HCA-NYS
A Conversation About Federal Regulatory and Reimbursement Policy for HHAs

Colin Roskey
Lincoln Policy Group
Scully, Roskey & Missmar
September 7, 2018

What a Year!

- Per the Balanced Budget Act of 2018
- New case mix system
- 30 day payment periods
- Case mix adjustment model with 216 categories using measures such as “early” or “late” time period; institutional discharge or community admission; 3 functional levels; comorbidity adjustment
- Behavioral adjustment to base rate to account for diagnosis coding and visit volume changes (-6.42%)
- Budget neutral rate setting except for behavioral adjustment
- 30-day LUPA ranging from 2-7 visits depending on case mix category

Proposed Patent Driven Groupings Model

- Very little change from proposed HHGM
- Better align payment with patient needs
- Increase access to home health care to vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. impact of therapy volume on payment
- Allow patient characteristics to better determine payment
- *Used with Permission: Abt Associates, Medicare Home Health Prospective Payment System: Case Mix Methodology Refinements. Overview of Home Health Grouping Model. November 18, 2016*

Proposed Patent Driven Groupings Model - Impacts

- Two 30-day periods within a 60-day episode
- 60-day certification period remains unchanged
- Plan of Care corresponds with 60-day certification
- OASIS time points remain unchanged
- RAPs continue - except for new Agencies
- LUPA category remains - with significant changes
- Case Mix Weight is calculated per 30 day period
- Partial Episode Payment Maintained
- Outlier Policy Maintained

PDGM – 216 HHRGs

- Admission Source and Timing
  - Community Early/Community Late
  - Institutional Early/Institutional Late
- Clinical Groupings
  - MMTA
  - Neuro Rehab
  - Wounds
  - Complex Nursing Interventions
  - MS Rehab
  - Behavioral Health
- Functional Level
  - Low/Medium/High
- Comorbidity
  - None/Low/High

CMS Resources to Model Agency Impacts

- "PDGM Grouper Tool" at https://go.cms.gov/1RoGVoi
- "PDGM agency-level financial impact estimate CY 2019 at https://go.cms.gov/1RoGVoi

Payment Policy Change: RPM!

- CMS is proposing to define remote patient monitoring in regulation for the Medicare home health benefit and to include the cost of remote patient monitoring as an allowable cost on the HHA cost report. BFD!

Evidence is Critical – so is Consistency: A Review of Industry Arguments So Far

- Particularly our concern that CMS must examine relevant data, and provide data or evidence to support the behavioral assumptions it may make.
- Courts have determined that agencies cannot make presumptions, but must use critical factual material and "relevant data" to support their position.
- Until such time as CMS can provide this to support the behavioral assumptions under the new model, the community is arguing that CMS must avoid making any behavioral payment adjustments.
- CMS has stated under SNF PDPM: "…we do not have any basis on which to assume the approximate nature or magnitude of these behavioral responses…lacking an appropriate basis to forecast behavioral responses…" they chose note to adjust payments based on projected provider behavior.
- Ultimately, CMS must have consistent policy and use replicable, actual evidence that is demonstrable and with clear guidance to providers.

Three Key Areas of Concern

- **Behavioral Assumptions**
- CMS' proposal to make payment adjustments to address certain behavioral assumptions that are not based on observed evidence and that could result in unintended consequences.
- CMS must implement PDGM by demonstrating a rational connection between evidence actually observed after implementation of the new payment model and any changes in the model made by CMS as a result of these data-based observations.
- Unfortunately, the proposed rule's behavioral assumption of negative 6.42% is not based on observed data and far exceeds past actual behaviors exhibited by the industry since the current payment system was developed.
- **Cost Reports**
- The use of unaudited cost reports -- that are inconsistent from provider to provider – as a basis for establishing new payment rates.
- All data upon which payment reform is based should be accurate and reliable.
- **Clinical Groupings**
- The payment model does not consider TEP member recommendations on clinical groupings.

What Else is New?

- Potentially competing federal legislation to assure that *actual, not assumed*, evidence is the basis for payment adjustment coming from Senators Kennedy and Cassidy (R-LA) and Collins (R-ME).
- Each bill will also likely include a phase-in provision designed to limit one year payment swings to 2 percent.
- Nurse practitioner ordering legislation continues to gather co-sponsors S. 445 (44) and H.R. 1825 (180).
- Federal landscape for major Medicare legislation looks uncertain as of September. Election looms large, but lame duck opportunities may present “vehicles” for our initiatives.

What Does the Fall Look Like?

- FEAR!
- Final Rule expected by November 1, most likely with nominal changes from Proposed.
- A new majority in the House is likely to push health care issues as major domestic policy initiatives immediately should they win control, including efforts to shore up Affordable Care Act consumer protections, reduce drug prices, and strengthen Medicare and Medicaid.
- Expect a new environment to be VERY health care “heavy” and contrasted with comparative GOP efforts to curtail ACA and support market-based alternatives, like AHPs and HSAs.

Life Moves Pretty Fast!

- Please understand prediction-based content here is subject to change quickly in a dynamic federal policy environment.
- Please stay in touch with questions or comments: colin@lpgdc.com or 202-448-1645
- Thank you!