Why is Legislation Needed to Refine the Home Health Payment Model?

Partnership for Quality Home Healthcare

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What are the details of the New Payment Model? The Balanced Budget Act of 2018 (BBA) required the Centers for Medicare and Medicaid (CMS) to develop a new payment model for the Medicare home health program. According to BBA, the new model will be **budget neutral**, the payment system shall be based on a **30-day unit of service**, and the therapy thresholds shall be eliminated in the case-mix adjustment. Home health providers welcome a better payment model that aligns payment to patient characteristics.

What Guidance Did CMS Offer in Their Planned Roll-out of the New Model? In its Home Health Perspective Payment System (HHPPS) model Proposed Role for 2020, CMS included a 8.01% base rate reduction adjustment under the Patient Driven Groups Model (PDGM) – up from the previously proposed 6.42% reduction – that would start before any actual behavioral changes occur. This one-year reduction could reduce payments in the Medicare Home Health Program by an estimated $1.298 billion in 2020, causing instability to all providers, threaten access to care, and harm the Medicare home health program for seniors. The home health community believes Congress did not intend for home health to be cut by $1.298 billion in 2020. The Congressional Budget Office in the BBA estimated the new payment system would have no effect on federal spending.

What is a "Behavioral Assumption" Cut? Without any data or evidence, CMS makes assumptions or guesses about provider behavior in a new payment system. Simply, CMS assumes that providers systemically will change their coding to maximize payment in a new model. There is no evidence to support this assumption. In fact, CMS' own analysis of home health payments (CMS' 2017 Fee-for-Serve Supplemental Improper Payment Data Report) indicates that improper payments due to incorrect coding was zero dollars. This is in direct contrast to CMS' assumptions about provider behavior in the new payment system. No data or evidence warrants a 8.01% ($1.298 billion) cut to home health providers.

How Has Congress Responded? Congress Agrees a Behavioral Assumption Cut (without evidence) to Home Health is Unwarranted. The Home Health Payment Innovation Act (**S. 433 & H.R. 2573**) has been introduced in the 116th Congress, which requires CMS to use actual data, "observed evidence," before making behavioral assumptions in the payment system. This legislation also reinforced the need for a new model to be budget neutral and limit an agency's losses or gains to 2% per year. In response to CBO discussions about this legislation last Congress, the home healthcare community, provided some redrafting suggestions that have been incorporated into this year's bill. These suggestions further finetuned the bill's language about "observed evidence" and also modified the 2% phase in requirements, ensuring that budget neutrality would be met by 2029.

How Have Other Sectors Been Treated in Their Payment Models? A behavioral assumption cut without data is not sound payment policy. CMS, in issuing the Skilled Nursing Facility (SNF) model, refused to make assumptions about provider behavior, stating that it would "not make any attempt to anticipate or predict provider reactions to the implementation of the proposed [payment model]." CMS declined to make assumptions about such behavior in the SNF system because it "lack[ed] an appropriate basis to forecast behavioral responses." Other payment systems have included behavioral adjustments that were extensively researched including the hospital sector (general acute care and long-term acute care hospitals transitioning from DRGs to MS-DRGs in FY 2008), and the Inpatient Rehabilitation Facility PPS implementation in 2002 which included a modest, evidence-based behavioral assumption reduction. The home health payment model should be treated in the same way as other payment models: by using a data-driven approach to behavioral assumptions.