

## Freeze on Home Health Reimbursement Is Unwarranted

The “Deficit Reduction Act,” or S. 1932, would also deprive home health agencies of their 2.8 percent update in 2006. The House of Representatives votes on the bill next week, as early as February 1, 2006. A cut to home health agencies is clinically and fiscally unwise given its tremendous value to both patients and to taxpayers. Homecare is the preferred by seniors, and homecare is by far the most cost-effective setting for healthcare in America, as Health and Human Services Secretary Mike Leavitt has pointed out. Additional reasons for opposing the home health freeze follow:

- The Medicare Payment Advisory Commission (MedPAC) bases its recommendation for a freeze on home health reimbursement in part on the recent growth in the number of Medicare home health agencies (HHA) nationwide. In fact, between 2003 and 2004 the number of HHAs grew by about 335. Florida and Texas, however, together accounted for 395 new agencies. Twenty-eight states saw a decline, while 7 plus the Virgin Islands had no gain or loss. Only 15 states and Washington DC had an increase. Several rural states experienced a dramatic loss of HHAs. The number in Montana declined from 47 to 37 in just one year, while Wyoming saw a reduction from 37 agencies to 28.
- MedPAC also bases its recommendation for a freeze on home health reimbursement on a claim of profit margins of 16 percent in 2004, with 20 percent of HHAs having negative margins. These numbers are distorted because CMS excluded from the data hospital based and nursing home based home health agencies whose inclusion MedPAC acknowledges would have reduced the margin. MedPAC also gives disproportionate weight to large HHAs with higher margins through utilization of a weighted methodology rather than a method that gives equal weight to all providers. Using this latter methodology would reduce margins significantly, e.g., from 16 percent to 7.12 percent.
- Imposition of a freeze on home health reimbursement based on flaws in the Medicare home health Prospective Payment System imposes a penalty on all providers without addressing underlying problems. The home health industry has identified a number of areas that need refinement including the HHRG case mix system, the ten-visit therapy threshold, and reimbursement for non-routine medical supplies for wound care and other patients whose care requires expensive medical supplies. Refinement of PPS should address the issue of any distorted margins for patients who meet the ten visit therapy threshold and any distortions that threshold may have caused in home health payments. The industry has made a number of recommendations for refinements and has met several times with the CMS PPS team to continue discussions on our recommendations. CMS plans to issue a Notice of Proposed Rulemaking to refine the structure of home health PPS later this year.
- CMS will base its refinements on studies performed by Abt Associates during the last several years. CMS and Abt Associates have convened a Technical Expert Panel that is addressing refinements to the home health PPS. The panel is considering recommendations related to case mix weights, the therapy threshold, and reimbursement for medical supplies. The HHS Office of Inspector General is also conducting several studies on home health PPS, including case mix and the therapy threshold.

- MedPAC’s claim of a 16 percent profit margin is inconsistent with a CMS report, *Health Care Industry Market Update: Home Health*, published in September 2003, which states that the median operating margin for publicly traded HHAs was 2.3% in 2002 and that the home health “sector has limited access to the public capital markets....Wall Street gives these companies very low market valuations.” Other industry data analysis, based on all available home health agency cost reports including hospital and nursing home based agencies, indicate a margin in the area of 7 percent as well as a large numbers of agencies with margins below zero. These disparate reports on profit margins would indicate that the actual margins are not yet definitively determined.
- Congress and CMS are urging HHAs to invest in telehealth and health information technology. Adoption of technology is a primary goal of the Quality Improvement Organizations in the 8<sup>th</sup> Scope of Work (SOW) and in CMS’s initiatives for transformational change in home health quality and corporate culture. According to CMS’s *Health Care Industry Market Update: Home Health*: “While ultimately a benefit, the initial investment in information technology may be a significant cost to many HHAs.” Freezing home health reimbursement will deprive numerous HHAs of the resources they require to invest in technology to achieve transformational change in the quality of care and cost savings for the Medicare program. Home health agencies are also preparing for the advent of Pay for Performance with adoption of evidence-based best practices, as well as investment in health information technology. If deprived of the resources they need to make this transformation then the goals of the 8<sup>th</sup> SOW and Pay for Performance may not be met.
- For numerous home health agencies, the freeze in reimbursement is in addition to reduced HHRG rates, effective January 1, 2006, resulting from CMS’s adoption of Core Based Statistical Areas for the wage portion of home health reimbursement. This applies to a number of metropolitan areas and some areas formerly classified as urban but now given rural status. No home health agency is able to reduce salaries and benefits for nurses and therapists commensurate with the level of reimbursement reductions precipitated by the revised wage index. While reducing reimbursement to many wage areas, the July 14, 2005, final rule simultaneously acknowledges a 3.3 percent increase in the cost of providing home health services.
- HHAs are experiencing increasing difficulty recruiting and retaining nurses and therapists, the largest single labor component, placing upward pressure on wage and benefit levels. Growth in costs for this critical component of home health operations must be fully accounted for in reimbursement rates. HHAs also continue to be at a competitive disadvantage in hiring nurses and therapists in areas where the local hospitals have been reclassified to a higher wage area, a benefit not available to home health agencies.
- When MedPAC was developing home health recommendations for 2007, it would have been operating on the assumption that home health agencies would receive a 2.8 percent market update in 2006. If home health agencies do not receive this inflation adjustment in 2006 (due to the budget bill passing) then another reduction in 2007 on top of the 2006 reduction would be redundant.

- AAHomecare recommends that before further reductions to home health reimbursement are made, the home health Prospective Payment System be refined first, that home health agencies not be deprived of the resources they need to invest in health information technology and telehealth as well as in transformational change in quality and corporate culture, which Congress and the Department of Health and Human Services are urging them to do. Then reassess and adjust as appropriate.

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