



ENSURE ADEQUATE AND APPROPRIATE PAYMENT FOR MEDICARE HOME HEALTH SERVICES

ISSUE: The Centers for Medicare & Medicaid Services (CMS) administratively has promulgated a 2.75 percent across-the-board rate reduction for home health services for 2008, 2009, and 2010, as well as a 2.71 percent cut for 2011. The 2.75 percent cuts scheduled for 2008 and 2009 have been implemented. Over the next five years (2009-2013) these cuts will reduce outlays for home health by \$7.59 billion unless Congress blocks them. 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.”

In its 2009 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress eliminate the home health market basket update for 2010 and accelerate the application of the 2011 coding creep adjustment proposed for 2011 (2.71 percent) to 2010—reducing current rates in 2010 by 5.46 percent. MedPAC also recommended that Congress direct CMS to rebase home health payments in 2011, using 2007 costs as a base. MedPAC did not recommend that rates be rebased to any particular level in relation to costs and left open the issue as to the level of average margin that should be targeted. 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. MedPAC suggested that a study on reform options take place concurrently or in advance of the across-the-board cuts that it recommended.

A 5 percent rural payment differential or “rural add-on” for home health services delivered in rural areas expired on December 31, 2006. This has resulted in rural home health agency closures and threatened access to home health care for beneficiaries living in rural areas.

In February 2009, the Office of Management and Budget (OMB) included MedPAC’s 2009 recommendations for deep cuts to home health as part of the Obama Administration’s proposed FY 2010 budget. OMB also called for applying a

“productivity adjustment” to the market basket update beginning in 2011 and bundling of hospital and post acute care payments beginning in 2013. OMB estimated that its proposals would reduce Medicare home health spending by \$34 billion over ten years.

In November 2009 the House passed health care reform legislation (the “America’s Affordable Health Choices Act” (H.R. 3962)) that includes the MedPAC and OMB recommended cuts in home health care while increasing the depth and severity of these cuts. Over ten years these harmful cuts in the House bill, according to the Congressional Budget Office (CBO), would take \$54.7 billion from the Medicare home health program. This proposal appears to move payment rates to a zero or less than zero margin in spite of MedPAC sentiment otherwise. Also, the House bill does not include any of MedPAC’s recommendations regarding a study and development of payment system reforms designed to align payments with quality and resource utilization.

In October the Senate Finance Committee completed mark up of its health care reform proposal that would cut payments to the home health benefit by \$43.2 billion over ten years, a reduction of \$13.6 billion from the House proposal. \$6.8 billion of the savings in the Senate plan would come from targeting outlier abuse by placing a cap on aggregate outlier payments at 2.5 percent and a provider specific cap on outliers at 10 percent of revenues. The Senate proposal would delay rebasing to 2013 and phase it in over four years, delay the productivity adjustment until 2015, and reduce the market basket update by 1 percent in 2010 and 2011, instead of eliminating it altogether in 2010. It would reinstate the home health rural add on at 3 percent for six years and provide a \$500 million fund over ten years for vulnerable patient support.

RECOMMENDATION: Congress should: 1) Reform the Medicare home health payment model to achieve a more reliable payment distribution that reflects varying resource uses and costs incurred in providing care to individual patients; 2) Reject any proposals to cut the home health market basket inflation update or impose additional rate reductions for home health agencies; 3) Reinstatement the rural add-on payment for home health services in rural areas; 4) Block the home health case mix rate reductions and reform the regulatory process for evaluating case mix changes; and 5) Reject proposals to bundle home health payments into hospital or other provider payments.

RATIONALE:

- The home health cuts in the House Tri-Committee health care reform proposal would take \$54.7 billion (the Senate \$43.2 billion) over ten years from a Medicare benefit that expends about \$16.5 billion per year (\$1 billion less than in 1997) and that is under control in terms of expenditure growth (see chart below).
- The proposed cuts are totally disproportionate to the cuts affecting other providers—currently home health is 3.7 percent of Medicare spending while it would suffer 10.2 percent of the cuts in the House bill, 9.4 percent in the Senate. Projected home health spending over this period would be cut by 17.2 percent in the House bill, by 13.6 percent in the Senate bill.
- The home health cuts in the House proposal are over \$20 billion more than those proposed by the Obama Administration (the Senate proposal \$9 billion more), and go well beyond MedPAC’s recommendations for cuts while ignoring MedPAC’s recommendations for true payment system reforms.

- Currently, about one third of Medicare home health agencies (HHAs) have negative Medicare profit margins (Medicare pays less than the cost of providing care). The National Association for Home Care & Hospice (NAHC) has calculated as many as 1 million beneficiaries could lose services and that by 2011, nearly seventy percent of home health agencies will have negative Medicare profit margins if the proposed cuts in the House plan are implemented, by 2016 if the Senate cuts are implemented.
- MedPAC fails to evaluate the impact on care access that occurs with the current wide ranging financial status of HHAs. Regardless of average margins, there is a wide range in agency margins and thus a wide range in impact that the proposed across-the-board cuts would have. There is no evaluation to date of the completely reformed home health payment model put in place in 2008. In the event that the wide range in margins continues, a more sophisticated payment model connecting payments to resource use should be developed.
- MedPAC's proposal to reduce home health payments is based on claims that home health agencies are making excessive profit margins on Medicare services. MedPAC's financial analysis of Medicare HHAs, projecting a 12.2 percent margin for 2009, is unreliable. First, it does not include any consideration of the 1,626 agencies (21 percent) that are part of a hospital or skilled nursing facility. In some states, hospital-based HHAs make up the majority of the providers (ND 85.0 percent; SD 76.5 percent; MT 66.7 percent; OR 63.0 percent). Facility-based HHAs have an average Medicare profit margin of negative 6.19 percent. Second, the MedPAC analysis uses a weighted average, combining all HHAs 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 9,700 very diverse HHAs. When all agencies' margins are included and given equal weight, the true Medicare margin would be about 2 percent. About 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, and system changes to adapt to the new home health payment changes.
- Home health agencies are already in financial jeopardy as a result of Medicaid cuts and inadequate Medicare Advantage and private pay rates. Ongoing study of home health cost reports by NAHC indicates that the overall financial strength of Medicare home health agencies is weak. The average all-payor profit margin (inclusion of Medicaid, Medicare Advantage, private insurers, and private pay patients) for freestanding HHAs is reduced to about 1 percent when taking into account losses from non Medicare payors.
- Recent cost reports reveal that the average Medicare margin for rural agencies is negative 3.52 percent. The loss of the 5 percent rural add-on payment for home health services in rural areas has resulted in reductions in service areas, agency closures, and reports that some agencies had to turn away high resource use patients who are more expensive for agencies to serve. 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 the Congressional Budget Office (CBO) had expected under the new Home Health Prospective Payment System and are \$1 billion less than in 1997.

- Bundling home 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. 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 considered, 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 ten 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.

