



ENSURE ADEQUATE AND APPROPRIATE PAYMENT FOR MEDICARE HOME HEALTH SERVICES

ISSUE: The recently enacted Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148) mandates significant changes in the payment rate structure for Medicare home health services. In combination, the rate cuts and payment system reforms are estimated by the Congressional Budget Office (CBO) to reduce spending in the home health benefit by \$39.7 over 10 years. The changes include:

- A reduction in the home health market basket update by 1 percentage point in 2011, 2012, and 2013.
- Beginning in 2014, payment rates are rebased with a phase-in over four years with as much as a 3.5 percent rate reduction in each of the phase-in years.
- Application of a “productivity adjustment” to the market basket update, estimated to be about a 1 percentage point reduction in the market basket update each year beginning in 2015.
- The Secretary of Health and Human Services (HHS) must develop a voluntary pilot program of bundled payment models for a period of five years, including post-acute care providers such as home health agencies, by January 1, 2013.
- Establishing a cap on aggregate outlier payments at 2.5 percent and a provider-specific cap on outliers at 10 percent of revenues to address outlier abuses.
- Reinstatement of a rural payment differential, or add-on, at 3 percent for episodes and visits ending on or after April 1, 2010 and before January 1, 2016.
- Development of a study evaluating the need for further system reforms to maintain access to care.

Preceding these payment system reductions and reforms, the Centers for Medicare & Medicaid Services (CMS) reduced payment rates by 8.25 percent through consecutive 2.75 percent cuts in 2008, 2009, and 2010. These reductions are based on an unfounded

allegation by CMS that case mix weights have increased without attendant changes in patient characteristics, referred to by CMS as “case mix creep” or “upcoding”. A fourth cut of 2.71 percent is scheduled for 2011.

In its 2010 *Report to Congress*, issued prior to enactment of the reform legislation, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress eliminate the home health market basket update for 2011. MedPAC also recommended that Congress direct CMS to rebase home health payments in 2011. The Commission specifically rejected setting the rates based on average costs alone, recognizing the need for capital and a reasonable margin. Finally, MedPAC recommended that the payment model be reformed to focus incentives on quality of care and to address the wide variances in Medicare margins through consideration of such payment adjustments as risk corridors that would cap profits and losses.

The payment rate changes and proposed reforms raise significant concerns as to the ability of home health agencies to maintain access to quality services across the country. The expected result from these changes is that the majority of existing providers will receive a level of payment that falls far short of covering their costs.

RECOMMENDATION: Congress should:

- 1) Ensure that rebasing of home health payments provides for home health agency payment margins sufficient to protect access to care, meet payroll, provide adequate working capital, and offer a reasonable operating margin;
- 2) Restore rate reductions and reject proposals to cut further the home health market basket inflation update or to impose additional rate reductions;
- 3) Prevent any additional regulatory or legislative rate cuts through the 10-year period covered in the health care reform legislation;
- 4) Make permanent the rural add-on payment for home health services in rural areas;
- 5) Reform the regulatory process for evaluating case mix changes to prevent the imposition of inappropriate case mix rate reductions;
- 6) Reject proposals to bundle home health payments with hospitals or other providers.

RATIONALE:

- H.R. 3590 alone takes \$39.7 billion over 10 years from a Medicare benefit that expends about \$17.8 billion (about the same as in 1997) and that is under control in terms of expenditure growth (see chart below). The regulatory cuts add billions more.
- By 2017, the first year of full implementation of rebased rates, it is estimated that 57.6 percent of all home health agencies will have negative Medicare profit margins (Medicare pays less than the cost of providing care) if the rates are set at average cost.
- The National Association for Home Care & Hospice (NAHC) has calculated as many as 1 million beneficiaries could lose services as a result of home health agencies having negative Medicare margins.

- Reliance on average margins to set payment rates fails to adequately consider the wide variation in service costs and wide-ranging financial status of home health agencies. As such, across-the-board cuts endanger continued access to care in those locations with higher than average costs.
- MedPAC's proposals to reduce home health payments are based on claims that home health agencies are making excessive profit margins on Medicare services. MedPAC's financial analysis of Medicare home health agencies, projecting a 13.7 percent margin for 2011, is unreliable:

First, MedPAC does not include any consideration of the 1,316 agencies (12.4 percent) that are part of a hospital or skilled nursing facility. In some states, hospital-based agencies make up the majority of providers (ND 61.9 percent; SD 59 percent; MT 61.1 percent; OR 53.6 percent). Facility-based agencies have an average Medicare profit margin of negative 7.82 percent.

Second, the MedPAC analysis uses a weighted average, combining all agencies into a single unit, rather than recognizing the individual existence and local nature of each provider. It sees a single national profit margin for freestanding agencies as representative of over 10,500 very diverse agencies. When all agencies' margins are included and given equal weight, the true Medicare margin would be about 5.5 percent. Over one-third of home health agencies currently have negative margins.

Third, MedPAC margin data fails to recognize many agency costs, including the cost of telehealth equipment, increasing costs for labor, emergency and bioterrorism preparedness, taxes, normal marketing expenses, and system changes to adapt to the new home health payment changes.

- The average all-payor profit margin (including of Medicaid, Medicare Advantage, private insurers, and private pay) for freestanding agencies is reduced to about 2 percent when taking into account losses from non Medicare payors.
- Recent cost reports reveal that the average Medicare margin for rural agencies is negative 4.95 percent. The 3 percent rural add-on still results in an average margin below zero. In many rural areas, home health agencies can be the primary caregivers for homebound beneficiaries who have limited access to transportation.
- The "case mix creep" adjustment ignores increases in patient acuity, particularly a significant increase in orthopedic and neurologically impaired patients requiring restorative therapy. These changes in patient characteristics are documented in a report from the Lewin Group and directly correlate with changes in case mix weights.
- CMS alleges that the entire change in the average case mix weights between 1999 and 2005 is the result of provider upcoding or factors unrelated to changes in patient characteristics. If this had occurred one would expect to see a big increase in Medicare home health expenditures. In fact, as the chart below indicates, Medicare home health expenditures are far lower than CBO had expected under

the new Home Health Prospective Payment System and are about the same as in 1997.

- Bundling home health care payments into hospital or other provider payments would severely compromise both the quality and availability of home health care for Medicare beneficiaries. It would cause major disruption to the health care industry, be anti-competitive, increase the federal regulatory burden and erect a new and unnecessary barrier to beneficiaries' access to quality care. Most hospitals have no experience in the management of post-acute care and no infrastructure to manage utilization review. Hospitals are the highest cost sector so this is not the place to locate efficiencies in post-acute care. If bundled payments are adopted, they should go to community-based providers that have a breadth of experience in providing post-acute care and avoiding unnecessary hospitalizations.
- A study by Avalere Health (May 11, 2009) found that home health use saves Medicare dollars by reducing hospitalizations and nursing home stays. Based on the findings in this study, an estimated \$30 billion could be saved over the next 10 years by expanding access to home health for chronic disease patients. After the Balanced Budget Act of 1997 cut billions from the Medicare home health benefit, Medicare expenditures on skilled nursing facilities and hospitals skyrocketed.

