TESTIMONY

BEFORE THE

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

UNITED STATES HOUSE OF REPRESENTATIVES

ON

PAYMENTS TO CERTAIN MEDICARE FEE-FOR-SERVICE PROVIDERS

MAY 15, 2007

PRESENTED BY

Christine Chesny, RN, MHSA

President, MidMichigan Visiting Nurse Association

3007 North Saginaw Road

Midland, Michigan 48640

ON BEHALF OF THE

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

228 Seventh Street, S.E.

Washington, D.C. 20003

AND

MICHIGAN HOME HEALTH ASSOCIATION

2140 University Park Drive, Suite 220

Okemos, Michigan 48864

Thank you, Mr. Chairman, Ranking Member Camp, and Subcommittee members, for inviting me to present testimony on issues related to payment accuracy and legislative and regulatory payment refinements for the Medicare home health prospective payment system. My name is Christine Chesny. I am President of MidMichigan Visiting Nurse Association (VNA), a not-for-profit affiliate of MidMichigan Health, the largest health care system in north-central Michigan. MidMichigan Visiting Nurse Association provides home health, hospice, home medical equipment, palliative care and private duty nursing services to eleven rural counties in the heart of Michigan. As a part of the MidMichigan Health family of services, we support a continuum of care that includes: 4 acute care hospitals with 481 beds, a critical access hospital, a 200 bed skilled nursing facility and 40 assisted living beds, an urgent care center with mobile diagnostics, such as PET scanning, and over 300 physicians and mid-level providers on staff. I am also the immediate Past President of the Board of Directors of the Michigan Home Health Association (MHHA), and a finance committee member of the National Association for Home Care and Hospice (NAHC).

NAHC is the largest home health trade association in the nation. Among our members are all types and sizes of Medicare-participating care providers, including nonprofit agencies such as the VNAs, for-profit chains, public and hospital-based agencies and free-standing agencies.

Earlier this year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress eliminate the home health market basket update for calendar year 2008. Relying in part on MedPAC's recommendation the President's fiscal year 2008 budget proposes a reduction of nearly $10 billion in home health spending by imposing a five-year freeze in home health payments (2008 through 2012), and permanent market basket reductions annually thereafter of .65 percent. Additionally, the Administration also plans to reduce home health payments through regulatory changes by nearly $7 billion over the same five years. Home care, with its annual Medicare expenditures of only $13 billion, cannot sustain such draconian cuts without the loss of access to care throughout the country.

Preservation of the Medicare Home Health Market Basket Inflation Update is Needed to Protect and Preserve Care for Medicare Beneficiaries

MedPAC's rationale for freezing home health payments fails to address the true financial status of home health agencies. The recommendation is based on an incomplete analysis of Medicare cost report data that excludes a significant segment of home health agencies, ignores essential home care service costs, and relies on a methodology that treats home health services as if it were provided by one agency in just one geographic area. If enacted the MedPAC recommendation will severely compromise continued access to care.

In specific response to the recommendation, we note the following:

- ~~€€€€€€€€~~ The current Medicare home health prospective payment system (HHPPS) has been found to be seriously flawed and extremely ineffective at predicting the costs of care delivery. As a result, care for some types of patients can be reimbursed at significantly higher rates than agencies' costs while Medicare reimbursement for other patients is woefully inadequate. MedPAC has found that

the payment distribution system of HHPPS fails in over 75% of the case categories to fairly set rates in relation to the level of care. Payment is either significantly lower or greater than justified for the level of care. **These and other findings have led Medicare to undertake a wholesale revision of HHPPS that is scheduled to take effect on January 1, 2008.**

- The considerable shortcomings in the HHPPS are further illustrated by a dramatic range in profits and losses among home health agencies (HHAs). About 31% of all HHAs experienced financial losses under Medicare in 2002; that figure increased to 33% in 2004. **A five-year freeze would increase the number of agencies with Medicare margins of zero or below to around 60%.** These figures actually understate losses because Medicare cost report data excludes the costs of numerous items that are legitimate care expenses, such as telehealth services and respiratory therapy.

- **MedPAC's financial analysis of Medicare home health agencies, alleging a 16% margin, is unreliable**. **First,** it does not include any consideration of the 1,723 agencies (21%) that are part of a hospital or skilled nursing facility. In some states, hospital-based HHAs make up the majority of the providers (MT 63.2%; ND 65.4%; SD 60.5%; OR 58.3%). These HHAs have an average Medicare profit margin of negative 5.3%. **Second**, the MedPAC analysis uses a weighted average, combining all HHAs into a single unit, rather than recognizing the individual existence and local nature of each provider. **When all agencies' margins are included and given equal weight, the true average margin is 3.12%.** MedPAC fails to evaluate the impact on care access that occurs with the current wide ranging financial outcomes of HHAs. Instead, it sees a single national profit margin as representative of over 8,000 very diverse HHAs.

Our overall profit in home health at MidMichigan Visiting Nurse Association is just under 5 %. This number drops to below 3 percent when United Way, grant and other charitable funds are removed. We consider ourselves fortunate. Let me explain. As a non-profit free standing agency we receive charitable donations to support under and uninsured patient care including Medicaid. We also benefited from the generosity of local foundations as our agency first implemented laptop computers for clinicians in 1998. Since that time we have been even more fortunate to receive two USDA grants. These grants allowed us to acquire over 150 telehealth units, pulse based oxygen concentration meters, blood clotting time meters, and more computers for both branch offices and clinical staff. The USDA grants, which require an agency match total over $600,000. No small investment for any home health agency.

The use of technology has enabled our agency to more efficiently and effectively care for our patients while maintaining high quality outcomes. For other agencies unable to make this capital intensive investment, the economies are lost and their costs continue to rise. Even using technology to improve our productivity, our average miles per visit is 22 which translates into an expense of just under a half million dollars this fiscal year. Yet, CMS does not recognize telehomecare technology equipment and patient service costs as reimbursable by the Medicare program.

This brings me to my second point. Home health care services are local. And in our service area that means rural. The loss of the rural add-on and the changes in wage index has had significant impact on our agency and other rural agencies in Michigan and throughout the country. The wage index calculation is fundamentally flawed as rural hospitals are continuously reclassified to CBSAs eliminating their costs from the rural calculation. In our agency, the ramifications of the loss of the home health rural add-on and wage index change total over $1.2 million on a $9 million budget. We have had to make difficult decisions regarding our service area. We eliminated our two most northern counties 3 years ago. We also eliminated the majority of another county whose population is only 17,000 residents and are contemplating reducing the service area in the northern most reaches of two other counties. The void will not be easily filled. To my knowledge, no one in these areas is able to consistently offer the entire Medicare covered services in the home health benefit. Our agency is unable to afford the price that physical therapists demand for work in these areas. We have been persistently recruiting for a full time physical therapist for over 900 days.

- With the existing HHPPS, an agency's mix of patients (case-mix) can result in significant profits or losses unrelated to efficiency or effectiveness of care. Losses exist for agencies of all sizes and in all geographic locations that are a result of the flawed HHPPS. These agencies are essential care providers in their communities. An across-the-board cut or freeze would do tremendous financial damage to those agencies that are at break-even or losing money on Medicare.

- Home health agencies are already in financial jeopardy as a result of Medicaid cuts and inadequate Medicare Advantage and private payment rates. Ongoing study of home health cost reports by the National Association for Home Care & Hospice indicates that the overall financial strength of Medicare home health agencies is weak, and expected to diminish further. In 2002, the average all-payor profit margin for freestanding HHAs was 2.53%. **A more recent cost report data analysis indicates that the average all-payor profit margin for 2004 dropped to 1.55%.**

- Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the HHPPS.

- A loss of the market basket inflation update could leave home health providers no alternative but to cut down on the number of visits per episode or avoid certain high-cost patients altogether, which could have potential adverse consequences on care access and patients' clinical outcomes. It would be difficult for HHAs to continue to lower visit frequency without compromising quality of care. Outcome Concept Systems, a national home health benchmarking firm, has found, in general, that reductions in average visits below 20 visits per episode (the current average is around 18) result in lower outcome scores.

- Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, with better patient outcomes.

- Home health agencies have already experienced a disproportionate amount of cuts in reimbursement as a result of the Balanced Budget Act of 1997 (BBA). For example, under the BBA, Congress expected to reduce Medicare home health care outlays in FY 2006 from a projected $40.4 billion to $33.1 billion. The Congressional Budget Office (CBO) now estimates that home health outlays for FY 2006 were $13.1 billion. This reduction is far in excess of the reduction originally envisioned by Congress, and already has had a profound impact on beneficiary access to care and HHA financial viability. **Home health care as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.2 percent today**. By 2015 it is projected to drop to 2.6 percent of total Medicare spending.

- **Over the past 10 years, the Medicare home health benefit has been cut nearly every year, placing serious financial strains on HHAs:**

Year	Impact
FY 1998-1999	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
FY 2000	Home health care's inflation update was cut by 1.1%.
FY 2002	Home health care's inflation update was cut by 1.1%.
FY 2003	Total home health care expenditures were cut by 5% off previous year's rates.
CY 2004 (3/4 of year)	Home health care's inflation update was cut by 0.8%.
CY 2005	Home health care's inflation update was cut by 0.8%.
CY 2006	Home health care's inflation update of 3.3% was eliminated.

CMS' Proposed Revisions for the Home Health Prospective Payment System

As discussed earlier, all indications are that Medicare's current payment system for home health is flawed, and that, rather than across-the-board cuts that will harm those agencies that can least afford it, a redistribution of payments through refinements in the home health prospective payment system is the appropriate course of action. Medicare recently proposed major changes in the payment system to institute a more balanced reimbursement method to take effect in 2008. NAHC has strongly supported CMS efforts to restructure the system and to replace a poorly functioning case mix adjustment model that determines the payment rates for 80 different patient categories. However, as part of the proposed rule, Medicare added the administrative cuts proposed by the President in his 2008 budget, thereby jeopardizing the intended benefits of the reforms.

The intended purpose of the payment system changes was to refine the case mix adjustment so that the payments would be more fairly distributed. Instead, CMS put forward a blatant effort to extract over $7 billion from the system. Specifically the proposal would cut payment rates by 2.75% for each of the next three years (beginning in 2008). This cut will spell disaster for access to services.

The proposal indicates that the cuts are intended to eliminate the effect of increases in patient coding that does not reflect changes in the patients' characteristics. CMS assumes that, because the average case mix weight of home health patients has risen since the first year of the PPS (from approximately 1.135 to 1.233), every single point of that increase has been due to provider "gaming" of the system, or deliberately establishing a higher case mix weight to secure higher reimbursement under Medicare. CMS refuses to acknowledge that the patients under the care of home health agencies have dramatically changed since the inception of PPS in October 2000. Instead, CMS concludes that there has been absolutely no change at all.

I think that it is important for those of you unfamiliar with the payment system to understand what this assumption of gaming means. Home health patients are not simply taken onto service and "assigned" a case-mix weight by the home health agency. Instead, a physician orders specific care based on the patient's condition and needs. Once an agency accepts a patient for service, a registered nurse or therapist must visit the patient and do a full assessment of the patient's condition –an assessment that often takes as long as 1-1/2 or 2 hours to complete. Elements from the assessment are then used to establish a "score" for the patient relative to the severity of the patient's condition, the patient's functional ability, and. the services the patient requires. It is these scores in these areas – clinical condition, functional ability, and service needs – that combine to establish the case-mix score of the patient. The "score" then assigns the patient to a specific case mix weight.

To assume that any change in average case mix weight is attributable to "gaming" assumes that nurses throughout the nation are deliberately falsifying or changing patient assessments so as to ensure that the patient will receive a higher score that will translate into higher payment for the agency. There is no foundation for this adjustment other than a hazarded guess. Given our agency's experience with increasing age and acuity in the patient population, I believe the increase reflects the changing demographic of our patient population. First and foremost, the patients we treat are older. In our own agency in 2001, 24.9% of the patients we cared for were over age 80. In the most recent fiscal year that percentage had grown to 34%. Older patients are more frail. They are more likely to have numerous health conditions that contribute to the length of time and the amount of service required to recover from an illness, or learn to manage a chronic condition. This translates into a higher level of acuity for this patient population. In general, the intensity of service required by patients referred to us by our health system has increased significantly since the late 1990s.

In addition, we are often the first health care providers in our local area to see the results of technological innovations in health care. Residents of our service area who travel to

tertiary care centers return home with devices and treatment modalities requiring home care follow up. These tertiary hospitals rely on highly skilled home health clinicians to follow the care plans established and maintain the equipment, administer the medications and treatments as well as reporting results to the patient's physician and modifying the care plan as prescribed. Because these tertiary hospitals are either front line in clinical trials or early adopters, home care is often the first place the local health care provider experiences these advances in medical care.

CMS "case mix creep" assumption also fails to acknowledge a number of changes that have occurred within the health care system that are having an impact on the types of patients home health agencies are taking onto service, including:

1. Home health PPS has redrawn both the nature of patients served and the way those patients are cared for in the home. Home health has been transformed into post-acute, rehabilitation-oriented care. Instead of patients receiving the supportive personal care of home health aides for an extended period of time, physical and occupational therapy have taken on a greater role, leading to improvements in function and self-sufficiency. The average length of stay in home health services has dropped to less than 90 days from a pre-PPS average of over 150 days. Correspondingly, therapy visits have increased by over 25% to an average of five in a 60-day episode. This change was part of the congressional purpose behind the mandate to create the PPS . That change has benefited the patients and Medicare in that home health expenditures remain far below 1997 levels of $17 billion.

2. Patients are discharged into home health services from inpatient hospitals earlier than ever before. This is evidenced by the institution of the hospital transfer DRG policy. Under that policy hospital payments have been reduced in multiple DRGs because the transfer of patients from hospitals into home health has reduced the inpatient length of stay. Those discharges have lead to the admission of patients into home health with higher acuity levels than ever before.

3. The alteration of coverage and payment standards at Inpatient Rehabilitation Facilities (IRF) and Long Term Care Hospitals (LTCH) has increased the number of rehabilitation patients in home health as well as their level of service needs. For example, the phasing in of the 75% rule for IRFs has steered more patients with higher needs for therapy appropriately into home health services.

CMS has failed to utilize a sound methodology to determine the extent to which the increase in case mix weight is due to changes in patients or changes in coding. In its published analysis, for example, CMS admits that more patients are admitted into home health care from Skilled Nursing Facilities (SNF). This is a factor that the CMS scoring system considers as a strong indication of patients with greater care needs, yet CMS ignores this fact in reaching its conclusion that all the increase in case mix weight is "coding creep."

More alarming is the fact that CMS considers the increase in therapy services to be unrelated to any change in the nature of patients served. Effectively, this conclusion means that CMS considers the therapy visits to be unnecessary all across the country without ever reviewing actual patient care records. This conclusion flies in the face of the significant rehabilitative gains of the home health patients and the numerous structural changes in other care settings that impact on the patient population served by home health agencies.

Instead, the primary justification that CMS offers for its conclusion is that home health agencies have received policy clarifications and training on how to complete the patient assessment forms. That justification is a strong indication that CMS is desperately grabbing onto anything available to explain its action.

In 1997 with the Balanced Budget Act, Congress set in motion a revolution in the Medicare home health benefit. With changes to both the payment system and the scope of the benefit coverage, Congress shifted home health services into a rehabilitative oriented benefit with strong controls on expenditures. Those goals have been accomplished yet CMS, through its unfounded and unprecedented conclusion that patients have not changed since 2000, now seeks to undermine this remarkable Congressional success by instituting an 8.7% cut in payment rates through 2.75% reductions in each of the next three years. That proposal can only serve to derail the gains over the last seven years. I urge Congress to intervene and stop CMS before damage is done to Medicare beneficiaries.

CMS Should Not Undermine Its Worthwhile Effort To Refine the Home Health Prospective Payment System By Making Rate Cuts

In its proposal to reform and refine the Medicare home health PPS, CMS offers many improvements that will likely redistribute payments in an improved manner. NAHC and MHHA have long supported efforts to correct weaknesses in the PPS model. However, the additional proposal by CMS to reduce the base payment rate to account for increases in the average case mix weight will jeopardize the effectiveness of the proposed corrections. The indications of that threat are:

1. The "case mix creep" adjustment is applied to all home health agencies whether they engaged in abusive coding or not. In fact, any offending agencies are better positioned to absorb the impact of the cut than those agencies that did everything above board. This approach makes the many pay for the sins of the few (if any exist).

2. The increase in case mix weight is primarily due to an increase in therapy services to patients. To the extent that the current system encourages inappropriate increases in those services, the CMS reform proposal institutes a corrective course. Under the current system, higher payments occur whenever patients receive 10 or more therapy visits in a 60 day episode. The proposal replaces the 10 visit threshold with a system that changes payment rates at 6, 14, and 20 visits, with additional incremental changes between those points. This modification is intended to align payment more closely to patient needs. However, combining this change with the coding adjustment reduction is in effect a "double dipping" in that payment rates for patients with 10 or fewer therapy visits are greatly reduced through both the cut and the payment system reform.

3. The case mix weight adjustment is not the only step taken by CMS to reduce agency payment rates. To achieve budget neutrality with the system reforms CMS institutes an additional adjustment to the case mix weights. This adjustment reduces payments by approximately 4% based on an apparent assumption that providers of services will modify their care behavior to increase Medicare expenditures. The CMS proposal is devoid of transparency in that there is no explanation as to how this adjustment is calculated.

4. The true impact of the PPS reforms will not be known until some time after their implementation. The 8.7% payment rate reduction over three years through the case mix weight adjustment seriously complicates any ability to determine whether care and access change that may occur is due to weakness in the new payment model or errors in calculating the case mix weight adjustment. With the serious errors that we believe exist in that adjustment, the goals of the reform will not be realized.

The combination of these factors serves to destabilize the home health benefit at a time when it is intended to achieve greater accuracy in payment rates. In the midst of this chaos are the Medicare beneficiaries and the uncertain future for access to care in their homes.

Conclusion

Home health services are part of the solution to growing health care expenditures in Medicare. Increasingly, home health services are a less costly alternative to inpatient services and institutional care. Home care also has a long history of exceptional care quality. Invariably, our patients express high marks for home care services. Now is the time to support and expand access to home health services under Medicare and all federal health programs to address a growing population of elderly and disabled. Cuts to the home health benefit will only serve to prove that it is "penny wise and pound foolish." We need to look no further than to the increased expenditures for Inpatient Rehabilitation Facilities, Long Term Care Hospitals, and Skilled Nursing Facilities following on the heals of the massive home health services cuts in the Balanced Budget Act.

We respectfully recommend that the Committee:

1. Request that CMS suspend its plan to cut home health payment rates based on unfounded allegations of unwarranted increases in patient case mix weights as set out in its April 26, 2007 proposed rule.

2. Withhold any reductions in the annual inflation update for home health until the impact of the implementation of the prospective payment system in 2008. This step is particularly essential with the pending $7 billion in cuts in the CMS regulatory proposal.

3. Expand access to technology and telehealth services in home health services through grants, loans, and elimination of restrictions on the use of telehealth within the Medicare benefit.

4. Reinstate the rural add-on to preserve services in our nation's rural communities.

NAHC and MHHA look forward to working with the Subcommittee to address the home health payment adequacy issues as outlined in this testimony. This concludes my formal remarks. I would be happy to answer any questions from the Subcommittee members.