



Ruth L. Constant, EdD
Chairman of the Board

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

Val J. Halamandaris, JD
President

MAINTAIN THE ADD-ON FOR HOME HEALTH SERVICES IN RURAL AREAS

ISSUE: In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent add-on for home health services delivered in rural areas between April 2001 and April 2003. On April 1, 2003, the add-on expired. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 extended the rural add-on at 5 percent for a period of one year beginning April 1, 2004. It expires on March 31, 2005. In July 2004, legislation (S. 2659 and H.R. 4902) was introduced to extend the 5 percent rural add-on for another two-years, through March 31, 2007.

RECOMMENDATION: Congress should enact S.2659 and H.R. 4902.

RATIONALE:

Delays in Placing Rural Patients

- In a November 2002 findings by the Medicare Payment Advisory Commission (MedPAC), MedPAC staff indicated that hospital discharge planners report that patients in rural areas who need therapy may have delays in placement due to unavailability of therapists.

Workforce Shortages and Competitive Wages

- Rural agencies have greater difficulty hiring or contracting with therapists, and frequently must use nurses instead of therapists to provide a limited array of rehabilitative services. Not only is the patient rehabilitation progress restricted, but when an agency does not use a physical therapist for therapy services, it cannot qualify for the higher therapy rates allowed by the prospective payment system (PPS).
- Home health agencies generally cannot compete with hospitals to hire staff because they are unable to afford the wages, benefits, and large signing bonuses that hospitals offer. Further, home health agencies are not eligible for reclassification of their wage index – an option available only to hospitals. This problem can be even greater for rural agencies in cases where their rural hospital counterparts are eligible to become critical access hospitals or sole community providers, which afford them the opportunity for greater reimbursement. Despite this, rural home health agencies must offer competitive wages for skilled care workers that are comparable to wages paid in urban areas because of the nationwide nursing shortage. In certain frontier states, graduating nurses leave the state seeking better wages, thus compounding the workforce shortage.

Costs Often Higher Than for Their Urban Counterparts

- Agencies in rural areas frequently are smaller than their urban counterparts, which means that costs are higher due to smaller scale operations. Smaller agencies with fewer patients and fewer visits means that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a smaller number of patients and visits, increasing overall per-patient and per-visit costs. Smaller agencies have less likelihood of maintaining a high patient volume –which means they have less access to a varied case-mix. There are not always enough marginally profitable cases to offset the resource-intensive, expensive cases. Outlier payments are not sufficient to cover these costs. A small agency's census of patients is often inconsistent, which makes it difficult to retain consistent full-time staff.
- In many rural areas, home health agencies can be the primary caregivers for homebound beneficiaries with limited access to transportation. This means that rural patients often require more resources than their urban counterparts, and are more expensive for agencies to serve. Agencies are making decisions to not accept certain patients because of their limited resources, and access will suffer further.

Very Limited or No Access to Capital Resulting In Inability to Purchase Time-Saving Technology

- Access to capital has been difficult for home health agencies generally since 1997 due to the dramatic cuts under the interim payment system. Rural home health agencies, in particular, often lack access to the capital needed to take advantage of time-saving technological advances that could increase efficiency, such as home monitoring devices. This problem is compounded by the fact that Medicare payment policy does *not* allow for reimbursement of such devices.

Loss of Rural Add-On Will Result In Service Area Reductions

- The loss of the rural add-on, for the period of April 1, 2003, through March 31, 2004, resulted in reductions in service areas and the inability to care for the sickest Medicare beneficiaries. Access to care has become a critical issue in rural America. Prior to the loss of the rural add-on, there were already large areas (e.g., Montana) where certain counties have no home health services. Agencies are reporting that they have begun to eliminate delivery of services to remote areas. For example, agencies in Maine have had to eliminate delivery of services to outlying islands.

Rural Agencies Generally Have Lower Margins

- In its March 2003 Report to Congress, MedPAC found that profit margins of rural agencies were below those of urban agencies. Moreover, margins for rural home health agencies fell even further when adjusting for the loss of the 10 percent rural add-on in April 2003.
- To analyze the financial impact of the home health PPS, NAHC secured nationwide data contained in the annual Medicare cost reports filed by freestanding and hospital-based home health agencies. The cost report data does not fully reflect the impact of the October 2002 home health payment cut, nor does it reflect the one-year loss of the 10 percent rural add-on from April 1, 2003, through March 31, 2004. Using the single, most recent cost report from each home health agency in the data base, the average Medicare margin for all agencies was 2.59 percent. For rural agencies the average Medicare margin was **minus** 3.09 percent.