Evaluating an Impact Assessment of Home Health Prospective Payment System Payment Policies on Medicare Margins of Home Care Providers

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THE MORAN COMPANY

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In its Notice of Proposed Rulemaking for 2012 under the Home Health Prospective Payment System (HH PPS) promulgated on July 12, 2011, the Centers for Medicare & Medicaid Services (CMS) proposed to continue a series of adjustments it has made over the last three rulemaking cycles to offset observed changes in the average case mix of HH PPS patients. In responding to this proposal, the National Association of Home Care and Hospice (NAHC) is incorporating in its comments the results of an analysis it has performed of the impact of the proposed adjustments on the financial viability of home care providers. The Moran Company was engaged by NAHC to conduct an independent review of the data used, and the methodology employed in preparing this analysis, in order to render a judgment regarding the meaning of these results for policymakers.

High Level Overview of Methodology

In its analysis, NAHC seeks to estimate the effects of reimbursement policy changes on the margins home health agencies earn treating Medicare beneficiaries.

The analysis begins with a provider level margin analysis for a base year. Revenue and cost data from that base year are then separately projected forward to the rate year. Margins are recalculated in the rate year, and analyzed to determine how the proposed policies affect the distribution of margin outcomes across provider entities.

Data Employed

The NAHC methodology is based on the use of home health agency cost report data for a base year. In this analysis, the latest base year with a reasonably complete set of cost reports is 2009.

NAHC obtains the cost report data used in this analysis directly from CMS. Prior independent reviews of the NAHC methodology have verified that the CMS cost report data have been accurately transcribed into the database NAHC employs to conduct this analysis, and that the variables needed to accurately calculate costs and revenues are being extracted from that database and employed in the NAHC margin calculation.[1] Since we are informed that NAHC has not changed its methodology since the more recent outside evaluation, we saw no need to conduct a detailed verification of the underlying data.

Because Medicare cost report data often present data anomalies, NAHC trims the data employed in its analysis to eliminate cost reports with dubious values. We have examined NAHC's trimming criteria, and find them reasonable in light of the data being used. Its calculation of base

[1] Cowles, M. & Muse, D. "Home Health Agency Cost Report Analysis" *Muse & Associates*, 2003.
Price Waterhouse Coopers, *Analysis of Medicare Margins for Home Health Agencies*, 2006.

year Medicare margins is consistent with, and hence comparable to, the definition of Medicare margins employed by the Medicare Payment Advisory Commission. In the current analysis, NAHC is employing data from 2009 cost reports as the base year for projecting 2012 margins.

Trending Cost Information to the Rate Year

The NAHC methodology implicitly assumes that that the volume of patients and services remains constant over the interval between 2009 and 2012, and hence that cost increases between 2009 and 2012 reflect only input price inflation. NAHC uses the rate of market basket increases embedded in the CMS ratesetting methodology as its measure of input price inflation. We agree that this is the best available proxy for estimating year-over-year increases in the cost of inputs.

In its methodology, NAHC assumes no change in actual case mix in the rate year relative to the base year. Implicit in this decision is the assumption that any change in cost attributable to case mix change would be exactly offset by corresponding changes in the provider's case mix index—and hence revenues. We believe that this methodology choice is reasonable in light of the objective of the analysis.[2]

In our analysis, we considered whether NAHC should modify its cost projection methodology to take cognizance of productivity increases. Under current law, annual updates of the HH PPS rates will be adjusted beginning in 2015 to reflect assumed productivity gains. This policy, however, does not reflect a finding that productivity gains are in fact being achieved in home health care. In reality, the Bureau of Labor Statistics (BLS) measure of all factor productivity for ambulatory health care—the industrial code category in which home health services falls—has been negative or mildly declining for more than a decade. Hence we believe that NAHC's decision to exclude a productivity adjustment in its cost projections is probably conservative.

Trending Revenue Information to the Rate Year

In parallel to the constant volume assumption used to project costs to the rate year, the NAHC methodology starts with actual base year revenues, and adjusts them going forward to reflect reimbursement policy changes between the base year and the rate year. In each year, adjustments are made for the market basket component of the annual update, policy adjustments required under statute, and the discretionary adjustments CMS makes from year to year under its methodology. In 2010-2012, the largest adjustments have been for observed changes in case mix, which CMS attributes to changes in coding practices by HH PPS providers. Since the negative adjustments CMS has made in this period are materially larger than the annual updates, this estimating methodology measures the magnitude of the downward change in provider margins that would result if the proposed 2012 policies are finalized.

This methodology is, by conscious design, "static": it measures the impact that would result if providers made no adjustments to their operating models to offset revenue losses caused by downward payment adjustments. While one would expect providers to at least attempt to adjust their business models to mitigate the effects of downward pressure on margins, the NAHC

[2] See the final section for a more complete discussion.

margin measure is intended to accurately reflect the position from which providers would have to start to work toward positive margins if the proposed adjustments are finalized

NAHC's Results:

The following table presents the results of NAHC's analysis on the impact of the proposed rule on home health agency positive Medicare margins (PM). The table contains estimates of the percentage of home health agencies in each state that would, absent operating changes, experience negative Medicare margins if the rate adjustments CMS has proposed are finalized.

State	All	Rural	Urban	Free-standing	Hospital Based
Alaska	80.0%	85.7%	66.7%	60.0%	100.0%
Alabama	60.6%	68.8%	53.9%	51.4%	70.6%
Arkansasa	63.6%	62.5%	64.9%	45.5%	77.3%
Arizona	51.6%	88.9%	45.5%	42.6%	100.0%
California	65.5%	81.0%	65.0%	61.3%	93.8%
Colorado	42.7%	62.2%	32.9%	37.0%	72.2%
Connecticut	35.0%	0.0%	35.6%	33.9%	50.0%
District of Columbia	19.1%		19.1%	20.0%	0.0%
Delaware	50.0%	33.3%	53.9%	38.5%	100.0%
Florida	46.3%	62.9%	45.5%	44.4%	81.6%
Georgia	54.0%	52.9%	55.2%	44.2%	75.0%
Guam	100.0%		100.0%	100.0%	
Hawaii	66.7%	75.0%	60.0%	60.0%	75.0%
Iowa	57.4%	59.0%	51.9%	50.0%	73.7%
Idaho	76.9%	84.6%	61.5%	65.4%	100.0%
Illinois	51.1%	67.4%	49.2%	48.3%	76.2%
Indiana	59.7%	80.6%	52.4%	50.5%	84.2%
Kansas	57.0%	61.8%	47.4%	47.7%	69.4%
Kentucky	49.2%	59.0%	33.3%	27.6%	67.7%
Louisiana	34.7%	56.8%	32.4%	32.3%	88.2%
Massachusetts	31.8%	66.7%	30.6%	25.6%	80.0%
Maryland	45.7%	80.0%	40.0%	37.9%	83.3%
Maine	63.6%	76.9%	44.4%	55.6%	100.0%
Michigan	48.1%	69.7%	43.9%	44.5%	75.0%
Minnesota	59.1%	65.4%	51.2%	40.5%	74.5%
Missouri	60.7%	70.3%	51.9%	50.9%	83.0%
Mississippi	33.3%	36.8%	27.3%	16.7%	58.3%
Montana	64.0%	77.8%	28.6%	30.0%	86.7%

North Carolina	35.1%	48.8%	26.8%	25.3%	61.3%
North Dakota	91.7%	100.0%	80.0%	100.0%	90.0%
Nebraska	60.0%	80.0%	36.0%	21.7%	87.5%
New Hampshire	46.4%	64.3%	28.6%	46.2%	50.0%
New Jersey	60.0%		60.0%	30.8%	91.7%
New Mexico	57.8%	68.0%	45.0%	47.2%	100.0%
Nevada	51.1%	33.3%	52.4%	48.7%	66.7%
New York	53.9%	60.0%	52.4%	50.0%	100.0%
Ohio	40.9%	56.3%	36.5%	31.9%	82.4%
Oklahoma	68.9%	72.0%	65.5%	63.0%	86.7%
Oregon	96.2%	100.0%	90.0%	100.0%	94.7%
Pennsylvania	45.0%	67.4%	40.5%	35.2%	80.4%
Puerto Rico	58.3%		58.3%	57.9%	60.0%
Rhode Island	50.0%		50.0%	45.5%	100.0%
South Carolina	54.8%	60.0%	51.9%	41.7%	72.2%
South Dakota	59.3%	70.0%	28.6%	11.1%	83.3%
Tennessee	44.3%	48.7%	41.2%	32.4%	85.0%
Texas	59.1%	66.3%	58.2%	57.6%	83.0%
Utah	47.4%	50.0%	46.6%	46.4%	57.1%
Virginia	44.4%	55.1%	39.6%	35.5%	75.0%
Vermont	70.0%	71.4%	66.7%	66.7%	100.0%
Washington	61.0%	86.7%	46.2%	20.0%	100.0%
Wisconsin	74.5%	95.8%	52.2%	60.0%	100.0%
West Virginia	65.0%	62.5%	68.8%	51.9%	92.3%
Wyoming	68.8%	69.2%	66.7%	60.0%	83.3%
National	**53.2%**	**65.7%**	**49.7%**	**47.5%**	**80.9%**

The Meaning of These Results

Given the way in which the NAHC methodology was constructed, it is probably best interpreted as providing a lower bound on the potential impact of payment policy changes on the Medicare margins of HH PPS providers.

The estimates NAHC has developed are intended to shed light on the policy implications of an ongoing controversy. The large payment adjustments CMS has been making in recent years reflect CMS's view that most of the case mix growth observed under the HH PPS reflects changes in provider case documentation and coding practices, rather than "real" changes in patient acuity. CMS has, since 2007, been employing multivariate regression methods to estimate the share of observed case mix growth that is attributable to differences in patient

acuity, and then making downward adjustments for the amount of "nominal" growth observed in excess of the "real" growth it estimates has taken place. Cumulatively, by the end of 2012, downward adjustments for case mix growth CMS has taken or proposed approach 15%.

It is CMS's view that the impact of these adjustments on provider finances will be mitigated by additional revenues that providers may receive in excess of whatever additional costs they incur as "nominal" case mix rises. From the industry perspective, however, the CMS notion of "nominal" case mix growth is conjectural, and the measurement of the phenomenon is based solely on statistical models with very limited predictive power. The NAHC analysis is intended to show that while the margin benefits of supposed "nominal" case mix growth are speculative, the margin impacts of the negative payment adjustments CMS is actually making are real and documented.

Based on our review, we believe that the NAHC analysis provides policymakers with a realistic understanding of the potential financial impact of the CMS proposal, if "nominal" case mix growth proves illusory. While "nominal" case mix growth may occur, we caution that it might never be possible to determine definitively how much case mix growth is or isn't "real." Consequently, we believe that policymakers may find the NAHC results useful as they seek to understand the impact of the proposed payment adjustments on home health agencies.