

Home Health Rebasing: A Legal and Policy Analysis of Affordable Care Act §3131

Executive Summary

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (collectively, the “Affordable Care Act” or “ACA”), directs the Secretary of Health and Human Services (“HHS” or “Secretary”) to adjust home health payments under Medicare through rebasing by a percentage determined appropriate by the Secretary. This legal and policy analysis examines key issues relating to the implementation of this provision, which are summarized here and detailed below:

- I. The ACA grants the Secretary broad discretionary authority in implementing the rebasing provision (section 3131) and does not direct her to use it to reduce Medicare home health reimbursement.
- II. The ACA directs implementation to occur within certain parameters, including that the Secretary conduct an analysis to determine the appropriate percentage of any rebasing adjustment, that a single adjustment be applied across the home health sector, and that any such adjustment be implemented in equal annual increments between 2014-2017.
- III. Executive Orders require that any proposed regulation which, like this one, is designated by the Office of Management and Budget (“OMB”) as “economically significant” be subjected to detailed and cumulative quantitative analyses.
- IV. Pursuant to other applicable statutes and case law, the Secretary must also use the “most reliable available data,” including the cumulative impact of current and pending home health reimbursement reductions arising from legislative and regulatory action.
- V. Independent analyses indicate that: (1) the Secretary has already acted on factors specified in section 3131, (2) the savings scored by the Congressional Budget Office (“CBO”) have already been realized, and (3) further reduction could adversely affect the delivery of home health services in a number of States, which are projected to experience net Medicare operating losses by 2017.

As a result of these factors, it appears well settled that the Secretary must use her authority to ensure that section 3131 of the ACA is implemented in a manner that is based on detailed analysis and will preserve beneficiary access to Medicare-covered services.

It also appears clear that this undertaking must include a careful assessment of the home health sector's economics in each of the years 2014, 2015, 2016 and 2017 to ensure that the rebasing adjustment's equally-applied increments are appropriate, as well as to ensure compliance with the requirements of section 1895(b)(2) of the Social Security Act (“SSA”).

Background

As part of the Affordable Care Act, Congress directed the Secretary to adjust the prospective payment system's base payments to Home Health Agencies ("HHAs") by a percentage determined by the Secretary to be appropriate, reflecting four specified factors as well as other factors deemed relevant by the Secretary. See ACA § 3131, amending SSA § 1895(b)(3)(A)(iii). The statute vests the Secretary with significant discretion, subject to certain specified parameters including the use of a single adjustment percentage for the home health sector and the implementation of such adjustment in equal increments over a four year period (2014-2017). In addition, the provision is subject to the prevailing requirement that Medicare payments be adequate to "provide[] for continued access to quality services." SSA § 1895(b)(2).

Legal and Policy Analysis

I. The ACA grants the Secretary broad discretionary authority in implementing the rebasing provision (section 3131) and does not direct her to use it to reduce Medicare home health reimbursement.

A. Section 3131 Does Not Mandate that Rebasing Result in Payment Reduction

As shown below, the plain language of section 3131 is neutral. It does not require the Secretary to reduce home health payments but, rather, directs that a parameter- and data-driven analysis be undertaken. The absence of any language mandating a reduction is relevant given that, in other provisions of Title XVIII and the ACA that require a reduction in payment, Congress has stated the requirement in unmistakable terms. By contrast, such language is not present in section 3131.

As the Supreme Court has consistently reiterated, when interpreting a statute, the starting point – and frequently the ending point – is the language of the statute. See *Dean v. United States*, 556 U. S. 568, ___ (2009) (slip op., at 3) ("We start, as always, with the language of the statute" (internal quotation marks omitted)); *Community for Creative Non-violence v. Reid*, 490 U. S. 730, 739 (1989) ("The starting point for [the] interpretation of a statute is always its language"). In interpreting a statute, "courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat. Bank v. Germain*, 503 U.S. 249, 253-254 (1992). See also *Gonzales v. Oregon*, 546 U.S. 243, 259 (2006). It is against this backdrop that we examine the words of the rebasing provision of section 3131 of the ACA, which, in pertinent part, provides:

(a) Rebasing Home Health Prospective Payment Amount.—

* * *

(iii) Adjustment for 2014 and subsequent years.—

(I) In general.—Subject to subclause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage

determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and non-profit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

- (II) Transition.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2017. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.

The term “rebasing” generally means making changes to a payment policy’s base year rate with an effect likely to carry over to subsequent years. Rebasing, by definition, is a neutral term that leans neither toward the negative nor toward the positive. Rebasing by itself does not require, ordain, or mandate a payment reduction. This is made clear by the plain language of section 3131(a), which does not use the words “reduce” or “reduction,” or even terms, such as “budget neutrality,” that could be understood to require a reduction.

B. The Absence of Statutory Language in Section 3131 Requiring a Reduction Significant Given that Both the Social Security Act and the ACA Expressly Use Those Terms When Requiring a Payment Reduction

The absence of terms of reduction is significant both with respect to Medicare in general and rebasing in particular. By way of illustration, the Balanced Budget Act of 1997, Pub. L. No. 105-33 (“BBA”), required multiple reductions in Medicare payments and used the term “reduce” more than fifty times. For example, “[w]ith respect to all the capital related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments . . . by 10 percent.” BBA § 4522, amending SSA § 1861x(v)(1)(S)(ii)(I) (emphasis supplied). Section 1985 – which established the prospective payment system (“PPS”) for home health services – also used the word “reduction” when setting the method for calculating the initial base year payment. See SSA §1895(b)(3)(A)(ii).

Congress similarly did not shy away from using the term “reduce” in the ACA, where it appears over 150 times. However, Congress did not use this term or any variant of it in the rebasing provision of section 3131. “Where Congress includes particular language in one section of a statute, such as the ACA, but omits it in another section of the same Act, it is

generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.” *Dean v. United States*, 556 U.S. at 573 (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)); see *Keene Corp. v. United States*, 508 U.S. 200, 208 (1993) (same).

When Congress does intend the Secretary to reduce payments through rebasing, it says so explicitly. For example, in the American Taxpayer Relief Act (“ATRA”) § 632, Pub. L. No. 112-240 (Jan. 1, 2013), Congress directed the Secretary to rebase dialysis payments so as reduce payments to dialysis centers, as follows:

- (a) Adjustment to ESRD Bundled Payment Rate To Account for Changes in the Utilization of Certain Drugs and Biologicals.— Section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) is amended by adding at the end the following new subparagraph:

- (l) For services furnished on or after January 1, 2014, the Secretary shall, by comparing per patient utilization data from 2007 with such data from 2012, make reductions to the single payment that would otherwise apply under this paragraph for renal dialysis services to reflect the Secretary’s estimate of the change in the utilization of drugs and biologicals described in clauses (ii), (iii), and (iv) of subparagraph (B) (other than oral-only ESRD-related drugs, as such term is used in the final rule promulgated by the Secretary in the Federal Register on August 12, 2010 (75 Fed. Reg. 49030)). In making reductions under the preceding sentence, the Secretary shall take into account the most recently available data on average sales prices and changes in prices for drugs and biological reflected in the ESRD market basket percentage increase factor under subparagraph (F).’ (emphasis added.)

With respect to dialysis services, Congress used language that explicitly requires the Secretary to reduce payments. By contrast, section 3131 contains no such mandate. Rather, it requires the Secretary to evaluate a variety of factors in adjusting Medicare reimbursement for home health. The ACA therefore does not preclude the Secretary from providing for a zero percent, or even a positive adjustment, if either is determined appropriate as a result of the detailed analysis that must be undertaken.

- II. The ACA directs implementation to occur within certain parameters, including that the Secretary conduct an analysis to determine the appropriate percentage of any rebasing adjustment, that a single adjustment be applied across the home health sector, and that any such adjustment be implemented in equal annual increments between 2014 and 2017.**

- A. Section 3131 Requires an Analysis by the Secretary**

Congress’s use of neutral language in section 3131 that neither requires a reduction nor an increase in payment is underscored by the provision’s analytical framework. The section requires the Secretary to conduct an analysis to include consideration of such factors as (i)

changes in the number of visits in an episode, (ii) the mix of services in a home health episode, (iii) the level of intensity of services in a home health episode, (iv) the average cost of providing care per home health episode, and (v) other factors that the Secretary considers to be relevant. Consideration of these factors could not be assumed to lend itself to a given result.

In conducting any complex economic analysis, double counting must be avoided. See *Russell County Sportsmen v. United States Forest Serv.*, 668 F.3d 1037, ___ (9th Cir. 2011); *Novartis AG v. Kappos*, No. 10-1138 (ESH), slip op. at 24 (D.C.C. Nov. 15, 2012). In this instance, factors set out in section 3131 have already been taken into account during the course of the Secretary's post-ACA case mix adjustment process (see 77 Fed. Reg. at 67,068). As discussed in more detail below, the Secretary took into account changes in the number of visits per episode, the mix of services, and their level of intensity. Since the Secretary has already made adjustments based on these three factors, evaluating them again and factoring them into the cost structure a second time would run the risk of constituting double counting.

Further, Congress expressed its interest in a careful review of the home health sector. Section 3131's rebasing provision is limited to a single adjustment. Therefore, Congress gave the Secretary authority to include in her analysis consideration of differences between different types of HHAs, including hospital-based and freestanding agencies, for-profit and non-profit agencies, and urban and rural agencies. In doing so, the Secretary would ensure that any adjustment that may be implemented is "appropriate" to the home health sector as a whole.

Also integral to the Secretary's analysis is an assessment of the cumulative effect of regulatory and legislative reimbursement changes implemented since the enactment of the ACA. As discussed in Section III below, such a quantitative approach is required under applicable Executive Orders. In addition, analysis of productivity adjustments, sequestration, case-mix adjustments, and market basket changes are central to an informed determination both of an appropriate rebasing adjustment and its impact on all sectors of the home health industry.

Finally, since the provision is subject to the long-standing requirement under SSA § 1895(b)(2) to ensure that Medicare payment "provides for continued access to quality services", the Secretary's analysis must necessarily include such an assessment to ensure compliance.

B. Section 3131 Requires a Single Adjustment be Applied Across the Home Health Sector

While section 3131 grants the Secretary relatively broad authority, it expressly limits the Secretary to implementing a single adjustment, which is to be applied equally to all qualified home health care providers eligible to receive Medicare reimbursement. This determination is based on the explicit use in the provision of the following terms in their singular form: "a percentage", "Such adjustment", "the adjustment", and "such adjustment".

In light of its directive that a single adjustment be implemented across the home health sector, Congress provided the Secretary express authority to consider differences between various types of agencies, as discussed above, in order to ensure that this adjustment is universally sustainable.

C. Section 3131 Requires any Adjustment be Implemented in Equal Annual Increments between 2014 and 2017

The ACA expressly requires that any adjustment implemented under section 3131 be applied “in equal increments” over a “4-year phase-in” period. As a result, any adjustment (up to a capped 3.5 percent) that is applied in 2014 must also be applied in 2015, 2016, and 2017.

This aspect of section 3131’s rebasing provision is both unusual and particularly notable because it means that any adjustment which the Secretary implements in 2014 must again be applied to payments made in 2015, in 2016, and in 2017. If, for example, the Secretary were to implement an amount equal to 1 percent in 2010 as an adjustment in the 2014 rate, payments would subsequently need to be reduced by the same amount during each of the three subsequent years, for a total reduction of four (4) percentage points.

The equal application of any adjustment amount during each of the years 2014-2017 helps to elucidate the obvious care that Congress took to ensure that the Secretary undertake an analysis, that any adjustment implemented by the Secretary be “appropriate”, and that the Secretary consider differences between various types of agencies before applying the adjustment to the sector as a whole.

III. Executive Orders require that any proposed regulation which, like this one, is designated by the Office of Management and Budget (“OMB”) as “economically significant” be subjected to detailed and cumulative quantitative analyses.

President Obama’s Executive Order 13563 provides that the regulatory system “must promote predictability and reduce uncertainty.” Executive Order 13563 was expressly “designed to affirm and to supplement Executive Order 12866; it ... specifically reiterates five principles from Executive Order 12866. These principles generally involve consideration of benefits, costs, and burdens. Section 1 also asks agencies ‘to use the best available techniques to quantify anticipated present and future costs as accurately as possible,’ such as identifying changing future compliance costs that might result from technological innovation or anticipated behavioral changes. The goal of this provision is to promote careful and accurate quantification.”¹ (emphasis added.)

Executive Order 12866 (President Clinton) defines “economically significant” regulations as those that may “have an annual effect on the economy of \$100 million or more or adversely affect in a material way ... State, local, or tribal governments or communities.” (See section

¹ Memorandum for the Heads of Executive Departments and Agencies, and of Independent Regulatory Agencies from Cass Sunstein, Administrator, Office of Management and Budget (Feb. 2, 2011).

3(f)(1).) Proposed regulations that are deemed to be “economically significant” are to be subjected to “an assessment, including the underlying analysis, of costs anticipated from the regulatory action (such as, but not limited to ... any adverse effects on the efficient functioning of the economy ...) ... together with, to the extent feasible, a quantification of those costs.” (see section 6(a)(3)(C)(ii)) These quantitative analyses must take into account “the costs of cumulative regulations.” (See section 1(b)(11).)

Finally, section 6(a)(3)(C)(iii) requires “an assessment, including the underlying analysis, of costs and benefits of potentially effective and reasonably feasible alternatives to the planned regulation ... and an explanation why the planned regulatory action is preferable to the identified potential alternatives.”

Since the proposed HPPS regulation submitted by CMS has been deemed by OMB to be “economically significant”, detailed and cumulative quantitative analyses must be undertaken in compliance with Executive Orders 13563 and 12866. These analyses must account for the impact over four years – 2014, 2015, 2016, and 2017 – since any amount and adjustment applied in the first year must also be applied in the others. Each adjustment must also be appropriate. The analyses must also avoid double counting and ensure compliance with the section 1895(b)(2) requirement that Medicare payment policy be sufficient to “provide[] for continued access to quality services.”

IV. Pursuant to other applicable statutes and case law, the Secretary must also use the "most reliable data available," including cumulative impact of current and pending home health reimbursement reductions arising from legislative and regulatory action.

While the Secretary has broad discretion in issuing regulations, that discretion is neither unlimited nor untethered, with respect to the impact of the rules especially where the regulations make economic changes or impose new economic burdens. In such cases, Executive Order 12866, as amended, Executive Order 13563, the Regulatory Flexibility Act (“RFA”), 5 U.S.C. § 601 et seq., and the Data Quality Act, all impose detailed analytical requirements on agencies that are issuing significant rules, especially with respect to the impact of the rules on small entities, such as the majority of home health agencies.

The Data Quality Act, § 515 of the Treasury and General Government Appropriations Act for Fiscal Year 2001 (Pub. L. No. 106-554), directs the OMB to issue government-wide guidelines that “provide policy and procedural guidance to Federal agencies for ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by Federal agencies.” The courts, in assessing regulations – especially those issued under the Social Security Act – have normally required that CMS use the best available data in setting rates or making other policy decisions. See *Banner Health v. Sebelius*, No. 10-01638 (CKK) (D.D.C. May 16, 2013) (noting that CMS “failed to use the best available data,” in its Outlier Payment Regulations); *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, 26-30, 57-58 (D.D.C. 2008) (concluding that CMS was required to use, but failed to use “the best available data”).

Courts have consistently held that even where the Secretary enjoys discretion to implement a statute, she must base her decisions on the most reliable data available. See *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 41 (D.D.C. 2008) (emphasis added) (“the agency must use the most reliable data available to produce figures that can be considered sufficiently accurate”); *Alvarado Community Hosp. v. Shalala*, 155 F.3d 1115, 1125 (9th Cir. 1998) (approving standard requiring “the most reliable data available,” and noting that the most recent data available was “highly significant to an accurate determination”). (emphasis added)

Section 3131 requires the Secretary to “conduct[] [an] analysis” considering various “factors that [she] considers to be relevant” prior to making an adjustment determination. Therefore, even though the Secretary has been granted broad discretion to determine if an adjustment is necessary, she cannot ignore relevant factors and cannot rely on data that are not the most reliable data available. See *e.g. Cnty. of Los Angeles* at 1023 (holding that it is within the Secretary’s discretion to issue less than 5 percent of the annual DRG budget in outlier payments, but she must rely on the best available data to calculate the outlier payment threshold when more relevant data are readily available.).

As a result, when conducting the analysis required under section 3131, the Secretary should analyze the most current and accurate data, not solely data considered relevant during consideration of section 3131 or data that do not fully and accurately describe the home health sector’s financial status. In addition, the ACA contains an express requirement that any adjustment be implemented “in equal increments” over a “4-year phase-in” period. Since any adjustment must be applied in 2014, 2015, 2016, and 2017, and must be determined by the Secretary to be “appropriate,” the Secretary is obligated to ensure that any payment adjustment be applied in equal increments during each of the years 2014-2017, and that such adjustment is determined to be appropriate in **each** of those years. All of this must be done within the constraints of the relevant Executive Orders, RFA, and Data Quality Act.

VI. Independent analyses indicate that: (1) the Secretary has already acted on factors specified in section 3131, (2) the savings scored by the Congressional Budget Office (“CBO”) have already been realized, and (3) further reduction could adversely affect the delivery of home health services in a number of States, which are projected to experience net Medicare operating losses by 2017.

A. Data Analysis Provides Important Information in Evaluating the Effects of the Changes During the Past Three Years and Illustrates that Factors Specified in Section 3131 Have Already Been Addressed

The Partnership for Quality Home Healthcare has evaluated the factors specified in section 3131 and notes that three of the four factors specified have been addressed through market forces and separate regulations and have already applied an adjustment to the rate.

Table 1: Status of Factors Specified in Section 3131

Factor	Status
Number of Visits per Episode	Analysis of 2002 data against 2010 data shows little change since the inception of the Medicare Home Health Prospective Payment System.
Mix of Services in an Episode	Under the CY 2013 Final Rule, CMS decreased the 12.8% of total case-mix change by 8.03% to get a final nominal case-mix increase measure of 11.75%.
Level of Intensity of Services in an Episode	CMS fully adjusted for the 19.03% nominal case-mix growth from 2000 through 2009 and included case-mix growth related to the mix of services in episodes, through regulatory payment reductions implemented each year from 2008 through 2013.
Cost to HHAs of Providing Services in an Episode	Analysis of 2002 data against 2010 data shows that the cost per visit for freestanding home health agencies nearly doubled between 1997 and 2010, rising from \$64 to \$123.

Regarding the number of visits in an episode, a comparison of data from 2002 and 2010 indicates that there has been little change since the inception of the Medicare Home Health PPS, and even experiencing a decline in recent years. In its March 2012 report, the Medicare Payment Advisory Commission (“MedPAC”) found that, “between 1998 and 2001, the average number of home health visits per episode dropped from 31.6 to 21.4 and remained at about this level through 2009.”²

Regarding the mix of services in an episode, as well as level of intensity of services in an episode, CMS recently adjusted the case-mix of services in an episode. Case-mix represents the variations in conditions of a patient population served by HHAs.³ As a result of CMS’s 2008 analysis of 2005 data, the Agency found a 12.78 increase in the observed case-mix since 2000. CMS more recently conducted a more detailed analysis of the 2005 data, which found that 8.03 percent of the total change in case-mix was “real.”⁴ Therefore, CMS decreased the 12.8% of total case-mix change by 8.03%, resulting in a final nominal case-mix increase measure of 11.75%.⁵ CMS also fully adjusted for the observed 19.03% nominal case-mix growth and included case-mix growth related to the mix of services in episodes in regulatory payment reductions implemented each year from 2008 through 2013.⁶ CMS has evaluated, through regulation, the accuracy of payments with respect to the mix of services and level of intensity of services in an episode.

² MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2012, at 227.

³ 77 Fed. Reg. 67071.

⁴ See id.

⁵ See id.

⁶ See id.

In evaluating, with respect to the average cost to HHAs of providing services in an episode, data indicate that the cost per visit for freestanding home health agencies nearly doubled between 1997 and 2011, rising from \$64 to \$123.⁷ Considering this factor in any analysis should not support any determination by the Secretary that home health payments should be further reduced.

B. The CBO's Estimated Savings for Section 3131 Have Been Met and the Estimated Savings under the President's Proposed FY 2010 Budget Have Been Met

The CBO estimated that the home health reforms made by the ACA would save a total of **\$39.7 billion** over ten years. The CBO's score included both the payment adjustments made under section 3131, as well as a productivity adjustment established under section 3401. According to calculations undertaken by Avalere Health, the share of the total CBO score attributable to all home health provisions other than rebasing is **\$21.5 billion**, and the share related to rebasing is **\$18.2 billion**.

Since passage of the ACA, several regulatory changes have been implemented that reduce payments to HHAs. Avalere Health estimates that case-mix adjustments in 2011, 2012, and 2013 have and will reduce payments by a total of **\$19.03 billion** between 2010 and 2019. As shown in Table 2, the post-ACA regulatory reductions exceed the estimated score for rebasing; as a result, savings in excess of \$39.7 billion have achieved even prior to the imposition of any payment adjustment under the Secretary's rebasing authority.

Table 2. Comparison of CBO Estimate with Total Savings Achieved

Total CBO Score for ACA HH Cuts (Section 3131)	Estimated Savings from ACA HH Cuts⁸ (Excluding Rebasing)	Estimated Savings from ACA HH Rebasing⁹	Estimated Savings from Case-Mix Cuts¹⁰ (post-ACA)
\$39.7B	\$21.5B	\$18.2B	\$19.03B

In total, Avalere Health and the Partnership estimate that savings from the ACA provisions, case-mix adjustments, and sequestration will total approximately **\$72.5 billion** between 2011 and 2020. This exceeds the total estimated savings projected by the CBO for the ACA's home health provisions and is equivalent to a **22% reduction** in total Medicare home health funding.

Of note, the President's fiscal year (FY) 2010 Budget Proposal included a provision that would have achieved **\$37.07 billion** in projected savings over ten years through rebasing. Based on the data analyses undertaken to date, the impact of current law legislative and regulatory policies also exceed the President's proposed FY 2010 budget's projected savings.

⁷ Source: Avalere Health Analysis of CMS Medicare Home Health Cost Reports for Freestanding Agencies.

⁸ Calculated by Avalere Health.

⁹ Calculated by Avalere Health.

¹⁰ Calculated by Avalere Health, for the period from 2010-2019.

C. Rebasing Could Have a Disproportionate Effect Across States

According to analyses completed by Avalere Health and Dobson DaVanzo Associates which utilize the Medicare Payment Advisory Commission (MedPAC) for calculating Medicare margins, ten states will experience average negative Medicare margins and nine states will experience near-negative (0%-5%) margins by 2017 – even if the rebasing adjustment is set at zero percent. The analyses also find that if the rebasing adjustment is set at -1.2% per year, 19 states will experience average negative Medicare margins and 16 states will experience near-negative margins by 2017. Finally, the analyses reveal that if the rebasing adjustment is set at the statutory maximum of -3.5% per year, all States will experience average negative Medicare margins.

Table 3. Impact across States of Various Levels of Rebasing

Impact on States	If Rebasing Set at 0% Per Year	If Rebasing Set at 1.2% Per Year	If Rebasing Set at 3.5% Per Year
States Experiencing Negative Medicare Margins	AK, HI, ID, MT, NV, NY, OR, SD, WI, WY	AK, AR, CA, HI, ID, IL, IN, ME, MI, MT, NM, NV, NY, OR, SD, TX, VT, WI, WY	All 50 States and DC
States Experiencing Near Negative (0-5%) Medicare Margins	AR, CA, IL, IN, ME, MI, NM, TX, VT	AZ, DC, DE, FL, IA, MA, MD, MN, MO, ND, NH, NJ, OK, UT, VA, WA	N/A

D. Impact of Rising Operating Costs

In addition to insufficient revenue, rising operating costs such as labor and benefit costs, gasoline and other transportation costs, and regulatory compliance exacerbate the financial outlook for Medicare home healthcare. The CY 2013 final rule acknowledges that the “2010 data, the most recent and comprehensive data available at the time of the rebasing, show that **labor-related costs [(e.g., wages),] have increased faster than aggregate non-labor-related costs since 2003.**”¹¹ (emphasis added)

At the same time, home health agencies and other entities within the sector must comply with a range of new requirements that have proven to be costly to implement and monitor for compliance. These include the face-to-face encounter requirement under Medicare, as well as the mandatory offering of employer-sponsored insurance coverage for full-time employees and their dependents.

¹¹ 77 Fed. Reg. 67,091. (Emphasis added.)

E. Medicare Home Health Margins Are Declining Significantly

As discussed above, Medicare home health reimbursement has been reduced by an estimated \$72.5 billion as a result of ACA reimbursement cuts, CMS regulatory reductions, and sequestration. As a result, Medicare home health margins are declining significantly, and one-fifth of all states are projected to experience negative Medicare margins by 2017.

The implications of this scenario are even more troubling in light of the facts that these calculations are based on MedPAC's methodology and, therefore, exclude many commonly-borne costs such as payment of taxes, and that Medicaid and private pay rates for home health services are documented as being lower than Medicare. As a result, actual margins are lower than projected using the MedPAC methodology, and negative and near-negative Medicare margins cannot be offset via cross-subsidization from other payers. The combined effect of these factors is an untenable operating status for impacted states and providers.

As shown in Table 4 below, by 2017 industry-wide Medicare home health margins are projected to decline to **4.7%** – and the ten states listed in Table 3 will experience negative Medicare margins – even if the rebasing adjustment is set at zero percent. Margins are projected to be even lower and the number of states with negative margins is projected to rise if the rebasing provision results in further reductions to Medicare home health funding.

Table 4: Home Health Margins – Projected Decline

Year	0% Rebasing	-1.2% Rebasing	-3.5% Rebasing
2014	7.4%	6.3%	3.9%
2015	6.5%	4.2%	-0.9%
2016	5.6%	2.1%	-5.9%
2017	4.7%	0.0%	-11.4%

By way of comparison, an analysis¹² of financial statements submitted by publicly traded home healthcare companies to the Securities and Exchange Commission (“SEC”) indicates the outlook for Medicare home health providers may be even more precarious than shown above. The SEC filings analysis, which was conducted by Avalere Health, found that publicly traded home health companies – which tend to be among the most efficient operators in the sector – experienced a 63% reduction in their actual operating margins between 2009 and 2012.

Table 5: Home Health Industry Margins – Documented Decline

Year	2009	2010	2011	2012
Full Year Margin	7.6%	7.1%	4.0%	2.8%

¹² Based on analyses of SEC filings conducted by Avalere Health and Dobson DaVanzo & Associates.

Conclusion

Section 3131 does not contain language that expressly requires the Secretary to reduce home health payment rates. Instead, the statute grants the Secretary broad authority to adjust payments as she determines appropriate. Based on legal, policy, and data analysis, it appears well-settled that the Secretary must use her authority to ensure that section 3131 of the ACA is implemented in a manner that is based on detailed analysis and will preserve beneficiary access to Medicare-covered services.

It appears equally clear that the Secretary must also undertake a careful assessment of the home health sector's economics in each of the years 2014, 2015, 2016, and 2017 to ensure that the equally-applied four-year increments of any rebasing adjustment are appropriate, as well as to ensure Medicare beneficiaries have access to quality home care services in compliance with the requirements of section 1895(b)(2) of the SSA.

Further, it has been determined that changes consistent with the factors in the statute have already been evaluated in the promulgation of regulatory reimbursement adjustments, resulting in spending reductions that have been instituted subsequent to and beyond the anticipated scope of the ACA provisions.

In light of the prescribed and discretionary authority vested in the Secretary, the Executive Orders governing the rulemaking process, and the Secretary's obligation to consider the most reliable data available, it is the conclusion of this legal and policy analysis that a careful and detailed analysis must be undertaken of the home health sector's economics in the four years that would be impacted by any rebasing adjustment.