

MAINTAIN THE 10 PERCENT 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. Congress should extend the add-on for home health services delivered in rural areas.

RATIONALE:

Delays in Placing Rural Patients

- In a November 2002 presentation to the Medicare Payment Advisory Commission (MedPAC), MedPAC staff presented findings about access to post-hospital care from a focus group of hospital discharge planners that provide some clues to what's going on regarding access to home health care. The discharge planners indicated 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 offer signing bonuses of the magnitude that hospitals are able. Further, home health agencies are not eligible for reclassification of their wage index – this option is 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 and, because of the nationwide nursing shortage, those wages are becoming comparable to those paid in urban areas. 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 also has census inconsistency, which makes it difficult to retain full-time consistent 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 and widespread overpayments. Rural home health agencies don't have 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 has 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 that of urban agencies. Moreover, margins for rural home health agencies fell even further when adjusting for the loss of the 10% rural add-on in April 2003.
- To analyze the financial outcomes of the home health prospective payment system (PPS), NAHC secured nationwide data contained in the annual cost reports filed by home health agencies with Medicare. All the cost report data available for review preceded the October 2002 home health payment cut and the loss of the 10 percent rural add-on in April 2003. Using the single, most recent cost report from each home health agency in the data base, the average margin overall was 5.15 percent. For rural agencies the average margin was -0.46 percent.
- With consideration of the October 1, 2002, cut in home health payments and the loss of the 10 percentage point rural add-on beginning April 1, 2003, the estimated average margin for 2003 is 0.25 percent for non-rural and -10.36 percent for rural home health agencies. This estimate is calculated by applying the April 2002 "15 percent cut" as a 4.9 percent cut (the actual result) and applying the loss of the 10 percent rural add-on to agencies in rural areas.

