REINSTATE AND MAKE PERMANENT THE ADD-ON FOR SERVICES TO RURAL PATIENTS; ENSURE CARE ACCESS FOR RURAL AND UNDERSERVED PATIENTS

ISSUE: The Balanced Budget Act of 1997 (BBA) made a number of dramatic changes in the Medicare home health benefit, including requiring that home health move to a prospective payment system (PPS) and imposition of an interim payment system (IPS) until PPS could be put in place. The stringent payment limits under IPS, which were in place from October 1997 through September 2000, reduced home health outlays far more than expected, resulting in widespread home health agency closures and problems for beneficiaries in obtaining access to care. While the Congress made some modifications to the changes to home health made by BBA, and implementation of the PPS in October 2000 has provided some stability to the industry, many agencies have remained financially strained.

Additionally, agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and paraprofessionals, and better integrate the use of technologies in agency operations. As a result, agencies may be forced to refuse admission to patients whose care costs would place an agency at financial risk; further, insufficient payments could create perverse incentives to place limits on care, affecting the overall health care outcomes of patients. The Congress had sufficient concerns about the impact of PPS on beneficiary access to care that, in late 1999, it requested a study from the Medicare Payment Advisory Commission (MedPAC) on the advisability of excluding rural home care providers from the PPS system altogether.

In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent add-on for care delivered in rural areas between April 2001 and April 2003. As part of H.R.1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Congress restored the rural add-on at a 5 percent rate for the April 2004 through March 2005 period. In early 2006, Congress approved legislation (S. 1932, Public Law 109-362) to provide a reinstatement of the 5 percent payment differential for calendar year 2006. During 2007 legislation was introduced that would reinstate the 5 percent rural add-on, and, as part of H.R. 3162, the full House of Representatives approved a two-year extension of the 5 percent rural add-on for 2008 and 2009, but no further action was taken. The 5 percent payment differential expired at the end of 2006.

RECOMMENDATIONS: Congress should restore and permanently extend the payment differential (“add-on”) for care delivered in rural areas. Congress must also closely monitor the home health PPS to ensure that individual case payments are sufficient to maintain access to care. If the system's payments are found to be insufficient, Congress should increase the home health base payment. Further, Congress should direct the Centers for Medicare & Medicaid Services (CMS) to develop a more adequate system of “outlier” payments under PPS so that high-cost patients will have continued access to services. Finally, Congress should monitor adequacy of PPS payments so that agencies in underserved areas (rural, inner city, medical shortage areas) can continue to provide care to Medicare beneficiaries.
RATIONALE: Under current policies, there is no guarantee that the individual Medicare payment rates will be sufficient to cover the costs of care, particularly for higher-cost patients. The system also provides very limited allowance for agency costs that exceed the national rates. However, some agencies have much higher costs due to higher case mix, travel time, the need to provide escort services, and the like. In order for the home health PPS to be successful, it must be sensitive to variations in the health care marketplace that contribute to extraordinary care delivery costs. Finally, in cases where sufficient justification is available, case mix adjustors should be increased to ensure adequate reimbursement for care.