NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

June 2003

For more information, contact NAHC Government Affairs, 202/547-7424

SEEKING STABILITY IN THE MEDICARE HOME HEALTH BENEFIT—MARGINS EVAPORATE; AGENCIES IN FINANCIAL JEOPARDY

INTRODUCTION

During 2003, the Congress should provide much-needed stability in the Medicare home health benefit by rejecting proposals to increase home health beneficiary cost sharing and rejecting further cuts in payments and access to care. Further, serious consideration should be given to restoring home health care funding and extending the 10 percent rural add-on which expired on April 1 of this year.

Members of Congress have been advised by the Medicare Payment Advisory Commission (MedPAC) and others to further reduce expenditures on the Medicare home health benefit. These proposals come at a time when home health care spending has already been cut nearly in half since 1997, and the number of Medicare beneficiaries receiving home health care reduced by 1.3 million, or more than one-third.

MedPAC justified its recommendations based on a study of Medicare home health agency profit margins calculated by using 684 agency cost reports. The National Association for Home Care & Hospice (NAHC) took issue with many aspects of MedPAC's study, and undertook its own study of more than 6,000 home health agency cost reports, the results of which differed dramatically from those of MedPAC and are presented in this report (see **HOME HEALTH CARE IS JEOPARDIZED BY LIMITED AND SHRINKING PAYMENT RATES**). NAHC asked representatives of Muse and Associates to verify the methods used in its analysis of home health profit margins. Muse and Associates is a Washington-based health policy and strategic planning consulting firm that provides policy analysis, cost estimates, special studies, and information services relating to health care issues. Muse and Associates has considerable breadth and depth of experience in the Medicare and Medicaid programs.

ACCESS TO AND QUALITY OF CARE AT RISK

- According to MedPAC, in the first full year of PPS, 300,000 fewer Medicare beneficiaries found access to home health services. This represents a 12 percent decline in the number of Medicare home health users in just one year. This decline is on top of the one million-user decrease from 1997 to 2000. The reduction in the number of Medicare users precedes the payment rate cut of October 1, 2002, the loss of the 10 percent rural add-on, and pending post-payment adjustments (such as partial episode payment reductions or adjustments due to downcoding by the intermediaries).

MEDICARE HOME HEALTH USERS

1997	3.5 MILLION
2000	2.5 MILLION
2001	2.2 MILLION

- In 2002, a smaller percentage of Medicare beneficiaries received home health services than did in 1991 (5.5 percent v. 6.5 percent).

- In its March 2003 report, MedPAC indicates that in an October 2002 survey, five of 15 hospital discharge planners observed hospitals taking special measures to provide rural beneficiaries with home care—to the point of renting hotel rooms or temporarily housing patients in facility-owned apartments.

- MedPAC also found that beneficiaries with certain diagnoses (such patients requiring therapy, wound care, daily care, those having the need for expensive medicines or supplies, or patients with mental illness or cognitive impairments), particularly in rural areas, are experiencing problems accessing care.

- Preliminary findings of a study of beneficiary use of home health services made public at MedPAC's April 2003 meeting revealed that some patients who previously would have been home health users are now receiving care in skilled nursing facilities, most likely at a much higher cost to the Medicare program.

- MedPAC suggests that home health agencies can further reduce services to patients as the means of addressing rising costs and the lower payment rates it recommends. Since 1997, the average number of visits provided over a 60-day episode has dropped from 36 to 20. With the MedPAC analysis, the average episode would drop an additional two to three visits. MedPAC has offered no support for its assumption that there would be no adverse consequence to patients' clinical outcomes. And, study by Outcome Concept Systems, a nationwide home health benchmarking firm, indicates that a reduction in average visits from 20 to 18 per episode results in reduced outcomes for patients.

THE DECLINE IN ACCESS IS DEMONSTRATED BY DRAMATICALLY REDUCED OUTLAY PROJECTIONS

- In early 2002 CMS widely publicized data that projected significant growth in home health outlays, beginning in FY2002, which never materialized. CMS recently made available data

that indicates dramatic reductions over last year in outlay projections for home health. Projected spending for FY2002 has dropped from $13.3 billion to $10 billion. Over the next 10 years, reductions in projected spending are even more dramatic.

Medicare Home Health Expenditures

		% change		% change		% change
2001	2002	2001-2002	2003	2002-2003	2004	2003-2004
$9,302	$10,032	7.9%	$10,188	1.6%	$10,616	4.2%

Source: 2001 data is from the President's FY2003 budget, all other data is from the President's FY2004 budget.

- With passage of the Balanced Budget Act of 1997 (BBA97), Congress intended to reduce outlays for home health care in FY2002 from a projected $29.9 billion to $25.2 billion. CMS's most recent projection of $10 billion for FY2002 indicates that the cuts in the home health benefit have been severe and unprecedented.

- During 1997 the Congress contemplated reducing home health outlays for the fiscal year 1998–2002 period by $16.1 billion. Instead, the five-year cuts yielded over $73 billion.

Congressional Budget Office (CBO) Home Health Spending Projections FY 1998–2002 (in $ billions)

	Jan 97	Aug 97	Mar 02	Mar 03
1998	21.1	20.0	14.9	14.9
1999	23.2	21.2	9.7	9.7
2000	25.3	21.2	9.2	9.2
2001	27.5	23.3	9.1	9.1
2002	29.9	25.2	11.4	10.0
TOTAL	127.0	110.9	54.3	52.9

IMPOSITION OF COPAYS ON THE HOME HEALTH CARE BENEFIT WOULD INCREASE COSTS AND FURTHER ERODE ACCESS TO CARE

- The imposition of copays and other new cost sharing on the home health benefit is one of a series of options put forth by the Congressional Budget Office (CBO) *(Budget Options 2003)* for further cuts in Medicare. Congress chose to eliminate home health copays in 1972 and a home health care deductible in 1980. We believe these were important, far-sighted modernizations in the Medicare program—a recognition that home care copays and deductibles restrict access to home care, result in worse health outcomes, increase institutionalization in hospitals and nursing homes, and prove costlier for the Medicare program.

- The goal of any increased cost-sharing requirements is usually aimed at reducing utilization. Given the dramatic drop in beneficiaries receiving home health care, home health copays would be regressive and, in effect, a tax on seriously ill and disabled home health beneficiaries who are predominately women 75 years and older. Copays would place an additional federal administrative burden on providers, further diverting scarce resources away from patient care. Surveys have shown that recipients of the Medicare home health benefit are already paying out of pocket for a large percentage of the home care they need, since the home health benefit does not meet all of their home care needs.

- Patients going on service for home health frequently have already incurred copay and deductible costs through payments to physicians, who must order services and frequently provide care plan oversight (a 20 percent copay for physician services is assessed).

HOME HEALTH CARE IS JEOPARDIZED BY LIMITED AND SHRINKING PAYMENT RATES

A crucial element to securing and preserving access to Medicare home health services is adequate payment rates. Medicare introduced the home health prospective payment system (PPS) in October 2000. At the time, it was an untried and untested payment method, reliant on a complex approach that utilized a base payment rate for a 60-day episode of care, adjusted to one of 80 different categories based on patient-specific factors. While PPS represents a positive reform by introducing predictable payment levels and efficiency-oriented incentives, it still is in its infancy with significant improvements and refinements needed. Overall, PPS is increasingly failing to provide sufficient payment to cover the costs of care delivered.

UNDERSTANDING PPS FINANCIAL RESULTS

To analyze the financial outcomes of PPS, NAHC secured nationwide data contained in the annual cost reports filed by home health agencies with Medicare. These data include cost reports submitted since the beginning of PPS. The cost reports involved agencies from all states and US territories and include hospital-based and freestanding agencies. Over 6,400 cost reports were utilized in the data analysis. These cost reports represent reports filed for cost reporting years ending 12/31/00 through 6/30/02, the most current period available.

MEDICARE MARGIN

As a whole, the cost reports demonstrate declining Medicare margins with a significant portion of the agencies experiencing losses with Medicare where the costs exceed these Medicare revenues. Rural home health agencies have lower margins on average than non-rural agencies.

Overall, the cost report data indicates that more than 37 percent of home health agencies are estimated to have Medicare losses with costs exceeding revenues in fiscal year 2003. The data shows that nearly 31 percent of the studied cost reports indicate a Medicare margin of 0 percent and lower. On October 1, 2002, Medicare payment rates were reduced by 4.9 percent under a statutory requirement originally enacted under BBA97, but postponed several times by Congress. When the 4.9 percent reduction is considered, an additional 6.4 percent of the cost

reports would indicate a Medicare margin of 0 percent or lower, resulting in an estimated 37.1 percent of home health agencies experiencing losses on Medicare revenues.

PERCENTAGE OF AGENCIES WITH MEDICARE LOSSES

2001-2	2003 estimated
30.7%	37.1%

Average margins among freestanding and hospital-based home health agencies show a decline since the inception of PPS. This decline may be related to increased administrative costs for regulatory requirements, investment in new technologies to achieve efficiencies, higher wages to respond to the expanding nursing shortage, and legislatively-mandated reductions in the annual inflation update in three of the previous four years.

All cost reports reviewed indicate an average margin of 7.12 percent. When standardized using the single, most recent cost report from each home health agency in the data base, the average margin declines to 5.15 percent.

The estimated average margin for 2003 with consideration of the "15 percent cut" that occurred on October 1, 2002 and the loss of the 10 percentage point rural add-on beginning April 1, 2003 is 0.25 percent for non-rural and -10.36 percent for rural home health agencies. This estimate is calculated by applying the "15 percent cut" as a 4.9 percent cut (the actual result) and applying the loss of the 10 percent rural add-on elimination to 20 percent of the home health agencies over a six-month period.

AVERAGE MARGINS FOR HOME HEALTH AGENCIES

October 2000—June 2002 (All cost reports)	7.12%
October 2000—June 2002 (Most recent cost report)	5.15%
FY 2003 estimated	
–All home health agencies	0.25%
–Rural	-10.36%

RURAL HOME HEALTH MARGINS

As expected, rural home health agencies experience lower margins on average than non-rural agencies. While the reasons for this result are not precisely known, it is believed that reduced productivity due to travel time, smaller patient census, and lack of available community support structures are some of the factors that increase the cost of care.

The October 2000 to June 2002 cost report data indicates that the average margin for rural-located home health agencies is 1.41 percent. When the data is limited to the most recent cost report from the agencies, that margin declines to -0.46 percent. In contrast, the non-rural located agencies have a 10.8 percent margin with a decline to 8.12 percent when limited to the most recent cost report. As stated earlier, the margins precede the October 2002 "15 percent cut" and the loss of the 10 percent rural add-on in April 2003.

RURAL AND NON-RURAL HHA MARGINS

All cost reports	
Rural	1.41%
Non-rural	10.08%
Most recent cost report	
Rural	-0.46%
Non-rural	8.12%

WHY ARE THE MedPAC-CALCULATED MARGINS SO DIFFERENT?

In the March 2003, Report to Congress, Medicare Payment Policy, MedPAC provides an analysis of Medicare home health margins. That analysis differs significantly from this report. MedPAC estimates overall Medicare home health margins at 21.9 percent in 2001 and 23.3 percent in 2002. MedPAC estimated rural agencies have estimated margins of 21.6 percent in 2001 and 19.1 percent in 2002.

The margins displayed herein are significantly different than the MedPAC estimates for several crucial reasons.

1. This analysis relies on 6,425 cost reports. The MedPAC analysis used only 684 cost reports.

2. This analysis used cost reports as recent as fiscal year ending 6/30/02. MedPAC used reports only covering October 2000–June 2001.

3. Data used represented all types of agencies from across the nation. MedPAC did not include hospital-based home health agencies, which make up about 30 percent of all home health agencies. MedPAC also excluded most New England-based agencies because of data unavailability at the time.

4. MedPAC used weighted averages. This approach ignores the diversity of agencies in terms of geographic location and size. However, the expanded database used here indicates a weighted average of 11.96 percent in contrast to the limited data used by MedPAC that reported a 21.9 percent margin. It should be noted that these margins involve data prior to the October 2002 and April 2003 cuts.

5. MedPAC's trend estimate for 2003 did not have the benefit of successive year cost report data.

SUMMARY: MEDICARE AGENCIES REMAIN FINANCIALLY UNSTABLE

After weathering three years of the temporary and flawed reimbursement system called the interim payment system (IPS), home health agencies hoped that PPS would signal stability and predictability. However, home health agencies now face potentially devastating financial results under PPS with nearly 40 percent of all agencies operating at a deficit relative to Medicare costs and revenues. Rural agencies are at even greater risk.

With expenses pared during IPS, indications are clear that access to care is suffering. Further reductions in patient care are not an option as quality of care is placed at great risk. Stability can only be achieved through well-planned and precisely targeted reforms. Further across-the-board cuts will only increase the risks.

CONCLUSIONS AND CONGRESSIONAL ACTION NEEDED

- CMS is already working on refinements to the Medicare home health PPS. The refinements cannot be appropriately targeted and implemented if there is no stability in these early stages of PPS. Both Congress and CMS recognized that the implementation of an untested PPS posed some risks for patients, providers, and Medicare. It was anticipated that CMS would make any necessary adjustments when the impact of PPS could be properly analyzed. As such, it is premature for Congress to accept the MedPAC recommendation and institute across-the-board cuts and rate freezes before CMS has had the opportunity to finish its plan of action on PPS fine-tuning.

- The home care community recommends that Congress reject recommendations by MedPAC and CBO in order to stem further losses of access to home health services. While maintaining the status quo through restoration of the 15 percent cut, continuation of the 10 percent rural add-on, and application of a full inflation update will not guarantee the restoration of access to hundreds of thousands of individuals who have lost home health services recently, it should prevent further erosion in access. Congress should also undertake an immediate effort to institute corrective action to provide an opportunity for the full scope of the Medicare home health benefit to be honored and access restored.