CMS Administrator Promotes Telehealth for Home Health Agencies

According to the Medicare Payment Advisory Commission, around 3.4 Medicare beneficiaries received home healthcare services in 2016, for a total of approximately $18.1 billion spent, and including over 12,000 participating home health agencies. Now Seema Verma, Centers for Medicare & Medicaid Services (CMS) Administrator, is calling for remote patient monitoring to become a tool in home health agencies' toolbox as part of a more value-centric approach to care.

Verma released a statement earlier this month that encourages the agencies to use a telehealth platform to monitor patients whenever possible and appropriate (i.e., such as collecting vital signs, blood pressure, blood sugar, blood oxygen levels, weight, electrocardiogram readings and heartrate).

Verma noted that the benefit of a more expanded utilization of remote patient monitoring would allow home health agencies to achieve better results (to "leverage innovation to provide state-of-the-art care"), and would also free up more patient-time for physicians. Regarding the CMS proposal to classify remote patient monitoring as an allowable administrative cost, Verma said, "This will allow home health agency payment to reflect their use of innovative technology."

Studies have shown that using telehealth to monitor patients remotely (and to share data in real-time from provider to provider) not only can prove more efficient administratively and fiscally, but, more importantly, can result in superior health outcomes and more focused healthcare overall.

CMS proposes more spending toward home health agencies

The congressional Bipartisan Budget Act of 2018 tasked CMS with developing a new payment model in this regard. The proposed Patient-Driven Groupings Model (PDGM) suggests a $400 million increase (or about two percent) in Medicare reimbursement to home healthcare agencies, this in contrast to the $80 million (or 0.4 percent) cut that occurred last year.

If it is ultimately approved, PDGM would go into effect at the start of 2020. Administrator Verma believes it would be another step in the direction of a more value-based system for Medicare, at the same time ameliorating the administrative strain felt by home health agencies.

Currently, Medicare covers 60-day stretches of home health care, which includes payment according to the number of therapy sessions granted to patients. (the new payment system that CMS was tasked with implementing in Congress's) does away with including the number of therapy visits a patient receives, "because therapy thresholds encourage volume over value and does not acknowledge that all patients aren't the same, and some patients have complex needs that don't involve a lot of therapy."

Another change: the PDGM model would cover 30 days of home health care instead 60.

CMS says new model "removes the incentive to over provide"

Verma stressed that the proposed model would be in keeping with CMS's growing prioritization of value over

volume. Beyond that shift to a value-based focus, she noted a pragmatic logic underpinning the new model, stating that the proposed PDGM “removes the current incentive to overprovide therapy, and instead, is designed to reflect our focus on relying more heavily on clinical characteristics and other patient information to allow payments to more closely coincide with patients’ needs. Using patient characteristics to place home health periods of care into meaningful payment categories is more consistent with how home health clinicians differentiate between home health patients in order to provide needed services.”