

## Seeking Stability – The Case for Elimination of the 15% Cut

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**THE 15% HOME CARE CUT – AN AFTERTHOUGHT TO BBA97 CHANGES.** During discussions on the Balanced Budget Act of 1997 (BBA97), the Congressional Budget Office (CBO) advised the Congress that its target goal of reducing outlays in the Medicare home health program by \$16 billion would not be met by instituting planned payment changes including the interim payment system (IPS) and the prospective payment system (PPS). CBO recommended that an additional 15% cut from the per-beneficiary and per-visit payment limits be imposed in 1999. Total BBA97 changes (including the 15% cut) were estimated by CBO to yield \$16.1 billion in home health savings over fiscal years 1998-2002.

**THE 15% CUT IS NOT NEEDED TO MEET BBA97 TARGETS.** Under the BBA97, the Congress expected to reduce Medicare home health outlays by \$16.1 billion over five years. Instead, more than \$72 billion will be cut from home health outlay projections over the same time period. These savings were achieved without implementation of the 15% cut, which originally was scheduled for 1999 but was delayed by the Congress for a total of three years.

**BBA97 CUTS DESTABILIZED THE HOME HEALTH PROGRAM.** The BBA97 has had a dramatic destabilizing effect upon the home health program and on our nation's network of home health agencies. Since 1997 the number of home health agencies has fallen by more than 3,500, or 34%. Between 1997 and 1999 the number of beneficiaries served annually fell by nearly 1 million, reimbursement per patient fell by 38%, and overall outlays fell by 48%.

**IS THE 15% CUT TRULY A CUT OF 15% OFF PAYMENT RATES?** As originally crafted, the cut was scheduled to be implemented in October 1999 (concurrent with the home health PPS) and to reduce per-visit and per-beneficiary payment limits by 15%. From there, the Centers for Medicare and Medicaid Services (CMS) was instructed to use a “budget neutrality” factor (adjusting estimated payments to ensure that no more would be spent in the first year of PPS than was in the final year of the IPS) to establish the base payment rate under the PPS. While the Congress delayed the 15% cut, the budget neutrality factor was used in establishing the initial PPS payment rates, which resulted in a 12% reduction in the PPS base payment that had been calculated by CMS to be the average cost of an episode. CMS estimates that imposition of the 15% cut in October 2002 will result in a base rate reduction of approximately 7% below current rates. Once CMS has added in an inflation update of 2.1% for FY2003, the net effect will be a reduction of 4.9% in payment rates.

**WHAT IS THE CURRENT STATE OF THE HOME HEALTH INDUSTRY?** Despite the fact that agencies generally feel as though the Medicare home health PPS has promise, there are several factors that indicate that the program has not seen stabilization yet. In fact, CMS admits that the PPS case-mix system itself is only accurate in 3 of 10 cases. Also, while the number of agency closings have slowed, closures continue and there is no significant influx of new providers into the system. Further, the number of beneficiaries and episodes of care delivered remain far lower than expected under the PPS. The number of staff employed by home care agencies, which had dropped by about 175,000 full time employees between 1996 and 2000, has not increased significantly. Additionally, due to the market basket reductions in fiscal years 2000 and 2001, and scheduled for 2003, agency revenues have not kept pace with inflation. The Medicare Payment Advisory Commission (MedPAC), in determining earlier this year that the 15% reduction should be eliminated (along with an extension of the 10% rural add-on and elimination of the 1.1% market basket reduction in 2003), provided a framework for analyzing the state of home care. MedPAC believes that “the numerous recent changes, the immaturity of the current [payment] system, the lack of standards by which to judge the appropriateness of service use, and the uncertainty regarding both appropriate costs and the likely changes in costs all caution against substantial payment changes for this sector” (MedPAC, March 2002). Recently CMS published the “Health Care Industry Market Report” which found that the home care industry is fragmented and has great difficulty in accessing capital for needed technology improvements. Furthermore, the report demonstrates the financial instability of home health agencies as a result of changes implemented under BBA97 (June 2002).

**NO DATA AVAILABLE TO JUSTIFY FURTHER CUTS IN HOME HEALTH.** As of May 2002, *NO DATA* relative to agency costs under PPS is available, due in large part to CMS’ failure to compile the Provider Statistical and Reimbursement (PS&R) reports. Absent such data, it is impossible to determine what real costs agencies are incurring in the provision of home health services. Further, CMS HCIS data, which provides information about number of beneficiaries served, number of visits, number of episodes per patient, and case-mix factors have been held back due to lack of reliability. *No reliable data is available for any period since 1999.*

**CMS HOME HEALTH “GROWTH” FIGURES ARE HIGHLY SUSPECT.** With respect to growth rates, the CMS

Office of the Actuary and the Office of Management and Budget (OMB) have projected that, between FY2001 and FY2002, home health outlays will grow by approximately 42%, from \$9.3 billion to \$13.2 billion. **(The CBO projects home health spending for FY2002 will be \$11.4 billion, not \$13.2 billion, reflecting a growth rate of half that of CMS.)** The NAHC analysis of the 40+% growth figure shows that most of it relates to a one-time cash flow shift that occurred as the result of the transition to PPS. Most of the remaining growth estimates are based on guesses. Given the consistent errors on the part of both CBO and CMS in accurately predicting Medicare outlays for home health, and their tendency to overstate expected outlays as part of their projections, the current data should be viewed with great suspicion.

**THE GAO ANALYSIS OF THE IMPACT OF THE 15% CUT IS SEVERELY FLAWED.** The General Accounting Office (GAO) released a study that indicates that, on average, home health agencies are netting about \$700 on each episode that they provide. The GAO analysis is severely flawed and does not reflect the current state of home care, particularly since no one has access to real cost data. By relying on averaging, GAO ignores the diversity of home health patients, the variation in the range of agency costs, and the inconsistency of the home care marketplace, all of which make averaging extremely dangerous. The GAO methodology is also unreliable -- over the last five years, CMS, CBO, and GAO have consistently based analyses on faulty assumptions regarding home health agency behavioral reactions to reimbursement changes. Overall, Medicare prognosticators continually project that home health agencies will alter behavior to increase utilization and increase Medicare expenditures while reality shows that no such behavior occurs. Further, The GAO relies on an inflation rate applied to 1996-97 data. That approach ignores significant changes in home care including the increased use of information technology, telehealth services, specialist nurses, and alternative profession disciplines. The inflation index also does not account for new regulatory requirements such as Health Insurance Portability and Accountability Act (HIPAA) requirements, OASIS, and major workforce shortages that drive costs up before the index can include them. GAO's study ignores findings under the PPS demonstration that indicate that, as fewer visits are delivered, costs per visit increase. Finally, the GAO uses a simplistic approach that fails to account for basic, crucial revenue adjustments. These include partial episode payment (PEP) adjustments, significant change in condition (SCIC) adjustments, case mix downcoding, and low utilization payment adjustment (LUPA) losses. All indications are that these adjustments may affect 25 percent of all episodes.

**CAN HOME HEALTH AGENCIES SUSTAIN ANOTHER CUT?** Since the implementation of the BBA97, the financial instability in the home health industry has limited agencies' access to capital. In turn, this has prevented purchase of equipment that encourages efficiencies. The reduced inflation update over the last few years has added to this difficulty. Further, a temporary, two-year 10% add on for care provided to patients residing in rural areas is scheduled to sunset in April 2003. Additionally, while many agencies believe that the PPS has had a stabilizing effect upon their operations, many would be hard-pressed to absorb an additional 7% cut.

**HOW COULD ELIMINATION OF THE 15% CUT AND EXTENSION OF THE RURAL ADD-ON BE FINANCED?** Given the financial instability of the home health program over the last few years, it is difficult to determine whether or not the costs of elimination or delay of the 15% cut or extension of the 10% add-on could be absorbed by agencies. Since among Medicare providers, home health has absorbed far and away the greatest proportion of cuts from the BBA97, it should be given greatest preference in use of money that has been set aside for provider payment adjustments. Secondly, the Congress should direct CMS to step up its efforts to develop accurate data in home health costs and revenues, and evaluate modifications to the PPS case-mix system that might provide fairer distribution of resources, and make recommendations on rebasing of rates, if justified, to meet budget outlay targets.

**WOULD IMPOSITION OF A HOME HEALTH COPAYMENT BE WISE?** A number of concerns arise with respect to suggestions that the Congress impose a home health copay. First, a new copayment would add significant administrative costs relative to setting up new systems for collection and training of staff. Additionally, copayments are frequently raised as a means to reduce utilization -- with the home health program serving about 1 million beneficiaries less annually than it did in 1997, this does not appear to be a necessary step. Agencies anticipate that a copayment will result in significant losses due to uncollectible debt. Further, a copayment would fall most heavily upon the sickest patients, and could discourage use of home care that could help to ward off the need for more intensive, higher-cost care. Finally, it is questionable whether an affordable copayment would yield enough revenue to cover the cost of eliminating the 15% cut.

## **SENATE ACTION NEEDED**

### **PROFOUND CHANGES IN HOME HEALTH PROGRAM OVER THE LAST FIVE YEARS HAVE HAD A DESTABILIZING EFFECT UPON HOME CARE AGENCIES**

#### **HOME CARE AGENCIES SEEK PROGRAM STABILITY**

**The Senate must act NOW to pass legislation that will bring stability to the Medicare home health program. Provisions of this legislation should contain the following home care priorities.**

- Eliminate the 15 percent cut in home health payments scheduled for October 1, 2002;
- Extend the 10 percent rural add-on for home health services (expires in April 2003);
- Restore the full market-basket updates for home health and hospice;
- Limit OASIS data collection to Medicare patients;
- Oppose co-payments for Medicare home health services;
- Oppose nationwide expansion of home medical equipment competitive bidding; and
- Ease regulatory burdens on home care and hospice organizations.

#### **Eliminate the 15 percent cut in home health payments scheduled for October 1, 2002**

A provision in the House-passed Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954) eliminates the 15 percent reduction in home health payments. The National Association for Home Care (NAHC) supports this provision.

- The 15 percent cut is not needed to meet the Balanced Budget Act 1997 (BBA97) targets: Congress expected to reduce Medicare home health outlays by \$16.1 billion over five years. Instead, more than \$72 billion will be cut from home health outlay projections over the same time period. The actual reduction in home health outlays achieved as a result of BBA97 was 449 percent higher than expected under the bill (See Chart 1, Percent of Expected BBA97 Cuts Achieved).
- Of total BBA97 cuts, home care's share is more than 29 percent of program reductions, far in excess of those sustained by hospitals, skilled nursing facilities and physicians (See Chart 2, Percent Share of Cuts)
- Cuts have destabilized the Medicare home care program.  
Since 1997, the number of home care agencies has fallen by more than 3,500, or 34 percent  
Between 1997 and 1999, the number of beneficiaries served annually fell by nearly 1 million, reimbursement per patient fell by 38 percent and overall outlays fell by 48 percent.
- The Medicare Payment Advisory Commission (MedPAC) has recommended that Congress eliminate the 15 percent payment cut for home health services (Report to Congress, March 2002, Medicare Payment Policy, page 97).

#### **Extend the 10 percent rural add-on for home health services (expires in April 2003)**

A provision in the House-passed Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954) provides for an extension through the end of calendar year 2004 of the 10 percent additional payment for home health services furnished in rural areas. NAHC supports this provision.

- Costs per patient can be higher in rural areas than in urban areas because of small scale operations, the time and distances traveled to rural patients, and the differences in therapy services.
- The proportion of beneficiaries using home health declined more significantly between 1997 and 1999 in rural areas (-26 percent) than it did in urban areas (-19 percent).
- Rural agencies lost a larger proportion of their agencies than urban areas.
- MedPAC has recommended that Congress extend for two years the 10 percent add-on payments for home health services in rural areas (Report to Congress, March 2002, Medicare Payment Policy, page 96).

#### **Restore the full market basket updates for home health**

A provision in the House-passed Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954) would cut the inflation market basket updates for home health payments by about 40 percent on average over three years (through CY 2005). NAHC supports a full market basket update for home health.

- Due to home care market basket reductions in fiscal years 2000, 2001, and those scheduled for 2003, agency revenues have not kept pace with inflation.
- The costs of home care services have increased in the past few years due to new administrative responsibilities and reduced economies of scale due to lowered visit volume.
- Labor costs are increasing as a result of a shortage of nurses and home health aides combined with skyrocketing premiums for liability insurance, workers compensation insurance, and employee health insurance.
- MedPAC has recommended that Congress update home health payments by the full market basket for fiscal year 2003 (Report to Congress, Medicare Payment Policy, page 97).
- MedPAC found that there is no evidence that payments to home health are inappropriate or that costs will not grow at the same rate as input prices (Report to Congress, March 2002, Medicare Payment Policy, page 97).

### **Limit OASIS data collection to Medicare patients**

A provision in the House-passed Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954) provides for the creation of an 18-month Outcome and Assessment Information Set (OASIS) task force and suspension of OASIS collection and reporting on non-Medicare and non-Medicaid patients until after the task force reports. NAHC supports the creation of the task force but seeks to have the Senate go one step further and limit the OASIS collection and reporting to Medicare patients only, as provided for in The Medicare Appeals, Regulatory and Contracting Improvement Act (S. 1738).

- The cost of implementing and collecting OASIS data for non-Medicare patients is not covered by other payors.
- States are not using OASIS data to measure patient outcomes for non-Medicare patients because of the cost involved.
- The needs of Medicare and Medicaid patients are different and their outcomes cannot be compared.
- OASIS data set and outcome measures should not involve massive collection of excess data that is not essential to the measurement of home health quality and burdens providers with excessive paper work.
- OASIS must be simple, have clinical utility for all patients and be reliable and valid.
- OASIS outcomes should be risk adjusted and based solely on scientifically valid, reliable OASIS items.
- The reimbursement methodology should ensure appropriate compensation to agencies for the cost of collecting and analyzing data needed for an effective quality improvement program.
- Limiting OASIS to Medicare patients will help alleviate stress on patients and nurses and reduce the cost of OASIS administration for home health agencies.

### **Oppose co-payments for Medicare home health services**

Earlier this year, the House Ways and Means Committee reported out Medicare legislation that included imposing a beneficiary copayment on Medicare home health services. While the final Medicare legislative package adopted by the House (H.R.4954) did not contain a copayment provision, the proposal, however, may arise in the Senate. NAHC opposes a copayment on home health services.

- Copays are regressive and tax the sick.
- Copays will restrict access to home care, result in worse health outcomes, increase institutionalization and prove costlier for the Medicare program.
- Copays will fall most heavily on the oldest group of beneficiaries who are predominately women 75 years and older.
- Copays will place an additional federal administrative burden on providers further diverting scarce resources away from patient care.

### **Oppose nationwide expansion of home medical equipment competitive bidding**

A provision in the House-passed Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954) would establish a nationwide competitive bidding program for home medical equipment (HME) and off-the-shelf orthotics. NAHC opposes efforts to institute a nationwide competitive bidding program for HME since such a policy:

- Reduces beneficiary choice by allowing only those suppliers with winning bids to serve Medicare beneficiaries;
- Reduces quality since, under competitive bidding, price becomes the main buying criteria;

- Raises costs in the long run by promoting supplier monopolies that reduce competition; and
- Creates a huge national bureaucracy at CMS while providing little in the way of program savings.

### **Ease regulatory burdens on home care and hospice organizations**

The Medicare Appeals, Regulatory and Contracting Improvement Act (S. 1738) would significantly ease regulatory burdens for home health providers. Similar legislation passed the House last year and was included in the House-passed Medicare Modernization and Prescription Drug Act (H.R. 4954) this year. The regulatory relief would include:

- Allows providers to correct minor errors and omissions on claims without having to appeal the claim.
- Postpones recovery of overpayments through the first level of appeal.
- Allows hospice providers to contract with other hospices for core services.
- Prohibits imposition of sanctions and recovery of overpayments if a provider incurs them by following written erroneous guidance from Medicare contractors and allows for a five-year repayment plan in extreme hardship.

**Home Health Reductions Exceed \$174 Billion Between FY98 and FY2007**

	<b>FY97</b>	<b>FY98</b>	<b>FY99</b>	<b>FY2000</b>	<b>FY2001</b>	<b>FY2002</b>	<b>FY2003</b>	<b>FY2004</b>	<b>FY2005</b>	<b>FY2006</b>	<b>FY2007</b>	<b>10 year totals FY97-FY2002</b>
CBO 1/97 Home Health Baseline (in \$billions)	19.0	21.1	23.2	25.3	27.5	29.9	32.3	34.9	37.6	40.4	43.4	315.6
CBO 7/97 Estimated BBA97 Cuts (in \$billions)	0	-1.1	-2.0	-4.1	-4.2	-4.7	-5.3	-6.0	-6.6	-7.3	-8.1	-49.4
7/97 Revised Baseline (1/97 Baseline less BBA97 Cuts) (in \$billions)	19.0	20.0	21.2	21.2	23.3	25.2	27.0	28.9	31.0	33.1	35.3	266.2
CBO 3/02 Home Health Baseline (in \$billions)	17.5	14.9	9.7	9.2	9.1	11.4	12.5	14.3	17.0	19.8	23.1	141.0
Actual Cuts (in \$billions)	n/a	-6.2	-13.5	-16.1	-18.4	-18.5	-19.8	-20.6	-20.6	-20.6	-20.3	-174.6

\$174.6 billion in home health savings from BBA over 10 years (FY98-FY2007)

\$72.7 billion in home health savings from BBA over 5 years (FY98-FY2002)

For questions regarding this chart, contact National Association for Home Care, Government Affairs, at 202/547-7424.

## BBA97 Budget Cuts: A Comparative Analysis of Impact on Medicare Providers

<b>Chart I: Congressional Budget Office (CBO) Projections for Outlays and Reductions Over Fiscal Years 1998 through 2002 (in \$ billions)</b>					
	January 1997 (pre-BBA outlay projections)	August 1997 (BBA outlay projections)	Projected BBA Outlay Reductions	March 2002 Outlay Projections	Actual BBA Outlay Reductions
Home Health	127.0	110.8	-16.2	54.3	-72.7
Inpatient Hospital	482.6	449.7	-32.9	456.7	-25.9
Skilled Nursing Facilities	83.3	73.8	-9.5	61.6	-21.7
Physicians	169.5	165.0	-4.5	184.0	+14.5

<b>Chart II: Percent of Expected BBA Cuts Achieved</b>			
	Actual BBA Outlay Reductions (in \$ billions)	Projected BBA Outlay Reductions (in \$ billions)	Percent of Expected BBA Cuts Achieved
Home Health	72.7	16.2 =	448.8%
Inpatient Hospital	25.9	32.9 =	78.7%
Skilled Nursing Facilities	21.7	9.5 =	228.4%
Physicians	-14.5	4.5 =	-332.2%
Total Medicare	247.8	116.4 =	212.9%

Chart II: The actual reduction in home health outlays achieved as the result of BBA97 was 449% higher than expected..

<b>Chart III: Percent Share of Cuts</b>			
	Actual BBA Outlay Reductions (in \$ billions)	Total Medicare Reductions (in \$ billions)	Percent Share of Cuts
Home Health	72.7	247.8 =	29.3%
Inpatient Hospital	25.9	247.8 =	10.5%
Skilled Nursing Facilities	21.7	247.8 =	8.8%
Physicians	-14.5	247.8 =	-5.9%

Chart III: Of total BBA97 cuts, home health's share is more than 29% of program reductions, far in excess of those sustained by hospitals and skilled nursing facilities. Outlays for physician services saw an overall increase. The percent of total cuts sustained by home health is particularly significant since home health comprises less than 5% of total program outlays.