Cuts to home health care providers are unwise

By Al Cardillo

VIEWPOINT

Say your employer takes 8 percent from your paycheck this week as a penalty for you possibly being late to work sometime next week, despite a long record of punctuality.

That's what the federal government is doing for Medicare-covered home health services in 2020 with cuts of $1 billion nationwide.

Your paycheck is obviously a serious matter. But consider the impact of presumptive cuts like these on services to vulnerable citizens. Indeed, these cuts come at a time when home health providers who deliver these services under Medicare have, on average, operated at a loss for 18 years in a row in New York, due to chronic Medicare underpayments.

A cut of 8 percent on top of wafer-thin margins or red ink is unsustainable. Last time the feds made such big moves on Medicare home health reimbursement, 20 years ago, 25 percent to 30 percent of existing home health agencies folded.

This new cut is called a "behavioral adjustment," and it rides along with an entirely new reimbursement system for Medicare home health services, known as the Patient Driven Groupings Model, which otherwise rightly seeks to better align reimbursement with services.

Just like it sounds, this federal cut being waged by federal administrators, not Congress, assumes that all providers, regardless of past record, may attempt to change their coding or billing practices to overcome PDGM's reimbursement corrections.

The fact that New York's Medicare home health providers are constantly faced with financial losses is one reason why we applaud the intent of this reimbursement change, in theory. It's the right thing to do. Plus, analyses show New York providers are overwhelmingly doing the right thing already. Which is why this "behavioral adjustment" is so incredibly counterproductive.

A bipartisan bill known as the Home Health Payment Innovation Act would correct this problem. This bill, in both the House and Senate, recognizes that behavior-based payment adjustments should only happen if the evidence shows a valid reason for doing so, such as faulty billing.

The state and federal governments otherwise also have many investigative and integrity units empowered to surgically address bad actors in health care. These new federal cuts cast a wide net, without any evidence, and before a single claim has been submitted for the new reimbursement system. That must change.

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PERSPECTIVE

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