Home Health Prospective Payment System Rule for CY 2016

What It Means for Home Health Agencies in New York State

On July 7, the U.S. Centers for Medicare and Medicaid Services (CMS) issued proposed payment changes for home health in a regulation known as the Home Health Prospective Payment System (HHPPS) rule for calendar year (CY) 2016.

Given the expanding need and importance of home health care as our population ages, most would expect the proposed rule to include policy changes that improve the value of Medicare home health services for patients and taxpayers. This regulation, unfortunately, proposes significant funding cuts that will directly harm home health agencies and the homebound Medicare beneficiaries receiving such critical services in all areas of New York.

Here are four major reasons why this proposed rule is concerning:

ONE **Across-the-Board Payment Reductions**: The rule includes a third year of the four-year phase-in of "rebasing" adjustments. Rebasing is a technical term for resetting the base of home care reimbursement – a process required by the Affordable Care Act (ACA). However, CMS has used the statutory basis of ACA for implementing cuts of -3.5 percent to all Medicare home care payments – the largest percentage cut allowed by ACA – without using current, reliable data for substantiating this decision to pick the largest possible cut.

In laying out its four-year course of rebasing cuts, starting in 2013, CMS has routinely neglected to assess the impact of such reductions on service access for the entire duration of the four-year period, simply allowing a -3.5 percent cut to continue, by default, each year on the course of cuts initiated in 2013. What's more, beyond these base reductions, CMS is now also proposing to cut approximately $300 million more out of home health funding via a new two-year case-mix weight (CMW) cut, also based on outdated, incomplete data. This across-the-board reduction would not only put further strain on home health agencies across the state but it appears to be a maneuver by which CMS is attempting to exceed the limit of cuts allowed by law.

The combination of this ongoing -3.5 reduction along with a proposed two-year 1.72 CMW reduction is a critical blow at a time when New York home health agencies have reported negative unweighted Medicare margins for the 13th consecutive year, based on a Medicare Cost Report analysis from the National Association for Home Care (NAHC).

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TWO **More Patients & Communities at Risk:** When CMS released its rebasing regulation in 2013, it projected that "approximately 40 percent" of all home health agencies would be operating at a loss by the end of 2017 as a result of that cut. This is simply **not** the case in New York where approximately 70 percent of home health agencies are already experiencing negative Medicare margins. NAHC projects that this share of New York agencies operating in the red will increase to 76.2 percent by 2017. This trend is unsustainable and will only continue under the crushing weight of further rebasing cuts where New York is clearly at risk of greater harm than shown in the national projections of Medicare margins, which are bad enough.

With CMS now proposing an additional reduction of $350 million in 2016, more agencies will be imperiled, placing an even greater percentage of Medicare beneficiaries, home health jobs, and providers at risk.

THREE **Rural Home Health Providers at Greatest Risk**: More than 225,000 potential Medicare home health beneficiaries live in New York's 24 designated rural counties. These rural patients are served by approximately 30 New York home health agencies that are some of the most financially at-risk providers in the U.S., with data to back this up: Rural agencies had an aggregate -40.4 percent unweighted operating margin in 2013 (according to NAHC), well before the rebasing cuts began to take hold, which means this percentage is likely far worse today. CMS's additional proposed cuts for 2016, which have no regard for regional differences or characteristics of different state home health programs, is likely to cause many of these small, rural providers to close – which would force thousands of rural seniors out of their communities and into more costly institutional facilities far from home.

FOUR **Further Cuts Undermine an Already Complex Value-Based Purchasing (VBP) Reform Project with Specific Concerns for New York Providers**: CMS's CY 2016 proposed rule creates a mandatory Home Health VBP program in nine states with a proposed payment withhold adjustment increasing from 5 to 8 percent over a five-year period. CMS did not include New York in this proposed pilot project, though its status under VBP could change as CMS finalizes its rule for release in November. New York's concerns about this project are unique, given the state government's determination to substantially alter the Medicaid program and its orientation with Medicare services through the federal waiver process.

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Congress needs to be aware of these state-level program changes so that they align with the path that CMS is attempting to take on the federal level, and to assure that these converging value-based payment propositions are occurring in a unified, seamless fashion. Specifically, New York State has recently released a "Draft Medicare Alignment Paper" with proposals to integrate Medicare and Medicaid value-based payment efforts though ACOs and bundled payments. The state would also include Medicare beneficiaries in the Medicaid VBP models through global payments, integrated primary care, bundled payments, and total care for a subpopulation.

Because New York is vigorously pursuing VBP from the Medicaid payment perspective, it is critical for home health agencies to be able to invest in the infrastructure necessary to participate without the potentially competing demands of a federal project – and without the crushing blow of further reimbursement cuts virtually assuring that providers wanting to function in either project (federal or state) will be unable to make the investments necessary to do so. New York providers have enough work activities ahead of them to prepare for the New York-initiated Value Based Payment project without the added focus of a federal project or the blow of additional cuts on an already fragile infrastructure. To ensure that all parties are able to successfully approach this newly chartered territory, whether nationally or here in New York, CMS should develop a voluntary application process for interested home health agencies to apply for VBP participation and change its payment regimen to recognize the need for capital investment which will make VBP successful.

Your Support Needed

Reflecting these and other concerns, a bipartisan group of lawmakers has written a letter to CMS that calls for important corrections to this regulation before it is finalized. The letter is being prepared by Reps. Greg Walden, Tom Price, Earl Blumenauer and James P. McGovern. It specifically requests that CMS "reconsider its proposed case mix cut until it evaluates the specific causes of case mix changes from 2012 to 2014," among other recommendations related to CMS's 2016 HHPPS proposal.

HCA, our member agencies and our federal partners, working on behalf of frail seniors, urge your signature on this important letter and your support for a more rational approach to federal payment and program changes that protect the Medicare home health benefit for your constituents.