



2018 Proposed Rule: Reject Drastic New HHGM Payment System for Home Care

The Issue

Home care providers, stakeholders and partners across the nation are urging the federal government to halt a new proposal that would fundamentally overhaul the Medicare home health reimbursement system to the tune of **\$1 billion in cuts, beginning January 2019**.

This payment system, (called the Home Health Groupings Model, or “HHGM”) is the most drastic reimbursement change affecting the home care sector in decades. Because it is not budget-neutral (which should be a fundamental requirement when modifying any payment system), CMS needs to rescind this policy change and put into place a stakeholder-involved process to make rational and methodical policy changes that will not have dire consequences on America’s home care agencies.

Further, the U.S. Centers for Medicare and Medicaid Services (CMS) has yet to schedule any meaningful simulation demo of this fundamental payment change, so that providers and consumers can understand the implications of HHGM for patient care and services. CMS has extended similar demonstration and/or voluntary participation periods for other major payment initiatives, and this proposal should be no different.

Analysis of the HHGM system indicates that it would result in significant variation in reimbursement rates by states and regions, would reward inefficiency but not high quality outcomes (by redistributing payments away from services such as physical, occupational and speech therapy) and create access issues for patients in rural and under-served areas.

CMS must also provide access to – and a demonstration of – the data sets and assumptions justifying HHGM, given that the proposal (now only in conceptual form, “on paper”) appears contrary to the very purpose of existing risk-based models of Medicare home health reimbursement.



How Home Health Reimbursement Works Now

Medicare home health services are currently billed in what's called a 60-day "episode." The purpose of this episodic system is to create financial risk for providers, so that home care organizations deliver the right amount of services without driving costly overutilization.

In essence, all Medicare home health services are paid at a uniform "base" rate of reimbursement (with some adjustments to account for regional wage differences, the patient's clinical characteristics, and other critical factors), as long as at least four or more visits are delivered to the patient during the 60-day period. This system works by minimizing financial incentives for agencies to deliver too many or overly costly home visits.

What is CMS Proposing?

CMS says it has found that utilization (i.e., the number, duration or level of home care visits) is highest during the first 30 days of a 60-day episode. This is why CMS is proposing to divide the episodes in half, from a 60-day billing increment to 30 days. These new 30-day increments would be paid at different levels using a whole new set of complex scoring factors. The intent is to establish new rates for the first 30 days when CMS says care is more costly, whereas the current system does not distinguish between the costliness of an early half of the 60-day episode (the first 30 days) versus the latter half of the episode (the last 30 days).

This proposal will cut nearly **a billion dollars** (\$950 million) from the home care system at a time when **New York providers are already shouldering major financial losses from CMS's previous manipulations with the reimbursement system**. These past reimbursement changes, called "rate rebasing," have relied upon unrepresentative data samples to reduce payments, without regard to the impact on patient care. The result has been a series of four annual, 3.5-percent cuts that have been arbitrarily imposed on the industry, **leaving New York providers with an average -6.97% Medicare operating margin**. In the last five years, providers have experienced nearly 18% in cuts to the Medicare home health benefit at a time when spending has been essentially flat. The HHGM would take yet a further toll on the financial viability of New York providers, continuing to impose uneven reimbursement levels across the system.

Problems with the 30-Day HHGM

CMS's proposed HHGM essentially has two parts: 1) moving to a 30-day reimbursement increment (from a 60-day episode); and 2) revising the acuity methods by which rate adjustments are made for serving patients with certain clinical characteristics.

Here are some reasons why this is a problem:

- The purpose of the current 60-day episode is to create a feasible window of risk for providers. **Reducing this period to 30 days is a fundamental departure from the intended risk model currently in operation.** A 30-day reimbursement cycle would constrain the window of time by which risk is effectively balanced out across the duration of a patient's time on service with the home care agency.
- Lacking any substantive data justification, it appears that CMS has assumed payment cuts first, by determining where the highest costs occur, and then adjusting the reimbursement increments accordingly. **This creates a slippery slope, in which CMS could adjust the increment for reimbursement to whatever time duration generates the most cost reductions – without regard to the needs of the patient throughout the duration of his or her time on service.**
- Departing from the long-established standard for other payment changes, **HHGM overhauls a 17-year payment model in a non-budget-neutral manner.** This is extraordinarily foolish and will undoubtedly lead to agency closures and a reduction in services.
- CMS is basing this change (to a 30-day increment and associated clinical scores) on the notion that costs are highest during the first 30 days of care as opposed to the final 30 days of an episode, thus necessitating different reimbursement rates for the early versus the latter half of an episode. **But there's good reason for these cost differences. For one, the first 30 days that a patient receives home care are typically when the patient is most at risk,** especially in cases where a patient is receiving home care after a hospital visit. This is why hospitals are penalized when a patient is readmitted to the hospital within 30 days of discharge, and it's why home care agencies are scored by their ability to keep the 30-day hospital readmission rates in check through the front-loading of critical services at the start of care (i.e., during the first 30 days). Indeed, even CMS acknowledges that more complex cases are driving costs in the first 30 days of care, as these higher-cost periods are preceded by institutionalization (i.e. hospital or nursing home care) in as many as 40% of cases. **Patients coming from the hospital, in particular, may be recovering from surgery and, therefore, are in need of intensive wound care or therapies that legitimately account for higher costs during the first 30 days of care as opposed to the final 30 days of an episode.**
- **This reimbursement change needs to be tested to avoid unintended consequences,** such as the possible financial incentive for agencies to spread patient care visits and interventions in a way that is contrary to the progression of a patient's care needs, especially in the case of patients who are discharged from the hospital.
- While January 1, 2019 may seem like a reasonable start date for HHGM, CMS's proposal won't be finalized until November. **This leaves providers just over one year to adjust to payment changes separately going into effect in 2018 as they train their staff, work with billing and clinical software vendors, and attempt to determine the financial impact of the new HHGM well before January 1, 2019.**

Recommendations

HCA urges Congress to **direct CMS to withdraw the HHGM as part of its proposed 2018 home health payment rule**. This will allow time for CMS and industry stakeholders to discuss, analyze and formulate changes to the payment system that will not cause significant disruption in services. HCA asks that this process take place in 2018, with the introduction of a demonstration in later years. Importantly, **HCA asks Congress to insist that a new model be developed and implemented in a budget-neutral manner**.

There is a long precedent for CMS using demonstrations and voluntary mechanisms to test major reimbursement changes, particularly in the case of new risk models. In fact, CMS, just recently (in August 2017), rescinded an episode-based model set to go into effect for the hospital sector, and it made a prior one voluntary. To use CMS's own words: "Many providers are currently engaged in voluntary initiatives with CMS, and we expect to continue to offer opportunities for providers to participate in voluntary initiatives, including episode-based payment models. **We are concerned that engaging in large mandatory episode payment model efforts at this time may impede our ability to engage providers, such as hospitals, in future voluntary efforts**" [emphasis added].

If this is true for hospitals, why doesn't the same logic apply for home care?

A demo and/or voluntary initiative would properly simulate a range of processes for further evaluation and testing, including: billing, care-authorization, fiscal projections, patient care impacts and integration issues with IT vendors.

Lastly, following a testing period, HHGM should undergo a multiple year transition period or phase-in to further acclimate providers to these major changes.





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