

## **MedPAC Recommends Freeze in Home Health Payments in Report to Congress**

In its annual report to Congress on Medicare payment policy the Medicare Payment Advisory Commission (MedPAC) has again recommended a freeze on home health base payment rates. MedPAC's recommendations are often the starting point for congressional discussion and deliberation on Medicare payment changes each year; while these annual recommendations are in no way binding on Congress, they have had great influence in Medicare debate. With the U.S. Senate and House of Representatives now reviewing all options for reducing the surging budget deficit as they draw up their respective fiscal 2006 budgets, the MedPAC recommendations take on a significant role this year.

As reported earlier, the MedPAC commissioners at their January meeting voted to recommend a freeze in Medicare home health payment rates for 2006 (the vote tally on the recommendation was unanimous, with 15 commissioners voting "yes," zero "no," and two absent). This report to Congress provides MedPAC's rationalization for its recommendations. Statistical evidence on matters related to access to care, Medicare margins, and the reliability of the payment structure under the home health prospective payment system (PPS) is included in the commission's analysis.

In analyzing whether 2005 Medicare payments are adequate, MedPAC cites a change in direction regarding utilization of home health. After several years of decline in the number of users of the benefit, the number increased to 2.5 million in 2002 and to 2.6 million in 2003. MedPAC points out that most communities have access to a Medicare-certified home health agency, with 99 percent of all Medicare beneficiaries living in an area that is served by at least one agency and 97 percent living in an area served by more than one agency.

MedPAC's report denotes that a slight improvement in access to services occurred in 2003 -- 77 percent of beneficiaries polled indicated they had no problems in accessing care that year, compared with 76 percent in 2002.

In further analysis of the adequacy of pay rates, MedPAC finds that although the number of home health users has increased, the average number of total minutes per episode fell by 8 percent between 2001 and 2003. According to the data, the decline was most evident in home health aide services and nursing care, while the volume of therapy services has remained about flat over a three-year period. Although the volume of services may have declined, MedPAC notes that in all categories of its analysis the percentage of patients achieving positive outcomes has increased.

MedPAC also points to an increase in the number of home health agencies (from 6,888 in 2002 to 7,530 in 2003) as another sign that payment rates are sufficiently high. MedPAC notes, however, that the increase in numbers may not reflect the creation of new agencies, since CMS has been assigning unique identification numbers to home health agency branches during the time period covered by the data.

The chief support for MedPAC's recommendation to freeze home health payment rates appears to be its analysis of freestanding home health Medicare margins for 2003 and projected margins for 2005. In its review of home health agency cost reports, MedPAC determines that agencies averaged a 13.6 percent profit margin in 2003 and projects a margin of 12.1 percent for 2005. However, this analysis excludes all hospital-based home health agencies and utilizes a revenue-weighted averaging calculation that fails to account for the unique, local characteristics of home health agencies.

MedPAC does find that profit margins vary based on agency location and size. Rural agencies have the lowest margin (a projected 6.1 percent for 2005), according to the analysis, and larger agencies have the highest (between 12.6 and 14 percent projected for the top 40 percent of agencies for 2005).

MedPAC does not address the future of the 5 percent rural home health add-on, offering only a somewhat generic analysis that in the absence of the add-on, rural agency margins would be lower than those of urban agencies. Meanwhile, MedPAC notes that rural agency service areas decreased by 4.2 percent between 2002 and 2003.

Analyzing whether Medicare payments should change in 2006, MedPAC contends that even though input prices (locality-dependent costs such as supplies and labor) have risen over the past several years, the cost of producing an episode of care has fallen as a result of fewer visits and shorter stays. At the same time, MedPAC notes that the upward pressure on wages in order to recruit and retain staff may offset these cost decreases.

MedPAC covers the use of technology in home care as an efficiency-enhancing tool, and posits that no additional payment is necessary to promote adoption of technological advances. That's because the home health PPS provides an incentive and reward for the adoption of technologies that reduce the number of visits necessary to deliver care, MedPAC reasons.

The report also offers a potential glimpse at the future of Medicare payments in an evaluation of whether the structure of the home health PPS should change, in which MedPAC finds that costs may vary widely within case-mix groups. For example, out of the 80 case-mix groups in the home health PPS, MedPAC determines in reviewing the number of minutes of care in the episode that 42 of those have a coefficient of variation greater than 1.0. Variation this wide indicates that the case-mix adjustment methodology falls far short of the cost explanatory power that was expected.

MedPAC also notes that the case-mix adjustment system fails to consider certain patient characteristics that have significant bearing on the cost of care, such as use of a ventilator, inability to self-administer injectable medication, and availability of informal caregivers. These comments are a prelude to MedPAC's current effort to examine alternatives to the existing prospective payment system.