



## **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.

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 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.

On July 14, 2009 the chairs of the three committees in the House of Representatives with jurisdiction over health care reform released legislation (the “America’s Affordable Health Choices Act” a.k.a. the “Tri-Committee Proposal”) that includes the MedPAC and OMB recommended cuts in home health care. Over ten years these harmful cuts, according to the Congressional Budget Office (CBO), would take \$56.8 billion from the Medicare home health program.

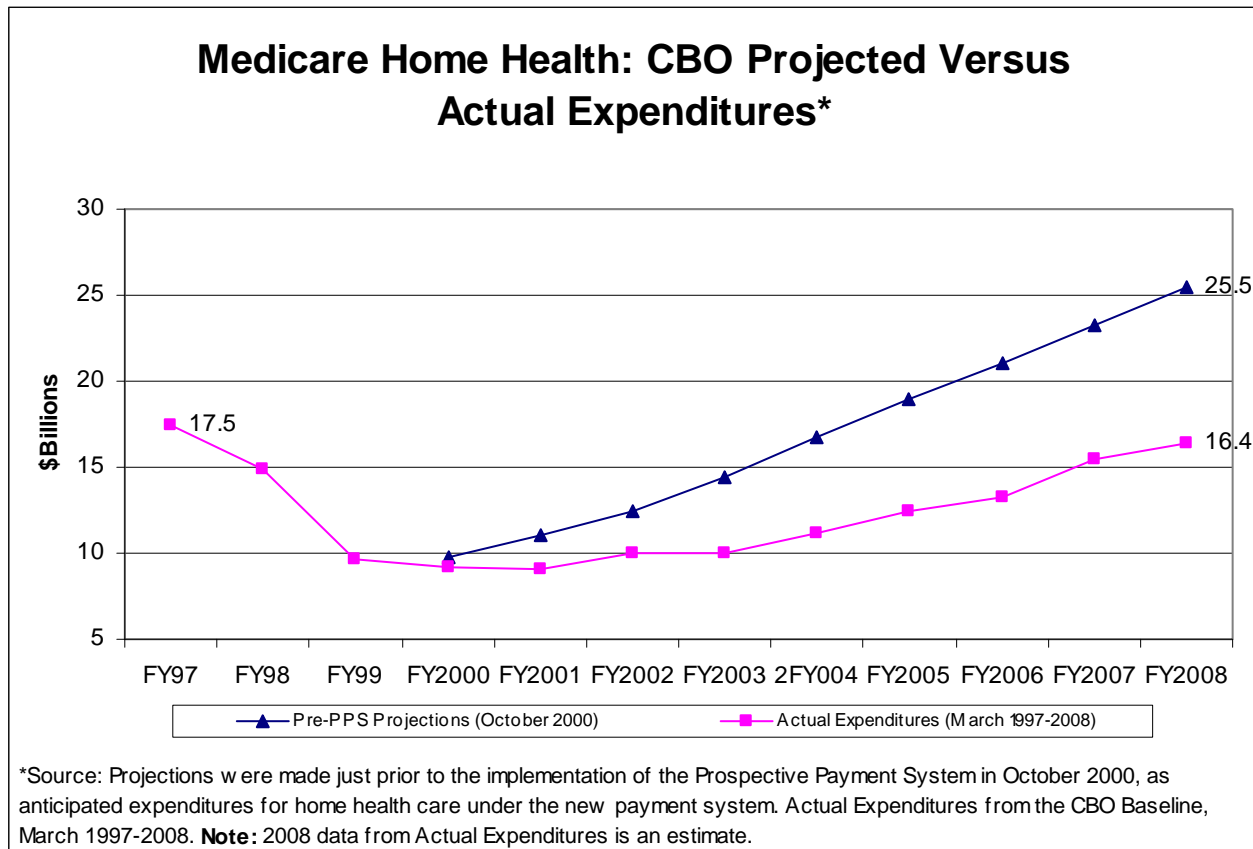
**RECOMMENDATION:** Congress should: 1) Reform the Medicare home health payment model to achieve a more reliable payment distribution that reflects varying resource uses and

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) Reinstate the 5 percent 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 \$56.8 billion over ten years from a Medicare benefit that expends about \$16.4 billion per year (\$1 billion less than in 1997) and under control in terms of expenditure growth (see chart below).
- 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 two-thirds of home health agencies will have negative Medicare profit margins if MedPAC's proposed freeze, accelerated CMS regulatory cuts, and rebasing of payment rates are implemented.
- MedPAC fails to evaluate the impact on care access that occurs with the current wide ranging financial situation 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 in payments 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 the National Association for Home Care & Hospice 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.



For more information, please contact NAHC Government Affairs (202-547-7424) (6/25/09)