



228 Seventh Street, SE
Washington, DC 20003-4306

Rate Rebasing in Medicare Home Health Services:

A Review of the 2014 HHPPS Proposed Rate Rule

Background

The Patient Protection and Affordable Care Act of 2010 (PPACA) requires that Medicare reset or rebase the home health services episode payment rate beginning in 2014 and phased-in proportionately over a four (4) year period. The legislative mandate provides some direction to Medicare on the factors required to be considered in the calculation of the rebased payment rate. Specifically, it provides:

“(I) IN GENERAL.—Subject to sub-clause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and free-standing agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

This provision requires that Medicare consider costs, but not use costs as the exclusive factors in the rate calculation. The Medicare Payment Advisory Commission (MedPAC), in deliberating its 2010 recommendation on the rebasing of home health payment rates, clearly stated that they did not support rates based solely on costs, recognizing a need for capital by home health agencies (<http://www.medpac.gov/transcripts/0108-0109MedPAC.fnal.pdf>. Pp. 203-207).

MedPAC recommended that home health services payment rates be rebased because of significant changes in the nature of the services provided during the 60 episode of care along with what it perceived to be “overpayments” for services evidenced by continuing double-digit Medicare margins in comparison to costs. The average episode of care in the base year used for rate setting involved 37 visits primarily made up of nursing and home health aide services while the current care utilization in an episode is less than 20 visits with few aide services and significantly more therapy visits. From 2001 through 2011, MedPAC’s calculation of margins shows freestanding HHAs with an average ranging from 16-18%.

On June 27, 2013, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that sets out the proposed rates for home health services in 2014 along with the methodology used by CMS in calculating such. <http://www.gpo.gov/fdsys/pkg/FR-2013-07-03/pdf/2013-15766.pdf>. While the proposed rule states that the impact on home health services spending would be a reduction of \$290 million in CY 2014, in actuality it is far greater as the proposal, if finalized, would trigger four consecutive years of 3.5% reductions in the primary payment rates, totaling a 14%

reduction by 2017. That level of rate cuts is estimated to reduce Medicare home health spending by well in excess of \$25 billion over the next ten years.

The proposed rule is open for the submission of written public comments through August 26, 2014. This White Paper offers a report on the makeup of the proposed rule, an impact analysis, and a critical review of its shortcomings.

The Proposed Rule

General

The CMS proposed rule combines a rebasing of the base-level rates for normal episodes, per visit payments for Low Utilization Payment Adjustment (LUPA) episodes, and the add-on payments for Non-Routine Supplies (NRS) along with a recalibration of the case-mix weights assigned to each of the categories within the case-mix adjuster. This presents a complication in an initial review as it makes the 2014 proposed rates seem much greater than the 2013 rates. However, the recalibration is proposed in a budget neutral manner by reducing each of the case-mix categories by 26.02%. (Alternatively, by dividing the case mix weights by 1.3517 which CMS states is the average weight in early 2012).

CMS chose to recalibrate the case mix weights so that the average weight is 1.0. This appears to be some sort of housekeeping action as it is not required under the law. To balance the recalibration with the payment rates, CMS increased those rates by 1.3517. This leads to some confusion when comparing the 2013 rates with the proposed 2014 rates.

Another factor to be considered is that CMS proposes to modify the case mix adjustment model slightly to remove certain diagnoses from having impact on the “scoring” of a patient. CMS suggests that two categories of codes are “too acute” to represent patients who can be cared for in a home health setting and likely represent the inpatient diagnostic code for the patient. Additional codes are proposed for removal on the basis that the condition would not require a home health intervention. Removal of these codes is estimated to drop the average case mix weight from 1.3517 to 1.3417 and reduce home health spending by 0.5% in 2014. However, CMS does not account for this adjustment either in the recalibration of the case mix weights or the payment rates.

The Proposed Rates

The proposed rates for 2014 reflect a 2.4 Market Basket Index adjustment to reflect estimate costs increases in 2014. In addition, these rates reflect a rebasing adjustment of -3.5% for episodes, +3.5% for per visit LUPA rates, and -2.58% for Non-Routine Supplies. The resulting rates are as follows:

CY 2014 Proposed 60-Day National,

Standardized 60-Day Episode Payment Amount: \$2,860.20

Proposed CY 2014 National Per-Visit Payment Amounts

2014 Per-Visit

Home Health Aide	\$54.91
Medical Social Services	194.34
Occupational Therapy	133.46
Physical Therapy	132.56
Skilled Nursing	121.23
Speech-Language Pathology	144.03

LUPA Add-on Amount, CY 2008. \$87.93

Proposed CY 2014 NRS Payment Amounts for HHAs That DO Submit the Required Quality Data

<u>Severity Level</u>	<u>Points</u>	<u>Weight</u>	<u>Payment Amount</u>
1.....	0	0.2698	\$14.53
2.....	1 to 14	0.9742	52.45
3.....	15 to 27	2.6712	143.82
4.....	28 to 48	3.9686	213.67
5.....	49 to 98	6.1198	329.49
6.....	99+	10.5254	566.69

Proposed CY 2014 NRS Conversion Factor \$53.84

As in recent years, payment amounts are increased by 3% for services provided in rural areas. In addition, rates are reduced by 2% for HHAs that do not comply with requirements to submit OASIS and HHCAPS quality data.

Finally, these rates are adjusted by the area wage index. CMS proposes to continue to use the pre-floor, pre-reclassification hospital wage index. CMS expects to adjust the wage index geographic areas consistent with the 2010 Census in CY 2015.

These rates are derived through the inclusion of the item-specific rebasing adjustment, removal of outlier payments, a wage index stabilization adjustment and the market basket index inflation update. Given that the episode rates do not account for the case mix adjuster recalibration, they appear much higher than 2013 (\$2138.52). The difference is addressed through significantly reduced case mix weights resulting in an overall decrease in episode rates in comparison to 2013. Effectively, the base rates are reduced by about 1% when standardized with the 2013 system. However, when adding the impact of the removal of certain ICD-9 codes from the HHPPS scoring system, it can be expected that 2014 revenues would be 1.5% lower for the same services in 2014 compared to 2013.

Outlier Payment

The proposed Outlier episode policy remains the same as in 2013. Under the Medicare law, outlier payments should not exceed 2.5% of total home health spending. Section 1895(b)(3)(C) of the Social Security Act. To meet that standard, CMS engages in a series of spending estimates and establishes a “loss-sharing ratio” and a “fixed dollar loss (FDL) ratio.” With the loss sharing ratio, Medicare pays the additional estimated costs of an episode of care at the ratio’s percentage for those costs above a threshold amount, the FDL. CMS proposes to continue to apply a loss-sharing ratio of .80.

In the past, CMS uses the FDL to address changes in outlier spending. The FDL in 2013 is 0.45. That was a change from 2012 (0.67) and allowed for a greater number of episodes to qualify for outlier payment.

In estimating spending in 2014, CMS notes that outlier payments in 2014 may only reach 1.82% of total home health payments. Normally, that would warrant a further reduction in the FDL to qualify more episodes for outlier payments. However, CMS has held off on such action, proposing to keep the FDL at 0.45, until it further evaluates the spending data.

CMS Rebasing Methodology

CMS fully outlines its rebasing methodology in the proposed rule. <http://www.gpo.gov/fdsys/pkg/FR-2013-07-03/html/2013-15766.htm>. Further, CMS issued a rebasing report prepared by its rebasing contractor, Abt Associates, which details how it constructed the calculation of average episode costs,

per visit, costs, and non-routine supply costs. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Analyses-in-Support-of-Rebasing-and-Updating-the-Medicare-Home-Health-Payment-Rates-Technical-Report.pdf>. Set out below is a summary of the rebasing methodology.

The calculation of average costs was done through the use of FYE 2011 cost reports. After extensive “trimming” of unusable or aberrant cost reports, Abt Associates used only 6252 cost reports out of the 10,327 available. Cost reports were eliminated from consideration because of the absence of cost or payment data, missing episode counts, “not settled” status, small size of provider, and other aberrancies.

The cost report database used by Abt included freestanding and hospital based HHAs.

The proposed rule references that CMS performed FYE 2011 cost report audits on 98 HHAs, but chose not to use the audit result findings. Those audits determined that approximately 8% of claimed costs should be disallowed for unspecified reasons. There is no indication that the audited HHAs were provided or afforded appeals rights on the findings. Since the initiation of HHPPS in October 2000, there have been no other known cost report audits for HHPPS years.

Episode Rate Rebasing Methodology

To determine its proposed 2014 episode payment base rate, CMS developed two separate calculations: estimated average payment per episode and estimated average cost per episode. The estimated average payment per episode was then compared to the estimated average cost per episode. The ratio of the difference to the payment calculation then represented the percent difference that would make up the rebasing adjustment. The CMS calculation shows that difference at 13.63%. In conformance with the method and limits set out in the rebasing law, CMS calculated the rate change required for a four-year phase in at 3.6%, but applied the 3.5% annual allowable adjustment limit.

The Proposed rule does not offer the mathematical calculation that CMS performed to divide 13.63 into four installments of 3.6. ($13.63/4=3.4075$).

Average cost methodology

The average episode cost calculation was performed by Abt Associates partly using the same methodology applied in the calculation of the original HHPPS episode base rate. Abt used cost reports from FYE 2011 to determine average weighted costs per visit by discipline. The per visit costs were then multiplied by the average visits per discipline within a non-LUPA episode. The estimated 2013 average cost per episode was then calculated by CMS by multiplying that calculation by the 2012 and 2013 Market Basket Index adjustments, 2.4 and 2.3 respectively. CMS displays this calculation as follows in the proposed rule:

2013 Estimated Cost Per Episode

2011 Estimated Cost Per Episode	Factor for 2011–2012 Visit Distribution Difference	2012 Market Basket Update	2013 Market Basket Update	2013 Estimated Cost Per Episode
\$2,453.71	× 0.9958	× 1.024	× 1.023	\$2,559.59

Payment per episode was calculated by CMS with an entirely different methodology. CMS took the base episode rate in 2012 (\$2138.52), multiplied it by the average case mix weight (1.3517), reduced it by the 2013 case mix creep adjustment (1.32), increased it by the 2013 rate update (1.3) and applied an outlier adjustment to remove the impact of outlier payments (.975). It is displayed as follows:

2013 Estimated Average Payment per Episode

2013 Estimated 2012 National, Standardized 60-Average Day Episode Payment Rate Payment Per Episode	Budget Neutrality Factor to Account for Case-Mix Weight Adjustment to 1.00	2013 Payment Reduction for Nominal Case-Mix Growth	2013 HH Payment Update Percentage	Outlier Adjustment
\$2,138.52	x 1.3517	x 0.9868	x 1.013	/ 0.975

The result is a calculation of the 2013 Estimated Average Payment at \$2,963.65.

In proposing the episode rate for 2014, CMS took the 2013 average episode payment:	\$2963.65
x 2014 rebasing Adjustment	x 0.9650
x Outlier Adjustment Factor	x 0.975
x Wage Index Standardization Factor	x 1.0017
x 2014 Market Basket Update	x 1.024
2014 Episode Base Rate	\$2860.20

LUPA Per Visit Rate Calculation Method

In calculating per visit LUPA rates, CMS used a different approach because the data showed that per visit costs are far in excess of the 2013 per visit rates, by as much as 133%. As a result, CMS proposes that 2014 per visit rates be capped at a 3.5% increase above what they would otherwise be. CMS proposes the cap, alleging that the law requires it to be applied to individual payment rate updates rather than to the rates in the aggregate (see discussion below).

The 2014 proposed LUPA rates starts with the per visit cost calculations made as part of the Abt Associates episode cost calculation. It then simply increases those results by 1.035 to represent the adjustment limit, applies the outlier adjustment of 0.975, a wage index budget neutrality adjustment of 1.00003 and a 1.024 HH Market Basket update.

Non-Routine Supplies (NRS)

CMS performed separate calculations of payment and costs on non-routine supplies (NRS). Abt calculated the average 2011 NRS per visit cost to be \$2.26 leading to an average episode cost for NRS at \$42.01 in 2011 and \$43.59 in 2013. Using 2012 claims data, CMS estimated the payment per episode at \$48.38. The difference between estimated payment and cost for NRS is 9.92% resulting in an annual 4-year reduction of 2.58%.

Impact of Proposed 2014 HHPPS Rates

CMS estimates that the overall impact of the proposed rate rebasing and other rate changes is a reduction in Medicare spending of \$290 million in 2014. That represents a decrease of approximately 1.5% in comparison to estimated 2013 payments.

The impact analysis provided by CMS in the proposed rule shows a somewhat disparate impact, in the aggregate, on HHAs depending upon type and geographic location. Freestanding, proprietary HHAs are estimated to have the greatest negative impact at a 1.7% year to year reduction in Medicare revenue between 2013 and 2014. Voluntary and Non-profit HHAs are estimated to experience a 0.8% reduction in revenue. Rural located HHAs are expected to have a 1.4% revenue reduction with urban HHAs at a 1.5% reduction. Mid Atlantic providers are estimated to have a 0.2% reduction with West South Central HHAs hit at 2.1%. Larger HHAs are estimated to see a 1.2% reduction while HHAs with 100-249 "first" episodes at 1.8%.

These data do not tell the real impact of the proposed rates for several reasons.

First, the CMS analysis does not look at all at the impact on access to care. It looks merely at Medicare payment amount changes. **Second**, the analysis is a one year impact assessment rather than the full four years of the rebasing action. The proposed rule has a 14% rate reduction in total over that period and the final decision on rebasing in 2014 affects all of those years. **Third**, the focus on payment amounts disregards the impact on HHA financial stability as it ignores that costs will increase in 2014 and later years. Rather than a \$290 million decrease in spending, it is a \$700 million decrease in the amount that would be spent in the absence of the proposed rate rebasing changes. CMS compares 2014 spending outcomes to 2013 to reach its projection. **Finally**, the impact analysis is in the gross aggregate rather than local where care is provided. As is detailed below, HHAs currently experience a wide range of financial outcomes with Medicare that is not reflected in the use of “averages.”

The impact analysis performed by NAHC demonstrates that the continued delivery of home health services throughout the country is at high risk if the proposed rule is finalized. NAHC estimates that by 2017, 72.29% of all HHAs will be paid less than the cost of care and that the average Medicare margin will be -9.77%. This estimate come by way of reviewing over 8,200 FYE 2011 cost reports from all types of HHAs from all over the country. In Alaska (91.7%), Hawaii (100%), New York (89.9%) and Oregon (87.2%) in can be expected that the entire home health infrastructure is at risk of crumbling to nothing. That is certain to lead to an access to care crisis and increased Medicare spending as patients seek care in the only viable option remaining: high cost care settings.

State	% of Agencies at or Below 0	Weighted Profit Margin
Alabama	32.2%	11.7%
Alaska	75.0%	-36.3%
Arizona	47.8%	1.1%
Arkansas	51.1%	-6.1%
California	60.6%	-2.7%
Colorado	42.2%	7.4%
Connecticut	28.6%	12.3%
Delaware	40.0%	3.8%
District of Columbia	40.0%	8.7%
Florida	47.9%	4.2%
Georgia	33.3%	12.2%
Guam	75.0%	-10.5%
Hawaii	77.8%	-18.2%
Idaho	56.4%	-5.7%
Illinois	54.1%	1.6%
Indiana	59.5%	-1.6%
Iowa	54.1%	-1.7%
Kansas	51.4%	4.3%
Kentucky	42.4%	9.4%
Louisiana	31.3%	10.4%
Maine	44.0%	-1.3%
Maryland	46.7%	4.1%
Massachusetts	37.4%	3.6%
Michigan	49.7%	-1.0%
Minnesota	47.8%	-3.4%
Mississippi	16.7%	9.2%
Missouri	53.6%	0.6%
Montana	72.4%	-7.1%

State	% of Agencies at or Below 0	Weighted Profit Margin
Nebraska	60.3%	3.5%
Nevada	55.4%	-2.9%
New Hampshire	37.9%	10.0%
New Jersey	47.6%	1.6%
New Mexico	59.3%	-2.1%
New York	77.3%	-24.3%
North Carolina	33.8%	9.6%
North Dakota	80.0%	-26.8%
Ohio	35.3%	8.7%
Oklahoma	52.3%	3.3%
Oregon	80.9%	-14.5%
Pennsylvania	36.7%	5.4%
Puerto Rico	57.1%	-0.1%
Rhode Island	19.1%	11.8%
South Carolina	43.6%	6.9%
South Dakota	48.4%	-4.4%
Tennessee	26.0%	13.6%
Texas	53.8%	0.9%
Utah	37.7%	-0.2%
Vermont	33.3%	2.8%
Virgin Islands	50.0%	-6.7%
Virginia	41.7%	4.8%
Washington	64.7%	-12.1%
West Virginia	39.1%	7.8%
Wisconsin	65.9%	-11.6%
Wyoming	74.1%	-11.0%
National	49.77%	2.23%

Source: Medicare / CMS data as analysed by the National Association for Home Care & Hospice

Data from home health cost reports indicates that in 2011 a base payment rate of \$2,192.97 per episode resulted in 32% of all home health agencies receiving payment less than the costs of care. Comparatively, the 2014 proposed rates would be the equivalent of \$2116.01. Further, cost report data showed a wide range in financial outcomes for home health agency Medicare services in 2011. This wide range of outcomes demonstrates that a rate based on average episode costs would have significant adverse impact on access to care, particularly as the rebasing moves into the four-year phase-in. By 2017, all but those few HHAs with margins in excess of 25% in 2010 can be expected to be paid less than their costs.

Medicare Margin	Number of HHAs	Percentage of HHAs	Medicare Revenues
> 50%	215	2.4%	\$268,512,736
50% - 25%	1,736	19.0%	\$4,458,742,101
25% - 20%	848	9.3%	\$2,240,643,409
20% - 15%	836	9.2%	\$1,905,883,037
15% - 10%	884	9.7%	\$1,903,145,295
10% - 5%	872	9.5%	\$1,560,327,610
5% - 0%	814	8.9%	\$1,245,384,149
0% - -5%	635	7.0%	\$886,163,084
-5% - -10%	456	5.0%	\$545,682,950
-10% - -15%	332	3.6%	\$435,363,004
-15% - -20%	260	2.8%	\$300,902,379
-20% - -25%	211	2.3%	\$253,655,396
<-25%	1,033	11.3%	\$1,067,089,182
	NATIONAL	9,132	\$17,071,494,331

METHODOLOGICAL FLAWS IN THE CMS CALCULATIONS

There are a number of methodological flaws or weaknesses in the manner in which CMS calculated the proposed 2014 HHPPS rates. These include:

1. The use of proxies to calculate average episode costs and payments.

CMS did not use either episode costs or episode payments in calculating those crucial elements in rate rebasing. As described above, payments are estimated using the base payment rate multiplied by the average case mix adjustment. Costs are calculated using average per visit costs multiplied by the number of visits.

NAHC used actual episode payment and actual episode costs and finds that CMS proxies fail the test of validity. The actual episode cost in FYE 2011, using the same Abt provider cost reports, is \$2,498.40 in contrast to the proxy estimate of \$2,453.71. A difference of \$44.69 is material.

The actual non-outlier episode payment is \$2890.06 in contrast to the proxy calculation of \$2963.65 by the CMS method. The difference of \$73.59 is also material.

The combined difference between actual and proxy calculation is \$118.28. This difference alone would lead to a much lower rebasing adjustment than the 14% proposed by CMS.

2. The failure to apply the 3.5% adjustment cap in the aggregate rather than in the "siloes" approach used by CMS.

In applying the 3.5% adjustment cap separately to the LUPA per visit rates, CMS proposes per visit rates that are as much as 28 points below cost of care. This leads to an estimated reduction in home health spending in 2014 alone of \$40-50 million. Over the next 10 years, the total impact approaches \$1 billion.

Overall, the formula employed by CMS assures that the average reimbursement to an HHA will be below average cost as the LUPA payments will fall below costs.

3. The failure to consider all reasonable alternative methodologies that improve the likelihood of continued access to care.

CMS explored limited alternative methods of calculating the rebased rates. Essentially, it confined the alternatives to those that would reduce the rates further. However, commonly used rate setting methods were ignored. For example, CMS could have evaluated rates based on the median rather than the mean. The median episode cost, using the Abt data, is \$2567.69 or \$113.98 higher than the CMS proxy estimated mean.

4. The failure to include all usual and necessary direct and indirect costs.

To preserve the financial and clinical benefits achieved through this flexible use of episodic reimbursement, rebased payment rates must include the following:

- All allowable costs under Medicare cost reimbursement principles
- Costs considered as non-reimbursable under Medicare cost reimbursement principles, but related to clinical services used in the care of Medicare home health patients, including, but not limited to:
 - Telehealth services and equipment
 - Respiratory therapy
 - Nutritionist and dietician services
- All properly allocated costs of provider-based HHAs
- A full allocation of Administrative and General (A&G) costs including an allocation to those costs that are non-reimbursable under Medicare cost reimbursement principles
- Formal and informal home office costs not reported on the Medicare cost report
- Business costs that are allowable under IRS standards of “usual and customary business expenses” and that are recognized as expenses under generally accepted accounting principles in the United State, including, but not limited to:
 - Taxes on income, franchises, and state provider taxes
 - Bad debts
 - Business development and marketing costs related to community and professional awareness to ensure true informed patient choice of provider
 - Fundraising costs in a nonprofit

5. The failure to account for fully and include the costs on new regulatory obligations of HHAs.

The following are known new cost areas related to recent changes in legislative and regulatory requirements:

- Medicare physician face-to-face encounter rule—HHAs report significant increases in training, systems development, and other administrative costs to achieve compliance
- HHCAPS (Medicare patient satisfaction surveys)—while not as extensive a cost increase as the face-to-face encounter requirement, the increase exceeds standards of materiality
- Physician qualification administration, e.g. physician follow-up on PECOS enrollment

- Therapy assessment and documentation—new costs include the increased assessment by professional therapists and the restriction on use of therapy assistants for those visits where the assessments occur as well as increases care documentation costs
- Implementation and administration of OASIS-C including administrative cost of training and implementation and increased staffing costs related to higher turnover caused by OASIS-C
- Mandatory employer costs/penalties under the health care reform law
- Electronic Health Record upgrades to achieve interoperability with hospitals and physicians
- HIPAA compliance
- Transition to ICD-10 coding
- Increased staff training on all of the regulatory changes
- Changes in clinical and administrative productivity due to new rules
- Wage and benefit changes, including minimum wage and overtime requirements under the Fair Labor Standards Act along with state-specific changes such as “living wage” laws in New York State and San Francisco

These are just a sample of the new costs and are not meant to be an exhaustive list of recent cost increases triggered by legislative or regulatory requirements. The rate rebasing must include all relevant costs that are not otherwise reported in the Fiscal Year cost report used by CMS in the rebasing analysis. Where current data is not available, CMS should use reasonable estimates.

6. The failure to establish budget neutrality to account for the payment reductions triggered by the removal of certain ICD-9 codes from the HHPPS scoring system.

The CMS proposal reduces overall payments by 0.5% in 2014 through the removal of numerous ICD-9 codes from the HHPPS system of scoring that credits these diagnoses leading to higher reimbursement. The impact of this change is to reduce the average case mix weight to 1.3417 from 1.3517,. The effect will be to reduce payments in home health by \$100 million in 2014 alone. However, CMS continues to use a case mix weight of 1.3517 in all of its calculations for 2014 rates.

BUSINESS VIABILITY

While HHAs do not require the degree of “bricks and mortar” as do inpatient facilities, cash flow and access to capital are essential to maintaining a stable home health care business. Currently, the financial status of HHAs is unstable as evidenced by the wide range in Medicare margins. That range is primarily due to extreme visit cost variations with much of these costs outside the control of the HHA. The absence of a margin for HHAs provides no capital, no financial cushion, and no funds to address new costs incurred that are not part of a payment rate. This need is highlighted by the Medicare rule that requires new HHAs to present at least 6 months of capitalization in order to qualify for Medicare participation.

The CMS proposal completely fails to recognize that “average cost” reimbursement is a recipe for a serious loss in access to care. While NAHC submits that the CMS methodology fails to achieve a proper calculation of average cost or average payment, even if it ultimately does so, such rates would be inadequate. That standard virtually guarantees that 50% of the HHAs will be paid less than cost. Greater efficiencies may be possible that would reduce that risk. However, all indications are that most efficiencies have been achieved already as rate reductions are having a direct impact on margins. A “cost plus” rate setting is essential to meet normal business operational needs and to continue access to care.

An HHA's need for capital includes the following:

- The acquisition of new technologies to improve efficiencies, clinical outcomes of patients, and meet regulatory requirements. The acquisition of technologies is a capital intensive investment that can only be made through a reasonable margin.
- Demographics indicate that the demand for home care will continue to grow. An HHA's expansion requires capital achieve only through reasonable margins.
- All businesses require working capital, particularly in health care where costs are incurred prior to receipt of reimbursement. In addition, health care can experience seasonal variations in demand with working capital needed to address cost and revenue imbalances.
- The implementation of new regulatory requirements necessitates advance financing as development, training, and system acquisitions are upfront costs.
- Cost of capital/borrowing.
- Disaster and extraordinary costs and cost reserves. Recent floods, tornadoes, and hurricanes are prime examples of the types of recent costs that are not built into base payment rates.
- Sufficient capital to address financial concerns related to the blend of varying third-party payers and the respective differences in payment rates compared to costs.

A reasonable average margin is also needed to provide a cushion throughout the HHA community to protect against the weaknesses inherent in any national payment model in accurately addressing the resource needs and costs of highly varying individual providers. In other words, in the absence of highly accurate case mix adjustment and other adjusters that address non-clinical related cost drivers such as travel time, population density, and cultural considerations, a payment rate must be sufficient to provide reasonable reimbursement to maintain access to care overall. In that respect, the inherent weaknesses include:


- Unusually high cost patients
- Frontier locations
- Inner-city agencies with security/escort costs, lower visit productivity, and higher compensation requirements
- The general explanatory power (R-squared) of the case mix adjuster

The opportunity for profit/surplus also creates an operational incentive that is a longstanding component in US business models. Profit opportunity is a well-respected behavioral incentive to achieve goals that can benefit patients, Medicare, and the provider of care. In the advent of value-based purchasing and potential penalties for failing to reach outcome standards, there is a growing recognition that financial rewards and penalties belong in health care as a way of triggering desired behavior. A margin opportunity in the home health payment rates serves that same purpose.

A margin opportunity also aids in encouraging and permitting investment in innovative technologies, care processes, and care delivery models. In the absence of those opportunities, health care is stuck in the current model of care that has proven to fall short of our needs.

Finally, a reasonable margin is needed to attract interest in investment in home health services. This investment is vital to the future of home care services as demographic trends demonstrate a growing need and demand for home health services. While entry in home health care is not as capital-intensive as inpatient settings, there is still a significant financial obligation to organically create a home health agency or to acquire an existing entity. The financing for such undertakings will be available only if the investors conclude that the return on their investment equals or exceeds the return that would occur through investment in other sectors. Absent a return, investors will look elsewhere.

For example, if there is a growing need for home health services, parties will seek to meet that demand by creating or expanding services. However, if investors determine that a better return can come from



financing the development of nursing homes or assisted living facilities, the investor will turn to those sectors. The resulting inadequate supply of home health care will then relegate seniors to the institutional care settings that offered the better financial return for investors.

The recognition of the need for a “profit” exists in virtually all public and private sectors of our economy. The defense industry would not exist if it could not be profitable. Similarly, roads, sewer treatment plants, and missions into outer space would not be possible if the public purchases that are part of those sectors did not provide a reasonable opportunity for profit. The health care economy is no different.

Any consideration that “average cost” payment rates provide an opportunity for a margin based on efficiencies is misplaced. HHPPS is now in its twelfth year and HHAs have had the concomitant efficiency incentives throughout that period. Still, many HHAs experience negative margins because of costs beyond their control that are not addressed through the case mix adjustment model or the area wage index. For example, productivity of staff is greatly affected by geographic area as travel distances between patients increase non-productive time with costs and no offsetting revenue. Similarly, patients with needs for extended visit time decreases overall productivity in terms of per patient revenues/costs. MedPAC has recognized that margins are significantly related to per visit cost differences rather than efficiencies (http://www.medpac.gov/chapters/Mar11_Ch08.pdf. PP. 187-188).

NAHC recommends that CMS engage in an in-depth analysis and study of the health care economics at play in the home health care marketplace in determining the level of profit/margin that is reasonable to offer in rebased rates of payment. The home health agency marketplace is not the equivalent of the hospital, physician, or nursing facility marketplace. For example, hospitals have significant opportunity to balance the financial outcomes of both extensive commercial payments and public program payments. Home health agencies have little commercial insurance revenue and most of it comes from low paying, low utilizing Medicare Advantage plans and Medicaid managed care plans. Instead, home health care services are predominately financed through government programs including Medicare, Medicaid, the VA, and TRICARE. Overall, these programs provide little or no margin opportunity outside Medicare. While Medicare may not be responsible for payment rate shortfalls in other public program, NAHC believes that Medicare must recognize the need for a margin opportunity in its rates and the dynamics of the home health care marketplace overall. If the level of Medicare margin falls below what is needed to create and sustain a home health agency overall, the entire organization is at risk and access to care for Medicare patients and non-Medicare patients both suffer.

NAHC recommends that the economic study proposed be undertaken on an expedited basis and that CMS convene a meeting of all stakeholders and available experts to craft the study design.

CONCLUSION

Rate rebasing is not a simple task for CMS. It has serious consequences to Medicare, providers of care and the patients served. As such, it must be performed carefully and correctly. The CMS proposal fails on numerous counts, but most notably in the absence of any consideration as to its impact on access to care. The proposal should be abandoned and replaced with one that puts care access first, considers all methods of calculating rates, recognizes all of the current costs of care, and includes an appropriate margin to secure operating capital and a fair return on investment to allow for continued modernization of home health care for today’s health care delivery innovations.