Project Sword – A MedPAC Rebuttal

Analyzing cost report data to reveal the true financial status and trends for home health agencies

By Kalon Mitchell

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Acknowledgements

I have worked on developing this report almost entirely on my own. However, as with all the projects I have worked on in my career, I depended on others to help me. This project would have never happened without the help of three people that were essential to allowing me to create this content.

John Loury, President, Cause + Effect Strategies

Developing this data at the level that is provided in the charts included in this report and creating the cost report spreadsheets requires business intelligence technology and tools. Over the last five years, I have learned to use the Sisense BI environment. When I contemplated working on this project, I had no access to Sisense. My contacts at Sisense introduced me to John who had some experience in the post-acute market and was aware of these issues. His company provides general BI services to many different markets including home health. He agreed to provide me with access to Sisense at no charge to work on this project, without his generosity, and Sisense, this could not happen.

David Kerns, CEO, The LTM Group

In my last blog post in April, I conceded defeat regarding the strategy of conveying this information through a blog. After 26 weekly posts, I had failed to get the attention of anyone in the industry in a position to get this information out to the people that needed to know it. I changed my strategy in a last attempt to convert this data into actionable information. Instead of delivering this message myself, I began a search for someone who could deliver it for me. Someone with credibility and the respect of HHAs and their advocates.

After an interview of David by HHCN, I messaged him on LinkedIn, as I had done with many other HHA providers and advocates. David responded and offered to help. He read some of my posts and he reached out to me, and we began our relationship regarding this project. He provided the services of his finance director, Mat Noggle, who worked with me for over a month validating the cost report data associated with the agencies that LTM owns. He connected me with other agencies that provided additional data validation. He shared my content with others and introduced me to Andrew Donlan, editor of HHCN.

David stepped up and delivered for me and the home health industry, both of us owe David our gratitude.

Beth Mitchell, CEO of Mitchell home management

My wife has been instrumental in many of the successes of my career by allowing me to focus on my company and work with few distractions. For this project, she provided the time and space I needed to work on my blog and develop this data. She created a “bubble” around me that allowed me to focus on Sword without the interruptions or the distractions associated with daily life. She often reviewed my blog content and she helped with the PowerPoint version of this project. This was at the expense of her time, our shared vacation time since October, and the duties required to maintain our home. She never complained about this arrangement. Like John and David, I would not have been able to make this happen without her.

Executive Summary

MedPAC and CMS have cooperated with each other to significantly reduce spending on home health since 2020. These cuts are based on data they both present through their annual reports to congress (MedPAC) and the proposed and final rules (CMS). Their data uses Medicare only profit margins to represent the financial health of the home health industry. This is less than 50% of their market share and is shrinking annually. Based on this data, MedPAC has recommended a 7% reduction in payments again in 2025.

Hospitals are paid below cost by Medicare, this is subsidized by commercial health plans, including MA, which pay hospitals well above their costs pushing their all-payer margins into positive territory. Because of this arrangement, hospital profits are represented by MedPAC using all-payer margins. MedPAC has recommended a 3% increase for hospitals in 2025.

For home health, MedPAC and CMS do not use all-payer margins to measure the financial health of HHAs. When I calculate these margins for HHAs as MedPAC did for hospitals, HHAs have negative all-payer margins in 2022.

The combination of cuts to Medicare reimbursement and below cost payments by MA are driving many agencies out of business. The data provided through this project demonstrates the seriousness of this situation and the need to address it quickly. Just stopping the cuts will not fix the problem, CMS must change the home health base payment rate to the extent that home health agencies will be profitable again using total revenue and expenses to measure profit. For this essential sector of healthcare to survive and expand to meet the needs of Medicare patients, they must make a profit.

Legislation to freeze the cuts will do little to fix the problem since the status quo is unsustainable. CMS must adjust home health payment base rates to the extent that all-payer margins are like hospitals, or at least positive, on average.

Introduction

This report is intended to provide an alternative view of cost report data for home health agencies compared to the data prepared annually by MedPAC for congress. I will be comparing the data I have compiled from the 2020 – 2022 cost reports with the data presented by MedPAC in their March 2024 report. This MedPAC report includes recommendations to congress for payment base rate changes to each healthcare sector. In my report, I will include charts provided by MedPAC in their report and reference their conclusions from this data, as I understand and interpret them.

I refer to this project as "Sword". Each year since 2019 I have watched as MedPAC and CMS have beat up the home health industry with this cost report data. Using it as a club to defend their position that home health agencies make too much money, and they need to give some of it back.

Each year, the industry and their advocates fight back with anecdotal evidence and desperate pleas. Each year, this strategy has failed to change the behavior of CMS and MedPAC as they have tightened their chokehold on the home health industry. The cost report data provided in this report is intended to be used to even up the odds between HHAs and these government entities that seem to be bent on decreasing home health Medicare spending at any cost.

I encourage everyone to read this MedPAC report (March 2024) and develop their own judgements regarding the MedPAC recommendations for home health. It is important that you understand their projected point of view to understand the impact their report makes on congressional support for HHAs and spending on home health under Medicare.

The MedPAC report is long (over 200 pages), but the chapter on home health (Chapter 7) is less than 20 pages. Everyone with a stake in the home health business should read this chapter and develop their own opinion on MedPAC conclusions and their motives that contribute to their point of view of cost report data.

After you finish their report and this one, you will see two very different images of the home heath industry and its future, both developed from the same set of cost report data from the same source.

I will publish this report on my site (kaloncon.com) along with spreadsheets that include the individual data elements used to calculate all payer margins for each individual home health cost report. I have validated many of these individual reports with the help of home health providers and

found no errors between what is provided in this data through Sword and what was submitted by home health providers in their cost reports. Although the spreadsheets will not include the agency identifier (Medicare number or CCN), it will include the cost report number. Any agency can validate their own data. If you do, and you find a problem, please contact me.

These spreadsheets can be used to reproduce all the data and visualizations I will provide in this report. The data was developed using the Sisense business intelligence tool. To reproduce my margins or validate any of the charts, you will not need a business intelligence environment like I used to develop this data, only Excel or a similar spreadsheet application.

I hope that by delivering this level of transparency, I can convince you that this representation of the data is accurate and possibly convince other stakeholders and CMS and MedPAC as well.

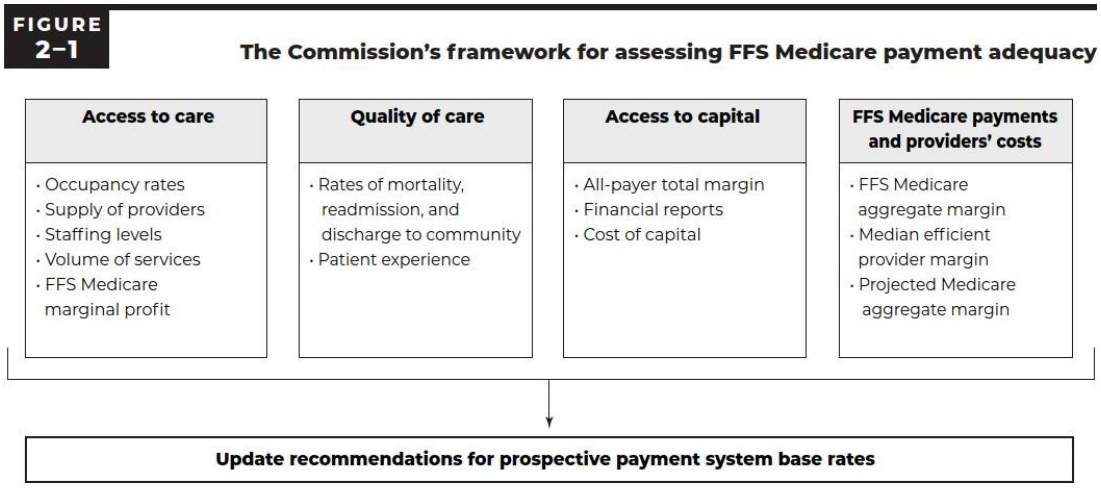
Assessing Payment Adequacy

In this section, I will provide information on how MedPAC determines if payments are appropriate for a given sector of healthcare.

In the first chapter of their report, MedPAC provides details regarding the financial challenges faced by Medicare given the increasing age of the population and the associated costs of the Medicare program. These challenges are significant. MedPAC makes recommendations in their reports intended to balance these challenges in spending against the needs of Medicare beneficiaries to have access to care covered by the Medicare program. This includes access to care in the home in their chapter on home health (Chapter 7).

In their second chapter, MedPAC describes their methodology for determining payment adequacy. This is relevant to Sword in that the conclusions derived from the cost report data by MedPAC and through my own research provide significantly different points of view on whether these goals are being met for the home health industry.

In Figure 2-1 of the MedPAC report, they provide a chart that describes their framework for assessing Medicare payment adequacy for all provider sectors covered in their report.



Note: FFS (fee-for-service). We use multiple measures of margins in our payment adequacy analysis for different purposes. We define "FFS Medicare marginal profit" as ((FFS Medicare payment – costs that vary with volume) / FFS Medicare payment). This marginal profit is an indicator of beneficiary access to care. The "all-payer total margin," defined as ((payments from all payers and sources – cost of providing services) / payments from all payers and sources), is a measure of a sector's access to capital. "FFS Medicare aggregate margin," defined as ((FFS Medicare payments for service – cost of providing service) / FFS Medicare payment for the service), is a sector-wide measure of the relationship between FFS Medicare's payments and providers' costs for services.

Source: MedPAC.

These topics are meant to measure all provider types involved in the Medicare program. Some are less appropriate for home health. Under Quality of Care, MedPAC's conclusions are like my own. I have only researched this briefly using CAHPS star ratings downloaded into my Sisense data model. Basically, we agree that there has been no significant change in quality of care for home health as it is measured by CMS over the period covered in this report.

This leaves the three other categories and their subtopics as they apply to HHAs. I have added a few subtopics of my own that are in italics.

- Access to Care
  - Supply of providers
  - Volume of services
  - FFS Medicare marginal profit
  - *Referral rejection rates*
  - *Profit margins by agency size*
- Access to Capital
  - **All-payer total margin**
  - Financial reports and cost of capital
- FFS Medicare Payments and Provider costs
  - FFS Medicare aggregate margin
  - **Median efficient provider margin**
  - Projected Medicare aggregate margin

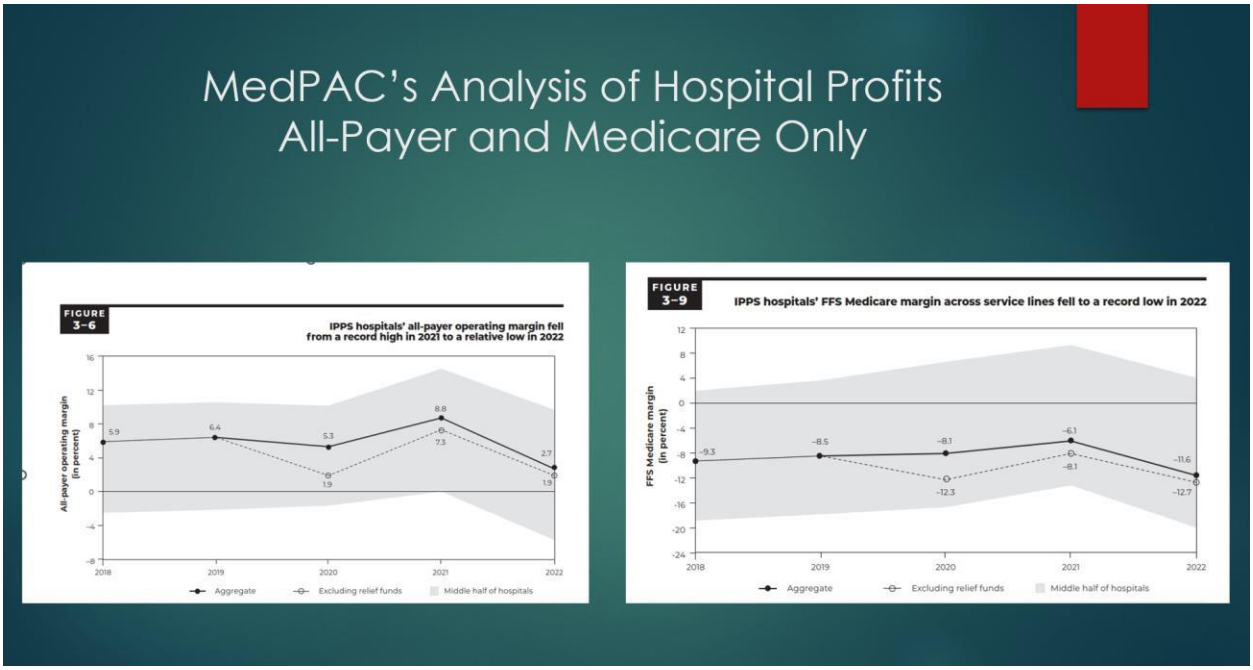
The two topics in bold are MedPAC objectives for the analysis of all healthcare sectors, but MedPAC provides no data I can see for HHAs on these topics.

Hospitals

This section describes the financial performance of hospitals as reported by MedPAC. Most importantly, their all-payer margins and the associated MedPAC recommendations. This may seem to be outside of the scope of home health, but it is important to understand how financial health is measured for hospitals and how this is different from how HHAs are analyzed by MedPAC.

MedPAC provides this data in Chapter 3 of their report. Their data on profit margins by provider sector is key in developing their recommendations for base rate changes for each provider type.

In these charts from Chapter 3 (3-6 and 3-9), MedPAC provides the profit margins for hospitals using all-payers and Medicare FFS only from 2018 - 2022.



When it comes to reporting on hospitals, MedPAC leads with all-payer data. This data shows an industry that is mostly profitable when revenue from all-payers is included, but when looking at Medicare only, it is well under water.

The importance of this is that MedPAC and CMS understand and acknowledge this fact. Commercial health plans subsidize Medicare for hospital reimbursement. Without their reimbursement level being well above Medicare, and these all-payer margins, net all-payer margins would be negative, and hospitals would not be solvent.

When base rate changes are recommended by MedPAC, it is this overall hospital all-payer margin that is used to measure the financial health of hospitals and the extent of these recommended payment base rate changes.

In 2022, for both charts, we see a significant drop in both margins. This drop is not directly related to reimbursement, but an increase in healthcare costs that is not specific to Medicare FFS or commercial insurance. In fact, it is not specific to hospitals. This expense related drop in profit margins is found in all cost reports for all provider types in 2022.

CMS includes market basket indexes each year in the proposed rules that are intended to adjust each payment base rate to compensate for increased expenses. For 2022 in home health, this was 2.6%.

The average home health cost per census in 2021 was $4,065. This increased to $4,318 in 2022. This means that the actual increase in home health costs per census from 2021 to 2022 was 6.22%. If you measured this for all provider types, including hospitals, you would find similar errors in these CMS estimates that underestimated this growth in costs for 2022.

When CMS makes these errors in predicting costs, they do not make up the difference later. It is healthcare providers that pay for these errors.

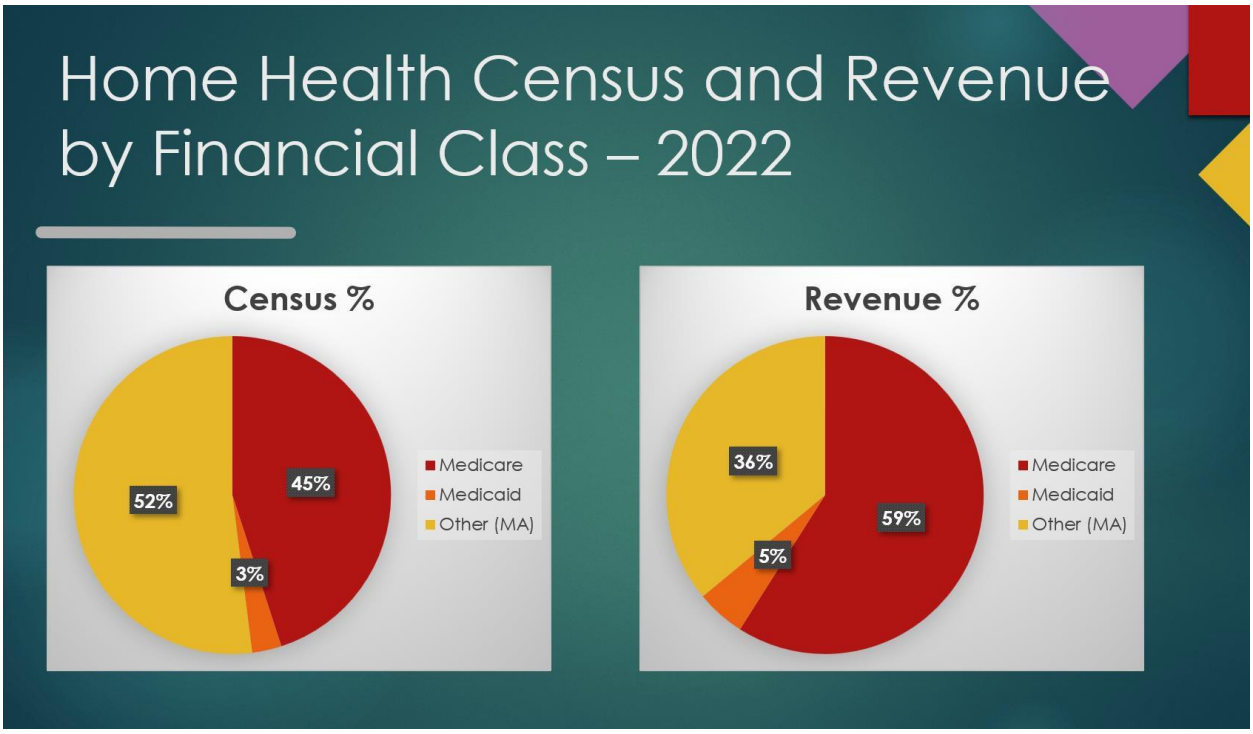
MedPAC acknowledges in their chapter on hospitals that this drop in margins threatens a significant portion of hospitals. They use the "gray" area of their charts surrounding the line of profit margin data points to illustrate the distribution of hospitals above and below the mean all-payer margins each year. They point out that a significant number of hospitals now have negative all-payer margins in 2022 even though the industry average is still positive (2.7%). MedPAC expresses concern for this and has recommended that congress increase hospital payment rates by 3% for 2025.

If these cost increases continue at a similar rate in the years after 2022 this increase will be inadequate to compensate for these errors in past calculations of expense increases or the continued underestimation of expenses by CMS in the calculation of all payment base rates, including hospitals and home health.

Home Health

Revenue and Census by Financial Class

In the cost reports, revenue, census and visits are broken down by three financial classes. These are Medicare (FFS Part A), Medicaid, and Other. If we use the values for census and revenue by these three financial classes, we can compare them. Here are the ratios of census and revenue by financial class for 2022:



About four years ago, I had loaded this home health cost report data into Sisense for an unrelated project. When I discovered this data existed and how to process it in Sisense, I created these pie charts out of curiosity, using census and revenue. I expected them to be similar, as you can see, they are not.

It was this discovery that best illustrates the problem that CMS and MedPAC would prefer not to talk about. Although Medicare provides healthy margins for home health agencies, these margins are offset by "Other" insurance.

Another important feature of these pie charts is related to the census ratio. It is well documented that Medicare Advantage is growing as a percentage of the total Medicare beneficiary population in comparison to Medicare Part A. In 2021, the ratio of the Medicare beneficiary population under both plans became equal and MA now has a larger portion of these beneficiaries.

When we look at this census ratio for 2022 from the cost reports, we can see that the Medicare and Other financial classes have nearly the same ratio as we see in the Medicare Limited Data Set claim data and other data sources measuring this ratio of Medicare Part A to MA beneficiaries.

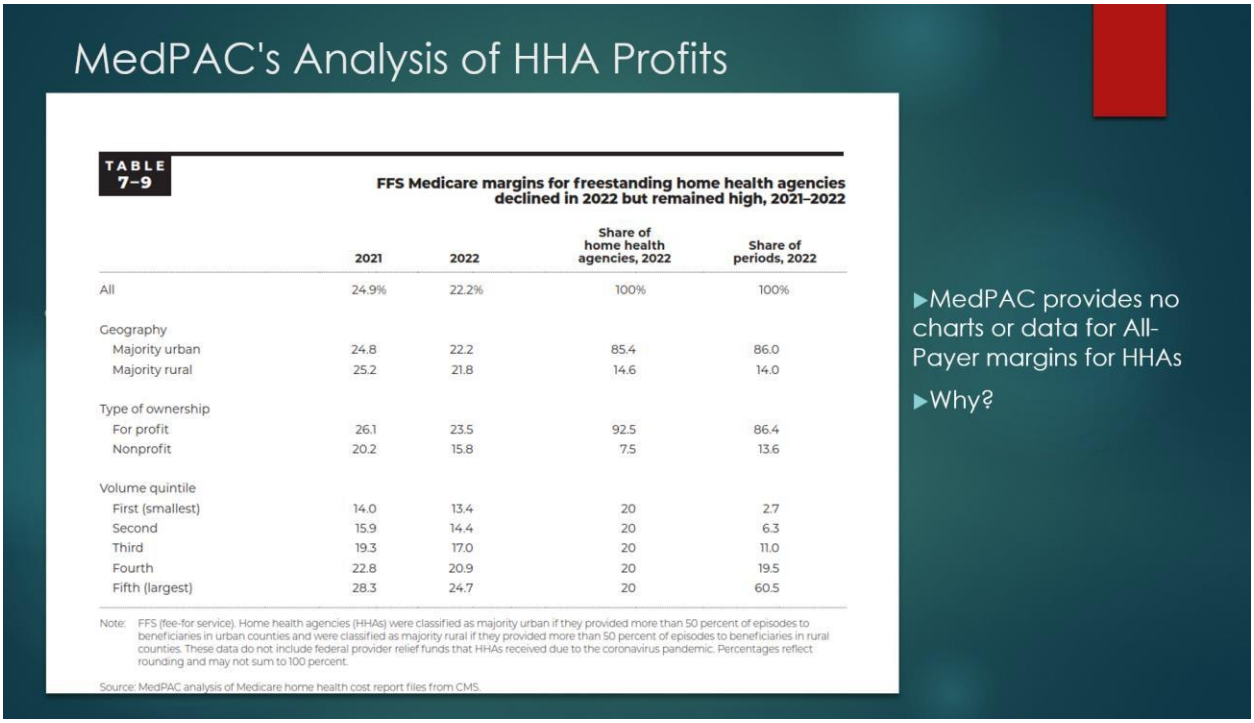
Since the Medicare revenue and census are known values in the cost report, this means that the financial class of "Other" is almost entirely Medicare Advantage for the home health industry. For the remainder of this report, I will refer to the cost report financial class "Other" as MA or Medicare Advantage.

Home Health Profit Margins

MedPAC Home Health Profit Margins

In this section of the report, we will look at the data provided by MedPAC to represent the financial health of home health agencies. Instead of leading with all-payer data, as they did with hospitals, this data is nowhere to be found. Instead, they provide the margins under Medicare only, by year.

While Medicare pays hospitals below costs and are subsidized by commercial insurance, they pay home health agencies a comfortable profit margin. Here are the MedPAC home health margins from the March 2024 report, Table 7-9:



Sword Profit Margins

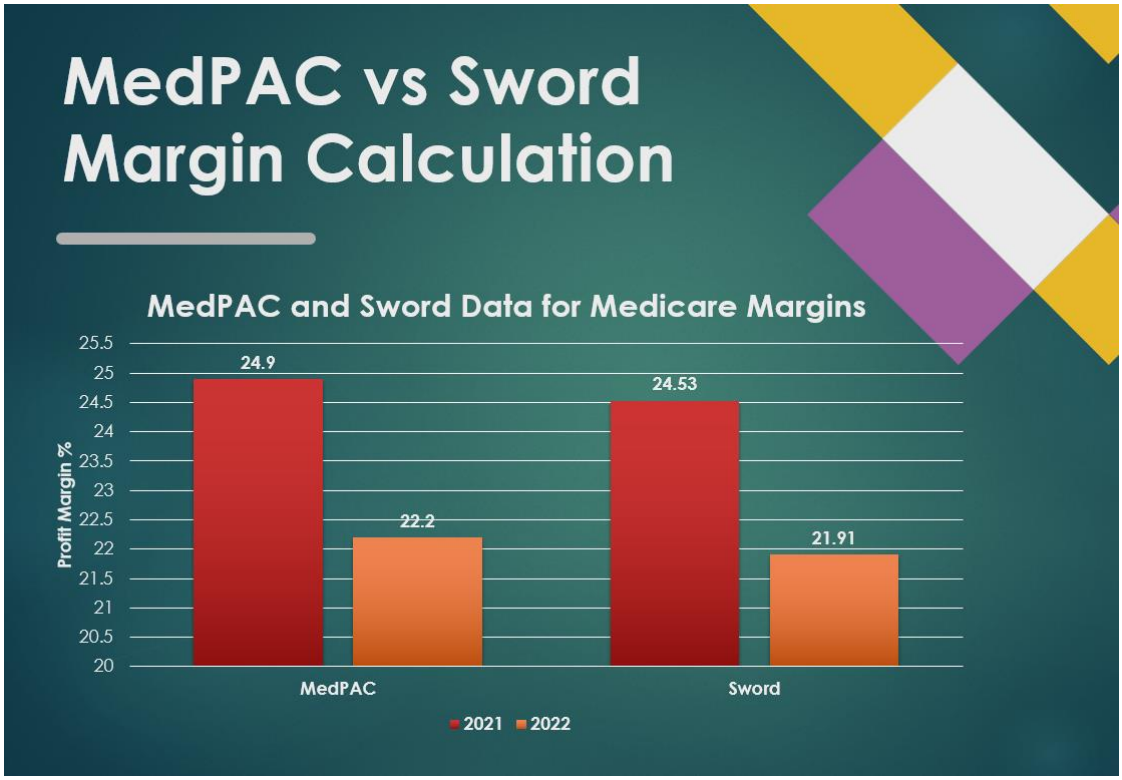
Home health cost report data has been the focus of my research. This data exists for all provider types, but developing this data takes time. To calculate profit margins, you need revenue and expenses. These values are included in the cost report data, but the results calculated can vary depending on which cost report data elements you use to represent these values, and which cost reports you include when calculating these industry averages.

MedPAC does not include any information I could find that describes either of these criteria. In the hospital chapter, they mention that all reported operating expenses are used for calculating expenses. CMS and MedPAC both mention that they apply statistical methods to “trim” the data and exclude outliers.

I also developed a standard methodology to eliminate outliers statistically (Z-Score) and to eliminate cost reports where you could not calculate a valid profit margin because one of the

values were missing or zero. This methodology is documented in the Data Analysis and Criteria section of this report.

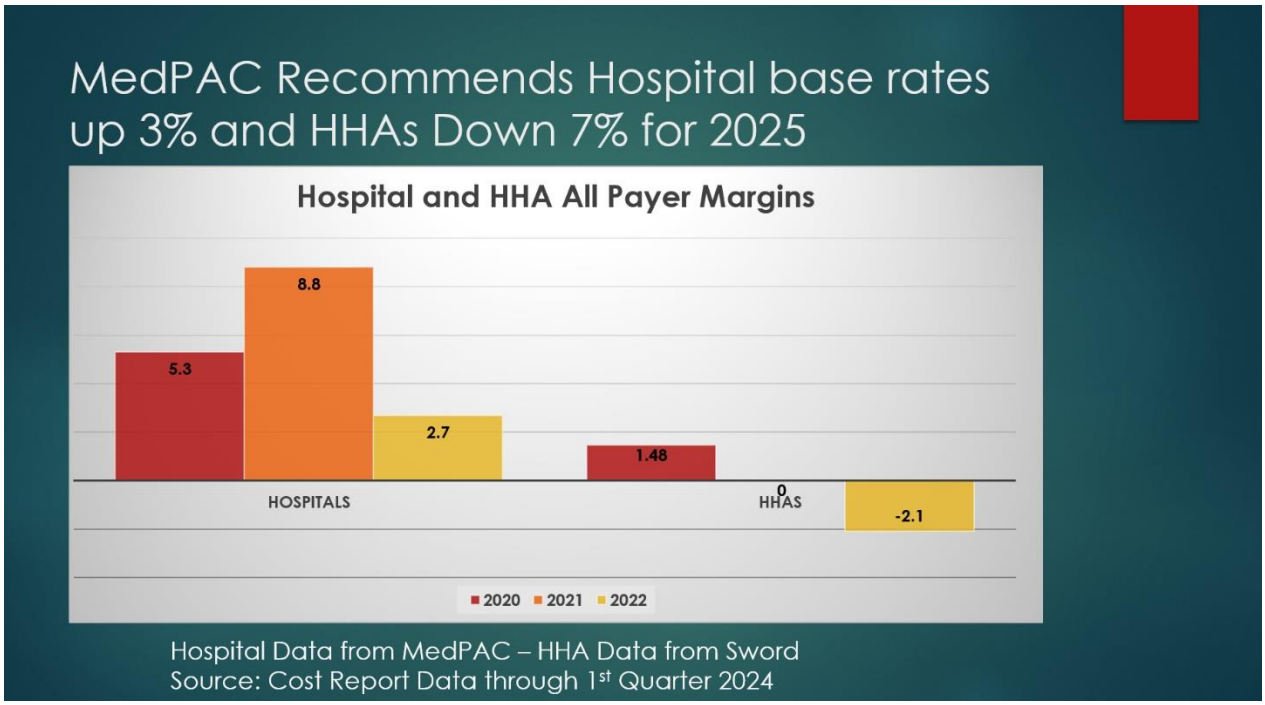
Using this methodology, I calculated the same Medicare only margin values for 2021 and 2022 that MedPAC calculated in table 7-9 using home health cost report data. This would allow us to compare our results.



These results are nearly identical. I believe that they show that MedPAC and Sword both use total Medicare revenue and total operating expenses, as MedPAC did with hospitals, to calculate these Medicare only profit margins for home health.

Based on these margins, using Medicare only data, MedPAC has recommended a 7% decrease to the base rate for home health agencies in 2025 while recommending a 3% increase for hospitals. This hospital increase was based primarily on their overall financial performance using all-payer margins. Why not use the same criteria for HHAs?

Here is what overall margins would look like for hospitals and home health using all-payer margins for home health provided through Sword and the hospital all-payer margins provided by MedPAC.



This is a problem. Without understanding the all-payer margins for home health, you can't make a valid recommendation on changes to the base rate. If you do understand the severity of this situation, how could you recommend additional cuts to HHAs?

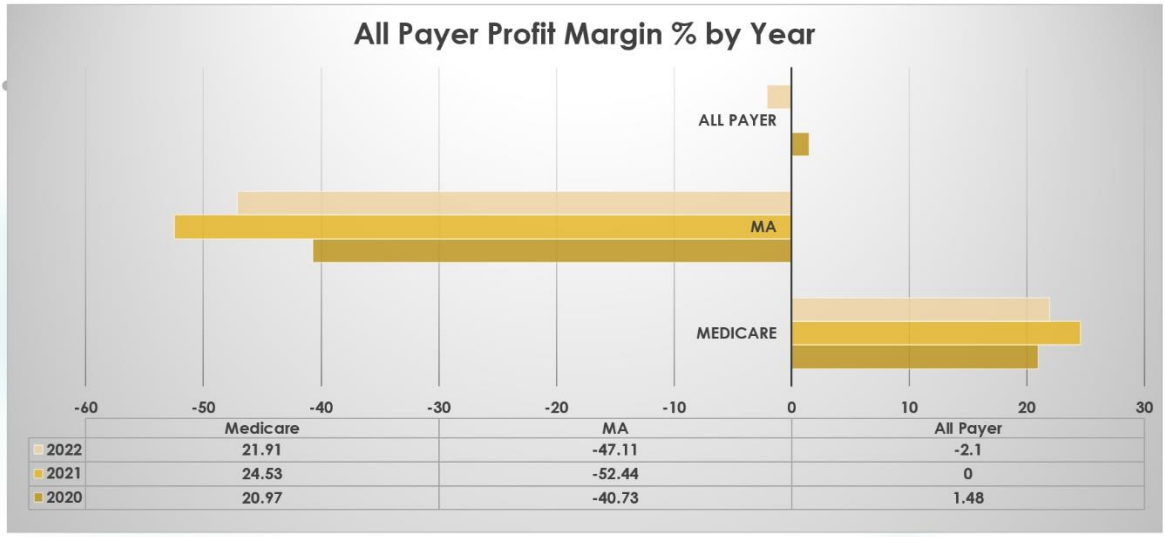
Why are hospitals worthy of base rate increases and HHAs subjected to additional cuts? Why doesn't MedPAC provide this all-payer data for HHAs? What is going to happen to HHAs if this continues? What has already happened after 2022?

There is no doubt that if MedPAC provided this home health all-payer data, it might be somewhat different from what I reported, however, they would be similar enough to tell the same story and significantly worse than what is reported by MedPAC for hospitals.

We can look at another data element in the cost report that does not require any calculations. It is net income. We can simply count the number of cost reports that reported a negative net income as a percentage of the total cost reports. When we do this, we see that these HHAs reporting a loss have increased each year, 30.6% in 2020, 32.65% in 2021 and 38.27% in 2022. How could these reported negative net incomes be possible in an industry with 20% plus margins on average? This is the question that MedPAC and CMS should be answering.

If we look at these margins separately, comparing Medicare margins, MA margins, and overall all-payer margins, we can see how differently a "Medicare only" view of home health margins by MedPAC compares to their financial reality.

HHA Margins for Medicare and MA



	Medicare	MA	All Payer
2022	21.91	-47.11	-2.1
2021	24.53	-52.44	0
2020	20.97	-40.73	1.48

Home Health Profit Margins by Agency Size

When MedPAC and CMS provide their view of cost report data, they do it through ratios of totals of the data. They sometimes break it down by categories like geography or type of ownership. Using Sisense, I have built the data back into individual cost reports. I can duplicate these categories, but the most interesting comparison is by agency size. When we break down profit margins by agency size, we can see that HHAs are not affected equally by the permanent adjustment cuts by CMS and MA reimbursement.

CMS makes these cuts under the pretense of a "behavioral adjustment" related to the reduction of visits after the implementation of PDGM in 2020 compared to the prior payment model. These "permanent adjustments "to the payment base rate since 2020 have been applied equally to all home health Medicare payments like a flat tax.

As we can see with the home health all-payer margins, these cuts and increasing costs have driven the industry into negative all-payer margins on average. While MedPAC and CMS portray HHAs as fat and wealthy, the reality is that many of them are being driven out of business by the dual threat of the permanent adjustment cuts by Medicare and the below cost reimbursement of a growing MA market share.

This view of agencies by size will show us that these threats are greater for smaller agencies which are unable to reduce their visits at the industry average rate or negotiate well with MA plans.

Before we can begin, we need to define size. I decided to create groups based on the annual census from the cost reports. I chose t-shirt sizes to represent them. I picked groups that represented either a significant portion of the number of agencies or a significant portion of the total census. I came up with these annual census ranges for Small, Medium, Large and XL.

I originally established these groups using cost report data for 2021, but I use these ranges for each year in the cost reports. Here are the ratios of census and agencies under each group in 2021:

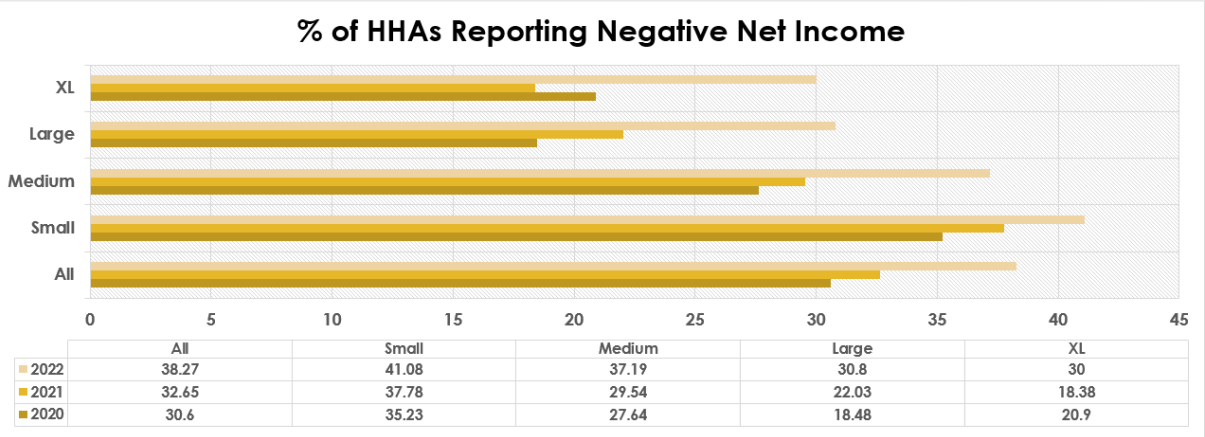
Breaking Down Cost Reports by HHA Size Using Annual Census for 2022

Agency Size	% of All HHAs	% of All Census
Small (0 – 500)	57.26	10.91
Medium (501 – 1500)	25.64	22.54
Large (1501 – 5000)	14.15	34.98
XL (5000+)	2.95	31.57

Small agencies are most of the agencies, but just over 10% of the census. XL agencies are only 2.95% of the agencies but have 31.57% of the census.

Now let's look at our previous data on reported negative net income broken down by these size categories:

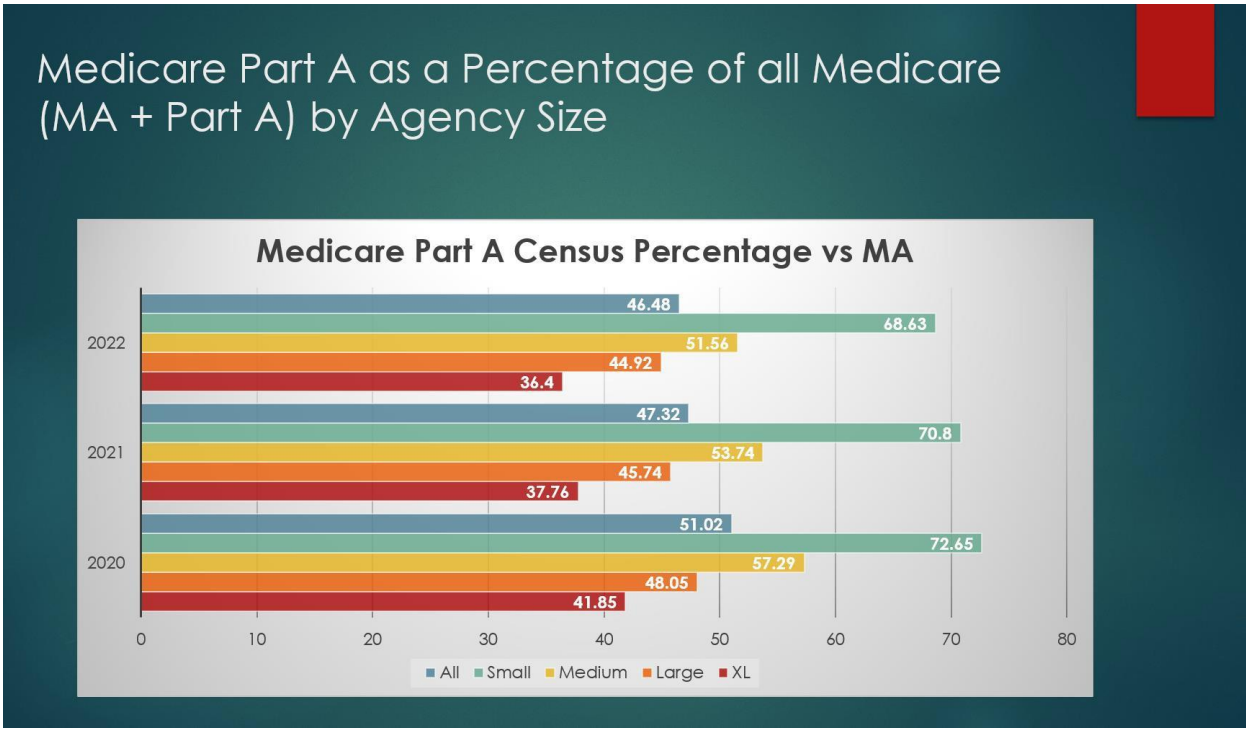
HHAs Reporting Losses Are Increasing



	All	Small	Medium	Large	XL
2022	38.27	41.08	37.19	30.8	30
2021	32.65	37.78	29.54	22.03	18.38
2020	30.6	35.23	27.64	18.48	20.9

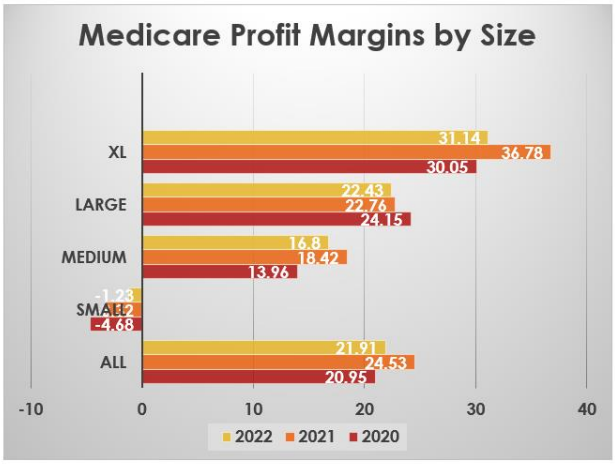
We can see that small agencies lead the way with these reported losses, but we see a significant jump for Large and XL agencies in 2022 as expenses exceeded expectations under all health plan payment models.

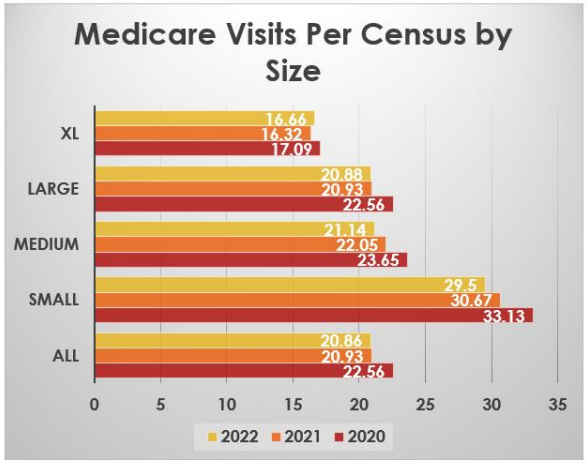
When we look at these agencies by size, we can see interesting characteristics of their market within home health and the plans they depend on for reimbursement. Looking at Medicare Part A census as a percentage of Medicare Part A and MA combined, we can see that small agencies have a much higher ratio of Medicare Part A patients, on average, compared to the rest of the industry. XL agencies are mostly MA.



This may seem like good news for these small agencies given the much better reimbursement from Medicare Part A. However, it is these agencies that are in the most danger. Due to their lack of scale with a smaller workforce, they are unable to reduce Medicare visits to decrease costs as their larger HHA competitors can. Here are the Medicare only profit margins by agency size along with their visits per census from 2020 – 2022:

Medicare Margins and Visits by HHA Size

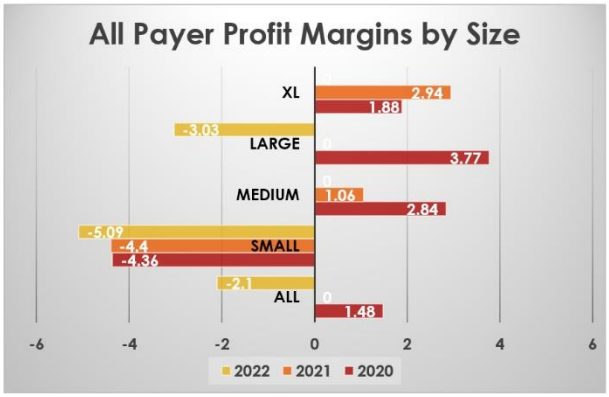


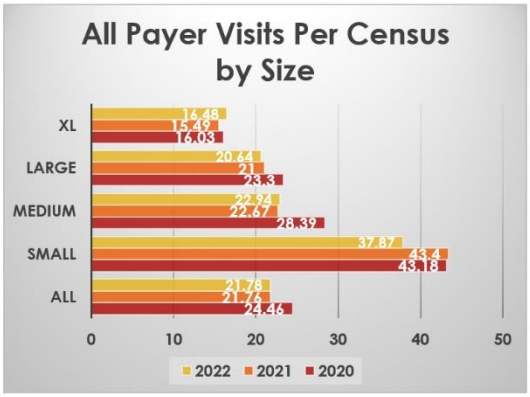


This shows that Large and XL agencies make much larger profits under Medicare than the industry average while Small and Medium agencies have less. Small agencies, on average, can't even make a profit under Medicare with their visits at a much higher rate than other HHAs.

If we look at the impact of all-payer margins by agency size, we see a different perspective.

All Payer Margins and Visits by HHA Size





My interpretation of this chart is that as the home health industry trends away from Medicare Part A to MA beneficiaries, the strategy of reducing visits to reduce costs creates a new problem, decreasing MA revenue.

While CMS has moved to the PDGM payment model, unlinked directly to visits, most MA plans and Medicaid still pay HHAs based on visits made to patients. As larger agencies reduce these visits to improve Medicare profits, they lay the groundwork for reduced MA reimbursement when these patients transition to MA.

Smaller agencies do better under MA than the industry average due to their larger visits per census, but they still can't make a profit, on average. Remember our initial chart by size that showed that small agencies are mostly part A and large agencies are mostly MA? Both agencies are dealing mostly with the payment model they struggle with the most. Larger agencies have successfully reduced visit costs, only to suffer for it under their primary payer, MA. Smaller agencies can't reduce visits but do better (lose less) under MA than other HHAs.

Access to Capital

In MedPAC's criteria for recommending base rate changes, they include Access to Capital as one of their four pillars for evaluating the health of each provider sector. Under this pillar is all-payer margins, which we have seen is absent for home health.

The reason for this omission is unclear, but stranger still is the data they provide that they insist portrays home health as a growing and healthy segment of the healthcare industry.

Table 7-1 shows the number of home health agencies declining each year. Table 7-2 shows the share of Medicare Part A beneficiaries receiving home health treatment is in decline. They mention the decline of 30-day periods billed and other indicators of an industry shrinking in the face of growing demand. Each one of these charts they spin as either good news or that it is no big deal.

MedPAC provides anecdotal evidence of merger and acquisition deals, even though everyone knows that these deals are rare and getting rarer. HHCN has reported that these mergers and acquisitions have been stagnant for several years.

Recently, Enhabit announced that they had suspended their search for a buyer. I have seen their cost reports collectively. They are more profitable than the industry average with a higher Medicare Part A census than most, but MA is killing them. They have low operating expenses and appear to be efficiently run, but their future is clear. Their market share of MA patients is growing. As their patients transition to MA, like the rest of the industry, each patient switches from generating a significant profit to a substantial loss. Any organization looking to purchase them would do so in consideration of this future and its financial impact.

If Enhabit and others hoping to grow in the home health industry can survive this crisis until a solution is implemented, their future will be brighter when the market recovers.

I see this situation as very similar to the real estate crisis in 2010. The valuation of real estate and the associated debt became out of line with the risk. Eventually, the industry collapsed. Those that were first to recover were those that managed to survive and prepare for the regrowth of the industry.

If you look at each individual cost report through the spreadsheets I provide, you will see a large majority of these HHAs are in serious financial trouble. Many of these agencies have such poor financials, they would not be able to get a loan from a bank, let alone sell their company at a reasonable price. Very few show growth in overall profit margins since 2019.

Our healthcare system cannot deal without care in the home. It is the cheapest form of healthcare and in the setting most preferred by patients. Without HHAs, many of these patients would have to be treated in acute settings or receive no care at all. I think everyone involved understands this CMS, MedPAC, MA plans, hospitals and HHAs.

I also think that organizations can allow themselves to focus on short term goals at the expense of the long term. Medicare has been successful in reducing spending. The government recently announced an extension of the date when Medicare will become insolvent. CMS and MedPAC are judged, in part, by their ability to reduce and control spending. I believe that this goal has superseded their goal of maintaining access to post-acute services. They are creating a new "bubble" in post-acute care. Like the real estate industry in 2010, if nothing is done, this bubble will burst. When this happens, much more money will be spent by the government to repair this diminished sector of healthcare quickly. These agencies may not be "too big to fail", but the home health industry is indispensable for maintaining cost effective care for aging patients.

With the delay in the availability of cost report data, we may not see a collapse coming until it has already happened. In the MedPAC report, they focus on 2022 as the most current year of data. So does CMS in the upcoming proposed rule for 2025. When the cost report data is available, what will 2023 look like? What is happening now?

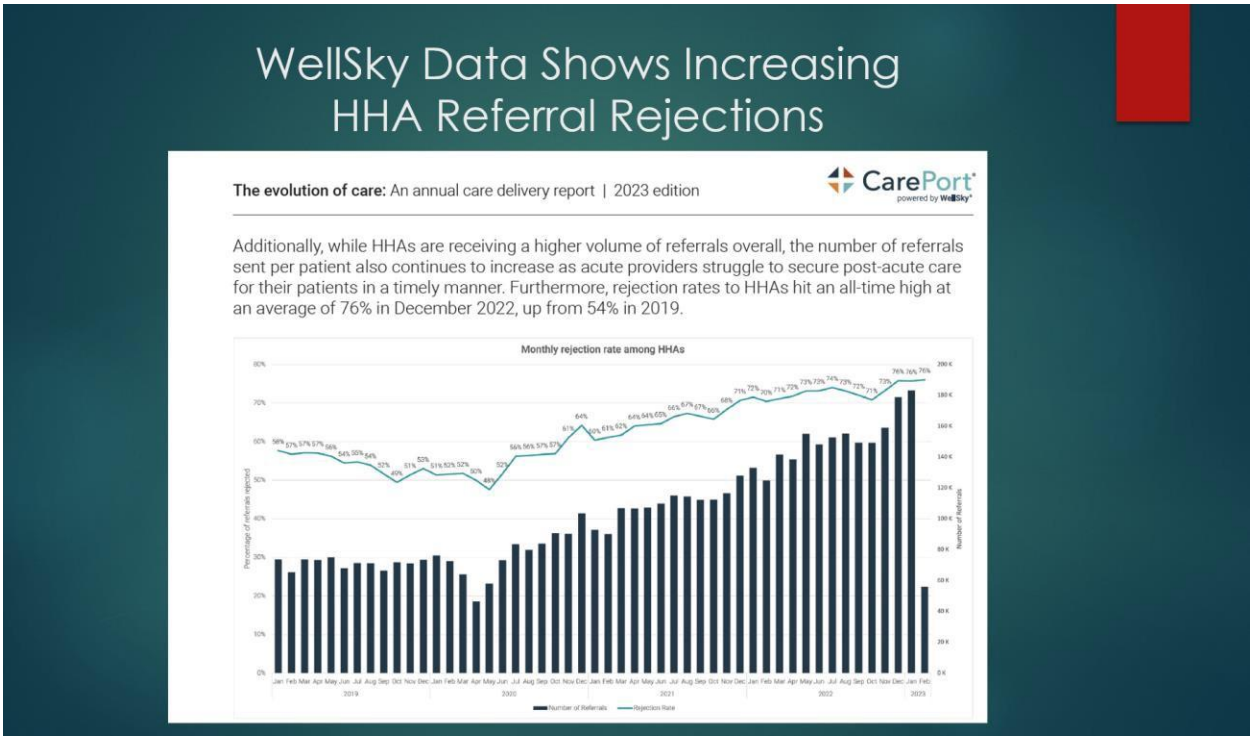
To answer this question, I looked for data from other sources that might be more current and represent the health of HHAs collectively and their ability to support the increasing demand for their services. I found what I was looking for from a published WellSky report.

Referral Rejection Rates

WellSky acquired a company called CarePort that provides data on the transition of care between acute and post-acute care. They analyze factors like how long it takes for post-acute treatment to begin, readmissions and so forth.

The publish a report annually called the evolution of care. This report includes a chart that shows the increasing rate of rejection of home health referrals from hospitals documented from WellSky data. These are referrals by hospitals to HHAs that go without a response. The referral is then reattempted, also with an increasing lack of success.

Studies have shown that one of the key factors in a successful patient post-acute recovery is a quick transition to home health care after the hospital discharge. This is known to reduce complications and readmissions and it is one of the quality-of-care factors used for value-based payments by CMS.



This WellSky data shows that these rejection rates, which were stable through 2019, began rising in 2020 and have increased at an accelerated rate. These rates were 54% in 2019 and hit 76% in 2022.

WellSky attributes this increase to the difficulty in obtaining staff and other industry capacity issues, but I believe this is directly related to the declining home health all-payer margins and the contraction of the home health market through these financial losses and their inability to obtain capital and expand to meet this increasing demand. Many agencies, to reduce costs, begin constricting their service area and rejecting referrals they once accepted.

Cost report data is significantly delayed. The first large batch of data for 2023 will come in late July. This will be too late to make an impact in the legislative cycle for 2025. WellSky published this rejection rate data in June of 2023 and included data through February of 2023. It is possible that if we see a collapse in the ability of HHAs to cope with this increasing demand, we can see it here before we see it in the cost reports.

Timing is everything with data. CMS will announce their proposed rule soon. No doubt it will include additional permanent adjustment cuts, underestimated market basket expense adjustments, and more bad news for HHAs.

CMS is the only entity capable of avoiding disaster for HHAs. It must happen this year and it must begin with suspending these cuts for 2025. If MedPAC and CMS want the home health industry to grow to meet demand, they need to suspend these cuts for the future (eliminate temporary adjustments) and work toward payment base rates under all-payer margins for HHAs that resemble those of hospitals measured the same way.

If they are willing to allow commercial insurance to subsidize reimbursement for hospitals, they must be willing to compensate HHAs and maintain higher Medicare margins to keep home health

all-payer margins high enough for HHAs to survive and thrive. Medicare spends over ten times as much on hospitals than they do on home health, this trade off is a bargain for CMS and taxpayers.

My hope is that WellSky will publish this referral rejection data again soon with 2023 included. In late July, about 70- 75% of the 2023 cost reports will show up in the 2nd quarter cost report data update. My hope is that I can incorporate this data into Sword quickly enough to communicate it to CMS and other industry stakeholders before the proposed rule comment period for 2025 expires and CMS finalizes their cuts to the home health payment base rate. Even if I can't, any reasonable person should understand what is at risk given the data I have already presented.

Medicare Advantage

Anyone reading this report understands at this point the significant disparity between Medicare reimbursement and home health payments under MA. Many of you believe that the answer is for Medicare Advantage health plans to pick up this slack and deliver rates closer to what Medicare offers HHAs. Unfortunately, this is not going to happen. I will explain why.

In the narrative of this report, MA appears to be the villain. Their reimbursement for HHAs is well below the costs paid by agencies to provide this care and is unsustainable given the cuts by CMS to home health Medicare rates and its combined effect on overall profit margins. When I initially discovered the imbalance that existed between Medicare and MA reimbursement in home health through the cost reports, my first instinct, like many of you, was to conclude that MA plans are pocketing large profits from underpayments to home health.

A couple years ago, I began researching this issue by developing an understanding of the MA business model and what drives it. As it turns out, there are limits to the profits these plans can make. What follows is based on my understanding of these regulations through my research.

Under the Affordable Care Act, regulations were created to limit the profits of all health plans as a ratio of the premiums they collect from employers and other entities paying for this coverage. These regulations are referred to as the Medical Loss Ratio or MLR. For large health plans, they are required to spend 80% of their premiums for the health care expenses of their covered beneficiaries. Almost all of this is spent through claim payments to providers.

On the MLR website, you can download spreadsheets for each health plan submitted to CMS by these payers annually that provide detailed financial information. This is an audit requirement for all health plans like the directive to providers to submit cost reports. In these spreadsheets they use separate tabs to break out MA revenue and spending and spending under employer-based plans.

I downloaded and examined nearly 200 of these financials and found that nearly all of them reported claim reimbursement very close to the 80% threshold. As you might expect, none of them I saw exceeded this threshold as the remaining 20% is what these plans use to cover their business operations and generate a profit.

When I was an employer, I had a company health plan through Anthem. Each year, we would receive a rebate that was approximately equal to one month's premium. Many of you have received

similar rebates. This is the difference between what your plan paid out in claims and this 20% profit cap. This rebate is required by the MLR when the 20% margin is exceeded.

These same regulations apply to MA plans and the premiums paid to them by CMS. CMS premiums paid to MA plans are based on the total spending for Medicare beneficiaries under Medicare Part A by county. Each year, CMS publishes a price book where these rates are calculated as a monthly total. MA plans bid on these counties and if they bid below these rates, based on Medicare payments, they can use the difference to provide their customers additional benefits we see in their advertisements like dental, vision, lower co-pays and gym memberships. These benefits do not come from their 20%, but the remaining balance that would have otherwise been paid to providers.

Competition between MA plans has driven these bids down to allow for plans to increase these supplemental benefits for their customers. This comes at the expense of all healthcare providers through a lower overall pool of MA reimbursement funds.

What this means is that reimbursement under MA for all healthcare providers is less than 80% of the total spending by Medicare for the same providers in each county. In other words, total provider reimbursement under MA will always be less than 80% of total Medicare Part A spending.

As is documented by MedPAC through the difference in Medicare and all-payer reimbursement, these commercial health plans reimburse hospitals at rates between 140% and 160% of Medicare payments and subsidize hospitals for the below cost payments they receive from Medicare. This applies to employer-based plans and MA plans.

The entire “pie” of available reimbursement through MA plans is under 80% of Medicare payments so where does this money for hospitals come from? The answer is that it comes from the rest of the providers.

Any changes in provider reimbursement under MA are zero-sum transactions. By that I mean that any increases to reimbursement to any healthcare provider by a MA plan does not come at the expense of the MA plan but comes from other providers.

This is the root cause of poor MA reimbursement for home health. I do not have data to back this up, but I believe that the same thing is happening with Skilled Nursing Facilities (SNF).

In 2022, there is an uptick in the spending by MA plans overall in home health, but this is below the larger uptick in costs. Any success by individual HHAs or groups of HHAs to negotiate better MA rates comes at the expense of other providers, most likely other HHAs.

Any legislation that might require a relationship between MA payments and Medicare payments will come at the expense of hospitals. As much as I would like to root for this to happen, it seems unlikely that hospitals will give up their much higher MA reimbursement as they see it as the key to their survival, just as HHAs view Medicare Part A reimbursement.

This is the paradox that is at the root of the financial problems for HHAs. Hospitals need MA and other commercial health plans to be profitable, HHAs need healthy Medicare profits to compensate for low MA reimbursement. When a patient switches from Medicare to MA, hospitals cheer and HHAs boo.

CMS sometimes acknowledges that MA plans pay HHAs poorly in the proposed rules for home health. Their response is that these agencies are free to decline this reimbursement. This is not true from a practical standpoint. Hospitals refer patients to HHAs as their partners. They refer to HHAs both MA patients and Medicare patients at the ratio that they exist in their service area. HHAs are not free to reject the patients that hospitals would prefer to have without a negative impact on their relationship, so they take them all.

CMS also makes the point each year when responding to provider comments to the proposed rule that what other health plans pay to home health providers is not their concern. This is an extremely hypocritical position given their dependence on these same commercial plans to subsidize hospitals.

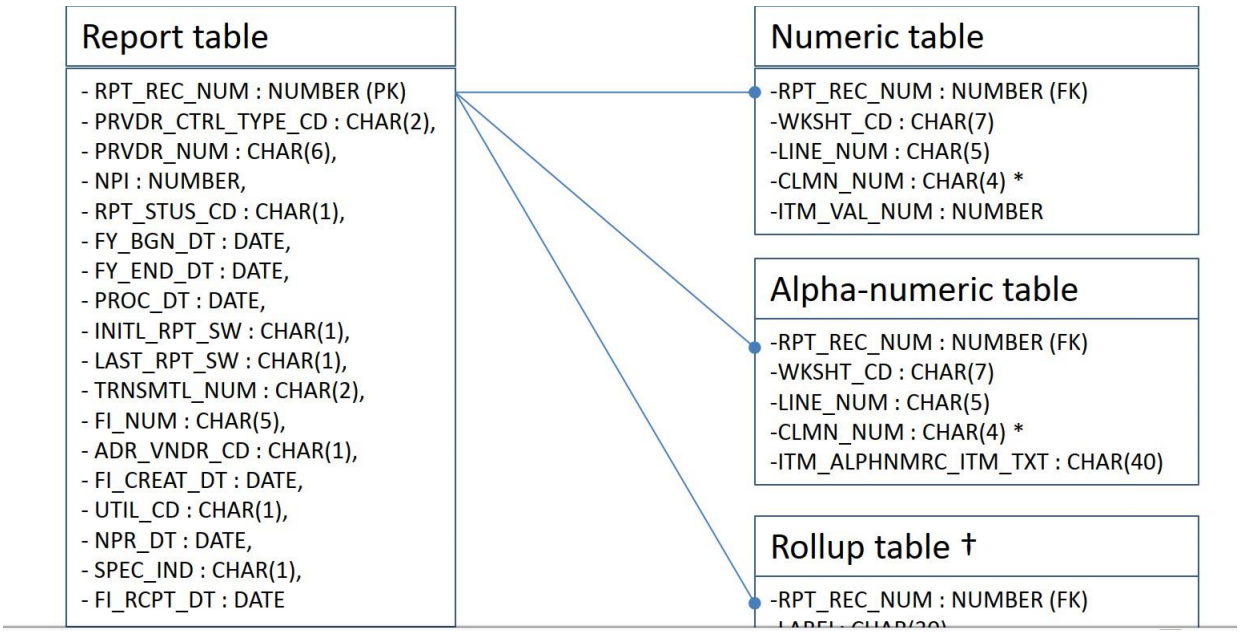
Data Analysis, Criteria and Validation

The development of the cost report data was most of the work required to create the Sword project. I have been working on it for nearly a year. There is a lot to be learned from this data and I have only scratched the surface. The focus of this project is all-payer profit margins for HHAs. Fortunately, this limits the cost report data we need to use and validate.

Basically, we just need total revenue, total expenses and a unit of measure for services (Census). On my website, I will provide detailed documentation of the data used, how it was prepared and even the data itself.

For 2022, there are 10,541 home health cost reports as of the 2nd quarter 2024 update of this data in April 2024. This is what MedPAC and CMS start with when they analyze and report on cost report data. This data is organized and published by HCRIS (Healthcare Cost Report Information System).

The data used for this analysis is provided through the Report table, which describes heading data associated with individual cost reports. The Report table includes the provider and dates when the report was submitted and processed. The Numeric table includes each of the individual data elements identified by cost report worksheet, line and column number.



There are millions of these individual data elements in the Numeric table. In Sisense, I have developed a data model that selects the data elements involved in the calculation of profit margins (Cost Report Worksheet F1) and the census and visit statistics (Worksheet S2) and I create additional fields for the cost report header record that include all the relevant data for calculating all-payer margins. I added additional calculated fields for data validation. This allows us to have one record for each cost report. It looks like this:

Cost Report Data Validation - Table

FY	RPT_REC_NUM	MedicareRevenue	MedicareCensus	MedicaidRevenue	MedicaidCensus	OtherRevenue	OtherCensus	TotalRevenue	CalcTotalRevenue	TotalCensus	CalcTotalCensus	OperatingExpenses	Neti
2020	513674	$718,768	98	$0	0	$2,955	43	$721,723	$721,723	140	141	$908,226	$-10
2020	515709	$2,971,174	487	$37,621	5	$463,870	345	$3,472,665	$3,472,665	833	837	$3,068,879	$60
2020	512681	$3,861,883	448	$0	0	$429,764	207	$4,291,647	$4,291,647	650	655	$3,490,769	$85
2020	512636	$1,477,405	170	$0	0	$145,070	89	$1,622,475	$1,622,475	253	259	$1,396,426	$33
2020	515410	$1,561,127	215	$3,541	3	$166,928	160	$1,731,596	$1,731,596	376	378	$1,552,868	$20
2020	512629	$8,920,243	1,048	$65,852	23	$787,794	262	$9,773,889	$9,773,889	1,315	1,333	$7,852,599	$2,0
2020	514862	$5,264,475	773	$0	0	$714,435	256	$5,978,910	$5,978,910	1,018	1,029	$4,351,515	$1,8
2021	533691	$832,477	126	$0	0	$121,483	192	$953,960	$953,960	317	318	$1,248,516	$-29
2021	531014	$4,026,195	389	$0	0	$319,051	266	$4,345,246	$4,345,246	643	655	$3,652,424	$69
2021	533227	$2,625,041	478	$21,574	5	$277,057	297	$2,923,672	$2,923,672	775	780	$2,787,073	$13

These records are used to create all the Sword charts in this report and the spreadsheets representing the cost report data.

These individual cost reports and their data elements have been validated by multiple providers to verify that they match the data they submitted in the cost reports, no errors were found. Some of these providers also compared the cost reports to financials used internally and no significant differences were found.

The CMS process for collecting and validating this data is riddled with problems. The raw data includes many records that need to be eliminated because they do not include the data necessary to calculate profit margins or they are outliers. To eliminate these records, I applied these rules:

Rule 1 – Eliminate all cost reports where Total Revenue and Total Census are missing or 0

It might seem that this would be rare, but each year about 25% to 35% of the cost reports have this problem. I had not figured out what causes this until the validation process for Sword. What I have discovered is that when cost reports are mailed in by the provider or their vendor to CMS instead of entered in the CMS portal, CMS enters the provider ID and dates into the portal for them, but no detailed data for the report. This creates a report header record with no detailed information. For 2022, there were 3424 cost reports with this problem, 32.5% of the total.

Rule 2 – Eliminate all cost reports where one of the values for census or revenue is zero for a specific financial class, but not both.

Having no revenue and census for a financial class is not uncommon. Especially for Medicaid, but many of the cost reports have a value for one and not the other. This is one of the many validation errors inherent in the process of collecting cost report data. This is most common in the "Other" financial class.

Rule 3 – Eliminate cost reports entered with duplicate financial information.

This is a problem that I detected while writing my blog and trying to identify HHAs that were associated with each other. What I found is that some of these enterprises duplicated financial data for each individual cost report by CCN in their organization when they entered their data into the cost report system.

This problem is associated with multiple organizations but could be caused by a single vendor entering this data. In 2022, there were 38 of these duplicates.

Rule 4 – Eliminate all cost reports with a Z-Score greater than 0.3 or less than -0.3

Z-Score is a statistical method of measuring the distance of a value of the mean of all values. In other words, how far it is from the average. I learned this process using ChatGPT and applied it to the cost report data using the mean all-payer margin value. This should eliminate outliers for revenue and expenses as well.

When all these rules are applied, the count of cost reports for 2022 goes from 10,541 to 5,433. Similar results occur with the prior years, 2020 and 2021. Both CMS and MedPAC use some similar processes to remove outliers, but their process, results and the values they use are not documented in their reports to congress, their websites, or the proposed rules.

When this report is published on my website, I will include spreadsheets for each cost report year that include rows for each cost report, columns for all the relevant values from the cost reports and calculated values such as Medicare only and all-payer margins. A data dictionary will be provided that describes where each cost report data element comes from and how these margins are calculated.

Each spreadsheet will have a tab that includes all the original cost reports in the data, a tab for the cost reports that were excluded by one of the rules, and a tab for the remaining cost reports that were used for the margin calculations and the charts in this report.

The provider identifier (CCN) has been removed, but any provider should be able to locate their own data using the cost report number assigned by CMS. Anyone may validate their own data or recreate the data I have used collectively for this report.

Conclusions and Recommendations

The data from Sword clearly shows that the Medicare only profits reported by CMS and MedPAC do not reflect the actual financial condition of home health agencies. CMS and MedPAC use this inaccurate and incomplete information to conclude that HHAs are making too much money. MedPAC recommends 7% cuts to the base rate for home health in 2025 even though they have negative all-payer margins. They recommend a 3% increase for hospitals even though their overall margins are positive and much higher than home health.

This is pushing home health toward the brink of failure as an institution.

The combination of CMS payment cuts and the below cost reimbursement of MA plans have caused the industry to contract as demand for home care is increasing. Capitol is unavailable for expansion to meet this demand given the current financial conditions of individual agencies and the trend toward an even darker future for HHAs.

The answer can't be found in getting more money from MA plans as this money is a subset of the money spent by CMS under Medicare and would come from other providers.

In commercial markets, when healthcare expenses increase, health plans must increase premiums. Competition controls the extent of these increases, and the Medical Loss Ratio controls the profits of the health plans.

Under Medicare, there are no market forces controlling spending for healthcare. CMS acts like the fed managing interest rates. They are supposed to manage the base rate payments to make sure that federal spending is controlled, but healthcare is available to all that need it for each sector of healthcare. In other words, they use these base rates to manage profit margins for each healthcare sector, keeping them in the range they feel is adequate.

For home health, CMS and MedPAC have clearly prioritized their first goal at the expense of the second one. They have managed to convince congress and many stakeholders that home health can absorb their cuts and still maintain profitability. The truth is that HHAs are not profitable, on average, to begin with and it is getting worse every year. CMS and MedPAC are hiding this truth.

The industry cannot afford to maintain the status quo, let alone absorb additional cuts. MedPAC and CMS must acknowledge the actual financial position of HHAs and take immediate action to adjust their base payment rates. When CMS and MedPAC present Medicare only profit margins, they must include margins under all-payers as well, as they do with hospitals. This must happen in this legislative cycle, or it may be too late to avoid a collapse of this essential part of the Medicare program.