

PROPOSED CUTS TO MEDICARE HOME HEALTH PAYMENTS ARE UNSUPPORTED AND DISPROPORTIONATE AS COMPARED TO OTHER MEDICARE PROVIDERS

MEDPAC's HOME HEALTH MARGIN ESTIMATES ARE UNRELIABLE

HOME HEALTH MAKES UP ONLY 3.5% OF TOTAL MEDICARE SPENDING

PROPOSED CUTS TO MEDICARE HOME HEALTH SPENDING ACCOUNT FOR 11% OF TOTAL MEDICARE CUTS

HOME HEALTH USE IMPROVES OUTCOMES FOR MEDICARE BENEFICIARIES AND REDUCES MEDICARE SPENDING

President Obama's proposed budget for 2010 being considered by Congress adopts the cuts to Medicare home health reimbursement recommended by the Medicare Payment Advisory Commission (MedPac) in its Report to Congress of March 2009¹. As it has each year since 2005, MedPac recommended that Congress eliminate the market basket adjustment in 2010. MedPac also recommended that Congress advance the planned 2011 reductions in reimbursement for coding adjustments to 2010 reducing payments for home health services by an additional five and one-half percent (5.5%). These cuts would reduce Medicare home health reimbursement by over \$550 million next year, by \$13 billion over the next five years, and by an estimated \$34 billion over the next ten years. The net effect of these cuts is disproportionate in that the home health industry which is presently 3.5% of the total Medicare spend will bear 11% of the total Medicare program cuts: more than triple its proportionate share.² MedPac based its recommendations on its determination that home health agency margins were excessive. It claims that home health Medicare margins were 16.6% in 2007 and estimates those margins at 12.2% for 2009. (MedPac Report 2009 at 196 and 198.) MedPac acknowledges that about 20 percent of home health agencies are presently operating at negative Medicare margins, and noted that smaller agencies tended to have a higher rate of negative margins. (MedPac Report 2009 at 196.)

The home health industry has consistently disputed the methodology employed by MedPAC in determining Medicare margins of participating home health agencies. Most recently, the

¹ Available at: http://www.medpac.gov/documents/Mar09_EntireRepor.t.pdf (referred herein to as "MedPac Report 2009").

² Home health cuts total \$34 billion out of total program cuts of \$314 billion over 10 years. Source: Department of Health and Human Services, Budget in Brief, May 7, 2009, pp. 54-55, and 61: available at: <http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbrief.pdf>

National Association for Home Care & Hospice³ (NAHC) reiterated this position in its March 17, 2009 statement for the record before the House Ways and Means Committee⁴. NAHC maintains that MedPAC's methods of analyzing home health margins are erroneous in three respects:

1. MedPAC disregards facility-based home health providers' margins in its calculations (about 21% of Medicare participating home health agencies are facility-based);
2. MedPAC aggregates all home health margin calculations so that the home health industry is measured as if it were composed of a single agency, instead of over 9,700 distinct home health agencies; and
3. Cost Report data MedPAC uses in its calculations of margins fails to recognize legitimate and appropriate business costs including the cost of telehealth equipment and its related administrative and general costs, increasing costs for labor, emergency and bioterrorism preparedness, and system changes required to adapt to the new 2008 Medicare home health payment changes.
4. In addition, Medicare home health cost reports have become unreliable since the inception of the prospective payment system which means that the core data used to determine industry margins is also unreliable.

In this paper, we review the impact of these factors to counter MedPac's conclusions of inflated Medicare margins for Medicare home health agencies.

HOSPITAL-BASED BIAS INCREASES MEDPAC'S AVERAGE MEDICARE MARGINS

MedPac arbitrarily ignores the impact of negative operating margins for about one-fifth of home health agencies. Hospital-based home health agencies are those agencies owned and operated by hospitals⁵. The Medicare Principles of Reimbursable Cost require all providers to allocate cost using the methods prescribed under these provisions. Ironically MedPAC uses the argument that these same allocation methodologies skew the actual Medicare costs of hospital-based agencies and therefore omits them from their home health margin calculations.

³ The National Association for HomeCare and Hospice is the largest national home health trade association with membership comprised of all types and sizes of Medicare-participating care providers, including proprietary, public, nonprofit and facility-based agencies.

⁴ Available at: <http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=7684>; (referred to herein as "NAHC Testimony").

⁵ A few agencies are owned and operated by independent skilled nursing facilities but will be referred to as hospital-based for simplicity.

Presently, there are 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 providers⁶. Facility-based home health providers have an average Medicare profit margin of negative 6.19 percent. (NAHC Testimony – 6th bullet). In its Report to Congress of March 2008, MedPac determined that hospital-based agencies had a negative margin of 4.9% in 2006⁷.

Ignoring one-fifth of the industry (on a numbers basis) where 62.6% operates at a negative margin artificially inflates the reported average margins of home health agencies. As is discussed below, because MedPac uses a weighted average basis for calculating margins, the impact of the negative margins for hospital-based agencies is not linear or easily extrapolated to calculate the impact on MedPac's findings, but would result in a significant reduction of their calculated average margin. Also a point of concern is a number of these hospitals are sole community providers and/or are located in rural and/or frontier areas.

MEDPAC AVERAGES AREN'T TRUE AVERAGES

MedPAC analysis of Medicare margins uses a weighted average, combining all home health agencies into a single unit, rather than recognizing the individual existence and local nature of each provider. MedPac believes that a single national profit margin for freestanding agencies is representative of over 9,700 very diverse home health agencies. When all agencies' margins are included and given equal weight, the true average Medicare margin would be closer to 5 percent. NAHC has determined that about one third of home health agencies currently have negative margins, and this number will grow to over two-thirds if their recommended proposed cuts are implemented. (NAHC Testimony - 4th Bullet.)

MedPac's own data demonstrates that there is wide variability in Medicare margins among homecare providers. In MedPac Report 2009, MedPac expressly recognizes this variability when it states:

“The variation in freestanding home health agency margins is similar to our findings in prior reports. The agency at the 25th percentile in the distribution had a margin of 3.1 percent in 2007 and the agency at the 75th percentile in the distribution had a margin of 26.1 percent. . . . About 20 percent of providers have losses under Medicare, and the composition of this group of HHA's with respect to ownership and geography does not differ from the full population of Medicare participating HHA's.” (MedPac Report 2009 at 196.)

Methodology to calculate Medicare Margins as a single provider using total Medicare Revenue less total Medicare Costs is not reflective of the composition of the home health provider industry for the following:

⁶ North Dakota 85.0 percent; South Dakota 76.5 percent; Montana 66.7 percent; and Oregon 63.0 percent. (NAHC Testimony – 6th bullet).

⁷ Available at: http://www.medpac.gov/documents/Mar08_EntireReport.pdf

- ✓ Home Health Industry, similar to other type of providers, is comprised of a vast variety of provider types (For Profit & Non Profit, Free Standing & Provider Based, Municipal & Public Health Providers)
- ✓ Home health providers consist of providers who have vast differences in their geographic service areas (Rural, Urban & Frontier)
- ✓ Home health is and has been a “cottage industry” made up of small to medium size providers (average Medicare revenue per provider is only \$1.8 million)
- ✓ **22.6%** of freestanding providers had profit margins under 0% (losses in Medicare)
- ✓ **30.2%** of freestanding providers had profit margins under 5%.

Hospital-based agencies which as previously stated are already operating at negative margins are not included in MedPAC’s data. In light of this wide variation in margins, it is inappropriate to use a single average margin to determine reimbursement changes. Across the board adjustments to reimbursement can have significantly varying impacts on financial operations of home health agencies. Ultimately, across the board cuts will affect access to care, particularly in areas where agency margins are lower than the MedPac calculated average.

MEDICARE HOME HEALTH COST REPORT DATA USED TO CALCULATE MARGINS IS UNRELIABLE

On October 1, 2000, Medicare reimbursement for home health services changed from a cost reimbursement system to a prospective payment system. As a result of this change, the incentive for home health providers to file complete and accurate report costs diminished significantly. Over time the accuracy of data contained in Medicare cost reports has deteriorated. Additionally, providers have no incentive under the prospective payment system to contest or appeal disallowances of legitimate costs because the disallowance does not impact reimbursement. Moreover, historically CMS and providers have disagreed about the allowability of certain legitimate business expenses.

UNRELIABLE COST REPORTS

The home health industry has long been concerned about the use of cost report data to determine Medicare payment policy. NAHC and Medicare cost reporting experts have determined that the accuracy and consistency of the Medicare Cost Reports among home health providers has deteriorated since 1999 due to the following factors:

1. Home health agency cost reports have not been used as a basis for provider specific reimbursement since 1999; therefore providers do not put the necessary and appropriate resources into the preparation and validation of cost reports;
2. Home health agency cost reports have not been subject to on- site audits by CMS or fiscal intermediaries since approximately 2001;
3. CMS desk review procedures of Cost Reports are not adequate to detect errors in allowable/non-allowable/excludable costs and/or approved cost allocation methodology;
4. The number of new Medicare providers has increased by approximately 2,800 since 2001 from 6,900 to 9,700, an increase of 40%. The vast majority of these new providers' financial personnel have never had the proper training to understand the principles and/or methodologies required for filing the Medicare Cost Report;
5. Transition of financial staff of those providers in existence in 2001 has further diluted the cost reporting expertise among home health agencies;
6. Methodologies used to calculate Medicare cost are not consistent among home health providers, producing cost report data that is not comparable;
7. NAHC has found numerous errors and lack of consistency in their analysis of filed cost reports (22% had to be excluded from their data for not meeting minimum standards). This included instances of obvious non-compliance with program guidance for both statistical and cost information; and
8. Technology is becoming a major strategy in the delivery of quality care to homebound home health patients, yet the cost of tele-monitoring with its related share of administrative and general costs is not included in the calculation of Medicare margins.

As a result of these factors, the cost report data used by MedPac for its calculation of margins is inherently flawed, and therefore the MedPac margin calculation is inaccurate.

LEGITIMATE BUSINESS EXPENSES IGNORED

The methodology used by MedPAC to derive its average margins fails to recognize many agency costs, including many legitimate and necessary business expenses incurred in the ordinary course of business. This is the result of MedPac's use of Medicare cost report data. CMS policies for allowable costs that may be included on the cost report haven't been updated in over ten years, since the advent of the Interim Payment System and the Prospective Payment System. Additionally the MedPAC margin analysis fails to recognize cost to implement telehealth programs, , increasing costs for labor, recruitment and retention of personnel, emergency and bioterrorism preparedness, and required system changes to adapt to the new 2008 home health Medicare payment changes.

Workforce shortage (particularly the national nursing shortage) has caused many home health agencies to invest substantial resources in telehealth monitoring to better manage the care for homebound patients. Vital signs, weight and other clinical data provided by monitors are used to decide changes in frequency of visits or whether visits should be rescheduled because of patients' needs. This not only improves care for the patient but maximizes the productivity of limited clinical personnel in the agency. CMS does not allow costs for telehealth or telemonitoring equipment on cost reports based on its view that these technologies cannot substitute for home visits. The use of telehealth equipment does not replace hands-on care giving in the home, but rather serves as to assist with clinical decision making and management of the patient's condition.

The home health industry finds itself at a crossroads with regard to improving its technology infrastructure. Rapid advances in telemonitoring and telehealth technology have outpaced the industry's ability to adequately develop its infrastructure. Implementing these new technologies, along with the systems and electronic health record capabilities to fully exploit the cost savings available by use of this technology, is expensive. However, the capital costs associated with implementing telehealth and telemonitoring systems is enormous. These costs are included in unallowable costs of the cost reports and therefore are not considered in determining agencies' margin

In addition if home health is to continually expand its cost savings and quality driven benefits to the total health care system they need to have funding available for advances in technology. Home Health will need profit margins to fund the following capital initiatives:

- Electronic Health Record (EHR) - ARRA only provides \$17 billion of funding to eligible professionals (physicians) and hospitals. Heavy reliance on hospitals and physicians makes it imperative home health providers implement an EHR solution. However home health is only one of the providers referenced as eligible in the law for HIT grants from a \$2 billion undesignated pool.
- Tele-health/Tele-monitoring, as previously stated
- Point of Care (POC)- Only 65% of home health are using POC technology currently.
- Back Office (Revenue Cycle, financial, payroll, OASIS)
- Decision support tools/business intelligence (BI)

CONCLUSION

Over the past twelve years, home health agencies have already experienced a disproportionate amount of cuts in reimbursement. The Balanced Budget Act of 1997 implemented an Interim Payment System that caused the closure of one-third of home health agencies. The current Prospective Payment System which was estimated by CBO to reduce Medicare home health care

payments to \$33.1 billion by fiscal year 2006 resulted in actual payments of \$13.1 billion IN 2006. A Congressionally mandated 5% rural add-on to assist rural providers expired in 2006. In 2008, CMS implemented a series of negative reimbursement adjustments totaling 11% to address what it called “case mix creep”. Now President Obama’s budget proposes to further reduce home health spending by cutting \$13 billion over the next five years from a \$16 billion program. These reductions are far in excess of the reduction originally envisioned by Congress.

Medicaid reimbursement cuts, and inadequate Medicare Advantage and private pay rates are taking their toll on home health agencies. The National Association for Home Care & Hospice indicates that the overall financial strength of Medicare home health agencies is weak with an all-payor margin for freestanding home health agencies averaging 4 percent. (NAHC Testimony – 7th Bullet.) The NAHC Testimony best sums up the current state of affairs with respect to the proposed cuts as follows:

“NAHC believes that MedPAC’s recommendations fail to address the true financial status of home health agencies. The recommendations are based on an incomplete analysis of Medicare cost report data that excludes a significant segment of home health agencies, ignores essential home health care service costs, and relies on a methodology that treats home health services as if they were provided by one agency in just one geographic area. If accepted, the MedPAC recommendations will severely compromise continued access to care.”

It is ironic that MedPac and the President would propose these significant cuts to a program that has clearly demonstrated it is an efficient and cost effective alternative to institutional care. A study on the effectiveness of Medicare home health services recently released by Avalere Health concluded that Medicare home health agencies saved the program over \$1.7 billion in CY 2005-2006 and reduced hospital readmissions by more than 24,000.⁸ Congress needs to realize the impact that continued across the board cuts will have on the home health industry and on beneficiary access to care.

RECOMMENDATIONS:

For the foregoing reasons, we recommend that Congress:

1. Consider rejecting any proposals to cut the home health market basket inflation update or impose additional across the board rate reductions for home health agencies;
2. Consider targeting any necessary cuts to improve the integrity of the benefit, such as limiting outlier payments (based on provider-specific outlier revenue) which have been significantly abused in some areas;
3. Consider implementing a two year moratorium on new providers to enable CMS to develop additional certification standards relating to owners, administrators

⁸ Medicare Spending and Rehospitalization for Chronically Ill Medicare Beneficiaries: Home Health Use Compared to Other Post-Acute Care Settings; Avalere Health, May 21, 2009: (and a copy is attached).

and other key personnel, and operations to improve the integrity of the benefit;
and

4. Consider reinstatement of the 5 percent add-on payment for home health services in rural areas for two years to permit development of targeted adjustments to recognize increased costs of providing care in rural areas.

[ATTACH COPY OF AVALERE STUDY]