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PRESERVE ACCESS TO RURAL HOME HEALTH SERVICES

ISSUE: In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent payment improvement for home health services delivered in rural areas between April 2001 and April 2003. On April 1, 2003, the payment improvement expired. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reinstated the rural payment improvement at 5 percent for a period of one year beginning April 1, 2004, ending on March 31, 2005. At the beginning of the 109th Congress, H.R. 11 the Medicare Rural Home Health Services Improvement Act was introduced to extend the 5 percent rural payment improvement for another two-years, through March 31, 2007. A Senate companion bill will soon be introduced.

RECOMMENDATION: Congress should enact the Medicare Rural Home Health Services Improvement Act of 2005.

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.

Cut in Reimbursement 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 payment improvement, 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.

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 rehabilitative services. Not only may these circumstances have an impact on a patient's rehabilitation progress, 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 have difficulty competing 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 care workers that are comparable to wages paid in urban areas because of the nationwide nursing and staffing shortages. 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 mean 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.

Rural Agencies Generally Have Lower Margins

- Since MedPAC has been studying Medicare home health margins, it has consistently found that the profit margins of rural agencies were below those of urban agencies.
- 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. Cost reports for 2003-4 reveal that the average Medicare margin for urban agencies was 4.87 percent. For rural agencies the average Medicare margin was **minus** 4.91 percent.

(2/05) For more information, contact NAHC Government Affairs, 202-547-7424