HOME HEALTH GROUPINGS MODEL: Wrong Approach to Payment Reform

Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

HOMECARE & HOSPICE

National Association for Home Care & Hospice

The CY 2018 Centers for Medicare & Medicaid Services (CMS) Proposed Rule for the Home Health Agency (HHA) Prospective Payment System includes the Home Health Groupings Model (HHGM). This policy must be withdrawn because CMS has not provided the complete data to accurately model or understand the impact of HHGM on patients or providers, an essential aspect of any public regulatory review. It is especially crucial with this proposal given that CMS projects it will significantly reduce Medicare reimbursement for home health services by as much as **$950 million in 2019 alone**.

The home health provider community supports efforts to better align Medicare payments with patient characteristics and care needs, but we do not have the adequate information or time to fully understand the HHGM impact prior to the September 25 comment deadline. Payment reform of this magnitude should be implemented thoughtfully, with full disclosure of data and ample opportunity for stakeholder participation and input.

The Issue

The HHGM, if implemented, would completely overhaul the current home health payment system, cause enormous disruption in the field, and negatively impact patient access. This proposal from CMS comes at a time when federal policy continues to support care in the most cost-effective settings, like home health services, yet HHGM is a significant obstacle to delivering the type of quality care that Medicare beneficiaries need in their home.

The HHGM is a wholesale payment reform measure that would replace a 17-year payment model in a non-budget neutral manner with dramatic and wide ranging affects at the provider level. The HHGM bases payment amounts on an untested model that relies on certain patient characteristics that have not been determined to be valid or reliable indicators of care needs. It also would replace the historically used 60-day episodes with 30-day "periods" even though Medicare retains a 60-day standard for the patient assessment and plan of care. This change conflicts with CMS' efforts to reduce administrative burden by requiring providers to bill twice as frequently and manage patient care in a framework inconsistent with the payment system.

HHGM would:

- Create access to care barriers for vulnerable home health patients;
- Significantly cut reimbursement for many types of home health patients without Congressional authorization;
- Compound five years of rate cuts that total nearly 18% in a benefit that has had essentially flat spending since 2010; and
- Impose non-budget neutral reforms in home health services at a level that previously caused significant harm to patients, e.g. with the Interim Payment System (1998-2000), nearly 1.5 million Medicare beneficiaries lost access to care following the closure of more than 4,000 home health agencies virtually overnight.

The HHGM would redistribute payments away from medically-necessary home health services such as physical therapy, occupational therapy and speech-language pathology that are currently producing Medicare savings in innovative value-based care, alternative payment systems and bundled payment models. In the long run, HHGM could result in higher Medicare costs as patients are forced to access institutional care rather than receive appropriate care in their own homes.

This redistribution of Medicare reimbursement for home health services also varies significantly across states and regions with little explanation, with some states and congressional districts hit much harder with greater cuts to Medicare reimbursement than others. **A change of this magnitude is also likely to put patient access at risk for Medicare beneficiaries in rural and smaller communities with few HHAs and America's Veterans who largely depend on home health.** While a majority of states are expected to be negatively impacted by HHGM, preliminary modeling demonstrates that home health providers in Utah, Florida, Michigan, Tennessee, and Idaho will be hit especially hard and will face the most severe Medicare cuts.

The Solution

There are fundamental revisions that must be made to the proposed HHGM for it to be a workable payment model for the home health provider community. These changes will ensure that access to care is maintained for one of Medicare's most vulnerable beneficiary populations who are older, sicker and poorer, on average, than other Medicare patient groups.

1. HHGM policy must be withdrawn as a part of the HHA CY 2018 Final Rule
2. HHGM must be revised to be implemented in a true budget-neutral fashion
3. CMS should initiate a partnership with industry and beneficiary stakeholders to design and develop a payment model that supports a patient-centered, quality-driven system
4. HHGM must be phased-in over a multiple year transition period, beginning no sooner than 2020

Need for Transparency & Collaboration

The HHGM development process was not adequately transparent and only vague details were provided despite ongoing requests for data. Additionally, the proposed rule still does not provide enough information to accurately replicate the potential impacts of the HHGM. Since industry leaders have not been able to fully research, model and provide specific comments on the HHGM, it must not be finalized as part of the CY 2018 payment rule and we encourage ongoing dialogue and coordination with CMS to improve the HHGM before implementation. The table below highlights the information necessary to fully assess the impact and provide meaningful comment on HHGM as proposed – much of which were not included in CMS' proposed rule:

Information Needed to Fully Assess Impact of Proposed Rule	Included in Proposed Rule or supplemental materials?
CY16 Claims and OASIS Assessment Data	No
CY 2017, 2018, and 2019 (under HHGM) HH baseline	No
Explanation for how CMS treated 60-day episodes with no visits day 31+	No
Description of "behavioral assumptions", other factors included in impact estimates	No
Case Mix Weights	Yes
LUPA thresholds	Yes
Outlier threshold	Yes
ICD-10 codes associated with clinical groupings, comorbidities	Yes
Functional status thresholds	Yes

We urge CMS to withdraw the HHGM policy and instead work with stakeholders in a more inclusive process that leads to policy changes that do not limit access to beneficiaries or diminish provider resources as the current proposed HHGM system does.