September 22, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1672-P
PO Box 8016
Baltimore, MD 21244-8016
Via www.regulations.gov

RE: CMS-1672-P

Dear Administrator Verma:

The Home Care Alliance of Massachusetts (HCA of MA) - on behalf of our 100 home health agencies serving more than 110,000 Medicare patients annually - appreciates the opportunity to comment on the Proposed Rule: *Medicare and Medicaid Programs; 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; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements.*

The HCA of MA believes that our member agencies are dedicated to ensuring the quality, efficiency, and integrity of the Medicare home healthcare benefit for homebound seniors. Their services allow senior citizens and individuals with disabilities to receive physician-ordered medical and rehabilitative treatment to remain in the safety and dignity of their own homes. Our agencies are active partners in the various Medicare ACO and alternative payment models demonstrations. They are essential partners in making these new models of care deliver on the promise of better outcomes at lower costs.

We appreciate the opportunity to react to the wide-range of policy updates contained in the proposed rule. We, in particular, will appreciate your consideration of our significant concerns around the scope, cost and lack of transparency regarding the proposed 2019 payment reform model.

As our comments indicate, we believe payment reform of this magnitude should be implemented thoughtfully and carefully, with full disclosure of data and ample opportunity for stakeholder participation and input, and recognition of the time and costs associated with it.

I. Proposed Implementation of the Home Health Groupings Model for CY 2019

We recognize CMS' efforts toward development of a home health reimbursement system that more closely reflects for patient characteristics that account for variations in resource utilization, including reducing a high dependence on utilization of therapy services as a case mix adjuster. However, the degree of change associated with HHGM seems disproportionately outsized given the status and trends in the industry in 2017.

First and foremost, we must point out that the Medicare home health sector has experienced more rate cuts over the last decade than any other health care sector in the Medicare program and is the only provider type that has not had an increase in Medicare reimbursements since 2009. We have absorbed cuts from ACA mandated rebasing, sequestration, MACRA and case mix adjustments. Yet, according to MEDPAC data, the percentage of beneficiaries using home health services has remained relative the same – at around 9% - for the past five years. Despite growth in the demographic sector that we most serve – Medicare beneficiaries over 80 years of age, spending has been relatively flat, as well.

Given the enormity of the changes this sector of health care has had to withstand, the members in our state are proud of their ongoing commitment to improve patient outcomes and reducing costs and to training and retaining a quality staff capable of meeting the new clinical challenges that have come with Medicare program innovation.

As we look at the 2019 proposal, we see a degree of payment change in a single year that is almost unprecedented in any health care sector, one that is potentially disruptive to access to care and to the stability of the entire Massachusetts home health industry. We also not that the implementation of this payment model change is not driven by any regulatory or statutory requirement or deadline.

All of which leads us to voice the following specific concerns:

- **Moving home health reimbursement from the current case-mix system and 60 day episodes of care to the HHGM assessment and 30 day episodes is a radical change.** Yet, CMS proposes to implement the HHGM without testing it in real-time, based only on modeling using historical – and potentially outdated - claims and utilization data.

- **The implementation of this change is in a non-budget neutral manner, a highly unprecedented step for CMS to take without Congressional directive.** As mentioned above, the home health industry has been asked to absorb annual rate cuts for the past decade while preserving access. In Massachusetts, our ability to recruit staff to meet need is almost at a breaking point. Transitioning to the HHGM or any similar new payment model will require agencies to invest significant resources to reprogramming billing systems, retraining staff, and revamping operations. The transition needs to be budget neutral and these costs need to be recognized.

- **The HHGM has not been fully presented to the home health industry for comment.** We believe that a reference to CMS' ongoing research relative to a new payment model was made on a January 2017 Open Door Forum call. At that time, only vague details were provided despite the industry's ongoing requests for data. Additionally, the proposed rule does

not provide enough information to accurately estimate the potential impacts of the HHGM on HHAs.

- **The impact analysis includes vague "assumptions on behavioral responses as a result of the new case-mix adjustment methodology."** These behavioral assumptions are not articulated in the proposed rule, and in the absence of such, we have grave concerns – based on past history with such "assumptions" in our industry - that CMS has dramatically underestimated the financial impact of the HHGM. Industry modeling in absence of clarity around behavioral assumptions suggests that the budget reduction could be double or triple CMS' estimate. Much more transparency is needed, including an impact analysis that does not resort to guesses about how agencies will respond to the payment changes.

On behalf of Massachusetts home health agencies, we ask that:

- **CMS withdraw this proposal in the final rule and undertake a more deliberative and collaborative approach to working with the home health industry** to develop a more transparent and gradual transition to a new payment model.

- CMS revise HHGM to be implemented in a true **budget-neutral** fashion. Budget neutrality is an essential hallmark of past payment reform policies and is an important protection against system-wide fiscal destabilization. Budget neutrality must be required to ensure that a new payment system does not simultaneously destabilize an entire sector of health care services. CMS should recognize the voluntary, one-time operational costs to agencies, and **build these into budget assumptions as well, at least for the first year.**

- **CMS commit - as was done with the Home Health PPS system – to implement payment reform with a limited demonstration project to test the model using real-time patient assessment and utilization data before implementing this change nationwide.** Such a demonstration would help CMS monitor and control the impact.

- CMS examine more closely how such a new payment model would impact bundling and other alternative payment models which are now – at least in Massachusetts– a large part of the home health and health care landscape. **We do not want to see the promise of innovation jeopardized or threatened by a new model that has yet to be adequately tested or reviewed by clinical leaders in the home health community.**

II. Request for Information on CMS Flexibilities and Efficiencies

HCA of MA appreciates the opportunity to work with CMS on ways to construct rules that are "less complex" and "reduce burdens", as stated in the Request for Information ("RFI") contained in the proposed rule. We believe a starting point for this must be the burdensome **F2F requirement**, a duplicative, onerous burden for providers and physicians alike, with little justification in terms of positive impact on patient care, program integrity or effective eligibility oversight.

As repeatedly stressed in prior-year comments and other outreach, CMS' implementation of the F2F rule is confusing to all involved, including physicians, HHAs and hospitals. CMS has tried to mitigate

the confusion in various ways, but those solutions fail to provide basic clarity, ease of application or sensible application. As a result, the rule is creating an access-to-care barrier, and practitioners find that it is easier to recommend care for patients in alternative settings to home health care.

HCA believes CMS made the home health F2F physician encounter requirement much more burdensome than the Affordable Care Act (ACA) ever intended and that physicians conducting the F2F encounter should be able to simply sign and date the beneficiary's plan of care which would serve as an attestation that the F2F encounter has been met.

A F2F solution needs to be workable and amenable to home care providers and physicians alike. We urge CMS to do the following:

- Eliminate or significantly modify the physician documentation requirements so that physicians no longer must spell out why the patient's clinical condition requires Medicare-covered home health services, nor require such an insurmountable level of documentation in their own files.

- Modify this requirement so that the F2F mandate can be met through the completion and collection of the separately signed and modified (if necessary) 485 form.

- Establish F2F exceptions for patients who have been recently discharged from an inpatient setting, individuals in rural areas where access to a physician or non-physician practitioner is limited, and individuals unable to leave home or have a physician perform a home visit.

- Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

III. Other General Comments

The Home Care Alliance of MA strongly urges CMS to do more in the area of targeted fraud enforcement and prevention, including:

- Reforming the existing medical review and fraud and abuse prevention processes to identify and target specific agencies that have excessive utilization rates rather than cut payment rates for all agencies;

- Conducting a thorough review of the deemed-status accreditation process that bypasses state oversight in allowing new agencies to enter the Medicare market.

The Home Care Alliance of MA remains committed to working with CMS, home health clinical leaders, and beneficiary stakeholders to design and develop a payment model that supports a patient-centered high-quality system. Regrettably, that model is not HHGM in its current form. Providers in our state need more time to gain information about the HHGM and to begin effective implementation strategies, thus our call for its **withdrawal from the 2018 Final Rule**.

We pledge to use the time ahead to join with CMS to offer constructive solutions to payment system reform that is **truly budget neutral** and does not compromise patient care.

Sincerely,

Patricia M. Kelleher
Executive Director