Proposed Clarifications to Medicare Home Health Payment Reform

Background:
The Bipartisan Budget Act (BBA) of 2018 (Public Law 115-123) contained significant reforms to the Medicare Home Health benefit and payment structure. Included in these reforms was a shift to a 30-day unit of service from the current 60-day model and authorization for the Secretary of Health and Human Services to make prospective and permanent adjustments to reimbursement rates based on assumptions of provider behavioral changes. These reforms are currently mandated to go into effect in calendar year 2020. Additionally, the BBA attempted to address problems associated with the long standing face-to-face/physician documentation certification requirement, but likely will not have the impact intended.

Issue/Concerns:

- As signed into law, BBA calls for a shift to a “30-day unit of service.” The intent behind this reform was to shift the 60-day payment episode to a 30-day payment episode while keeping a 60-day standard for service certification, patient assessment, and documentation. There is concern that CMS could interpret the “30-day unit of service” beyond payment and also apply the 30-day standard to service certification, patient assessment, and documentation requirements;
- Allowing for prospective “behavioral” adjustments based on assumptions and predictions poses the threat of unintended consequences that may end up creating a non-budget neutral payment system;
- By mandating a 2020 start date, providers and other stakeholders will not have the necessary time to evaluate, understand, or offer comment on the reformed payment system. Additionally, CMS may not have the time needed to implement the reforms for a smooth transition;
- With any large-scale reform, there is always the threat of unintended consequences. This situation is no different. In changes of this magnitude, a demonstration program would be useful to prevent confusion among CMS, MACs, and providers, as well as disruption to the delivery of high-quality care; and
- While the correction to the face-to-face/physician documentation certification was well intended, it lacks the directive necessary for its full impact to be realized. As signed into the law, the provision essentially codifies CMS’s current practice of possessing the option to consider the home health agency record in determining claim status.

This Proposal Would:

- Clarify that the 30-day unit of service would apply to reimbursement alone and not affect service certification, patient assessment, or documentation;
- Ensure that payment modifications would be based on objective evidence and data rather than preemptive assumptions and predictions;
- Modify the start date for reforms to take place from 2020 to no earlier than 2020;
- Require that the payment model be tested first under a demonstration. This would be implemented prior to 2022; and
- Make a directive that CMS also consider the home health agency record in conjunction with the physician record when determining claim status. This is optional under current law.