

August 29, 2018

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
ATTN: CMS-1689-P  
PO Box 8016  
Baltimore MD 21244-8016

Via [www.regulations.gov](http://www.regulations.gov)

RE: CMS-1689-P

Dear Ms. Verma:

I am writing on behalf of the Home Care Alliance of Massachusetts to comment on the Proposed Rule: 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. The Home Care Alliance of Massachusetts is the trade association that represents approximately 100 Medicare certified home health care agencies in Massachusetts, including VNAs, hospital-based agencies, and for-profit agencies.

Thank you for your consideration of our comments, submitted on behalf of these agencies, on the above referenced proposed rule. Our comments on the provisions of the proposed rule are organized in the order in which they are presented in the Federal Register notice.

### **CY 2019 Home Health Wage Index**

Over the years, we have repeatedly expressed concerns to CMS about inequities in how the wage index is calculated and implemented for home health agencies as compared to hospitals within the same Core-Based Statistical Area (CBSA). The wage index for home health agencies is based on pre-floor, pre-reclassified hospital wage data, but hospitals in the same geographic regions have the ability to apply for re-classification to another CBSA and may be eligible for the rural floor wage index. For example, within Massachusetts, every hospital in the Worcester CBSA and two hospitals in the Providence-Bristol CBSA have been re-classified to the Boston CBSA, effectively increasing their wage index by approximately 9% and 20%, respectively. Hospitals in Massachusetts also enjoy a high rural wage index floor, based on wage data from one small hospital on Nantucket, an island resort community. This inequity has for many years created a competitive advantage for hospitals in recruiting and retaining increasingly scarce nurses and therapists. Contrary to CMS' past assertions, we believe that the statute DOES give CMS authority to address and correct some of these inequities.

Faced with these wage index inequities, home health agencies across Massachusetts – already at a serious competitive disadvantage – struggle to compete with their local hospitals for increasingly scarce nurses and therapists.

We have in the past, and now once again, **recommend that CMS include wage data from Critical Access Hospitals in calculating the wage index for home health agencies and other non-hospital provider types, in order to make this wage index more reflective of actual local wage practices.**

In 2015, CMS indicated that the entire wage index system was under review, and a move to a Commuting-Based Wage Index was being considered. What became of that review? We urge CMS to implement a system that not only recognizes variations between localities, but also treats all provider types within a local market equitably. Until such a system is in place, **we urge CMS to adjust the 2019 home health agency wage index to reflect a policy to limit the wage index disparity between provider types within a given CBSA to no more than 10%.**

### **Proposed Payments for High-Cost Outliers under the HH PPS**

HCA of MA appreciates CMS suggesting that more attention needs to be paid to modifying the home health payment rule to address access to home health care for patients with chronic, complex conditions especially where the goal of home health care plan is to maintain or prevent further decline of the patient's condition rather than improvement of the patient's condition. The reference to addressing outlier payment modeling to address care needs of patients with amyotrophic lateral sclerosis (ALS) is especially welcome in MA where advocacy for this disease and these patients has been led by the Frates family of Boston. Our members are experiencing first-hand the financial risk associated with accepting an open-ended commitment to serve ALS patients who they can anticipate will systematically create losses for their agency over an often-prolonged period of time, with needs ever increasing. A review of the outlier provision relative to these patients is welcome and long overdue.

HCA of MA offers a number of suggestions to reform payment to improve these patients' access to care in the home:

1. Identify specific diseases, like ALS, that are systematically underpaid, even under the current outlier policy, and **exclude outlier payments for such patients from the fixed dollar loss amount and cost sharing percentage up to the full reasonable cost of care at those agencies accepting them for care.**
2. If necessary, separately identify those agencies in each area who agree to accept high cost ALS patients under the above exception.
3. **Undertake a demonstration to test whether an alternative payment mechanism under the home health benefit similar to Disproportionate Share Payments or a Special Needs Plans would provide full access to home health care for ALS and similar patients.**
4. **Undertake a demonstration of a bridge program that is a combination of the appropriate features of the Medicare home health and hospice benefits.** It would constitute a cost-effective alternative to the use of both benefits and assure access to patients needing "Advanced Disease Management" (ADM). This ADM benefit would blend the curative treatment approach of home health and the palliative care benefits of hospice in a manner that allows a seamless transition for persons whose disease process is highly likely to advance and result in death within a two-year period.

HCA of MA would be willing to work alongside CMS to remove unintended barriers to this benefit for persons with ALS and other progressive neurodegenerative diseases.

### **Proposed Implementation of the Patient-Driven Groupings Model for CY 2020**

We recognize and applaud CMS' efforts toward development of a home health reimbursement system that more closely reflect patient characteristics that account for variations in resource utilization and reduce incentives to overutilize therapy services. We appreciate the fact that CMS has provided an estimate of the anticipated financial impact of the PDGM for every agency. However, we have some concerns about how this model is to be implemented.

The proposed PDGM represents a major change to the way home health agencies will be reimbursed, requiring extensive advanced planning by both the MACs and provider agencies. Agencies will need to make extensive changes to their clinical and administrative operations to successfully transition to the new system. In order to ensure a smooth transition to the new model and ensure that there is no disruption in access to services for patients, **we urge CMS to consider delaying implementation by one year. We also encourage CMS to conduct a limited demonstration program** to evaluate the accuracy of the model, the need for greater operational guidance, and the effect that the change will have on beneficiaries.

We are concerned that the proposal to set the LUPA visit threshold at the 10<sup>th</sup> percentile for each payment group is needlessly complex and will unnecessarily complicate the care planning process for home health professionals. Varying and recurrent LUPA thresholds will be confusing to implement and are not directly related to patient clinical needs. This increase in administrative complexity siphons resources from efforts to serve patient needs and improve care quality. **We recommend that CMS retain the current LUPA thresholds under the PDGM, and perhaps revisit LUPA thresholds in future years.**

We are concerned about the three "behavioral assumptions" CMS has used in calculating the 30-day budget-neutral payment amounts. We strongly believe that any behavioral adjustments should be based on data demonstrating that a measurable behavior change did occur, not on unsubstantiated guesses about what might happen in the future. The proposed rule appears to make behavioral assumptions that are not supported by actual data or evidence—in contrast to requirements of the Bipartisan Budget Act of 2018 ("BBA of 2018"). The proposed behavioral assumption changes with a 6.42% reduction would exceed past actual case mix adjustments made by CMS since the development of the current payment system.

In addition, we would argue that **two of the three assumptions you outline should be discounted because they already exist in the current PPS methodology.** Agencies already are incentivized to report the highest paying clinical diagnosis code on the claim, and also to develop and deliver plans of care that exceed the LUPA threshold. While the specific diagnosis weights and LUPA thresholds will be different under the PDGM, the incentives themselves are not changed. Therefore, we believe that you have significantly overestimated the impact of these behavioral assumptions and that the related adjustments to the 30-day payment amounts are far too large. **We urge CMS to eliminate the adjustments related to Clinical Group Coding and the LUPA threshold.**

We believe that the requirement under section 1895(b)(3)(D)(i) of the Act that CMS annually determine the impact of differences between assumed behavior changes and actual behavior changes supports our recommendation that CMS be more restrained in your estimates of the impact of behavioral assumptions. **We strongly urge CMS to implement a much smaller adjustment upon the outset of PDGM and to adjust it in future years based on ACTUAL behavioral changes, not on ASSUMED behavioral changes.**

### **Split Percentage Payment Approach**

**We support CMS' proposal to continue the split payment approach for existing agencies.** We anticipate that changing from a 60-day billing period to a 30-day period will be disruptive to agencies' operations and will increase their back-office costs. Continuing the split payment approach at the current 60/40 and 50/50 splits for early and late periods, respectively, will give agencies cash-flow breathing room to make the transition to the new payment system.

Regarding the request for comments about phasing out the split payment approach, we recommend that CMS retain the split billing approach for early periods indefinitely, but we could support a phase-out of split billing for late periods over a two-or three-year period. Claims data show that agencies provide higher frequency services during the first few weeks of an episode of care, and the admissions process includes significant administrative costs. Continuing the split payment for early periods would help agencies meet those higher up-front costs.

We also take exception to the two agency examples used to demonstrate the program integrity vulnerabilities resulting from RAP payments. The two examples demonstrate problems with CMS' oversight of the agency accreditation process and a failure in the claims processing system, not necessarily a problem with the RAP payment itself. Which Accrediting Organization approved those two agencies? It appears that they were established for the sole purpose of defrauding the Medicare program and should never have been approved in the first place. In addition, the MAC should have identified red flags early on if these agencies failed to submit final claims for ten months in one case and more than a year in the other case. Reasonable administrative controls and edits within the claims processing system should have caught these schemes early on.

### **Changes Regarding Certifying and Recertifying Patient Eligibility**

We support the proposal to align regulatory language about documentation of the patient's eligibility for home health services with existing sub-regulatory guidance. The HCA applauds CMS' proposal to eliminate the regulatory requirement at 42 CFR 424.22(b)(2) that the certifying physician, as part of the recertification process, provide an estimate of how much longer skilled services will be required. The HCA agrees that the elimination of this recertification requirement would result in a reduction of burden for certifying physicians by reducing the amount of time physicians spend on this process.

Keeping with CM'S goals for physician's paperwork reduction as outlined in the "patients over paperwork" agenda, we request that CMS consider revisions to the physician's burden of the face to face documentation requirement. While the requirement that a patient must have a F2F encounter with a physician as a condition of payment became a statutory requirement with the Affordable Care Act of 2010, we believe that the intent of the statute could have been met much more simply than the complicated set of requirements CMS developed relative to the documentation that must be in both the home health agency's and physician's records, requiring that the physician medical record must document to the standard outlined by Medicare in Chapter 7 Home Health Services coverage manual. This has resulted in excessive, time consuming and frustrating documentation 'back and forth' between agencies and physicians, as well as medical review denials for "insufficient documentation" for care that clearly meets medical necessity standards. **We recommend that the F2F rule be further revised to allow that the requirement be met by the inclusion of a simple and concise signed and dated**

**statement of the encounter in the same plan of care document the physician signs to order the home health services.**

We also recommend that CMS further relieve the paperwork burden on physicians by allowing a non-physician practitioner to perform the encounter and certify the home health benefit.

### **Remote Patient Monitoring**

We strongly support the proposal to recognize the costs associated with remote patient monitoring as allowable administrative costs on the HHA cost report. We believe Medicare policy on this service has seriously lagged behind the broader healthcare marketplace and has inhibited more widespread adoption of this technological tool to enhance patient empowerment and outcomes. We would, in fact, **recommend that CMS remove the requirement that remote patient monitoring may not be used as a substitute for in-person home health services.** We believe that the literature demonstrates that appropriate use of remote patient monitoring can, in fact, reduce the number or frequency of needed in-person home health services, reducing overall costs without compromising quality or patient outcomes.

### **Home Health Value-Based Purchasing (HHVBP) Model**

We support the HHVBP model which aims to improve the quality and delivery of home healthcare services to Medicare beneficiaries by giving HHAs incentives to provide better quality care. We appreciate the positive changes CMS has made to the HHVBP and support moving forward with this without delay.

We are concerned, though, that all of the measures are focused on improvement, when stabilization sometimes is an appropriate goal for certain patients. **We recommend that CMS modify the HHVBP to recognize stabilization in the scoring.** We support reweighting the claims measures; however, we question the proposal to dramatically increase the weight of the 60-day hospitalization measure from 6.25% to 26.25%. We are concerned that agencies will focus too much emphasis on this one measure at the expense of other important measures. We recommend that the rehospitalization measure be weighted somewhere between the current weight and the proposed weight. We also support CMS's goal of reducing the maximum number of points allowed for improvement. Weighting improvement in scores equal to absolute performance has been a significant flaw in this program.

### **Removal Factors for HH QRP Measures**

**We support the proposal to replace current six criteria with the proposed seven factors outlined in the proposed rule. We also support the proposed addition of *Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program.*** While we strongly agree that the objective measurement and reporting of quality measures is important, we are encouraged that CMS recognizes that measuring quality entails costs that can often exceed the value of the data.

### **Training Requirements for Accrediting Organization Surveyors (488.5(a)(7))**

We strongly support CMS' proposal to require consistent, comprehensive training for AO surveyors. We agree that this new requirement may reduce disparity rates; however, we do not believe this change goes far enough.

**We recommend that CMS undertake a rigorous review of the entire “deemed status” system.**

Agencies that enter the Medicare and Medicaid programs via accreditation by a deemed status accrediting organization bypass state oversight. We note that the Commonwealth of Massachusetts is currently developing a new set of regulations specifically to strengthen state oversight of agencies that enter the Medicare and Medicaid markets through the deemed status process. Since they are not subject to routine state certification surveys, agencies certified by the accrediting organizations are not subject to the civil monetary penalties that could result from surveys conducted by state agencies. Furthermore, anecdotal evidence seems to indicate significant variation in the rigorousness of the accreditation process between the various AOs. **We urge CMS to fix the flaws and loopholes in the deemed status program.**

### **General Comments**

The Home Care Alliance of MA strongly urges CMS to do more in the area of targeted fraud enforcement and prevention. We urge CMS to utilize the existing medical review and fraud and abuse prevention processes to identify and target specific agencies that have excessive utilization rates or aberrant billing practices rather than cut payment rates for all agencies. We also recommend that CMS expand the targeted moratorium on new agencies to be nationwide until the deemed status review is completed.

Thank you for your consideration of our comments and recommendations.

Sincerely,

Patricia M. Kelleher  
Executive Director