August 31, 2018

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1869-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, Maryland 21244-8013

Submitted via: regulations.gov.

Re: CMS–1689-P: Medicare and Medicaid Programs: CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National accrediting Organizations

Dear Administrator Verma:

ElevatingHOME and VNAA submit the following comments on the CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National accrediting Organizations.

ElevatingHOME and VNAA advance quality, value and innovation in home-based care and represents mission-driven providers of home and community-based health care, including hospice, across the United States. Our members provide high-quality, patient-centered care at home, as well as offer support for family caregivers. ElevatingHOME is an 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, affordable care. ElevatingHOME was formed by the leadership of the Visiting Nurse Associations of America (VNAA) with leaders and stakeholders from across the country. ElevatingHOME and VNAA are striving to align, unify, and strengthen the home-based care industry.

Our specific comments on the proposed rule follow.

Payment

We appreciate CMS' positive home health payment update. With so many changes impacting home-based care providers; Home Health Value Based Purchasing, the IMPACT act implementation, Review

Choice Demonstration and a massive payment reform change proposed. It is vital to invest in agencies providing care to the ever-growing Medicare population.

Payment Reform

ElevatingHOME and VNAA support CMS in its efforts to reform the payment model. While we agree that linking payment to the patient is admirable should be the focus of payment, we strongly believe that there is still more work to be done on the Patient-Drive Grouping Model.

Timing

ElevatingHOME and VNAA are concerned that the nationwide implementation of PDGM on January 1, 2020 will be too complex and large a set of changes for home health agencies to navigate smoothly given the short timeframe. PDGM as proposed is a dramatically different payment system for Medicare home health services. The proposed PDGM would make numerous, multi-dimensional, and complex changes to HHPPS. While the Bipartisan Budget Act of 2018 identified the start day as January 1, 2020, we believe that with CMS' encouragement, there could be a minor adjustment of "no sooner than…" which would allow sufficient time to make sure that the implementation and any methodology refinement is handled without potentially impacting patients.

Medicare Population and Home Health

Every day 10,000 more Americans qualify for Medicare. Further, these new enrollees are much more familiar with care provided outside of institutional settings and prefer recovery at home. Changes in the health care delivery system may also result in increasing aggregate expenditures. For example, to the extent that bundled payment arrangements and other advanced payment models may result in less use of facility-based care, home health may see increases in utilization. This care is safe, effective and high-quality care that is highly preferred by many patients and their families.

The growth in home health care should be anticipated and accounted for in estimations of budget impacted. Such changes will yield savings for the larger Medicare program, but may appear to be increases within the silo of Medicare home health expenditures but should not cause penalties to agencies.

Budget Neutrality and Behavioral Adjustments

Consistent with the statutory Bipartisan Budget Act of 2018 language on behavior change assumptions that are limited to only those resulting from implementation of the 30-day payment period and the case mix adjustment factors, CMS should only make adjustments (temporary or permanent) that specifically relate to actual behavior changes attributable to the implementation of the 30-day payment period and case mix adjustment factors.

This is a critical distinction because there are many factors outside of a home health agency's control that may affect aggregate home health expenditures. For example, as the baby boomer demographic group ages, growing numbers will suffer from both chronic conditions and functional limitations and many will eventually become homebound. It is predictable that such demographic and legitimate case

mix changes will result in growing numbers of vulnerable Medicare beneficiaries who will need home health care. In service to these beneficiaries, home health aggregate expenditures may rise.

CMS should clarify the scope of adjustments it will make as it assesses actual behavior changes and the impact on aggregate expenditures. CMS should only make adjustments that relate specifically to actual behaviors attributable to the change to a 30-day unit of payment and the case mix adjustment factors, not demographics and patient preferences.

Methodology for Determining and Making Adjustments

In addition, it is unclear what methodology CMS will use to update its data over time and how this will affect the way CMS determines any adjustments. For example, in next year's proposed rule, CMS would make assumptions and calculate the 30-day budget neutral payment amount (and HHPPS rates) based on CY 2018 data to set CY 2020 rates.

- Because the behavioral assumptions will be based on CY 2018 data, will CMS attempt to update its assumptions using CY 2020 data before comparing actual behavior to assumed behavior?
- How will the delay in the availability of clean claims affect the timing of CMS's assessment of behavior changes attributable to the statutorily required reforms, and subsequent adjustments?

CMS should clarify its methodology used to compare actual behavior to assumed behavior in making temporary and permanent adjustments. Further it is recommended that CMS use clean claims to make any home health payment reform assessments and adjustments required in the Bipartisan Budget Act of 2018.

Furthermore, there is concern that the potential magnitude of future temporary and permanent adjustments. Steep cuts would have a negative impact on home health agency operations and the ability to deliver high quality services to Medicare beneficiaries. Ultimately, negative adjustments could have a negative impact on patient access to quality care.

In the event that budget neutrality reconciliation necessitates a rate change of 2% or more, CMS should phase-in the reconciliation over two or more years depending on the level of rate change needed.

Admission source

Community referrals, currently 60 percent of all Medicare home health episodes, experience the most severe payment reductions. 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. 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, PDGM 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. Additionally, there is concern about how observation stays, but not admission in hospitals and other care anomalies such as surgical outpatient centers will be handled in the determination of location of referral.

The application of an admission source measure may seem warranted given data demonstrating different resource use but using such a measure could have the unintended effect of incentivizing HHAs to give priority to post-acute patients over those who are admitted from the community. This seems to be somewhat at odds with the overall goal for Medicare and Medicaid to provide more care at home to reduce the use of more expensive emergency room, hospital and skilled nursing home care. In addition, using an admission source, rather than a true measure of the patients acuity falsely assumes that patients discharging from a facility are inherently sicker, which is not wholly accurate.

The financial impact of the PDGM admission source measure also highlights the inherent weaknesses with all the other PDGM measures. If the admission source measure is withdrawn from PDGM, the use of the remaining measures certainly results in an unacceptably weak case-mix adjustment model.

The weight given to the admission source measures is comparable to the weight given to the Utilization Domain measure of therapy visit volume in the current HHRG model that has been criticized for creating the risk of abusive utilization incentives and a fairly weak case-mix adjustment model relative to all other patient characteristics.

CMS should re-evaluate the measures used in designing PDGM to eliminate the use of the admission source measure and limit measures to those that focus on patients' clinical and functional status and is truly reflective of the acuity of the patient.

Questionable Encounters

Under the previous grouping model proposal, there was discussion about questionable encounters or episodes that currently did not fall into one of the proposed episode allotments. While this iteration has expanded the number of episode types, we are concerned about episodes that still are not accurately captured. These episodes will likely cause agencies to use a secondary diagnosis as the primary or highlight other components of the patient to place them into an episode type. However, we believe that CMS should continue to add offerings and discuss with agencies what episode types are needed for appropriate and successful implementation.

Further, it is noted that in CMS' analysis of Agency Impact under PDGM all episodes that did not fit into one of the encounter codes was eliminated from computation. This could give the false impression that agencies will do better under the model than accurate. In the HHGM proposal, it was noted that this could be up to 25 percent of care delivered. CMS needs to provide an opportunity to include all episodes and guidance on how to report or suggested needed episode types.

Low Utilization Payment Adjustment (LUPA)

The PDGM proposal on LUPAs is a significant change from the present model that has been in use since 2000. Shifting from a LUPA with a set threshold capped at 4 visits in a 60 day episode to a LUPA

threshold that ranges from 1-6 visits over a 30 day period can have unintended consequences. Within the PDGM framework, some patients whose care would have led to a LUPA over 60 days will now qualify for a full payment unit. On the other hand, some patients whose care would have previously led to a full episodic payment to the HHA will now result in per visit payment to the HHA. The fluctuating LUPA thresholds proposed in PDGM will dramatically heighten the complexity of adjusting to payment reform.

PDGM is not a pre-tested model in any way, thereby raising risks for all involved. While CMS projects 8% of payment units to be LUPA, it could as easily become 20% or 2%. In doing so, patients and home health agencies are certain to be impacted. We would suggest greater education and clarification for LUPAs and potentially a consideration of whether such variation is necessary.

Proposed Elimination of Recertification Requirement to Estimate How Much Longer Home Health Services will be Required

ElevatingHOME and VNAA support CMS's initiative taken to seek improvements to the health care delivery system that will reduce unnecessary burdens for clinicians, providers, patients and their families. The proposed elimination of the recertification requirement to estimate how much longer home health services will be required begins to align documentation with providing care for patients who qualify for Medicare home health under *Olmstead* that states that improvement is not required, but care to maintain patients in their home is valuable and appropriate. This is a good first step in providing changes to facilitate agencies in caring for this population. We believe that other necessary steps include further guidance and education to physicians, providers and the Medicare Administrative Contractors who are currently rejecting payments for this type of episode.

Proposed Regulation Text Changes Regarding Information Used to Satisfy Documentation of Medicare Eligibility for Home Health Services

ElevatingHOME and VNAA support CMS's discretionary change to propose to amend its regulatory text to align with its sub-regulatory guidance allowing medical record documentation for the HHA to be used to support the basis for certification and/or recertification of home health eligibility, provided specified requirements are met.

Remote patient monitoring (RPM)

ElevatingHOME and VNAA support RPM expenses on cost reports and hope CMS will go further. We ask that CMS consider collecting RPM and Telehealth utilization data on final claims so that this data is available to CMS in analysis of effectiveness and payment. We also urge CMS to reimburse for RPM separately or include it as a positive adjustment in PDGM. RPM is such an important innovation that must face lower barriers to ensure full adoption.

Interoperability

ElevatingHOME and VNAA envision home-based care providers as an integral and critical component of high-quality health care delivery models. ElevatingHOME and VNAA advance the principles across the care continuum that health care starts at home, that the home is a lower-cost setting for care delivery,

and those outcomes are often best at home. In providing this care and working within the healthcare continuum.

A vital component of interoperability is electronic medical records and the ability to securely and quickly exchange medical information. While there have been attempts to expand interoperability by CMS and Congress through incentives, by in large, those incentives did not reach home health providers. Any timeline and requirements must be done with an eye towards sustainability of providers and that any rate changes consider the costs of true interoperability. Additionally, as these systems cannot be implemented overnight, it is vital to give at least 24 months from passage or change to the CoPs. Additionally, for providers of a certain size, it will be important to allow the continuation of medical records via mail or fax with strict transmission timelines.

Price transparency

ElevatingHOME and VNAA appreciate that CMS is working to educate health care consumers on the costs associated with their care. However, as we have seen through the Hospice PUF reporting, health care consumers believe that those costs that are associated with each component of treatment and the supplies is the amount that is reimbursed or paid to hospices. Unfortunately, that is wholly inaccurate. Further, that same report takes all of the associated costs and totals them up in a column attributed to what was billed to CMS and a separate column stating what is paid. Every time without fail that that report has been released, we get calls from the media and states asking why there are so many fraudulent or unallowed charges. This lends a disreputable air to the good work done by our members. Further, ElevatingHOME and VNAA have repeatedly ask that there would be clarification or a FAQ released to explain that the collection of all of the procedures and supplies is a quality assurance set in place by CMS and not actual billing and explain how reimbursement is made for hospice.

While educating the public on the costs of care is important, it must be done in a way that is clear and concise and does not further add confusion or lend a unintended air of impropriety.

Patients over paperwork

ElevatingHOME and VNAA support CMS' goal to move care and operations to "patients over paperwork" and would like to highlight a few areas of increased confusion and unnecessary administrative burden.

Disposable Negative Pressure Wound Therapy – *d*NPWT

There has been significant confusion and administrative burden and difficulty when CMS changed the way that *d*NPWT would be paid for and billed for and instituted a co-pay to be collected by home health agencies. These steps and confusion have led to less usage of the patient preferred (and complied with) dNPWT. Agencies have stated that they have questions about appropriate coding, how when and how often to collect the co-pay and other areas of concern about using *d*NPWT. We would ask that CMS work with ElevatingHOME and VNAA to develop answers to these questions and help move the focus back off of the paperwork and rightfully returned to the patient.

Review Choice Demonstration

This demonstration sadly seems to be in complete opposition to the Administration's claim of wanting to place patients over paperwork. This demonstration unfortunately requires highly qualified and trained clinicians to focus on paperwork over patients. It is our fervent belief that CMS and HHS could achieve much more with a collaborative effort amongst the home health industry and their representatives. No one wants there to be waste, fraud and abuse in the industry; it lowers the standing of the vital services provided to the current and future patients and their families.

During the Pre-Claim Review demonstration, 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 just added administrative burden to providers.

Advance Practice Nurses Should Be Able to Order and Certify for Home Health

Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives and advanced practice registered nurses (APRNs) play a critical role in providing home care services to Medicare beneficiaries, particularly in rural and underserved communities. While these providers are allowed to order nursing home care and prescribe some medicines, they are not allowed to certify patients as needing or qualifying for home health care.

This change would improve access to Medicare home care services by allowing nurses and other providers to certify Medicare patients for home health services. No other conditions of eligibility would be changed. Further, patients would no longer leave their coordinated care where they are currently seen by APRNs and go see a physician just to get home health. Efficient coordinated care should not be sacrificed, and payments duplicated just to meet an outdated and necessary requirement.

ElevatingHOME and VNAA appreciate the opportunity to offer comments on the Home Health proposed rule, as well as offering comments on solutions that would improve the home health benefit. ElevatingHOME and VNAA welcome the opportunity to serve as a resource. Please contact Joy Cameron, vice president of policy & innovation at jcameron@elevatinghome.org or 571-527-1536.

Best regards,

Joy Cameron
VP of Policy and Innovation