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RATE REBASING IN MEDICARE HOME HEALTH SERVICES: An HHFMA White Paper Review

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BACKGROUND

The Patient Protection and Affordable Care Act of 2010 (PPACA) requires that Medicare reset or rebase the home health services episode payment rate beginning in 2014 and phased-in proportionately over a four (4) year period. The legislative mandate provides some direction to Medicare on the factors required to be considered in the calculation of the rebased payment rate. Specifically, it provides:

“(I) IN GENERAL.—Subject to sub-clause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and free-standing agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

This provision requires that Medicare consider costs, but not use costs as the exclusive factors in the rate calculation. The Medicare Payment Advisory Commission (MedPAC), in deliberating its 2010 recommendation on the rebasing of home health payment rates, clearly stated that they did not support rates based solely on costs, recognizing a need for capital by home health agencies (<http://www.medpac.gov/transcripts/0108-0109MedPAC.final.pdf>. Pp. 203-207).

Data from home health cost reports indicates that in 2010 a base payment rate of \$2,312.94 per episode resulted in nearly 37.4% of all home health agencies receiving payment less than the costs of care. Further, cost report data showed a wide range in financial outcomes for home health agency Medicare services. This wide range of outcomes demonstrates that a rate based on average episode costs would have significant adverse impact on access to care.

Medicare Margin	Number of HHAs	Percentage of HHAs	Medicare Revenues
> 50%	277	3.1%	\$344,285,282
50% - 25%	2,235	24.9%	\$6,694,452,066
25% - 20%	800	8.9%	\$2,136,347,726
20% - 15%	836	9.3%	\$1,975,460,696
15% - 10%	756	8.4%	\$1,557,790,504
10% - 5%	712	7.9%	\$1,226,842,011
5% - 0%	671	7.5%	\$1,176,083,092
0% - -5%	589	6.6%	\$861,608,308
-5% - -10%	383	4.3%	\$510,054,411
-10% - -15%	308	3.4%	\$372,581,483
-15% - -20%	240	2.7%	\$319,515,709
-20% - -25%	195	2.2%	\$173,119,887
<-25%	990	11.0%	\$801,709,602
NATIONAL	8,992		\$18,149,850,777

It is notable that the financial outcome results referenced above are based on the reported Medicare allowable costs and do not include all the current cost elements involved in the delivery of care. For

example, the use of telehealth services have grown exponentially since the 1996 base year that Medicare used to calculate the existing base rate. Telehealth has become instrumental in the delivery of quality care. However, the cost report does not include telehealth as an allowable cost.

In addition, since FY2010, HHPPS rates have dropped following several legislative and regulatory changes. The CY2010 rates included a 2.5% increase related to the establishment of a 10% cap on outlier revenues accompanied by a reduction in the outlier “budget” to 2.5% of home health expenditures. That 2.5% increase was limited to CY2010 only. CY2011 HHPPS rates were reduced by a 3.79% coding weight change adjustment and a 1 point reduction in the Market Basket Index (MBI).

CY2012 rates are reduced by another 3.79% coding adjustment and a further 1 point MBI reduction. For 2012, the base episode rate is \$2,138.52 or 92.45% of the CY2010 rates.

The post-2010 rate changes will increase the number and percentage of HHAs with below-zero Medicare margins significantly. HHFMA estimates that nearly 50% of all HHAs will experience negative Medicare margins in 2012. Average cost-based payment rates through rebasing will likely destroy access to care in many parts of the country.

The Medicare margins data only show a portion of the financial status of home health agencies. The overall margin for Medicare-participating freestanding HHAs in 2010 is 3.15%. If hospital-based HHAs are included in the overall margin calculation, it is highly likely to be below zero as these HHAs generally have Medicare margins in the negative. The hospital-based HHA overall margins are not subject to computation through the Medicare cost report data.

REBASING PRINCIPLES

The Home Care and Hospice Financial Managers Association (HHFMA) prepared this White Paper to explore the issues involved in rebasing payment rates in the Medicare home health benefit. It addresses the cost factors that should be considered by Medicare as well as other factors relevant to the establishment of a rate that will ensure access to care. It does not address the appropriateness of Medicare exercising the authority in PPACA to consider differences in payment rates for providers based on their tax status, geographic location, or financial integration with another health care provider. HHFMA submits that a single base rate is the best starting point and that such factors can be better addressed if necessary through adjustments rather than separate base rates.

In preparing this paper, HHFMA enlisted expert inputs from HHA-employed financial managers, including Chief Financial Officers from nonprofit, proprietary, and hospital-based programs. In addition, the experts included individuals from national home health financial consulting companies. In all, the technical expert group totaled nearly 300 years of experience in home health care finances. The list of experts involved is attached. Over a six month period, the technical expert group evaluated

existing business practices, Medicare cost reporting, capital needs of HHAs, and trends in the delivery and financing of Medicare home health services.

The consensus conclusions are that the following elements must be considered in the rebasing of Medicare payment rates:

1. Inclusion of all types of HHA providers proportionately in the analysis of costs
2. Inclusion of all usual and necessary direct and indirect costs
3. The need for a reasonable margin in relation to usual and necessary costs
4. Accounting for the impact of costs changes that are expected through the impact of legislative and regulatory reforms that are scheduled to occur prior to the conclusion of the rebasing phase-in in 2017
5. The application of an updating methodology to address changes in costs on a timely and accurate basis

EXISTING COSTS

Since the onset of the Home Health Prospective Payment System (HHPPS), Medicare has allowed providers flexibility in the delivery of an episode of care condition on the patient still meeting the standards for coverage. This flexibility has improved patient outcomes (http://www.medpac.gov/chapters/Mar12_Ch08.pdf, P. 223) and helped restrain the growth in the costs of care and overall Medicare spending on home health services. Per patient spending in 2010 was \$5,318 in comparison to 1997 of \$4,704 (http://www.cms.gov/MedicareMedicaidStatSupp/08_2011.asp#TopOfPage. Ch. 7, Table 7.1). A per patient spending growth rate of 13% for the 14-year period of 1997-2010 is far less than virtually any other Medicare sector. For example, inpatient hospital payments grew from \$7,118 per patient to \$9,588, an increase of 34.7%. *Id.*, Ch. 5, Table 5.1. Skilled Nursing Facility per admission spending grew 213% between 1999 and 2010 from \$5,071 to \$10,808. These data suggest that HHPPS is working much better as a spending control than the payment models in other sectors. Any drastic change in payment rates is, therefore, likely to have significantly negative consequences for Medicare and the patients it serves.

To preserve the financial and clinical benefits achieved through this flexible use of episodic reimbursement, rebased payment rates must include the following:

1. All allowable costs under Medicare cost reimbursement principles
2. Costs considered as non-reimbursable under Medicare cost reimbursement principles, but related to clinical services used in the care of Medicare home health patients, including, but not limited to:

- a. Telehealth services and equipment
 - b. Respiratory therapy
 - c. Nutritionist and dietician services
3. Business costs that are allowable under IRS standards of “usual and customary business expenses” and that are recognized as expenses under generally accepted accounting principles in the United State, including, but not limited to:
- a. Taxes on income, franchises, and state provider taxes
 - b. Bad debts
 - c. Business development and marketing costs related to community and professional awareness to ensure true informed patient choice of provider
 - d. Fundraising costs in a nonprofit
 - e. Other business costs
4. All properly allocated costs of provider-based HHAs
5. A full allocation of Administrative and General (A&G) costs including an allocation to those costs that are non-reimbursable under Medicare cost reimbursement principles
6. Formal and informal home office costs not reported on the Medicare cost report

The data source for virtually all of these costs is the filed Medicare cost report. Medicare relied on the costs report data in the original calculation of base payment rates. HHFMA recommends that CMS convene a Technical Expert Panel (TEP) to develop the standards for review and acceptance of cost reports into the database that would be used in this calculation. HHFMA experiences are that some cost reports are unreliable and should be eliminated from consideration. A TEP can help guide CMS in setting standards on acceptance.

With respect to costs that may not be on the cost report, a sample provider survey is recommended. The TEP can assist in that effort as well.

NEW COSTS

There are numerous costs that HHAs are incurring or will occur as a result of new regulatory requirements imposed under the health care reform law, PPACA, or directly by CMS or other regulatory bodies. In addition, there are state legislated obligations that will increase the HHA costs, but do not yet

appear in filed FY2010 or earlier Medicare cost reports. These costs generally began in late 2010, during 2011, or are expected to come about through 2014.

HHFMA recommends that CMS develop a comprehensive, fact-finding process to determine and/or estimate the costs associated with the new requirements. HHFMA is ready and willing to work with CMS to develop the mechanisms and standards for this crucial information gathering.

The following are known new cost areas related to recent changes in legislative and regulatory requirements:

1. Medicare physician face-to-face encounter rule—HHAs report significant increases in training, systems development, and other administrative costs to achieve compliance
2. HHCAPS (Medicare patient satisfaction surveys)—while not as extensive a cost increase as the face-to-face encounter requirement, the increase exceeds standards of materiality
3. Physician qualification administration, e.g. physician follow-up on PECOS enrollment
4. Therapy assessment and documentation—new costs include the increased assessment by professional therapists and the restriction on use of therapy assistants for those visits where the assessments occur as well as increases care documentation costs
5. Implementation and administration of OASIS-C including administrative cost of training and implementation and increased staffing costs related to higher turnover caused by OASIS-C
6. Mandatory employer costs/penalties under the health care reform law
7. Electronic Health Record upgrades to achieve interoperability with hospitals and physicians
8. HIPAA compliance
9. Transition to ICD-10 coding
10. Increased staff training on all of the regulatory changes
11. Changes in clinical and administrative productivity due to new rules
12. Wage and benefit changes, including minimum wage and overtime requirements under the Fair Labor Standards Act along with state-specific changes such as “living wage” laws in New York State and San Francisco

These are just a sample of the new costs and are not meant to be an exhaustive list of recent cost increases triggered by legislative or regulatory requirements. The rate rebasing must include all relevant costs that are not otherwise reported in the Fiscal Year cost report used by CMS in the rebasing analysis. The actual depth and breadth of the non-reported costs is dependent on the cost reporting year used by CMS.

Assuming that FY2010 cost reports are used, the above list indicates that an extensive series of current costs are unreported.

HHFAMA recommends that a data recording and submission template for these costs be developed and applied, at least on a sample basis, to round out the cost data for consideration. This template should be developed immediately in order to secure reliable data in time for the 2014 scheduled rebasing.

BUSINESS VIABILITY

While HHAs do not require the degree of “bricks and mortar” as do inpatient facilities, cash flow and access to capital are essential to maintaining a stable home health care business. Currently, the financial status of HHAs is unstable as evidenced by the wide range in Medicare margins. That range is primarily due to extreme visit cost variations with much of these costs outside the control of the HHA. The absence of a margin for HHAs provides no capital, no financial cushion, and no funds to address new costs incurred that are not part of a payment rate. This need is highlighted by the Medicare rule that requires new HHAs to present at least 6 months of capitalization in order to qualify for Medicare participation.

An HHA’s need for capital includes the following:

1. The acquisition of new technologies to improve efficiencies, clinical outcomes of patients, and meet regulatory requirements. The acquisition of technologies is a capital intensive investment that can only be made through a reasonable margin.
2. Demographics indicate that the demand for home care will continue to grow. An HHA’s expansion requires capital achieve only through reasonable margins.
3. All businesses require working capital, particularly in health care where costs are incurred prior to receipt of reimbursement. In addition, health care can experience seasonal variations in demand with working capital needed to address cost and revenue imbalances.
4. The implementation of new regulatory requirements necessitates advance financing as development, training, and system acquisitions are upfront costs.
5. Cost of capital/borrowing.
6. Disaster and extraordinary costs and cost reserves. Recent floods, tornadoes, and hurricanes are prime examples of the types of recent costs that are not built into base payment rates.
7. Sufficient capital to address financial concerns related to the blend of varying third-party payers and the respective differences in payment rates compared to costs.

A reasonable average margin is also needed to provide a cushion throughout the HHA community to protect against the weaknesses inherent in any national payment model in accurately addressing the resource needs and costs of highly varying individual providers. In other words, in the absence of highly accurate case mix adjustment and other adjusters that address non-clinical related cost drivers such as

travel time, population density, and cultural considerations, a payment rate must be sufficient to provide reasonable reimbursement to maintain access to care overall. In that respect, the inherent weaknesses include:

1. Unusually high cost patients
2. Frontier locations
3. Inner-city agencies with security/escort costs, lower visit productivity, and higher compensation requirements
4. The general explanatory power (R-squared) of the case mix adjuster

The opportunity for profit/surplus also creates an operational incentive that is a longstanding component in US business models. Profit opportunity is a well-respected behavioral incentive to achieve goals that can benefit patients, Medicare, and the provider of care. In the advent of value-based purchasing and potential penalties for failing to reach outcome standards, there is a growing recognition that financial rewards and penalties belong in health care as a way of triggering desired behavior. A margin opportunity in the home health payment rates serves that same purpose.

A margin opportunity also aids in encouraging and permitting investment in innovative technologies, care processes, and care delivery models. In the absence of those opportunities, health care is stuck in the current model of care that has proven to fall short of our needs.

Finally, a reasonable margin is needed to attract interest in investment in home health services. This investment is vital to the future of home care services as demographic trends demonstrate a growing need and demand for home health services. While entry in home health care is not as capital-intensive as inpatient settings, there is still a significant financial obligation to organically create a home health agency or to acquire an existing entity. The financing for such undertakings will be available only if the investors conclude that the return on their investment equals or exceeds the return that would occur through investment in other sectors. Absent a return, investors will look elsewhere.

For example, if there is a growing need for home health services, parties will seek to meet that demand by creating or expanding services. However, if investors determine that a better return can come from financing the development of nursing homes or assisted living facilities, the investor will turn to those sectors. The resulting inadequate supply of home health care will then relegate seniors to the institutional care settings that offered the better financial return for investors.

The recognition of the need for a “profit” exists in virtually all public and private sectors of our economy. The defense industry would not exist if it could not be profitable. Similarly, roads, sewer treatment plants, and missions into outer space would not be possible if the public purchases that are part of those sectors did not provide a reasonable opportunity for profit. The health care economy is no different.

Any consideration that “average cost” payment rates provide an opportunity for a margin based on efficiencies is misplaced. HHPPS is now in its twelfth year and HHAs have had the concomitant efficiency incentives throughout that period. Still, many HHAs experience negative margins because of costs beyond their control that are not addressed through the case mix adjustment model or the area wage

index. For example, productivity of staff is greatly affected by geographic area as travel distances between patients increase non-productive time with costs and no offsetting revenue. Similarly, patients with needs for extended visit time decreases overall productivity in terms of per patient revenues/costs. MedPAC has recognized that margins are significantly related to per visit cost differences rather than efficiencies (http://www.medpac.gov/chapters/Mar11_Ch08.pdf. PP. 187-188).

HHFMA does not offer a recommendation on the level of profit/margin that is essential to achieve and maintain access to high quality home health services. However, HHFMA does recommend that any rebasing of rates consider that a level playing field on margins is necessary to secure success in reaching the access and quality of care goals. That means that actual applied payment rates must recognize cost variations that are outside the control of the HHA.

HHFMA does recommend that CMS engage in an in-depth analysis and study of the health care economics at play in the home health care marketplace in determining the level of profit/margin that is reasonable to offer in rebased rates of payment. The home health agency marketplace is not the equivalent of the hospital, physician, or nursing facility marketplace. For example, hospitals have significant opportunity to balance the financial outcomes of both extensive commercial payments and public program payments. Home health agencies have little commercial insurance revenue and most of it comes from low paying, low utilizing Medicare Advantage plans and Medicaid managed care plans. Instead, home health care services are predominately financed through government programs including Medicare, Medicaid, the VA, and TRICARE. Overall, these programs provide little or no margin opportunity outside Medicare. While Medicare may not be responsible for payment rate shortfalls in other public program, HHFMA believes that Medicare must recognize the need for a margin opportunity in its rates and the dynamics of the home health care marketplace overall. If the level of Medicare margin falls below what is needed to create and sustain a home health agency overall, the entire organization is at risk and access to care for Medicare patients and non-Medicare patients both suffer.

HHFMA recommends that the economic study proposed be undertaken on an expedited basis and that CMS convene a meeting of all stakeholders and available experts to craft the study design.

ACCOUNTING FOR PAYMENT SYSTEM REFORMS

Medicare rate rebasing must occur with recognition of the impact of other scheduled and anticipated reforms of the payment model for home health services including the potential for benefit restructuring and the institution of some form of beneficiary cost sharing. These reforms are likely to impact provider behavior relative to the patients served, the services provided, and the increased potential for bad debt.

System reforms outside the payment rate are highly likely to impact on the volume of episodes and visits, the nature and combination of service disciplines in the visits, and patient length of stay. Each of these changes would affect unit costs because of the constancy of fixed costs and the significantly changed

nature of semi-variable and variable costs. The clinical and service behavior changes triggered by payment system reforms are the background reason behind the PPACA mandate for rate rebasing as MedPAC pointed out that the episode makeup today is far different than the nature of 60 days of care in the original 1997-1998 base data period. Also, the 2008 case mix adjustment model changes, particularly those related to therapy visit volume, clearly instigated a behavioral shift to therapy patients and in increase in the level of utilization of therapy.

Currently pending is the development of a new case mix adjustment model. MedPAC is working on a model that eliminates the therapy utilization thresholds as payment amount determinants. Also, in the 2012 rate rule, CMS has significantly modified the case mix weights assigned to episodes that include 14 or more therapy visits, reducing payment rates for therapy episodes by 5% when there are 20 or more visits and 2.5% for 14-19 visit episodes. If experiences are a guide, these changes will lead to changes in the patient population served and the nature of the services.

To address these forces that affect episode cost, HHFMA recommends several action steps as part of the rebasing effort:

1. Any new case mix adjustment model should be in place and operational for a sufficient time to provide reliable data on changes in the patient population, episode makeup, and length of stay prior to finalization of rebased payment rates.
2. In the event that 1 above is not possible due to legislative mandates on timing of rebasing or the timing of the institution of a revised case mix adjustment model, CMS should develop a forecasting model to account for changes that are likely to occur. That model should be developed in consultation with stakeholders.
3. As stated earlier, the rebased rates should account for the costs and impact of legislative or regulatory changes effective after the point of the cost data used or scheduled for implementation before the completion of the rebased rate phase-in. Likewise, the rates should be recalculated at any time that future legislative or regulatory changes that impact cost occur. CMS should not wait years to adjust rates to account for these new costs.
4. Periodic rate rebasing standards should be established that will allow for consideration and application of reliable data on the impact of system changes on a timely basis. Home health services rates have not been rebased since the inception of HHPPS. That is too long given the frequently changing nature of costs and care. Periodic rebasing is necessary to address changes whether those changes lead to increased or decreased cost of the unit of care subject to payment.

RELATED ADDITIONAL REFORMS

The financial performance of the Medicare home health payment system is dependent on several factors. Episode rate rebasing can account for some of the changes that can occur over time. The case mix adjustment model is another crucial factor. There are two other factors that should be part of any rate

reform in order to develop a payment model that truly fits the service provided: the area wage index adjustment and the market basket index that is intended to adjust for inflation and cost increases. The current indexes should be seriously considered for revision if not replacement.

The area wage index that is applied is a pre-floor, pre-reclassification hospital wage index. The name alone indicates that it does not fit for home health services. While there are some similarities in area wage differences between hospitals and home health agencies, those similarities are rendered virtually inconsequential though the application of an index that ignores the reclassification of hundreds of hospitals and the application of the rural floor to hospitals but not home health agencies. Further, as well documented by MedPAC, the hospital wage index does not work to recognize appropriately the wage differences between hospitals in the various geographic areas. That means that home health agencies have a bad wage index made worse in its application to HHA payment determinations. HHFMA recommends that the area wage index be replaced with a model along the lines suggested by MedPAC. However, that wage index change must be made for all provider sectors subject to a wage index adjustment as the different provider sectors compete for and employ many of the same type of personnel.

The market basket index currently in use for home health services also is in need of revision. First, the index is designed to address changes in costs in the visit rather than the episode of care. An episode of care is made up of more complex parts than the visit. That full complexity must be evaluated in a proper market basket index review, including changes in visit unit costs, the discipline makeup of an episode, and the use of technologies. The visit cost change analysis currently employed by CMS is not a reasonable proxy for accounting for cost changes involved in a 60-day episodic bundle of services and supplies.

CONCLUSION

Rate rebasing is not a simple task for CMS. It has serious consequences to Medicare, providers of care and the patients served. As such, it must be performed carefully and correctly. The foregoing is offered with the sincere intent of constructive input and with the design to offer balanced guidance in the rate rebasing development and implementation. HHFMA stands ready to work in partnership with CMS in this vital project.