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Medicare Home Health Care in Rural America

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Overview

The past decade has brought many changes to the home health care industry, largely as a result of Medicare policy changes. These policy reforms include a new payment system, eligibility restrictions, and stringent fraud and abuse enforcement. In addition, Medicare now pays for home health care based on the location of the beneficiary, not the agency. To examine the impact of these changes on access to care, we evaluated the degree to which beneficiaries are served by agencies outside of their county. We constructed an analytical file by linking the 1997 five percent Medicare Standard Analytical File home health claims file to the Provider of Services file to obtain the characteristics of the beneficiaries' primary agency. This beneficiary-level analytical file included information on 162,241 Medicare home health users – including 43,488 rural residents – of 9,410 home health agencies. We examined the characteristics of rural beneficiaries served by urban agencies as compared with those served by rural agencies. Our findings demonstrate that urban agencies – either directly or through their branch offices – play an important role in providing home health care to rural Medicare beneficiaries.

Study Methods

Beneficiary information was linked to agency information for the beneficiary's primary home health agency. Approximately 6 percent of Medicare beneficiaries were served by more than one home health agency. In this case, we used the agency that furnished the most care to the beneficiary. Beneficiary characteristics include age, race (white or non-white), sex, diagnosis category, and geographic location. Agency characteristics include ownership, hospital-based or freestanding status, operation of branch offices, and geographic location. While we were able to ascertain if an agency operated branch offices, the location of those

branch offices could not be determined. Agencies operate branch offices that are distant from the parent office, in some cases hundreds of miles from the home office. Therefore, we may have identified a beneficiary as being served by an urban agency when she was actually served by a rural branch office of an urban agency. We compared aspects of rural and urban Medicare home health use and highlight those differences that are statistically significant and meaningfully different.

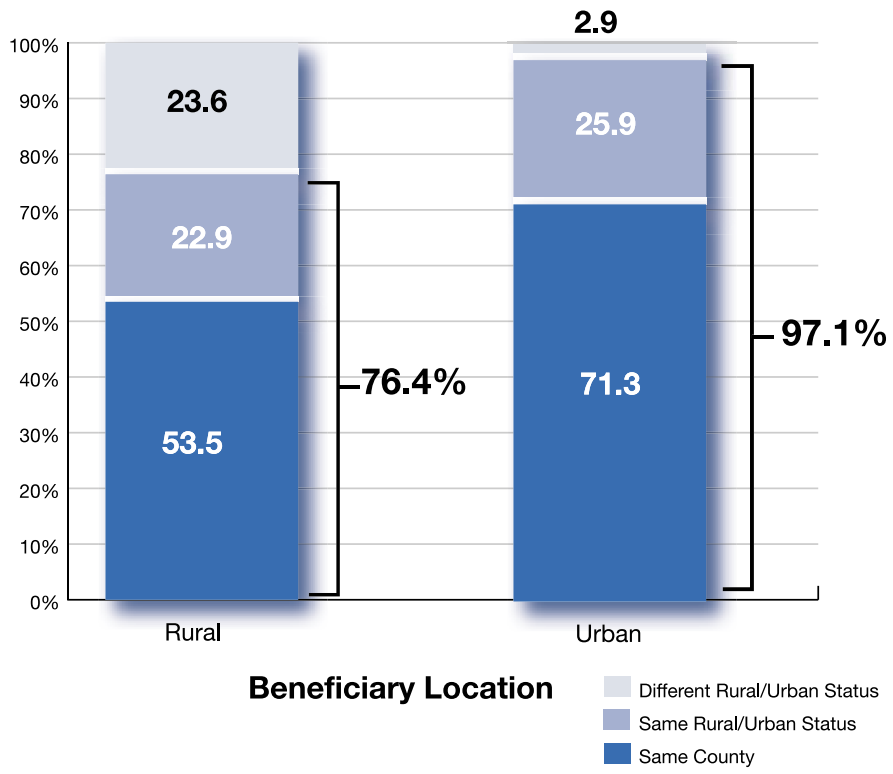
Key Findings

Most home health users were served by an agency in their home county – 54 percent of rural residents and 71 percent of urban residents – or a county with the same rural/urban status as their home county. One-quarter of rural home care users were served by an urban agency (or the branch office of an urban agency), while only 3 percent of urban residents were served by rural agencies.

We examined differences between rural home care users served by urban agencies and those served by rural agencies (*see Table*). Younger Medicare beneficiaries (aged 65 to 74) were more likely to be served by an urban agency while older beneficiaries (aged 85 and older) were more likely to be served by a rural agency. Non-white rural beneficiaries were more likely to be served by an urban agency than white beneficiaries. Rural Medicare home health users served by an urban agency were more likely to receive therapy services than those served by rural agencies. Not surprisingly, rural residents living adjacent to a metropolitan area were more likely to receive care from an urban home health agency than those living in counties not adjacent to a metropolitan area.

We examined characteristics of agencies serving rural home health users. Rural beneficiaries

Location of Home Health Agencies Serving Medicare Beneficiaries



Source: The NORC Walsh Center for Rural Health Analysis calculations using Medicare files

Note: Analysis is at the beneficiary level. Therefore, agencies serving more than one beneficiary may appear multiple times in the dataset.

Characteristics of Rural Medicare Home Health Users

	All	Received Care from: Urban Agency	Rural Agency
Total	100%	23.6%	76.4%
Age			
65-74	27.9%	30.2%	27.2%
75-84	44.2%	43.9%	44.3%
85 and older	27.9%	25.9%	28.5%
Race/Ethnicity			
White	88.4%	85.7%	89.2%
Non-white	11.6%	14.3%	10.8%
Ancillary Services			
Received Therapeutic Services	46.7%	51.6%	45.3%
Did Not Receive Therapeutic Services	53.2%	48.4%	54.7%
Urban Influence Codes			
Adjacent to a Large Metro Area and			
City of 10,000 or more	6.1%	6.7%	5.9%
No City of 10,000	4.9%	8.4%	3.8%
Adjacent to a Small Metro Area and			
City of 10,000 or more	16.8%	20.0%	15.8%
No City of 10,000	26.4%	42.1%	21.6%
Not Adjacent to a Metro Area and			
City of 10,000 or more	16.3%	7.5%	19.1%
Town of 2,500 to 9,999	21.4%	10.9%	24.7%
Totally Rural	8.1%	4.5%	9.2%

Source: The NORC Walsh Center for Rural Health Analysis calculations using Medicare files

Note: Analysis is at the beneficiary level. Therefore, agencies serving more than one beneficiary may appear multiple times in the dataset.

All urban-rural differences are statistically significant at the 0.001 level.

served by urban agencies were more likely to receive care from agencies operating branch offices (71 percent) than those served by rural agencies (45 percent). This suggests that some beneficiaries identified as served by urban agencies were actually served by the local branch offices of urban agencies. In addition, the urban agencies were more likely to be for-profit (58 percent compared with 33 percent of rural agencies) and freestanding (66 percent compared with 48 percent of rural agencies) than the rural agencies serving rural residents. Urban agencies in the Northeast and South played a greater role in caring for rural residents than urban agencies in the Midwest and West.

Discussion

The Medicare home health care industry has undergone radical changes in the past decade, including a new payment system and eligibility restrictions. These changes resulted in the closing of many home health agencies in the late 1990s. Agencies that closed were predominantly urban, for-profit, freestanding, and in the South – the same types of agencies that we found often serving rural residents. Because proportionately more urban agencies closed than rural agencies, access to care for rural beneficiaries was hypothesized to not be affected. However, this analysis found that urban agencies are an important source of home health care for rural Medicare beneficiaries.

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The home health industry appears to have adapted to the Medicare changes and stabilized in the last three years, but it is not known if urban agencies' willingness to treat rural home health users has changed since 1997, the year of our analysis. These findings serve as baseline estimates for future studies examining the impact of payment changes. In addition, they highlight the importance of considering the impact of Medicare changes on urban agencies when evaluating rural access to home care.

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The Walsh Center is part of the Department of Health Survey, Program, and Policy Research, NORC, a national organization for research at the University of Chicago. To obtain a copy of the full report or for more information about the Walsh Center and its publications, please contact:

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