

Recommend CMS to be Cautious and Transparent in Their Annual Update

BACKGROUND

On January 1st the Patient-Driven Groupings Model (PDGM) officially took effect as the reimbursement model for the Medicare Home Health benefit. This model made significant changes from the former prospective payment system including: a shift from 60 to 30 day episodes of care, the removal of therapy utilization in payment determination, the elimination of requests for anticipated payments (RAPs), and a revised case-mix methodology. PDGM is intended to transform home health care to a more patient-centric approach that reimburses based on patient need rather than ill-placed incentives. While some of these laudable goals are met, there remains opportunity for improvement.

In transitioning to PDGM, CMS was required to do so in a budget-neutral fashion. To meet that standard, CMS decided it necessary to make assumptions of how providers might behave in the new PDGM model and correspondingly made cuts to the base payment rate to offset projected increases in spending as a result of the aforementioned behavior changes. The provider behavior assumptions CMS utilized focused on clinical documentation practices, an increase in full episode payments with a corresponding decrease in low utilization payment adjustments (LUPAs) that are paid per visit, and increased accuracy in comorbidity documentation. In total, CMS attributed these three behavioral assumptions to a 4.36% cut to payments in the first year of PDGM, CY2020. Under current laws, CMS maintains the ability to add and/or modify the assumed behaviors used in rate setting, as well as the amount tied to those assumptions. This creates an unsteady environment for home health providers, as they will be potentially exposed to annual rate fluctuations.

INSIGHTS

Following the implementation of PDGM there have been reports of misunderstandings of what the model changed. Some mistakenly think the nature of the benefit has changed, and that removal of therapy utilization in payment determination means that therapy is no longer covered. This is inaccurate as only the reimbursement model has been altered, not the actual provision of the home health benefit. It is likely these misunderstandings are a result of CMS's behavior assumptions.

With CMS in the midst of their annual rulemaking process for CY2021, there is fear that new or additional actions, including revised behavioral assumptions, could bring further destabilization and unintended consequences in the midst of what has already been the biggest upheaval to the Home Health benefit in 20 years. Unintended consequences and destabilization risks patient access to care.

What Congress Should Do:

Given that very limited data will be available to CMS in this year's rulemaking process, it is imperative an abundance of caution be employed in their policy making. Congress should provide ample oversight to ensure stability and full provision of the benefit is realized in practice. Specifically, Congress should:

- Recommend that CMS make no adjustments to 2021 rates based on further assumed changes in behavior.
- Encourage CMS to rely only on evidence of demonstrated behavior change in the marketplace that can be attributed specifically to the implementation of PDGM.
- Request CMS provide full transparency in their rulemaking to include the publicizing of the following: all assumptions, data, calculations, and methods used in updating the base payment rate and per visit LUPA rates.



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