

Flawed MedPAC Recommendations on Home Health



MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) recommended in its 2009 report to Congress that the home health market basket update be eliminated for 2010 and that the application of the proposed 2011 “case-mix creep” adjustment (2.71 percent) be accelerated to take effect in 2010, reducing current home care rates in 2010 by 5.46%.

The Obama Administration has now included MedPAC’s 2009 recommendations as part of its proposed Fiscal Year 2010 budget.

Over five years, these cuts would slash more than \$13 billion nationally from the Medicare home health program, including approximately \$712 million from New York State, which would receive the fourth highest cut among all states. These unprecedented reductions follow \$198 million in Medicare reimbursement cuts to New York State home health agencies during the ten year period between 1997 and 2007.

HCA and NAHC Urge Opposition to Home Care Cuts

The Home Care Association of New York State (HCA) and the National Association for Home Care and Hospice (NAHC) urge Congress to reject the proposed cuts to home care which will further widen the gap between reimbursement and the cost of providing care to Medicare patients.

MedPAC Assertions versus Reality

MedPAC’s Assertion: MedPAC’s recommendation to reduce home health payments is based on its claim that home health agencies’ operating margins on Medicare services are an estimated 12.2%.

The Reality: HCA and NAHC data contradicts MedPAC as described below.

1. MedPAC’s analysis of the data 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 home health agencies comprise a significant percentage of home health providers.

In New York, facility-based home health agencies represent more than 25% of 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-11.43%** (based on 2007 Medicare cost reports).

2. MedPAC’s analysis uses a weighted average that overstates the positive margins of large individual agencies and, therefore, does not accurately represent the margins of all individual agencies. It further misrepresents a single national operating margin for freestanding agencies as representative of all – over 9,700 very diverse – home health agencies.

When all agencies’ margins are included and averaged together (based on simple instead of weighted average) the true average Medicare margin nationally of individual agencies would be

closer to 5%; while here in New York, unweighted Medicare operating margins remain negative for the seventh year in a row at negative -9.07% (unweighted 2007 data that includes hospital-based agencies).

3. MedPAC's margin data fails to recognize many agency costs, including the cost of telehealth equipment, increasing costs for labor, corporate compliance, emergency and bioterrorism preparedness, and computer and accounting system changes to adapt to the new home health payment changes.
4. Based on NAHC's analysis of 2007 cost reports of individual agencies, approximately one-third of Medicare home health agencies nationally have negative Medicare operating margins, **while here in New York more than half of home health agencies are reporting negative Medicare operating margins.**

MedPAC's Assertion: MedPAC's recommendation to accelerate CMS' case-mix creep adjustment to reduce Medicare home care rates by 5.46% in 2010 is based on the unfounded 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 payments under the Prospective Payment System (PPS) implemented in 2000. CMS based this flawed determination on a review of providers' OASIS case-mix data from 1999 to 2003.

The Reality: This assertion is unfounded based on actual agency experiences.

MedPAC's analysis of the data doesn't fully recognize real increases in case mix due to real increases in the severity of need that have occurred since the inception of PPS and that 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.

In fact, a closer analysis of OASIS data, conducted by the Lewin Group, discovered significant changes in patient characteristics from 1999 to 2003 (the same period encompassed by MedPAC's data review, used to back its "case-mix creep" adjustment). This analysis points to a growing incidence of more medically complex patient cases entering the home care system, including such factors as:

- Increase in patients with wounds
- Increase in patients with urinary incontinence
- Patients showed a substantial decrease in transfer capabilities
- Patients with gait abnormality (disorders or conditions creating problems walking) increased by 50%
- The number of beneficiaries with a primary diagnosis of diabetes increased by 17%
- Home health patients age 85 and over increased to 27% (a 4% increase)
- Increase in patients with cognitive function deficits
- Increase in patients with dyspnea (difficulty breathing)

CMS's dismissal of these changes as "modest" ignores the cumulative impact on the need for increased therapy services along with higher clinical and functional scores that increase the case-mix weight. The increased number of patients with ambulation and transfer deficits alone accounts for a significant portion of case-mix weight growth from 1999-2003.