Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1672-P
P.O. Box 8016
Baltimore, MD 21244-8016

September 25, 2017

Re: CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Dear Administrator Verma,

On behalf of ElevatingHOME, thank you for the opportunity to comment on the Home Health Prospective Payment System (HHPPS) proposed rule for CY 2018. The HHPPS proposed rule undercuts the industry's ability to serve patients, rather than investing in home-based care and laying a strong foundation for expanding patient access to services in the home and community. It proposes to dramatically and suddenly change the payment model for the entire home health industry.

ElevatingHOME strongly and unequivocally opposes the changes proposed in this rule as the changes will upend the entire home health model and result in significantly diminished patient access to quality home health services. ElevatingHOME calls on CMS to immediately withdraw the Home Health Groupings Model (HHGM) section of this proposed rule and engage in meaningful and collaborative development with home health industry leaders to develop any new payment models or alternative episode lengths. Specifically, CMS must rescind the HHGM portion of the proposed CY2018 HHPPS and instead release an Advanced Notice of Proposed Rulemaking (ANPRM) as was done with Skilled Nursing Facilities.

ElevatingHOME is a new industry organization launched to unify America's for-profit and not-for-profit home-based health (home health and hospice) care providers, and to advocate for high-quality, cost-effective care. ElevatingHOME's mission is to align, unify and strengthen the home-based care industry. Home-based care providers are critical components of value-based health care. These providers improve the health and wellbeing of patients, and address some of the most significant challenges in health care today. These challenges include medication management, uncoordinated care, and high rates of unnecessary hospital and emergency department utilization[i]. In addition to being an efficient service delivery model, patients continue to prefer their home and community for their care[ii] and, as a result, Medicare beneficiaries are increasingly utilizing home health services. ElevatingHOME works to strengthen and improve the delivery of high-quality and efficient care, and looks forward to working with the Centers for Medicare and Medicaid Services (CMS) to achieve this goal.

In its March 2017 report, MedPAC notes that the total number of home health users increased slightly in 2015, while the average number of episodes per home health user declined by 0.6 percent[iii]. During the same time, performance on home health quality measures improved, with the share of beneficiaries reporting improvements in walking and transferring increasing; and the share of beneficiaries hospitalized during their home health episode decreasing[iv]. By strengthening and supporting home-based care providers, the home-based care industry is improving patient outcomes, preventing and reducing unnecessary utilization of hospital and emergency department use, and preserving Medicare funding for the taxpayer and beneficiaries.

Home health patients are more vulnerable than other Medicare beneficiaries: 85 percent have three or more chronic conditions, as compared to only 62 percent of all Medicare beneficiaries[v]. Additionally, 48 percent of home health beneficiaries report fair or poor health, and 41 percent are in somewhat or much worse health than last year, as compared with 27 percent and 22 percent respectively for the general Medicare population[vi]. It is important to note that 27 percent of home health users report a serious mental illness, including depression or other mental disorders[vii].

Ensuring that these disproportionately vulnerable and medically complex patients have access to care in their homes and communities is a common-sense, cost-efficient way to provide them needed support. Investing in home health services will advance CMS' health improvement goals and provide targeted support for particularly vulnerable Medicare beneficiaries, making home health a critical component of high-quality, patient-centered, community-based health care delivery models.

Unfortunately, after years of rebasing and reductions in payment—and despite increased demand for home health services across all delivery models—CMS proposes another significant reduction in reimbursement that will impact access for patients. Many agencies, particularly those in rural, hard-to-serve areas, cannot sustain additional cuts. Continued payment cuts to home-based care runs counter to the high-quality, patient-preferred care option delivered at a lower cost to Medicare (over institutional-based care).

Home Health Grouping Model for CY 19

CMS proposes a new payment system, known as the Home Health Grouping Model (HHGM), for episodes beginning on and after January 1, 2019. The proposed payment model will:

- Pay a percentage of a national average payment amount based on a set of weighted patient characteristics;
- Include adjustments for low utilization (LUPA), partial episodes (PEP), and outliers;
- Reduced episode-length to 30 days; and
- Modify the Home Health Resource Group (HHRG) methodology used to determine the percentage adjustment including elimination of therapy visits and differentiation between institutional and community-based admits.

ElevatingHOME recommendation:

ElevatingHOME opposes the proposed HHGM and strongly urges CMS to rescind this provision. Instead, CMS should:

- **Release an Advanced Notice of Proposed Rulemaking (ANPRM) as was done with Skilled Nursing Facilities. This would allow for true collaboration, review, testing and revision prior to implementation.**
- **Engage in collaborative initiatives with home health industry leaders to develop new payment models or alternative episode lengths.**
- **Provide voluntary demonstration programs to test new models and, if necessary, revise the model based on the demonstration outcomes prior to national implementation.**

First, it is important to note that the Home Health Groupings Model (HHGM) proposal is not budget neutral. CMS estimates that it will result in a significant reduction of 4.3 percent in overall payments *in 2019 alone*—that is close to one billion dollars in additional cuts to the home health system. It is disingenuous to suggest that this policy is anything more than a budgetary exercise to further cut home health payments. This is a cut in reimbursement—a cut that will disproportionately hurt the most vulnerable home health patients, including community members and those with multiple chronic conditions. Cuts of this magnitude will result in diminished access to care, disincentives for agencies to serve (or not serve) certain types of beneficiaries, and strain agencies' ability to serve all patients who need home health services.

The massive shift from the traditional home health episode to HHGM is a radical change in how home health services are reimbursed. It uses an entirely new and significantly different case mix model focused on patient characteristics. It also shifts Medicare home health from a 60-day episode of care payment model to a 30-day episode of care payment model effective January 1, 2019. Most alarming, this radical change has been modeled only on paper and has never been tested by any agency in any area of the country.

The mandatory implementation of an entirely untested payment model is inappropriate and unprecedented. There is no real-world implementation or stringent evaluation of the model available for review, and no complete analysis to fully understand its impact on our industry. The group modeling tool was only released with the proposed rule, making it extremely difficult to fully interpret during the shortened comment period.

ElevatingHOME has read CMS' technical report on the HHGM and understands that in some respects, the structure of the HHGM is similar to the structure of the current payment system, including point scoring for functional items and different payments depending on the timing of the episode[viii]. We also acknowledge that a prospective payment system that is applied to a national average will result in significant variation between actual costs and payments both for individual patients and individual agencies. CMS has stated that their overarching goal is to achieve a system which, on average, pays appropriately for the care needed by patients and is appropriately adjusted to meet their unique needs. However, we are extremely concerned about the *specific* impacts of this proposed change, particularly since it is being implemented quickly and without any real-world testing. It is going from a CMS-commissioned modeling paper to nationwide mandatory participation with no steps in between. CMS refused numerous requests in the last 12 months to release the information and methodology needed to estimate the impact on agencies. Information was first available and released in the proposed rule on July 25, 2017.

Overall Agency Impact and Impacts on Beneficiaries

Given the abbreviated comment period caused by the late release of the proposed rule and the necessity to have the final rule approved by November 1st for a January 1, 2018 rate update,

ElevatingHOME members are not able to fully model the impact on their agencies or the industry overall. The grouper tool is complicated and requires a significant investment in staff time to understand how the HHGM proposal will impact an individual agency. However, ElevatingHOME members report several important and troubling findings from their preliminary analysis using the grouper modeling tool. The modeling outcomes have demonstrated consistent underpayment and adverse incentives for high-quality home-based care services.

Specifically:

1. *HHGM underpays for community-admitted users*

Community referrals, currently 60 percent of all Medicare home health episodes[ix], experience the most severe payment reductions. ElevatingHOME members support community referral episodes -those episodes not preceded by a hospitalization or post-acute care stay - and these patients continue to have a larger share of episodes over institutional referrals[x]. This trend can be expected—*and is desirable*—given the policy shift toward preventing and reducing primary hospitalization rates. Investing in services to keep this population in the least costly setting—the home and community—should be a core goal of Medicare payment policy. However, the grouper modeling tool indicates that agencies will be paid less for community-admitted users, as compared with those episodes preceded by an institutional stay. This creates a perverse incentive for agencies to move away from serving patients from the community and will limit access for these beneficiaries. Reduced access to home-based care will likely result in an increase in emergency department visits, an increase in hospital admissions and increased use of higher cost institutional care for patients who could otherwise have pre-acute conditions successfully managed in the home.

2. *HHGM underpays for patients with chronic conditions.*

Similarly, the proposed HHGM is not conducive to stabilizing and managing patients with significant chronic conditions. This represents more than 60 percent of the care home health provides to patients. By only considering if there is a co-morbidity and narrowing which chronic conditions and patient needs "count," this model will not represent the full complexity of the patient nor allow for full support and stabilization under the proposed payment. Supportive case management and patient stabilization services for patients with chronic conditions helps prevent rehospitalizations and allows patients to remain at home., In addition, these services are aligned with advanced payment models in MACRA/the Quality Payment Program.

Eligible clinicians rely on home health care to reduce their Medicare "spend" per patient and increase quality outcomes. This is done through a variety of methods including reliance on home health providers over skilled nursing facilities and successful chronic care management that reduces emergency room visits, hospitalizations and skilled nursing facility admissions.

3. *HHGM negatively impacts access to care in rural areas*

The proposed HHGM will reduce access to services in some rural areas, leaving those areas without home health care. Some agencies have indicated that they would no longer be able to provide care in some rural counties where they are currently the only provider. This would result in areas of the country where patients would not have access to any home health care.

4. HHGM disincentivizes behavioral health care and medication management

The proposed HHGM disincentivizes behavioral health care and medication management, training, and assessment episodes that help support individuals that prefer to stay at home. Behavioral health and Musculoskeletal Rehabilitation, both growth areas of home health care, will be reimbursed at significantly lower levels. ElevatingHOME opposes the decrease in payment for Medication Management, Teaching and Assessment (MMTA) episodes (over 66 percent of home health episodes based Medicare claims data) as MMTA episodes are vital for the stabilization of patients upon their return to home. Many patients and their families need assistance and training for a successful transition.

5. HHGM results in dramatic payment reductions

If HHGM is implemented, agencies would experience an average payment reduction of 17 percent from FY2017 rates. Home health agencies already operate on razor-thin margins, with large unreimbursable costs in technology, staff training, workforce development and reporting. Cuts of this magnitude are unsustainable. When modeling the shift from full 60-day episodes to 30-day episodes, ElevatingHOME members found that 34 percent of episodes would only be eligible for one 30-day episode. Based on conversations with ElevatingHOME members, many agencies are serving individuals where their cost-of-care already exceed the Medicare reimbursement. The proposed payments will not reflect the true costs of care, will underestimate the travel times and costs, and will exclude patient monitoring technologies that are not covered by traditional Medicare fee-for-service payment.

Implications of Revised Case Mix Model in HHGM

The revised case mix model is a radical departure from the existing case mix and will result in episodes that are not sufficiently reimbursed at a sustainable rate. Most notably, it entirely eliminates the therapy visit volume payment determinant that exists in the current model. CMS proposes 144 Home Health Resource Groups that determine the percentage of a standardized 30-day national payment rate that incorporates consideration of average agency resource use and costs, including those for non-routine medical supplies. ElevatingHOME offers the following comments on the model:

Musculoskeletal Rehabilitation

Over 10 percent of Medicare home health episodes[xi] are for Musculoskeletal Rehabilitation. This is an area of significant growth as a result of both the Comprehensive Joint Replacement (CJR) bundles and general medical care. Research shows higher quality outcomes and significant cost savings when this rehabilitation occurs in the home over institutional settings.[xii] However, under HHGM, CMS lowers the payment rates for this care. Many ElevatingHOME members are investing in technology to improve interoperability and communication with hospital orthopedic department and freestanding orthopedic providers. Members are very concerned that the lower reimbursement for this care that includes effective use of therapy, home health and interaction with the orthopedic teams will impact the great efficiencies and high-quality outcomes

Neurological Rehabilitation

Over eight percent of Medicare home health episodes are for neurological rehabilitation[xiii]. Rehabilitation in the home of patients who have suffered stroke and other neurological traumas continues to grow and this is an area of growth for home health agencies. The Centers for Disease Control and Prevention cite stroke as one of the leading causes of disability in the

United States. The costs of caring for stroke rehabilitation services in an inpatient setting over a home setting are nearly double.[xiv] The proposed payment for HHGM neurological rehabilitation episodes for early institutional referrals seem to be sufficient for care, however, neurological rehabilitation is not typically resolved in 30 days, requiring subsequent episodes of care. It is those later episodes where the significantly reduced payment is insufficient.

Behavioral Health

While behavioral health currently only represents three percent of Medicare home health care[xv], the need for behavioral health care services in the home and community continues to grow. The National Institutes of Mental Health, a division of National Institute of Health, reports that in any given year about 26 percent of adults have one or more diagnosable mental disorder. Six percent of those are disabled by a mental condition or are seriously mentally ill.[xvi] Moreover, mental health services include patients who are recovering from substance abuse and alcohol addiction. Serving these patients is an important national priority and all efforts should be focused on supporting care, not eliminating providers. Through HHGM, CMS is disincentizing home health agencies from providing this level of complex care as shown by the reduction in payment modeled for all levels of behavioral health care in comparison to episodes of care provided in FY2017.

Complex Nursing Interventions

Only about one percent of the care received in the home is for complex nursing interventions,[xvii] but is critical as more fragile patients discharge from hospitals straight home. Home-based care provides critical stabilization and transition care in addition to providing high-level care to patients receiving cancer treatments and recovering from serious injuries. Appropriate support to sustain this option is vital and ElevatingHOME agrees with the importance HHGM places on these complex patients through its proposed payment rate.

Wound

Over ten percent of home health care is for wound care.[xviii] ElevatingHOME supports ensuring that the proposed HHGM payment rate is sufficient for all levels of care and through both referral sources. This is important as most wound care referrals come from a community setting. Agencies enable patients to receive this treatment in their homes with high quality outcomes, high patient compliance and lower costs over care provided at wound care centers and hospitals.

Medication Management, Teaching and Assessment

Linking payment to the needs of the patient is a laudable goal. However, the proposed HHGM payment model does not consider the full patient and is not indicative of the level of effort needed to stabilize and maintain patients safely in their homes. This type of care is seen with all types of home health care episodes, but is the key component for supporting those with chronic conditions. Over 54 percent of Medicare home health care patients have five or more chronic conditions. Effective management of this population's costs and care is vital to stabilize and control expenses related to unnecessary rehospitalizations.

Adjusting for Diagnoses and Co-morbidities

ElevatingHOME has serious concerns with how the HHGM model adjusts for a primary diagnosis for the Clinical Grouping, as well as for multiple diagnoses and co-morbidities, which are common for home health patients.

Specifically, ElevatingHOME is concerned that claims will be rejected as "questionable encounters" if the primary diagnosis is insufficient to establish a Clinical Grouping. Agencies who have modeled their episodes using the Grouper Tool have found that 24 percent of their episodes are deemed "questionable"—a rate consistent with Abt Associates' 23.9 percent estimation[xix]. This means that 24 percent of claims will likely be rejected and returned to the provider for correction or more definitive coding. The returned claim will have the opportunity to offer new coding. However, there are a portion of episodes that do not fit in any of the six-episode domains.

ElevatingHOME is also concerned that secondary diagnoses will not be used to support primary diagnosis groups. Instead, secondary diagnoses will only be used to determine if a comorbidity adjustment is warranted. This is a missed opportunity to support primary diagnosis and to ensure the appropriate clinical grouping. Further, Abt's overview report of the Home Health Groupings Model[xx] discusses home health beneficiary's multiple health conditions and the current lack of complete documentation by home health agencies and ordering physicians. ElevatingHOME is concerned that when agencies consistently begin capturing secondary diagnoses, CMS will see this as agencies "gaming" the system, rather than providing a more complete picture of the patient.

In order to minimize claim rejections and increased backlogs of denial appeals, CMS must undertake significant education, outreach and communication for ordering physicians and home health agencies to comply with this new requirement. At the same time, CMS must accept that data shows the majority of home health patients to have multiple chronic conditions and that many patients will qualify for the co-morbidity adjustment.

Functional Level Determinations in HHGM

CMS proposes three Functional Categories: Low, Medium, and High, and provides a detailed rational for the inclusion or exclusion of various OASIS items to make this assessment. This is tied to OASIS items linked to activities of daily living (ADLs). However, when ElevatingHOME members modeled their patients using the Grouper Tool, they found that their patients were consistently scoring at much lower functional categories than anticipated based on their patients' characteristics. This disparity seems to indicate that the payment model is not able to accurately predict or consider the true functional level of the patient. This will result in inappropriate payments for patients in the short term—and agencies will have diminished incentives to serve complex patients if they know that they will be routinely underpaid for the complexity.

Low Utilization Payment Adjustment Determinations in HHGM

CMS proposes to maintain LUPAs (Low Utilization Payment Adjustments), however, through HHGM there will be new visit thresholds required by the specific episode type and intensity. ElevatingHOME is concerned that the new proposed LUPA thresholds now require significantly more visits to qualify as a full episode. Many agencies have found that their level of LUPAs instead of full episodes under HHGM has increased by 28 percent over their current 2017 levels. This threshold increase represents another payment cut to agencies.

Requests for Anticipated Payment

CMS does not propose changes to the RAPs (Requests for Anticipated Payment) requiring a NOI (Notice of Intent). They will still be paid in 2019 at the current 60/40. The proposed rule notes that other providers, like Hospice, are satisfied with 30-day payment cycles and do not submit NOIs or receive RAPs. Home health agencies agree that it will be important to maintain the RAP system. However, there

is concern that the timing of data submissions and payment will be out of sync, and that there will be additional complexity in the system. ElevatingHOME stresses the importance of educating the Medicare Administrative Contractors (MACs) and clearly articulating the system needs for both the MACs and the agencies.

CMS' goal should be to support—not harm—patients, and to encourage more care in homes and communities. The HHGM proposal represents a significant step backwards in patient care and system transformation. If this proposal is implemented, beneficiaries will lose access to high-quality health care in their homes, with the greatest impacts being felt by the most vulnerable patients. ElevatingHOME reiterates our objection to the HHGM proposal and instead encourages CMS to work with stakeholders, home health agencies and patients to transform the system and to bring high-quality care to patients into the home.

Home Health Rate Update for CY2018

CMS proposes that Medicare payments to HHAs in CY 2018 be reduced by 0.4 percent, or $80 million. The proposed decrease reflects the effects of:

- a 1 percent home health payment update percentage ($190 million increase);
- a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and
- the sunset of the rural add-on provision ($100 million decrease).

ElevatingHOME recommendation:
ElevatingHOME strongly opposes the overall reduction in payment rates to home health agencies. The proposed 0.4 percent reduction must be replaced with an overall payment increase that reflects the critical role of home-based care in value-based health care delivery models.

The home-based care industry has sustained years of payment changes that have not kept pace with the cost of providing high quality care. At the same time, it has been required to invest in burdensome and expensive reporting requirements. This path is unsustainable and further payment reductions will negatively impact home health patients and create barriers to accessing care.

While CMS maintains that the home health margins are too high against an unspecified standard, our members' experience is that Medicare payment rates already do not keep pace with the cost of caring for complex patients and maintaining a qualified and trained workforce. Further, existing payments fail to take into account the many other factors that are required to deliver and maintain high quality, patient-centered care. These costs include high labor, staff training costs, and investments in health IT.

- Investment in new technologies can improve access to care[xxi], improve care coordination, patient support and real-time monitoring.[xxii] New technologies may also be used to improve coordination with caregivers and community-based organizations. However, these technologies—and other costs associated with training staff and routine updates—require significant and ongoing investment and are not reimbursed.
- New data collection and reporting requirements require additional technology, workforce and training. A 2015 Pricewaterhouse Cooper's cost trend report[xxiii] cited that increasing technology costs account for 2 percent growth in administrative costs alone, per year.

- Preparing for value-based purchasing requires significant investment in new infrastructure.[xxiv] Providers must acquire/update data systems and analytics, invest in connections to community partners, build business acumen through talent recruitment and training, and develop and deploy evidence-based clinical guidelines. CMS' experience with other value-based purchasing initiatives demonstrates the need for these investments during the period of transition.

The proposed 0.4 percent cut will have the unintended but inevitable effect of reducing investment in infrastructure, thus compromising the future viability of providers. Cutting rates to the extent proposed will ensure that home health providers cannot be successful in the proposed value-based purchasing program or other health care system transformation. It will also ensure that patients and communities are not provided the advantages of new technologies such as telehealth.

In addition to providing access to health care services, home health agencies are employers and economic generators. An analysis by Avalere estimated that almost 1.9 million jobs were created by the home health industry nationwide.[xxv] As reimbursement rates are pushed further downward, agencies will be forced to make staffing choices that limit job growth and creation. Rather than investing in their workforce, agencies will need to retract and rebalance. A reduction in the workforce will also negatively impact patients' access to care, as agencies may not be able to serve as wide an area or be able to accept all patients because of insufficient staffing.

ElevatingHOME also expresses strong support for extending the rural health add-on. This will require Congressional action and we have called on Congress to act in a bi-partisan, bi-cameral way to quickly ensure that these critical payments are extended. These payments offer critical support to home health providers in rural areas and help to mitigate the challenges of service homebound patients in rural, hard-to-access locations.[xxvi]

Home Health Value Based Purchasing Demonstration

CMS has proposed the following changes to the Home Health Value Based Purchasing (HHVBP) program:

- to amend the definition of "applicable measure" to specify that the HHA would have to submit a minimum of 40 completed surveys for Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) measures to a performance score for any of the HHCAHPS measures, and
- For performance year (PY) 3 and subsequent years remove the Outcome and Assessment Information Set (OASIS)-based measure - Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care.

ElevatingHOME recommendation:

ElevatingHOME supports the alignment of the quality and reporting metrics to ease potentially conflicting and burdensome requirements asked of providers, but requests monitoring in implementation.

In this proposed rule, CMS moves to provide standard measures for both the Patient Survey Star Ratings system and the HHVBP model, and they propose that HHVBP HHCAHPS measures use 40 (rather than 20) completed surveys. The stars rating system already requires the use of 40 HHCAHPS surveys for a

participating HHA. This ensures enough variation to minimize random variations, but also provide star ratings for as many HHAs as possible.

CMS must carefully monitor the impact of this policy on small-volume agencies to ensure their continued ability to fully participate in value-based purchasing arrangements and to have an equal chance to benefit from providing high quality care.

ElevatingHOME members range from large agencies to small. Home health agencies often experience fluctuations in caseload from month to month, particularly small agencies. In the proposed rule, some data suggests a limited change overall in benchmarks and on total performance scores. We appreciate this analysis and agencies found for the most part there were consistencies in the scoring. We are particularly interested in additional data on the impact on the small volume agency cohort, who will be most affected by this change.

ElevatingHOME has worked with our members to analyze their concurrent interim performance reports that analyzed 20 and 40 HHCAHPS surveys across both large and small cohorts in determining quality measure scores. A few members have expressed concern about the "weight" that would be carried by a few fragile patients in small volume agencies. This weight could cause small volume agencies to score lower against their cohorts and result in overall payment reductions.

Currently, an HHA must generate performance scores on at least five applicable measures. If an HHA does not have a minimum of 20 episodes of care to generate a performance score on at least 5 measures, that HHA would not be included in the comparison or have a payment adjustment percentage calculated. Currently, "applicable measures" are those for which an HHA has provided a minimum of 20 HH episodes of care per year for the Oasis-based measures, 20 HH episodes per year for the claims-based measure, or 40 completed surveys for the HHCAHPS measures.

We express a concern—and request careful monitoring—of the number of agencies that are unable to meet this threshold. If the number of agencies that cannot generate performance scores on at least 5 measures increases, this policy must be reevaluated. As participation in the HHVBP demonstration is mandatory, all agencies must have the full opportunity to participate in, and benefit from, quality metrics. This is equally true for small-volume agencies that should not be penalized for their small case-load.

Home Health Quality Reporting Program

CMS proposes several changes to the Quality Reporting Requirements including:

- the replacement of one quality measure;
- the adoption of two new quality measures; and
- the reporting of standardized patient assessment data in five categories described under the IMPACT Act.

CMS solicits comments on the application of NQF measures developed for a different care setting to be applied to home health care. Social risk factors are most appropriate for reporting stratified measure scores and potential risk adjustment. Overall, ElevatingHOME supports the changes made to the quality-reporting program, however, there are two areas of concern.

First, it is important that the Quality Reporting Program appropriately synergize with any new quality requirements established by a new payment system and with the Home Health Value Based Purchasing Program. Any deviation among programs adds confusion and complexity at a time when there are significant ongoing changes in home health, such as Conditions of Participation, bundles, and the increased prevalence of managed care models.

Second, many of these additional OASIS measures are representative of the presence of services and are not a true measurement of clinical quality and patient outcomes. More directly, quality measures are determined through measurement of safety, patient-centered, equitable, timely, effective and efficient while OASIS measures are used to determine resource use. These are important distinctions and should be addressed as such. There is no evaluation of these measures being effective or efficient. These measures only equate to care demand across settings. While these items will allow for an improved description of patient need or acuity, these are not informative to the quality of care.

Request for Information

CMS invited comment on regulatory, subregulatory, policy, practice and procedural changes to reduce unnecessary burdens for clinicians, provider and patients/families, and to increase quality of care, reduce costs, improve program integrity, and make the health care system more effective. ElevatingHOME envisions home-based care providers as an integral and critical component of high-quality health care delivery models. ElevatingHOME advances the principles across the care continuum that health care starts at home, that the home is a lower-cost setting for care delivery, and that outcomes are often best at home. However, the home health industry is subject to a complex and duplicative set of the regulations that limit innovation and access. HHS can increase access to home health services by eliminating the following regulations:

- Face-to-Face Documentation: Eliminate all provisions of P.L. 111-148 Subtitle D, Sec. 6407 (Affordable Care Act) which modified Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act and remove the Office of Medicare Hearings and Appeals (OMHA) Facilitation's Settlement Conference Facilitation (SCF) pilot thresholds.
- Stratify the Improper Payment Rate: Stratify the improper payment rate for home health services section by improper documentation, overpayment, underpayment and inappropriate care in the yearly *Medicare Fee-For-Service Improper Payment Report*.
- Pre-Claim Review Demonstration: The pre-claim review demonstration should be officially and permanently rescinded.

Advancing regulatory reform by promoting common-sense measures to support and advance care in the home and the community makes sense for providers, tax payers and beneficiaries alike. More detail on each of these provisions follows.

Face-to-Face Documentation

The Affordable Care Act includes a requirement that a face-to-face encounter between a patient and a provider take place prior to certifying the need for Medicare home health services. CMS issued a Final Rule on November 16, 2012 that outlined the requirements for this encounter and other provisions with which the home health agency must comply or may not bill for the service. A Medicaid face-to-face encounter rule was finalized on February 2, 2016.

The implementation of this provision has been deeply flawed and inconsistent, and the impact on home health agencies and beneficiaries has been profoundly negative. The face-to-face encounter is between a physician and a patient—home health agencies are not able to control this event nor ensure appropriate documentation. Yet, home health agencies are subject to non-payment if the documentation requirements are not fulfilled. A dramatic and significant increase in the rate of "improper payments" to home health agencies occurring immediately upon implementation of the face-to-face documentation requirement is sufficient evidence of the adverse impact on the home health industry. For example, in 2013, the year prior to the start of Face-to-Face, the improper payment rate for home health care was about 17.3 percent. Following the implementation of Face-to-Face, improper payment rates skyrocketed to 51.4 percent in 2014 and 59 percent in 2015.[5] According to HHS[xxvii], a backlog exists of more than 800,000 appeals from health care providers challenging denied Medicare claims. Providers repeatedly experience conflicting guidance from the MACs, including incomplete or non-functioning websites and erroneous decisions resulting in additional appeals to a system that is already faltering under the weight and number of payment denials and appeals. Eliminating this regulatory requirement would significant reduce regulatory burden on home health agencies, MACs and the ALJ system.

Despite skyrocketing increases, Administrative Law Judges (ALJ) have found in favor of home health care providers in more than 83 percent of the cases.[xxviii] These reversals lend credence to the belief that the bulk of the documentation errors result from confusion and lack of clarity from the Medicare Administrative Contractors (MACs) on CMS' behalf.

Removing the appeal threshold amounts of $100,000 for one claim or 50 claims totaling at least $20,000 for Part A or $100,000 for one claim or 20 claims at $10,000, would increase the ability of home health agencies to participate in the Office of Medicare Hearings and Appeals (OMHA) Facilitation's Settlement Conference Facilitation (SCF) pilot. The SCF Pilot is one of many necessary attempts by OMHA to curb the growing backlog of Medicare appeals that began to accumulate in fiscal year 2012, when more requests for hearing were filed than could be adjudicated.[xxix] Specifically, OMHA estimated that providers that filed an ALJ hearing request after April 2013 could expect a delay of up to three years before a hearing would be held[xxx]. Currently, OMHA receives as many or more appeals every two months than it can process in a full year, and "figures suggest that at current rates, some already-filed claims could take a decade or more to resolve."[xxxi] This demonstration allows providers to remain "in line" with the traditional appeal process, but allows them to take advantage of the settlement agreement process which trims the timeline to approximately eight months from the date filed.

Recommended Action: Eliminate all provisions of P.L. 111-148 Subtitle D, Sec. 6407 (Affordable Care Act) which modified Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act and remove the Office of Medicare Hearings and Appeals (OMHA) Facilitation's Settlement Conference Facilitation (SCF) pilot thresholds.

Stratify the Improper Payment Rate

The home health industry is repeatedly accused of "improper payment rates" and false implications that the majority of home health care is fraudulent. CMS should stratify the improper payment rate to show that the bulk of the improper payment comes from a lack of or insufficient documentation.

ElevatingHOME suggests that the rate disclose the percentage of the rate related to:

- Documentation (incomplete or lacking)

- Overpayment
- Underpayment
- Inappropriate Care

Dr. Shantanu Agrawal, former Deputy Administrator and Director of the CMS' Medicare Integrity Program Office, stated in his May 24, 2016 testimony before the U.S. House of Representatives Committee on Energy and Commerce[xxxii] that the majority of the 59 percent of improper payments were because of poor or incomplete documentation.

Recommended Action: Stratify the improper payment rate for home health services section by improper documentation, overpayment, underpayment and inappropriate care in the yearly *Medicare Fee-For-Service Improper Payment Report*.

Pre-Claim Review Demonstration

This mandatory demonstration project was implemented in 2016 through a Paperwork Reduction Act (PRA) notice. While paused, ElevatingHOME believes that it is vital that the demonstration be fully rescinded.

During a pre-claim review, agencies are required to submit all documentation and claim paperwork to be approved before the claim can be submitted. The paperwork had to be approved in advance of submitting the claim. This step verified the appropriateness of the services and the eligibility of the patient. However, according to the Conditions of Participation for home health agencies, agencies must start providing services for patients within 48 hours of getting the referral or within 48 hours of the patients returning home. This means that agencies were treating the patient with no guarantee that their claims would be paid.

The impact on the agencies was profound and created a tremendous new paperwork burden *on top of* all other paperwork home health agencies are required to submit. Agencies reported spending 58 additional minutes for the first "pre-claim" submission for each beneficiary they serve. They reported one hour and 17 minutes for re-submissions.

While purporting to address waste, fraud and abuse, the Pre-Claim Review Demonstration is a blunt policy instrument that targets all providers and puts a disproportionate burden on good actors. Further, these efforts are duplicative of the face-to-face requirement. Nothing in the Pre-Claim process would stop bad actors from submitting falsified claims; Pre-Claim programs have no mechanism to identify these bad actors. Ultimately, this demonstration added little additional value in preventing fraud but resulted in improperly delayed or denied payments to agencies.

Recommended Action: Rescind the 6/21/16 Paperwork Reduction Act Notice CMS-10599.

Conclusion

CMS must engage in collaborative development with home health industry leaders to develop any new payment models or alternative episode lengths. CMS must pull back the HHGM portion of the proposed CY2018 HHPPS and instead release an Advanced Notice of Proposed Rulemaking (ANPRM) as was done with Skilled Nursing Facilities. This would allow for true collaboration, review and revision prior to implementation. ElevatingHOME requests that CMS call a meeting of providers and associations

after they have withdrawn the proposed Home Health Grouping Model so that we can begin a collaborative discussion on a new payment model.

Thank you again for your consideration of our comments and serious concerns. Please contact Joy Cameron, Vice President of Policy and Innovation to further discuss our concerns and hopes for future collaboration.

Sincerely,

Tracey Moorhead

President and CEO

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[xxx] *Medicare Appellant Forum*, Office of Medicare Hearings and Appeals, February 12, 2014, *supra* at pgs. 20-1. OMHA estimates a 28-month delay before a request for hearing is assigned to an ALJ. Once assigned, OMHA estimates an additional six-month delay before the hearing is held.
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[xxxii] Dr. Shantanu Agrawal 5/24/2016 U.S. House Energy and Commerce testimony quote "One area in Medicare fee-for-service on which we are focusing our efforts is in home health services, which have had particularly high improper payment rates in recent years, mainly due to documentation errors." http://docs.house.gov/meetings/IF/IF02/20160524/104979/HHRG-114-IF02-Wstate-AgrawalS-20160524.pdf