Impact of CMS' 2011 PPS Final Rule on NY's Home Health Agencies

To mitigate a growing threat to access to home care services in New York State, Congress must take action to fix damaging and/or arbitrary home health funding cuts/proposals advanced in the regulatory process by the U.S. Centers for Medicare and Medicaid Services (CMS) in its 2011 final rule for home health PPS. These damaging actions include 1) the imposition of an overly restrictive regulatory policy surrounding the new statutory requirement that requires home health patients to undergo a face-to-face physician encounter to access service; and 2) a proposal to reduce provider rates through an arbitrary case-mix adjustment. In addition, providers in New York State face an additional one percentage point reduction to the 2011-13 Medicare home health market basket update. This reimbursement cut further exacerbates the poor financial position of New York State's home care provider community.

The Financial Condition of New York State's Home Health Agencies is Dire

Between 1997 and 2010, home health agencies (HHAs) in New York State have experienced cuts in their Medicare home care reimbursement of $233 million. Cuts of this magnitude have had a debilitating effect on New York's already fragile home care infrastructure. Compounding this, HHAs in New York face further cuts of $1.9 billion over 10 years under the new health reform law.

While a March 2010 report by the Medicare Payment Advisory Commission (MedPAC) contends that the 2008 Medicare operating margin for HHAs nationally was 17.4%, MedPAC's analysis does **not** include institution-based providers or unweighted data, and is not an accurate representation of the financial health of HHAs in New York State. In fact, **home health Medicare margins in New York vary significantly from the MedPAC analysis and remained negative for the ninth year in a row, at -0.2% in 2009** (unweighted 2009 data that includes hospital-based agencies).

Furthermore, a joint HCA/NYAHSA (New York Association of Homes & Services for the Aging) 2010 survey, using the most recent cost report data available (from 2008) as well as financial survey data, found that 70% of HHAs in New York are reporting total operating losses and 44% must borrow money to meet their current operating expenses. Further, the data revealed that almost 60% of agencies are facing worse cash-flow issues this year, as compared to the prior year. Additionally, 75% of providers labeled these cash-flow issues as "serious" or "very serious." Continued Medicare payment reductions for home care services will further deny HHAs the necessary payments to cover the costs of providing care to Medicare patients and result in a further weakening of New York State's home care infrastructure.

CMS' 2011 Home Health PPS Final Rule

On November 17, CMS issued in the *Federal Register* the final rule for the calendar year (CY) 2011 home health prospective payment system (HHPPS) rates. CMS' rule implements many provisions of the federal health care reform law, the Patient Protection and Affordable Care Act (PPACA), including those provisions resulting in cuts. Throughout the debate and discussion that led up to the enactment of

PPACA, HCA communicated strong opposition to provisions of PPACA that imposed deep cuts to home care.

CMS' CY 2011 final rule represents a 4.89% decrease in total expected Medicare payments to HHAs for CY 2011. **For HHAs in New York, HCA estimates this reduction will result in a net decrease of over $36 million in reimbursement payments to provider agencies.** Nationally, total Medicare payments to HHAs will be reduced by approximately $960 million during the same period. This payment reduction includes the combined effects of: a market basket reduction, rate reductions that account for increases in aggregate case-mix (increases which are alleged by CMS as being unrelated to underlying changes in patients' health status, a.k.a. "case-mix creep" adjustment); and other outlier provision reductions mandated by PPACA.

The following outlines HCA's major issues and concerns with CMS' final rule for CY 2011 HHPPS and shows how some of these actions will adversely affect HHAs in New York as well as the patients that they serve. In many cases, the final rule goes beyond the scope of the original provisions as included in PPACA.

Issue 1: Delay or Repeal Medicare Home Health Physician Face-to-Face Encounter Requirement

CMS' final rule expands on the new statutory requirement (Section 6407 of PPACA) that, prior to physician certification of the home health plan of care, a physician must document that he/she or a designated non-physician practitioner has conducted a face-to-face encounter with the patient. While the law allows the contact to be with a Nurse Practitioner (NP) or clinical nurse specialist working in collaboration with the physician, or with a Physician Assistant (PA) working under the supervision of the physician, it does not alter the requirement that the physician sign the certification.

CMS' final rule further restricts the requirement to mandate that the face-to-face contact must occur within 90 days prior to the home health start of care, or 30 days after. In addition, if the clinical condition of the patient changes since the encounter, such that the primary reason the patient requires home health is unrelated to the condition at the time of the encounter, another face-to-face encounter is required within two weeks of the start of care.

Home health episodes without this face-to-face physician encounter would not qualify for payment under the Medicare program.

While strong physician engagement is a shared priority of HCA, there are many concerns and questions about CMS' requirement for implementing this PPACA provision. Some of these concerns include:

- CMS has not provided adequate education to the physician community so they will be prepared in time to meet all the requirements by the April 1, 2011 enforcement date. In fact, a survey of our membership found that 70% of New York HHAs believe their referring physicians will not be ready to comply with this requirement;

- Physician support for complying with the face-to-face requirement is weak. Over two-thirds of the physicians contacted by our members have expressed confusion or have complained to New York HHAs trying to educate them on this new Medicare home health requirement and half of physicians have said that they will refuse to provide the required documentation;

- Medicare beneficiaries who are homebound or, even worse, bedbound will face additional access to care burdens. Many will not be able to travel to their doctor's offices to satisfy the face to face requirement. Others risk early termination of their home health services as evidenced by our survey finding that 48% of our membership feel compelled to discharge patients that do not have a face-to-face physician encounter within the specified time period;

- Medicare home health patients in remote rural areas will face additional access to care burdens due to long travel distances to their doctor's offices and lack of transportation options; and,

- The requirement will impose additional operational and financial burdens on home health agencies and physicians. A survey of our members revealed that 40% of HHAs in New York will not be ready to comply with this requirement, which is now a Medicare condition of payment.

Recommendation: HCA joins our colleagues at the National Association for Home Care and Hospice (NAHC) in requesting that Congress delay the enforcement of the face-to-face encounter requirements and, if necessary, repeal the provision (PPACA Section 6407) and devise more constructive ways to secure physician involvement in home health care. Without a further delay or repeal of this proposal, the provision of home health services to the elderly will be significantly compromised, and patients will likely not be able to receive needed services.

The purpose of the face-to-face requirement was to enhance physician involvement in home health care, not to discourage physicians referring patients to care in their own homes. Further, any evidence of overutilization of Medicare coverage cannot be tied to a lack of physician involvement or the nature of physician/patient/home health agency communications. Any possible results of the face-to-face requirement serving as a measure of program integrity are far outweighed by the harm the requirement causes and the chilling effect it has relative to patient access to care.

Issue 2: Reinstate the Full Medicare Market Basket Update for Home Care

CMS' 2011 final rule applies a 1 percentage point reduction off the market basket in 2011, 2012, and 2013, as mandated by PPACA. The estimated one year impact of this reduction for New York HHAs is $7.6 million and $23 million over the three year period from 2011 to 2013. This cut is piled on top of approximately $233 million in cuts experienced by New York HHAs over the past 10 years which have resulted in 9 consecutive years of negative Medicare operating margins.

Over the years, the federal government and MedPAC have advanced numerous recommendations and proposals to eliminate or reduce the Medicare home health care market basket update based on misleading assertions that home health operating margins on Medicare services have consistently been between 12% and 17%.

HCA and NAHC challenge MedPAC's assertions on HHA operating margins based on the facts that:

1. MedPAC's data analysis does not include any consideration of the 1,626 agencies (21%) nationally that are part of a hospital or skilled nursing facility. In some states, hospital-based HHAs comprise a significant percentage of home health providers.

   In New York, facility-based HHAs represent more than 25% of all Medicare certified agencies. Nationally, facility-based agencies have an average Medicare operating margin of negative-6.19%, while, in New York, that number is negative-13.88% (based on 2009 Medicare cost reports).

2. MedPAC's analysis uses a weighted average which overstates the positive margins of large, and in many cases for-profit individual agencies rather than accurately representing the margins of all individual agencies. It further misrepresents a single national operating margin for freestanding agencies as if this margin was representative of all 9,700 very diverse home health agencies.

   When all agencies' margins are included and simply averaged together ("unweighted"), the true average Medicare margin nationally of individual agencies would be approximately 3%, while, in New York, unweighted Medicare operating margins for all agencies remain negative for the eighth year in a row, at negative-0.2% (2009 Medicare cost report data that includes hospital-based agencies).

Further reductions of the market basket update will only escalate the growing gap between payment and reimbursement for agencies serving Medicare patients. This payment gap, which is exacerbated every year that the home health market basket adjustment is reduced, compromises agency operations and the ability of agencies to deliver necessary care. Given the rising costs of basic operating expenses – personnel, clinical technology and medical records, fuel, medical supplies, insurance, corporate compliance and other general operating costs – the full market basket inflationary update is essential to help agencies maintain the necessary resources to meet patients' needs.

Recommendation: HCA and home health providers urge Congress to restore the home health market basket in 2011-2013 by eliminating the 1 percentage point reduction.

Issue 3: Reject Arbitrary Reductions in Reimbursement through CMS' Case Mix Interpretation and Establish a More Transparent Process

The 2011 HHPPS final rule includes a provision that reflects CMS' misperception of up-coding in Medicare home health services claims. As anticipated, CMS evaluated case-mix and coding changes between 2007 and 2008, specifically looking at unexplained changes in: therapy visit distribution that increased case-mix, increased use of secondary diagnosis fields and increases in reporting of hypertension. CMS estimates that these unexplained changes have resulted in a 17.45% increase in overall case-mix since the inception of HHPPS in 2000, and, as a consequence, CMS is revising its "case-mix creep" payment reductions in 2011 and 2012. Previously, CMS implemented rate adjustments through a three year 2.75% rate reduction beginning in 2008 to account for case-mix weight changes and planned to impose a 2.71% reduction in 2011.

CMS' CY 2011 final rule now imposes a **3.79 percent reduction** to the national standardized 60-day episode rate in CY 2011, while deferring the same 3.79 percent reduction for CY 2012 until CMS conducts further analysis of the case-mix data.

CMS' case-mix reduction of Medicare episodic payments by 12.04% from 2008 to 2011 (2.75% from 2008 to 2010 and 3.79% in 2011) will reduce payments to New York HHAs by $85 million for this period and cripple New York State's home care infrastructure.

HCA believes CMS' case-mix "creep" provision is based on the categorical assertion that home health agencies have intentionally gamed the system by coding their patients at a higher clinical severity in order to receive higher Medicare home health payments under the HHPPS. The data CMS used, and its consequent assumptions related to inflated coding, are flawed for numerous reasons, including the fact that the data doesn't recognize real increases in case-mix due to real increases in the severity of need since the inception of HHPPS. These increases are caused by: earlier and sicker hospital discharges; technology improvements which enable more complex patients to be cared for at home; improvements in the accuracy of OASIS coding that more precisely measure patient severity; and increased patient therapy needs, which also indicate a higher level of patient acuity.

Moreover, those agencies which did not contribute substantially to case-mix "creep" or are already at a low level of average case-mix should be protected from further cuts based on high case-mix weight. This is simple logic and fairness. To do otherwise is to unfairly punish lower case-mix agencies and lower case-mix patients, putting the very financial viability of long-standing agencies at risk. Finally, a recent study by NAHC revealed the potential risks from a combination of the proposed CMS case-mix "creep" payment cut of 3.79% in 2011 and 2012 and the scheduled rate cuts mandated by PPACA. Factoring in these combined reductions, the national percentage of HHAs with projected margins of 0 or less would be 41.2% in 2011 and 49.6% in 2012. In New York, the percentage of HHAs with projected Medicare margins of 0 or less would be 64% in 2011 and 74.4% in 2012, significantly worse than the national percentages.

Recommendation: HCA urges the New York Congressional Delegation to advocate against arbitrary reductions in reimbursement through CMS' case-mix interpretations. HCA asks that Congress instead support the establishment of a reliable and transparent process for determining whether the payment rate cuts are needed to account for improper changes in "case-mix scoring" that are not related to changes in the nature of the patients served in home health care or the nature of the care they received.

In the 111th Congress, HCA strongly supported legislation, the Home Health Care Access Protection Act (S. 3315/H.R. 4950) which was sponsored by Senator Susan Collins (R-ME) and Rep. James McGovern (D-MA). This legislation would ensure accuracy and integrity in the estimates of nominal case-mix changes by requiring that CMS work with the home care community to develop criteria and examine a valid sample of actual medical records rather than relying on hypothetical statistical extrapolations which have not fully explained the change in real case-mix. It is anticipated that this legislation will be reintroduced, and HCA will be asking the New York Congressional Delegation to cosponsor this important bill.

Sources - New York State Department of Health Medicaid Cost Report Data and HCA Survey Data