September ??, 2017

Submitted via regulations.gov Do we keep this??

The Honorable Seema Verma Administrator

Centers for Medicare and Medicaid Services 7500 Security Boulevard

Baltimore, Maryland 21244-1850

Re: CMS–1672-P: 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

Dear Administrator Verma:

I am writing on behalf of the Minnesota HomeCare Association, representing the interests of home health agencies in Minnesota. We appreciate the opportunity to respond to the policy changes to the Home Health Prospective Payment System (“HH PPS”) as proposed by the Centers for Medicare and Medicaid Services (“CMS”) on July 28, 2017 (“proposed rule”).

While we understand CMS’s efforts to consider payment reform to the home health industry, we also want to ensure that home health agencies remain financially viable in order to continue to serve Medicare beneficiaries in the home setting- the place most preferable and affordable to both the patients and payors. We are deeply concerned about the Home Health Grouping Model (HHGM) proposed for CY 2019 and feel strongly that the HHGM should be withdrawn from the Final Rule. Historically, changes of this magnitude have had a negative impact to both Medicare beneficiaries as well as home health agencies. Because the HHGM represents such a major shift from the current home health payment model, it is important that CMS provide agencies with clear and understandable information in order for them to determine the financial impact. We strongly encourage CMS to include stakeholders in the development and implementation of the HHGM.

We are concerned about the HHGM as a whole as we have not been able to analyze the impact due to its complexity and lack of information. One significant area of concern is around the proposed changes in therapy reimbursement. Section II.D of the Proposed Rule outlines the changes to the HHGM that will include a decrease in the impact of therapy services on re-imbursement related to the thought that some HHA’s are over-utilizing therapy services to increase their reimbursement. The wording used in the proposed rules is as follows: “Findings from the report suggest that the current home health payment system may discourage HHA’s from serving patients with clinically complex and/or poorly controlled chronic conditions who do not need therapy services, but require skilled nursing care. In addition, MedPAC believes that the Medicare home health benefit is ill-defined and the current reliance on therapy service thresholds for determining payment is counter to the goals of a prospective payment system. Under the current payment system, HHAs receive higher payments for providing more therapy visits, which may incentivize unnecessary utilization. MedPAC reiterated their recommendation in the March 2017 Report to Congress that CMS eliminate the use of the number of therapy visits as a payment factor in the home health PPS beginning in 2019.

However, on page 129 of the Proposed Rule, CMS goes on to say, “VA Clinical Practice Guidelines for Management of Stroke Rehabilitation “strongly recommend that rehabilitation therapy should start as early as possible, once medical stability is reached” and “recommend that the patient receive as much therapy as needed and tolerated to adapt, recover, and/or reestablish the premorbid or optimal level of functional independence.” This appears to contradict the logic of decreasing the payments to HHAs based upon therapy utilization. Many patients require extensive home health physical therapy services in order to prevent falls and potential fractures and to implement home exercise programs that help them maintain their strength and range of motion after their home care episode ends. Occupational therapy services are integral to ensuring that patients have all necessary adaptations to make their homes safe, which again, prevents falls with potential fractures, as well as preventing injuries and wounds related to improper shower set up and a lack of pressure relieving devices that are needed to promote healing of and prevent infections with pressure ulcers. Speech/Language Pathology services are integral to ensuring patients are safely swallowing, preventing recurrent aspiration pneumonia and improving quality of life. All of these therapy interventions are essential if HHA’s are going to prevent rehospitalizations. **If CMS determines that therapy services are going to have less of an impact on reimbursement, there is a greater likelihood that some agencies may be forced to decrease these high-cost services in an attempt to cut their overall cost of care, potentially leading to an increase in hospitalizations and patient mortality.** In particular, rural areas will have an increased burden with less payment for therapy services resulting in increased challenges in the recruitment and retention of therapy staff .

In addition, we have concerns that the proposed payment model will be partially based on timing (early vs. late) and referral source (community vs. institutional). In section III.E.5 of the Proposed Rule, Admission Source Category, CMS states, “In our review of related scholarly research, we found that

beneficiaries admitted directly or recently from an institutional setting (acute or post-acute care

(PAC)) tend to have different care needs and higher resource use than those admitted from the

community, thus indicating the need for differentiated payment amounts… They generally had

more than five medications than their non-hospitalized counterparts and required assistance with

medication management… Comprehensive and deliberate interventions in this timeframe could also potentially reduce re-hospitalization rates… We expect that HHA’s would provide more resource-intensive services after discharge from an institutional setting to educate patients in new medication management, facilitate discharge education for the patient and family, and provide support in the recovery from the illness that caused the originating hospitalization or institutional stay”.

You go on further to stress the higher acuity of PAC patients with the following statement:

“In its 2016 Report to Congress, MedPAC noted that, in their analysis of CY 2013 HH claims, beneficiaries admitted from the community tend to receive more visits from home health aides than their non-community counterparts, stating that “aide services were the majority of services provided in 14 percent of the episodes for community-admitted users compared with 5 percent for PAC users”.

In Minnesota, we have multiple HHAs that are not directly affiliated with a hospital group, therefore many referrals come directly from our partner clinics. Our goal is to promote the well-being of all people in our communities and to take a proactive approach to health maintenance rather than a reactive stance once they fail at home and are hospitalized. We see a great number of clinic referrals related to people who are failing at home because of lack of health literacy resulting in poor disease management. Many community-referred patients have chronic diseases/conditions, such as pressure ulcers related to decreased mobility and a lack of proper equipment which results in them spending the majority of their time in a recliner that lacks proper pressure relief. We also see patients who are referred from the clinic with infected wounds or uncontrolled edema, which again, leads to a lack of mobility and physical deconditioning, often times resulting in falls and subsequent injuries such as fractures. These are a few examples to show how home health can take a community referral, implement changes to the environment, provide education, medication management, and skilled services with the ultimate goal of improving or maintaining the health of the patient and preventing costly hospitalizations. Home health agencies that are not affiliated with a larger hospital system are likely to have a larger percentage of referrals from the community, and therefore the referral source payment element outlined in the proposed HHGM would reimburse those agencies at a lower rate than their hospital-affiliated counterparts. As stated previously, more information is needed by CMS to determine the financial implications of this payment reform as it relates to referral source, however, we have identified this as a concern, particularly for smaller agencies that are not affiliated with a larger health care system.

Further, we request additional information on the following issues so that we can fully understand the impact of the proposed HHGM:

* How will the 30-day episode periods be paid under the HHGM? How will this payment model affect LUPA and outlier payment?
* Has CMS considered what kind of education and tools will be provided to allow agencies to budget and plan so that there is no disruption in care.
* The proposed rule states that the total system value would be reduced by $950 million in 2019 if the final rule is fully non-budget neutral, or $480 million if the rule is partially non-budget neutral, with the total reduction still being $950 million when fully implemented. Further clarification is needed in order for agencies to understand these reductions.
* In Minnesota, we have a significant population of patients that reside in rural areas. We are concerned that the payment reform proposed by CMS would be unsustainable for many providers, particularly those in rural areas that are already struggling to provide beneficiaries with continued access to care in their homes.
* Has CMS considered how this payment reform will affect patient outcomes? We believe that if HHGM is implemented, as it is written in the proposed rule, agencies that are already struggling financially will have to make cuts in their workforce, which directly impacts patient outcomes and patient access.
* Has CMS researched the correlation of agencies that utilize therapy appropriately and the rehospitalization rates?

In Minnesota, we are diligently working to reduce re-hospitalizations. We are extremely concerned how this proposed rule will dramatically impact patient access to home care. With a decreased access to home care, beneficiaries will likely have increase hospitalizations and increased length of stays for TCU and hospitals.

In conclusion, we believe that skilled Medicare home health services are a cost-effective way to care for America’s disabled and elderly population. However, the increasingly complex regulatory changes and inadequate reimbursement from Medicare is causing significant strain on the sustainability of home health providers. {insert stats from MN on agencies that have closed in the past 5 years or so} We ask that CMS remove the language of the HHGM in the 2018 Final Rule. We further ask that CMS work closely with the home health industry leaders to allow them to research and comment on the payment reform of the HHGM. And finally, we ask that when a sustainable model is developed, with the input of stakeholders, CMS would test the payment reform on a small sample of agencies before implementing it to all home health agencies nationwide. The Minnesota HomeCare Association is committed to working with CMS and other stakeholders to develop a payment model that supports a patient-centered, high-quality system.

We appreciate the opportunity to provide comments.

Sincerely,

Kathy Messerli, Executive Director

Minnesota HomeCare Association

cc:

Hillary Loeffler

Director, Division of Home Health & Hospice