Co-Sponsor Home Health Payment Reform Legislation to Support America's Seniors

Partnership for Quality Home Healthcare

HOMECARE & HOSPICE
National Association for Home Care & Hospice

COUNCIL of STATE HOME CARE & HOSPICE ASSOCIATIONS

H.R. 6932 (Abraham, Buchanan, Sewell, Graves, DesJarlais)
S. 3545 (Collins, Stabenow, Nelson) and S. 3458 (Kennedy, Cassidy)

New Payment System for Home Health: Bipartisan, bicameral legislation has been introduced to refine home health provisions included in the Balanced Budget Act of 2018 (BBA) that requires Medicare to develop a new payment model for the Medicare home health program. 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.

CMS Final Rule to Cut Home Health by $1 Billion in 2020: CMS outlined the structure of the new payment system (called PDGM – Patient Driven Groupings Model), which will likely put into place a 6.42% "behavioral assumption" payment reduction for CY 2020. This possible one-year reduction could reduce payments in the Medicare Home Health Program by an estimated $1 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 that Congress did not intend for home health to be cut by $1 billion in 2020. The Congressional Budget Office estimated that 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 6.42% ($1 billion) cut to home health providers.

Congress Agrees a Behavioral Assumption Cut (without evidence) to Home Health is Unwarranted: All of the bills accomplish one change in the new payment system: H.R 6932, S. 3545, S.3458 all require CMS to use actual data, "observed evidence" before making behavioral assumptions in the payment system. The bills also reinforce the need for a new model to be budget neutral and limit an agency's losses or gains to 2% per year.

The Home Health Payment Model Should Be Treated Like Other Payment Systems: 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-drive approach to behavioral assumptions.

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Home Health Payment Reform & Legislation to Protect Services for America's Seniors

- The Bipartisan Budget Act of 2018 (BBA) requires Medicare to develop a new payment model for the home health benefit in 2020. Under the BBA, the transition to the new payment model must be budget neutral.
- In response to BBA, the Centers for Medicare & Medicaid Services (CMS) finalized a payment model called **Patient-Driven Groupings Model (PDGM)**.
- PDGM is a budget neutral payment system under which CMS will also make adjustments to payment rates based on assumed provider behavioral changes.
- PDGM cuts Medicare payment rates in 2020 by 6.42% - equaling more than $1 billion - in the first year alone based **purely on assumptions** about changes in provider behaviors in the new system.
- The home health community is highly concerned these **arbitrary and unfair payment cuts** could lead to **harmful service disruptions**.
- **Legislative solutions are needed** to ensure home health payments that provide for the care of the most vulnerable Medicare beneficiaries are not arbitrarily cut and that CMS uses observed evidence in its behavioral adjustments to the rates.
- Legislation, **S.3545** introduced by Senators Collins (R-ME), Stabenow (D-MI) and Nelson (D-FL), **S. 3458** introduced by Senators Kennedy (R-LA) and Cassidy (R-LA), and **H.R. 6932** introduced by Representatives Ralph Abraham (R-LA), Garrett Graves (R-LA), Scott DesJarlais (R-TN), Vern Buchanan (R-FL), and Terri Sewell (D-AL), would make the following changes to the home health payment model:
  - Require Medicare to institute rate adjustments only after HHA behavioral changes actually occur, basing any behavioral adjustment on **real, observed evidence**.
  - Ensure Medicare budget neutrality but require the **phase-in of any necessary rate increases or decreases** to be no greater than 2% per year to limit the risk of disruptions in care.
- S. 3545 also includes a provision that would permit the waiving of the homebound regulatory requirement to **enable greater flexibility** for Medicare beneficiaries in Medicare Advantage plans (and waiver programs) to receive home health services.
- **This legislation is vital** to ensure that the Medicare home health benefit is strengthened and secured for the growing number of seniors who depend on it.

HOME HEALTH PATIENT DRIVEN GROUPINGS MODEL

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- The Partnership is proud that CMS has consistently recognized the quality, value, and growth of the Medicare home health benefit to patients, and the value it creates through savings for the Medicare program.

- The Partnership believes in the strategic development of payment reforms that will allow more Medicare beneficiaries to be cared for in their homes as an alternative to more costly institutional care.

- The Partnership supports CMS' efforts to reform the home health prospective payment system to more accurately align payment with patient characteristics, quality, and to remove utilization-based incentives.

- However, despite a fruitful dialogue with providers and the Technical Expert Panel (TEP) this year, CMS did not incorporate critical policy recommendations from the TEP's Final Report into the CY 2019 home health final payment rule. It is concerning that the Patient Driven Groupings Model (PDGM) incorporates only minimal changes from last year's Home Health Groupings Model (HHGM), despite recognition that critical policy changes are necessary.

Aspects of the Patient Driven Groupings Model that are of greatest concern:

Behavioral Assumptions

- The Partnership is concerned making payment adjustments to address certain behavioral assumptions that are not based on observed evidence could result in unintended consequences.

- The Partnership believes CMS should implement PDGM by demonstrating a rational connection between evidence actually observed after implementation of the new payment model and any changes in the model made by CMS as a result of these data-based observations.

- Unfortunately, the final rule's behavioral assumption of negative 6.42% is not based on observed data and far exceeds past actual behaviors exhibited by the industry since the current payment system was developed.

Cost Reports

- The Partnership is concerned about the use of unaudited cost reports - that are inconsistent from provider to provider - as a basis for establishing new payment rates.

- The Partnership firmly believes that all data upon which payment reform is based should be accurate and reliable.

Clinical Groupings

- The Partnership has concerns about the accuracy of the payment model because it does not consider TEP member recommendations on clinical groupings.

THE HILL

Congress: Improve Medicare home health reforms to protect patient care

BY KEITH MYERS AND WILLIAM DOMBI, OPINION CONTRIBUTORS — 11/26/18 08:20 AM EST

When it comes to health care, we expect our treatment decisions to be based on actual observed clinical evidence and real-world data. Yet, a newly finalized home health payment model from the Centers for Medicare & Medicaid Services (CMS) moves away from evidence-based decision making toward dangerous assumptions that could disrupt care for some of our nation's most vulnerable seniors.

Millions of Medicare patients want to receive care in the comfort of their own homes. We owe it to them and America's growing senior population to do everything possible to ensure their access to high-quality home health care is not compromised.
Unfortunately, this newly finalized Medicare home health payment model, called the Patient-Driven Groupings Model (PDGM), has great potential to threaten the continuity of care for an estimated 3.5 million homebound seniors across the country rely on to remain safely in their homes as they age while protecting their quality of life.

The new payment model – the most significant to home health in decades – makes changes to Medicare reimbursement for home health services based on untested assumptions about providers' billing behavior, rather than any actual, evidence-based changes triggered by the new payment model that affect overall Medicare spending on home health services. Through these assumed behavioral changes, Medicare is likely to arbitrarily cut reimbursement rates to home health agencies by 6.42 percent – equaling more than $1 billion – in the first year alone.

With more than half of home health agencies bracing for such sharp and unexpected reimbursement reductions, the home health community has raised constructive concern with both CMS and Congress that these cuts may lead to unintended consequences – most notably a disruption in care for beneficiaries requiring home health to prevent expensive rehospitalizations, manage chronic conditions and assist seniors following an acute episode of care.

While the home health community has demonstrated strong support for reforms to align payment with patient characteristics and the removal of utilization-based incentives, it's critical patient care is protected during a transition of this magnitude.

Recognizing the serious impact PDGM will have on seniors and on the integrity of Medicare's home health benefit, a bipartisan group of lawmakers has listened to the concerns of the home health community and responded by engaging in a bipartisan policy solution. Three bills, introduced in the

House and Senate, would require Medicare to adjust reimbursement rates only after behavioral changes by home health agencies actually occur, instead of assuming changes might occur and imposing cuts without evidence-based reason.

The bipartisan bills (S. 3545, S.3458, and H.R. 6932), sponsored by Sens. Susan Collins (R-Maine), Debbie Stabenow (D-Mich.) and Bill Nelson (D-Fla.), John Kennedy (R-La.) and Bill Cassidy (R-La.), and Reps. Ralph Abraham (R-La.), Garrett Graves (R-La.), Scott DesJarlais (R-Tenn.), Vern Buchanan (R-Fla.), and Terri Sewell (D-Ala.) would stabilize access to care while CMS and stakeholders work together to improve Medicare payment reforms to ensure the delivery of consistent, clinically effective and high quality home health services.

In addition to requiring reimbursement changes be made on actual changes in billing behavior, these pieces of legislation will limit any necessary rate increases or decreases to no greater than 2 percent per year. This phased-in approach will allow additional time to shelter patients and providers from dramatic rate shifts.

Home health is a clinically advanced, cost effective and patient preferred way to provide care for seniors recovering from illness or injury. It allows seniors to heal in the comfort of their own homes rather than in a hospital or facility-based setting, thereby improving quality of life and reducing Medicare costs.

We urge lawmakers in Congress – while they still have time in the final weeks of this legislative session – to support home health payment reform legislation so we can make sure reforms are designed and implemented in a way that puts patient need at the center of decision making. This is more than just good policy, it's the right thing to do for disabled and senior Americans.

Keith Myers is Chairman of the Partnership for Quality Home Healthcare. William A. Dombi, Esq. is President of the National Association for Home Care & Hospice.

https://thehill.com/blogs/congress-blog/healthcare/418183-congress-improve-medicare-home-health-reforms-to-protect

MORNING CONSULT

Home Health Legislation Could Strengthen Payment Reforms, Protect Patients

BY TIM ROGERS
November 27, 2018

Quality health care in the United States today is largely guided by evidence-based practice — meaning that providers make conscientious treatment decisions for their patients based on proven, scientifically grounded evidence that has been shown to be effective.

They don't simply guess or make assumptions when it comes to care that could significantly affect someone's life or health. They rely on data, evidence and facts.

When it comes to critical policy decisions, shouldn't our nation's policymakers do the same?

This fall, home health providers certainly hope that members of Congress will pass health care payment reform legislation that indeed does depend on facts. It's important because, as it currently stands, a recently finalized home health payment model — the Patient-Driven Groupings Model — allows arbitrary rate reductions for home health providers based on assumptions — not actual behavior. If unaddressed by Congress, the PDGM stands to destabilize the home health care sector for the more than 3 million American seniors with Medicare who depend on the benefit annually.

Unfortunately, we already know from past experience that assumption-based rate reductions could lead to a drop in the use of home health services. And seniors need access to these services now more than ever before because of the rising tide of American seniors and an increased focus on ensuring patients receive care in the most clinically appropriate, lowest-cost setting — the home.

Absent a legislative solution, under the PDGM, the home health sector will be hit with Medicare reimbursement rate cuts of an estimated 6.42 percent — equaling more than $1 billion annually — starting in 2020.

American seniors rely on home health care in order to recover from injury, surgery and illness at home without requiring additional trips to the hospital. With the help of more than half a million skilled, professional caregivers, these homebound seniors receive safe and effective medical care that was once offered only in a hospital or a clinical setting. Data show that skilled home health care can be less expensive, but just as clinically effective, as care provided in an inpatient health care facility.

Our elderly, homebound patients can't afford cuts that threaten their care — particularly when the Centers for Medicare and Medicaid Services hasn't provided any rationale for them.

Rather than enacting changes to reimbursement based on assumptions under the PDGM, it's critical that our policymakers follow the facts and act upon evidence.

Fortunately, three separate pieces of legislation will ensure precisely that. S. 3545, S. 3458 and H.R. 6932 would amend several provisions of the Balanced Budget Act under which the PDGM was created — requiring Medicare to implement adjustments to reimbursement rates only after behavioral changes by home health agencies related to the new payment model that affect Medicare spending actually occur, instead of assuming changes might happen.

Additionally, S. 3545 includes a provision strongly supported by the home health community to permit the waiving of the homebound regulatory requirement to enable greater flexibility for Medicare beneficiaries in Medicare Advantage plans (and waiver programs) to receive home health services.

By requiring the new payment model to utilize observed evidence of behavioral changes, the bills would ensure a smoother transition to the new payment system — the most significant payment change to the home health system in more than 20 years — and, most importantly, protect patient access to continuity of care. They would also ensure Medicare budget neutrality but require the phase-in of any necessary rate increases or decreases to be no greater than 2 percent per year in order to limit the risk of disruptions in care.

Just as evidence and facts guide effective treatment, so should they guide smart policy. It's the common-sense and wisest approach — and one that puts the needs of American seniors at the forefront.

Tim Rogers is the chairman of the Council of State Home Care and Hospice Associations.

https://morningconsult.com/opinions/home-health-legislation-could-strengthen-payment-reforms-protect-patients/

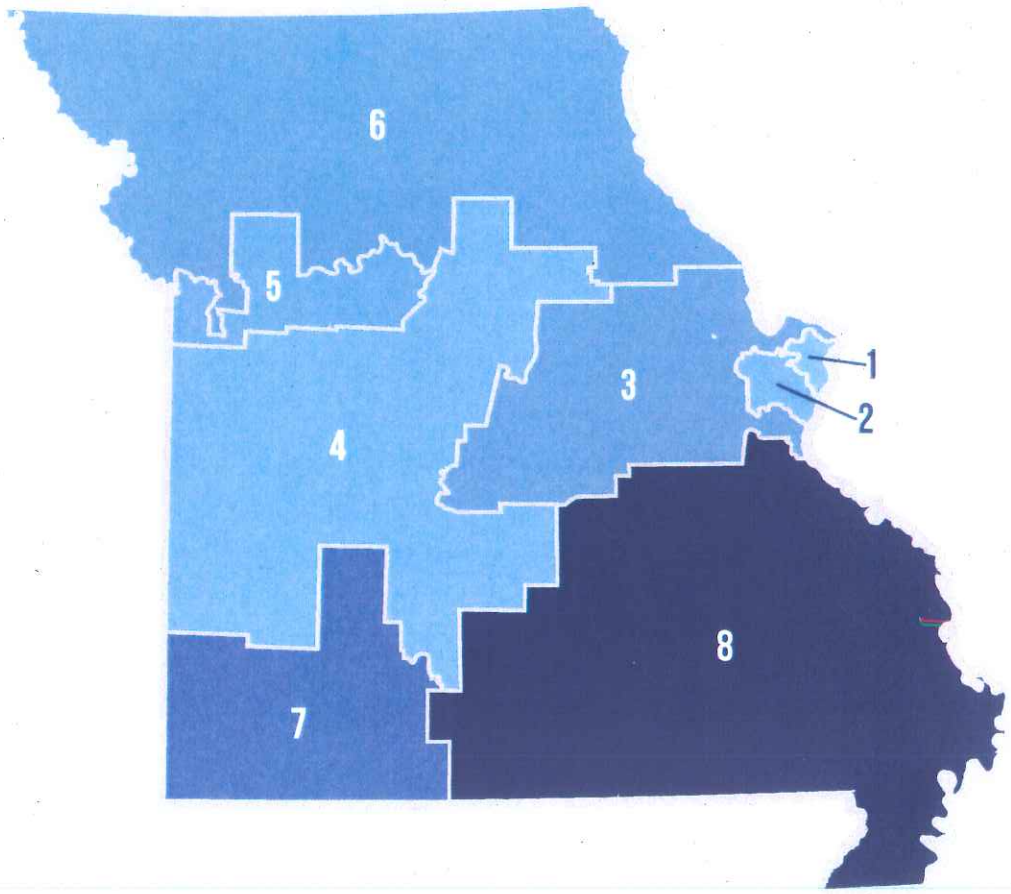
MISSOURI

HOME HEALTH STATISTICS FOR MISSOURI

Partnership for Quality Home Healthcare

Number of Medicare Home Health Beneficiaries	Number of Home Health Jobs	Annual Economic Labor Impact of Home Health	Number of Partnership Locations
60,862	21,533	$1,046,925,654	36

PARTNERSHIP HOME HEALTH AGENCIES PER CONGRESSIONAL DISTRICT



DISTRICT 1
1 LOCATIONS

DISTRICT 2
2 LOCATIONS

DISTRICT 3
4 LOCATIONS

DISTRICT 4
2 LOCATIONS

DISTRICT 5
3 LOCATIONS

DISTRICT 6
4 LOCATIONS

DISTRICT 7
7 LOCATIONS

DISTRICT 8
13 LOCATIONS