



NY Home Care Faces Major Medicare Operating Losses under CMS Rebasing Plan, Threatening Access to Care

In July, the U.S. Centers for Medicare and Medicaid Services (CMS) posted its annual proposal of reimbursement changes for Medicare home health services called the Prospective Payment System (PPS) rule. The PPS rule includes a rebasing proposal which recalculates the statistical base for Medicare reimbursement.

CMS's 'rebasings' formula, as designed in the rule, calls for a blunt **3.5% home health reduction** in each of the next four years, reducing payments to home health providers by **\$290 million nationally**. These cuts will dramatically worsen a decade-long trend of deep and escalating Medicare losses for New York State home health agencies, threatening access to care for homebound elderly and disabled Medicare beneficiaries.

NEW YORK IMPACT

New York's home care Medicare margins have **remained negative for eleven years in a row**, with an unweighted average margin of -19.27% in 2011 (the most recent year of data available). **Thirty-three percent of New York agencies had unweighted operating margins worse than -25% in 2011**, leaving no resources for capital to keep pace with increasing regulatory requirements and modernization through technology (i.e. home telehealth and electronic health records).¹

Accounting for the impact of rebasing, the National Association for Home Care and Hospice (NAHC) estimates that **77% of agencies in New York State will have**

unweighted Medicare operating margins at or below zero in 2014. (Only two other states – North Dakota and Hawaii – have a higher percentage.) The average unweighted Medicare operating margin for New York agencies is forecast at **-33%** and the average weighted New York State Medicare margin is **-24.3%** in 2014. (Only two other states have worse projected margins: Alaska and North Dakota.)

New York is among 13 states whose Medicare margins will plunge deeper into the red as a result of CMS's proposed 2014 PPS. These Medicare losses include the impact of the 2014 PPS on top of 20.15% in rate cuts since 2008. Meanwhile, as New York's operating margins plummet, other regions of the country where operating margins have been positive will continue to have positive margins in some cases, given that the rebasing formula is evenly applied regardless of regional variations in Medicare growth or spending patterns.

MAJOR FLAWS

By statute, CMS must use the "most reliable, available data" in its rebasing process. HCA asserts that **CMS used neither reliable, nor complete, nor recent data in developing its formulas.**

- **CMS's estimates use outdated, incomplete data:** CMS's estimate of a 13.63% national operating margin in 2013 is based on 2011 data. Its projections do not account for major new cost impacts affecting providers since that time, including: a 25% rise in fuel prices; the increasing cost of employee health benefits; regulatory requirements; and past cuts.

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¹ Unlike other providers, home health has no other payors that can offset losses in Medicare and Medicaid. In fact, an HCA analysis earlier this year found that 79% of NY home care providers were operating at a loss across all payors, not just Medicare.



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HCA and the home care community nationally also question CMS's sampling methods. NAHC's analysis of a broader sample of cost reports from 2011 shows a national home care margin of 11.25%, not 13.62%.

- **CMS only assesses the one-year impact of its proposal and fails to account for the effect on access to care:** In assessing only the 2014 impact of its proposal, CMS omits the cumulative impact of rebasing in the remaining three years: 2015 to 2017.
- **CMS's approach ignores regional differences:** By attempting to zero-out the national average home health operating margin, CMS's proposal severely jeopardizes providers in states like New York who are already operating at a net loss. Even assuming CMS's flawed calculation of a 13.63% national operating margin, **rebasings would reduce New York's unweighted operating margin to -33% – a nearly 50-percentage-point difference.**

HCA's RECOMMENDATIONS

CMS is expected to finalize its rule in late October. HCA urges New York's Congressional Delegation to contact CMS officials and press for:

- **A recalculation of CMS's rebasing formula** using more complete, accurate and up-to-date cost report data.

- **Greater transparency in CMS's calculations.** These calculations must account for true provider cost increases that have occurred in the two-year period between the 2011 cost reports and the 2013 base year used to estimate provider margins.
- **Consistent with the Affordable Care Act (ACA), rebasing must factor for the impact on access to care.** As a whole, CMS must conduct a more complete impact assessment of CMS's rebasing proposal over the entire four-year period, not just in 2014. A more rigorous look at the cumulative impact of these incremental reductions on beneficiaries and providers over four years would provide a better understanding of the rolling effect of 3.5% cuts in each of the four years through to 2017.
- **An explanation of how CMS arrived at its assumption that rebasing cuts of 3.5% are needed.** The assumption of a 3.5% reduction appears arbitrary, simply by enacting cuts at the ACA statutory maximum, and the rule fails to explain or justify the overall basis for its percentage reduction.

Rebasing at a glance

- *Rebasing is a process required by the Affordable Care Act to update the payment rates to providers.*
- *CMS's rebasing proposal calls for \$290 million in cuts nationally.*
- *CMS's 2014 rebasing proposal would put 77% of NY agencies' Medicare operating margins at zero or in the red.*
- *Even before rebasing is applied, 33% of New York agencies had Medicare operating margins worse than -25% in 2011, the most recent year of data available, due to past cuts. When all payors are accounted for, 79% of NY agencies are operating in the red.*
- *CMS's rebasing formula is rooted in unreliable, incomplete and outdated sets of data.*
- *HCA urges: a recalculation of CMS's rebasing formula using more accurate and complete data; a fuller, multiyear impact analysis, especially on access to care; and greater transparency in CMS's calculations.*