Medicare funding. Since the reversal of the prohibition and later institution of a risk-based managed-care model, there has been a surge of for-profits into the home-health/nursing-home/hospice field. Proponents of the managed-care model promised increased quality and decreased cost—but research is showing that the very opposite is true.

UNTIL 1980, FOR-PROFIT HOME-HEALTH AGENCIES were not allowed to receive Medicare funding. For-profits were originally excluded because home health was viewed as originating from a voluntary and public health-sector environment. By 1980, the

free-market model in health insurance had shifted significantly—to a managed-care model building on the work of Dr. Paul Ellwood and the beginnings of the Medicare managed-care benefit. In 2000, a risk-based managed-care model of reimbursement was instituted. Since then, the growth of for-profits among nursing homes, hospices, and home health-care has been nothing short of explosive. A number of pieces of research indicate that for-profits in these fields tend to create increased costs for the taxpayer and provide a reduced quality of care.

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Evidence of the risk-based model’s failure to meet the promise of managed-care pioneers to simultaneously increase quality and decrease costs for Medicare patients, compared to the Medicare fee-for-service (FFS) model, has been mounting for years.<sup>1</sup> In a separate though related development, the Medicare risk-based models have been accompanied by a rapid, significant dominance of for-profit providers—particularly among Medicare’s two largest post-acute care providers, home health and hospice—a result of which has been significant cost increases, with for-profit profit margins significantly exceeding those of nonprofits. A second result has been data raising significant questions as to whether for-profit-managed post-acute care providers deliver quality care at least equal to that delivered by nonprofits, with new data in Medicare home health indicating that for-profits provide lower-quality care at higher costs while garnering higher profit margins.<sup>2</sup>

This article examines the evidence Congress has ignored both at the broad level and—more specifically—at the level of home health and hospice, and the implications as we enter the Affordable Care Act era.

### The False Promise of Market-Based, Medicare Managed Care

Dr. Ellwood and other managed-care pioneers asserted, beginning in the 1960s, that the managed-care model used by commercial health insurers was successful in reducing costs and increasing quality of care, and should be adopted by Medicare.<sup>3</sup> However, the commercial populations, unlike Medicare, catered to young, middle-class or higher-income-level single adults and families with children, all with limited health risks.<sup>4</sup> But others criticized the use of managed care and privatization in health-care as ultimately more costly and less focused on patient care than the publicly operated programs, which are without profit incentives and are not privately owned.<sup>5</sup>

Nevertheless, in 1973 Congress began phasing in what is now called “Medicare Part C,” or “Medicare Advantage,” believing it would decrease Medicare costs.<sup>6</sup> Medicare Part C enrollment

has been increasing steadily from 6.9 percent in 1999 to approximately 15.7 percent of all Medicare beneficiaries in 2014.<sup>7</sup> However, the Part C plans have been found to cost approximately 10 percent more per Medicare beneficiary compared to Medicare FFS programs.<sup>8</sup> A recent National Bureau of Economic Research study indicates that the Medicare program has attempted to limit the increasing costs of Medicare Part C providers via changes to the risk factors included in the risk-based reimbursement formula.<sup>9</sup> The Part C providers mastered the adjusted formulas to maintain or increase profits. The Center for Public Integrity has presented evidence of Medicare Part C providers’ questionable billing practices, including questionable coding decisions to maximize reimbursement under the risk-based formula.<sup>10</sup> Another study has examined the quality of outcomes in Medicare Part C compared to Medicare FFS beneficiaries and concluded that the issue has not been well studied but that what study there is shows some limited, preliminary evidence that Medicare Part C may be less costly, depending on the methodology used.<sup>11</sup>

In addition to literature on the Medicare Part C program, there is substantial literature generally on for-profit quality-of-care performance and costs compared to that of nonprofits. The literature is particularly relevant to examination of post-acute care providers where for-profit care provision using risk-based models dominates. Studies of hospitals, health maintenance organizations, nursing homes, hospices, and dialysis providers have found that investor ownership is associated with lower quality and, where hospitals are concerned, higher costs.<sup>12</sup> In fact, after comparing performance differences—cost/efficiency, quality, access, amount of charity care, etc.—between private for-profit and private nonprofit U.S. healthcare providers, based on 149 studies of multiple relevant databases since 1980, Pauline V. Rosenau and Stephen H. Linder asserted, “Caution is warranted on policies that encourage private for-profit entities to replace private nonprofit providers of health care services in the United States.”<sup>13</sup>

## Medicare Home Health

The Medicare home health prospective payment system (PPS) took effect in October of 2000, instituting a managed-care risk-based model using home health resource groups (HHRGs). The HHRGs were based on twenty-plus elements from a national home health assessment instrument, Outcome and Assessment Information Set (OASIS), to reimburse for sixty-day episodes.<sup>14</sup> Much like the earlier diagnosis-related groups (DRGs) for Medicare inpatient care, the provider took the risk per episode for costs being above or below the reimbursement rate, creating the potential for profit or loss. Home health agencies began using OASIS in 1999. Beginning in 2003, the Centers for Medicare and Medicaid Services used multiple OASIS-based elements to create a nationally mandated set of quality indicators in the publicly available Home Health Compare (HHC) database and website.<sup>15</sup> The number of OASIS-based elements included in HHC expanded several times. Currently, HHC uses twenty-three elements for quality scoring. The data is updated quarterly, reflecting the prior twelve months. Consumers are encouraged to comparison shop HHC in their geographic area by reviewing agencies' quality scores when selecting a provider.

But Medicare home health expenditures have risen sharply since the inception of Medicare's risk-based prospective payment system (PPS): from \$8.5 billion in 2000 to \$18 billion in 2012—a 113 percent increase.<sup>16</sup> And home health is a major driver of geographic variation in Medicare service utilization.<sup>17</sup>

Investor ownership of home health agencies has grown rapidly, with for-profits accounting for 62 percent of all agencies in 2010.<sup>18</sup> The growth is significant—especially since historically, nonprofits and government agencies dominated home health, and for-profits were prohibited from owning Medicare-certified home health agencies until 1980. Medicare home health agencies have garnered significant profits under PPS, averaging 19.4 percent of revenues across all agencies in 2010—the second highest profit rate among all Medicare provider types.<sup>19</sup> Proprietary agencies' average annual profit

margin, 20.7 percent, is about 35 percent higher than the nonprofit average.<sup>20</sup>

A 2011 investigation by the Senate Finance Committee suggested that some proprietary agencies may have gamed PPS to increase profitability, possibly employing fraudulent means.<sup>21</sup> The Affordable Care Act of 2010 expanded Medicare's authority to stop payment for suspect or fraudulent home health services.<sup>22</sup>

In the aforementioned study I coauthored in 2014, my colleagues and I analyzed national cost and case-mix-adjusted quality outcomes from 2011 from over seven thousand Medicare-certified home health agencies to assess the performance of for-profit and nonprofit agencies. The data came from Medicare cost reports merged with data from Medicare's HHC quality outcomes database. Proprietary agencies scored slightly—but significantly—worse on overall quality and on three of the four quality subcategories, including patient hospitalization (28.4 percent versus 26.5 percent at nonprofit agencies). Quality measures were lowest in the South, where for-profits predominate. Proprietary agencies also had higher costs per patient (\$4,827 versus \$4,075 at nonprofits), were more profitable, and had higher administrative costs. Our findings raise further concern about Medicare's increasing reliance on for-profit agencies and the efficiency of its market-oriented, risk-based home care payment system.<sup>23</sup>

Further concern for home health quality performance exists in data from the Medicare Payment Advisory Commission (MedPAC). MedPAC has looked at average home health quality and found “quality measures appear to be steady for home health care on most measures.”<sup>24</sup> However, steady is not impressive. Home health performance has not displayed significant increases on most functional measures since 2007, and has not improved on the two adverse event measures (emergent care use and hospitalization) since 2004. MedPAC reported in 2014 that quality “measures either held steady or improved slightly [by 1–2 percent] in 2012 and 2013.”<sup>25</sup>

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increases for improvements in functional measures: walking (36 percent to 55 percent); transferring (50 percent to 53 percent); bathing (59 percent to 64 percent); medication management (37 percent to 46 percent); and pain management (59 percent to 66 percent). In another MedPAC analysis, emergent care use (where a lower score is better) was 21 percent in 2004 and 22 percent in 2010, and relatively stable each year in between. Hospitalization (how often home health patients had to be admitted to the hospital, also where a lower score is better) was similar, at 28 percent in 2004 and 29 percent in 2010, and also relatively stable in between.<sup>26</sup> The hospitalization rate is important because of the high Medicare costs of rehospitalizations and Medicare's efforts to control such costs.<sup>27</sup>

### The Hospice Medicare Benefit

The Hospice Medicare Benefit (HMB) was legislated in 1982, creating a risk-based model with four levels of care, each with a fixed per diem rate regardless of utilization per day.<sup>28</sup> The legislative goal was to simultaneously reduce Medicare end-of-life costs, primarily attributable to inpatient hospital stays, and improve patient end-of-life quality.<sup>29</sup> Unlike Medicare home health agencies, hospitals, and nursing homes, Medicare has not created a standardized, national, publicly available quality outcomes database for Medicare hospices, thus limiting research on comparative quality-outcome effectiveness of Medicare hospices.

Medicare hospice expenditures have risen sharply since HMB's inception, from \$205 million in 1989 to \$13.8 billion in 2011. Investor ownership of home health agencies has grown rapidly, with for-profits more than tripling their growth between 2000 and 2011, resulting in for-profits accounting for 57 percent of all Medicare hospices in 2011 compared to 30 percent in 2000.<sup>30</sup> This represents a significant shift in hospice ownership, which was dominated by nonprofits pre-HMB and in the early years of HMB. In 1995, for example, nonprofits represented 72 percent of all Medicare-certified hospices, compared to 43 percent in 2011. Medicare

hospices have garnered significant profits, averaging 7.5 percent of revenues across all agencies in 2010. However, proprietary agencies' average annual profit margins far exceed nonprofits, with for-profits' 2010 average profit margin at 12.4 percent, compared to 3.2 percent for nonprofits.<sup>31</sup> At the same time, there is some evidence that for-profit hospices are more costly than nonprofits. In 2010, for example, the average cost of a Medicare hospice beneficiary who died while in hospice was \$13,130, compared to \$10,990 for those in a nonprofit—a \$2,140 per beneficiary, or 15 percent, difference.<sup>32</sup>

Some studies indicate that the HMB may significantly reduce government expenditures<sup>33</sup> and improve quality of life.<sup>34</sup> There is also evidence that enhanced home-based hospice programs may save private insurers costs and improve patient and caregiver outcomes.<sup>35</sup> However, other studies, albeit limited, indicate that there may be a significant difference in the quality performance of the more costly, high-profit-margin for-profit Medicare hospices compared to nonprofits: Melissa D. A. Carlson, William T. Gallo, and Elizabeth H. Bradley used an organized logistics models method on a sample of 422 hospices nationwide, finding that patients in for-profits received “a significantly narrower range of services . . . than patients of non-profit hospices”—raising concerns about “the potential impact of profit status on the care their patients receive”;<sup>36</sup> Richard C. Lindrooth and Burton A. Weisbrod quantitatively analyzed national HMB admissions data, finding that “for-profit hospices are significantly less likely to admit patients with shorter, less profitable expected lengths of stay”;<sup>37</sup> and, while not specifically addressing quality, Melissa W. Wachterman, Edward R. Marcantonio, Roger B. Davis, and Ellen P. McCarty, in a study of 4,705 patients discharged from hospice, concluded, “Compared with nonprofit hospice agencies, for-profit hospice agencies had a higher percentage of patients with diagnoses associated with lower-skilled needs and longer lengths of stay”—further raising questions about for-profit higher costs while targeting patients with low-skilled needs.<sup>38</sup>

## Policy Implications

The evidence seems overwhelming that managed-care Medicare should not be as good as it gets for Medicare beneficiaries and taxpayers. There seems to be more than a reasonable amount of data supporting the adverse economic and patient-care effects of maintaining the current for-profit risk-based system—at least insofar as concern Medicare home health and hospice care. The data from these two programs should also prompt concern for other Medicare provider types displaying similar patterns, such as Medicare nursing homes. Medicare imposed a managed-care model on nursing homes in July 1998. Currently, 70 percent of Medicare nursing homes are for-profit, with a 2012 profit margin of 16.1 percent, compared to 5.4 percent for non-profits.<sup>39</sup> There should also be concern for the Medicaid program, which had over 74 percent of its enrollees in managed-care plans as of 2011, and is the focus of expansion under the Affordable Care Act.<sup>40</sup>

Is such data not sufficient to prompt Congress to review the current models? A great deal of time and energy has been and continues to be spent on hearings and legislative challenges to the Affordable Care Act. Much of this activity is based on tenuous projections about economic impact. In the meantime, the Medicare program, often criticized by Congress for cost concerns, seems headed in the wrong direction, with Congress paying no attention to evidence that seriously challenges the worthiness of the risk-based models and for-profit dominance.

### NOTES

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