



# Vital Corrections, Safeguards Needed in 2018 Home Health Payment Reform Act

The February 9, 2018 Bipartisan Budget Act includes sweeping changes to the payment system for Medicare home health services set to go into effect in 2020.

HCA, NAHC, the Partnership for Quality Home Healthcare and others urge Congress to enact a series of technical corrections and safeguards to this Act.

Such changes are necessary to make sure that the intricacies of payment reform are:

- ✓ Understood by providers and Medicare Administrative Contractors that pay for and make determinations (approve or deny) claims;
- ✓ Do not jeopardize access to care;
- ✓ Allow for a smooth transition to a new billing and claim system, as well as procedures for delivering vital care; and
- ✓ Are coherent with existing service regulations.

## ***Payment Reform Background***

Home health services are currently billed by a 60-day "episode." Under this longtime episodic system, a uniform base rate (with some adjustments to account for regional wage differences, clinical characteristics, and other diverse cost factors, etc.) is paid to providers to cover the total cost of home care services over this 60-day period.

The new payment changes enacted by Congress would:

- Replace the 60-day home health episode with a 30-day "unit of service" on a mandatory basis for all providers nationwide, without first testing these changes through a demonstration or transition process (as is traditionally the case for most payment reforms).
- Give the HHS Secretary extensive latitude for making predictive payment adjustments based on "assumptions about behavior changes that could occur," which is overly subjective and risks violating a separate assurance in the law that such payment model changes must be adjusted in a budget-neutral manner.
- Allow, but not require, home health documentation to be included in the full physician record for determining a patient's qualification for home care services. This existing new language presents a missed opportunity to correct a long-standing cause of almost all documentation errors in home health. It *allows* but does not *require* (as it should) the combination of physician and home health documentation to be viewed in full by CMS contractors as a justification for needed home health services.



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### Problems

- The change to a “30-day unit of service” goes beyond the scope of payment reform, crossing a line into service definitions. For instance, other regulations – such as physician certification timetables and assessment requirements – all cohere with a 60-day episode or service unit, not a 30-day structure.
- The method of mandatory, nationwide payment reform runs contrary to a longstanding precedent for CMS to use demonstrations and voluntary mechanisms to test the impact on a smaller scale first. As stated in a recent CMS statement for hospital payments, “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.” A voluntary pilot with a sample of providers is necessary to repair any unintended consequences that could imperil access to care on a widespread basis by first examining the implications of payment reform on a selective basis.
- Payment changes must remain budget-neutral. Any future updates should be based on historical, statistical evidence, not subjective predictions about behavior changes, as the statute currently will allow.

### Technical Solutions and Safeguards

HCA and partners recommend the following technical solutions for the integrity of payment reform and the protection of patient care:

1. **Change the 30-Day Unit of “Service” to a 30-Day Unit of “Payment,”** in keeping with the purpose of these reforms as a payment (not service) change, thus ensuring access to services and cohesion with other existing service regulations and standards.
2. **Payment Adjustments Should Be Limited In Response to Evidence of Behavior Changes – Not in Anticipation of Them.** The statute must be corrected so that payment adjustments are made in a statistically sound manner based on evidence reflecting actual changes in care and operational practices, not predictions of change.
3. **Make Payment Reform an Optional Demonstration Program to Test, Pilot, and Repair Problems before Widespread Adoption.**
4. **Substitute the Word “May” with “Shall” on the Merging of Home Health & Physician Documentation for Contractor Review** – to require use of combined physician and home health agency records in determining a patient’s qualification for home health services.



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