Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

July 20, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Responsibly Strengthening the Medicare Home Healthcare Benefit

Dear Secretary Azar:

Today, I am writing to you on behalf of the Partnership for Quality Home Healthcare. We are a national coalition of skilled home healthcare providers who are proud to offer a skilled care benefit to Medicare beneficiaries. The work of our dedicated health care professionals is valued by Medicare beneficiaries and their families for our commitment to quality and care provided in a patient's home. We take pride in the fact that home health professionals are particularly adept at effectively managing beneficiaries with multiple chronic conditions who suffer suboptimal outcomes and are responsible for a majority of Medicare spending. We are also proud that the Centers for Medicare and Medicaid Services ("CMS") has consistently recognized the quality, value and growth of this benefit to patients, and the value it creates through savings for the Medicare program. The Medicare home healthcare benefit is particularly important to the vulnerable population of seniors who tend to be older, sicker, and poorer than all other beneficiaries.

My letter today is to let you know personally of our commitment to improving the core components of this benefit. We recognize that payment models need to be periodically reviewed and evaluated. Retaining value for all communities served is always critically important. However, as home health providers – along with physicians and patients we serve – we want to offer our expertise as leading home health providers to assist CMS in the development of strategic payment reforms that will allow more Medicare beneficiaries to be cared for in their homes as an alternative to more costly insitiutional care, in turn providing savings to the Medicare program.

Background

In 2017, CMS proposed a new payment model for the Medicare home health benefit. This was a model proposed to quickly transform the payment for these services, yet little data was available and it hadn't been tested nor had CMS received input from the provider community. CMS received many comments on the proposed rule from healthcare providers of all types, patients, and Congress. In the short comment period, we at the Partnerhsip for Quality Home Healthcare invested time and resources evaluating all components of the proposed payment model and shared our research, data, legal and policy analysis regarding the impact with CMS in our comment letter. We also made recommendations that CMS could undertake to ensure there would be no disruption in the benefit, including convening a Technical Expert Panel ("TEP").

Earlier this year, CMS convened a TEP to review the previously proposed payment model. That panel included representatives from all types of providers and organizations with a "hands on" understanding of the benefit – including its strength and weaknesses. CMS experts participated as did CMS consultants, Abt Associates ("Abt"). Many of those that participated viewed the meeting as very helpful and the TEP final report included many of our recommendations. However, in spite of broad based agreement by the Technical Expert Panel Members regarding this particular area of concern, the CY 2019 Home Health proposed payment rule made minimal changes in the newly proposed payment model (on page 239 of the 2019 proposed rule, CMS states, "refinements were made to the comorbidity case-mix adjustment while all other variables remain as proposed in the CY 2018 proposed rule"). In essence, the PDGM proposal is basically the HHGM proposal with a single minor modification.

We support CMS's efforts to reform the home health prospective payment system to more accurately align payment with patient characteristics, quality, and to remove utilization based incentives. We believe that by working together we can improve the Medicare home health benefit to meet the needs of patients more efficiently and effectively, and help control Medicare spending.

We are drafting comments to this year's proposed rule that will contain many of the points we raised in the comments we submitted last year. However, we want to raise the four issues that continue to be of greatest concern.

I. Concerns with the Patient Driven Groupings Model ("PDGM")

As highlighted, we appreciate the opportunity we had to work with CMS and Abt during the February 1, 2018 TEP. During this TEP, we provided feedback on many critical issues with PDGM, including issues relating to the clinical groupings, our concern about the use of cost report data, and other technical issues. As we previously mentioned, we were pleased to help inform the TEP and encouraged to see many of our recommendations included in the final TEP

Report. However,we are concerned that the proposed rule does not include many of the critical policy recommendations of the TEP nor did it explore the Risk Based Grouper Model.

Clinical Groupings

The clinical groupings approach presents several concerns that have not been addressed by the PDGM. While more than 55% of all episodes fall into a single clinical grouping (MMTA) and the TEP summary report stated that "[t]he majority of TEP members indicated that the MMTA subgroup should be split into subgroups," the PDGM does not adopt this recommendation. We have concerns about the accuracy of the payment model as a result.

Behavioral Assumptions

We are also concerned about CMS' proposal to make payment adjustments to address certain behavioral assumptions that have not yet been observed. The behavioral assumption in the proposed rule of negative 6.42% is concerning. We want to work with CMS to ensure that any assumptions are based on observed data and do not result in unintended consequences. This magnitude of assumed behavior change would well exceed any past actual behaviors exhibited by the industry in the years since the development of the current payment system.

Cost Reports

Further, we have concerns about the use of cost reports as the data source used in establishing the new payment rates. Costs reports are not audited by CMS and are inconsistent from provider to provider. The data upon which payment reform is based must be accurate and reliable.

Budget Neutrality

Another issue of particular concern with the proposed rule is that it appears to seek to interpret the requirement of budget neutrality by interpreting an overall spending limit for home health services. The proposed rule states at page 152: "if expenditures are estimated to be $18 billion in CY 2020, but expenditures are actually $18.25 billion in CY 2020, then we can reduce payments (temporarily) in the future to recover the $250 million." **We do not believe this was the intent of the law and we want to express our concern and hope that this is resolved quickly**. CMS has highlighted that an increase in volume of Medicare beneficiaries receiving home health care "may represent a positive outcome of the PDGM," but while recognizing the value of the benefit for patients it has also expressed a desire to cap home healthcare spending in spite of the dramatic growth in beneficiaries which is likely to occur over each of the next several years as the "baby boomer" generation continues to age. In reviewing overall home health spending, CMS must also consider the considerable savings generated for the Medicare program resulting from the shift of post-acute patients from institutional-based care to home

health care. This shifting to home based care is steadily increasing and is particularly apparent in various alternative payment models administered by CMMI.

It is also important to emphasize that there are many reasons, aside from the introduction of a new payment model, as to why total Medicare home healthcare spending can vary from estimates. For example, patient volumes may be greater than projected because the patients have been shifted to home-based care from more expensive care settings. Additionally, patients shifted to home healthcare may have multiple chronic conditions or illnesses at greater rates than years past and which require longer stays. We are concerned that the present model does not appear to reflect the other attributes or reasons that may affect the amount of spending on home healthcare.

II. Home Healthcare Stakeholders are Eager to Work with the Administration on Sensible Solutions

We would greatly appreciate the opportunity to meet with you to discuss ways we can help CMS move from volume-driven to value-driven payments based on patient characteristics. We are ready and willing to work with CMS to get the policy right by collaborating with CMS in providing data, information, the patient's perspective, and policy options to improve the home healthcare benefit.

Sincerely,

Keith Myers
Chairman
Partnership for Quality Home Healthcare