5 REASONS:

CMS Should Work with Home Health Community to Improve the Home Health Groupings Model

Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

The Centers for Medicare & Medicaid Services' (CMS) Home Health Prospective Payment System (HHPPS) proposed rule for CY 2018 includes the implementation of the Home Health Groupings Model (HHGM), a payment reform approach that dramatically alters Medicare payment for skilled home health services, to begin as early as 2019. CMS did not solicit comment or seek industry input in the development of this proposed policy. The Partnership anticipates CMS will use the year ahead to fix this proposed payment model or develop more broad based alternatives by working with experienced, high quality providers.

1. HHGM would be a total overhaul of the payment system that is not budget neutral

HHGM is a payment reform approach that dramatically alters Medicare payment amounts for skilled home health services in a ***non-budget neutral*** manner with wide ranging affects at the agency level. The HHGM will also base payments on patient characteristics rather than expected care needs, and will replace the historically used 60-day episodes with 30-day "periods."

2. HHGM would redistribute Medicare payments unevenly across the system

Initial review of the HHGM indicates that there may be significant geographic disparity in the proposed changes to the groupings model resulting in varying differences in the reimbursement rates between states and regions as well as between for profits and not for profits. This will result in a payment model that doesn't tie payment to quality or value.

3. HHGM would put patient access at risk in rural and smaller communities

The significant variation in Medicare cuts resulting from HHGM across states and regions means rural and underserved markets would experience the largest cuts, putting access to care for vulnerable seniors at risk. Access to home health is particularly vital to Medicare home health patients residing in rural settings who are on average older, sicker and poorer than the general Medicare population.

4. HHGM would reward inefficiency but not high-quality outcomes

The HHGM would redistribute payments away from home health services such as physical, occupational and speech therapy that are currently producing Medicare savings in value-based care, alternative payment and bundled payment models. HHGM also favors HHAs who are inefficient in back-office operations and facility-based HHAs. HHGM would result in cuts for certain high-quality providers, while low-quality providers would be rewarded with the potential for significant increases in their payments.

5. The process was not transparent and CMS sought virtually no input from experienced, quality providers

Despite ongoing requests for the HHGM methodology and data, CMS only provided vague details about the HHGM, which makes accurately replicating the potential impacts of HHGM incredibly challenging, therefore leaving the Partnership and other industry leaders unable to research, model and provide specific comments on the HHGM.

The Partnership welcomes the opportunity to engage with CMS in the development of payment reform solutions, however, without more data and the specific methodologies, the Partnership cannot provide detailed and informed recommendations on how best to improve HHGM.