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August 31, 2018

The Honorable Seema Verma, Administrator

Centers for Medicare and Medicaid Services

U.S. Department of Health and Human Services

Attn: CMS-1689-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:

The Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services have proposed a number of reforms in the Medicare home health benefit along with setting out CY 2019 payment rates in the Notice of Proposed Rulemaking (NPRM). 83 Fed. Reg. 32340

(July 12, 2018). The changes include a completely new payment model that would take effect in CY 2019 and much more.

The National Association for Home Care & Hospice (NAHC) respectfully submits these comments regarding the proposals contained within the NPRM. NAHC is the largest trade association representing the interests of Medicare home health agencies (HHAs) nationwide including nonprofit, proprietary, urban and rural based, hospital affiliated, public and private corporate entities, and government run providers of home health care since 1982. NAHC members provide the majority of Medicare home health services.

NAHC is also an original provider-member of the Leadership Council of Aging Organizations (LCAO) as it has put patients first in its health policy and advocacy positions since its inception. Each year, NAHC members serve millions of patients of all ages, infirmities, and disabilities, providing an opportunity for individuals to be care for in their own homes, the care setting preferred by virtually all people.

These comments are also supported by our Forum of State Associations. Many of those individual associations will file their own comments. At the same time, several state home care associations are directly signing on to these comments. Those associations are listed at the end of these comments.

We greatly appreciate the efforts that CMS has employed to modernize the Medicare home health payment model. Further, the degree of transparency provided regarding the development of the Patient Driven Groupings Model (PDGM) has been crucial in permitting stakeholders to fully evaluate it and the potential impacts on patients and home health agencies. We look forward to working with CMS on this very important matter.

NAHC has established the following guiding principles for establishing an acceptable payment model:

1. Budget neutral transition to any new payment model.
2. No incentives that trigger undesirable behavioral changes
3. Sufficient reimbursement to cover the entire scope of the home health benefit
4. Payment amounts should be based on patient characteristics and clinical needs
5. The payment model should operate consistently with other aspects in service delivery.

6. All stakeholders should be given sufficient time to implement any changes in operations

7. Significant changes in payment models should be fully tested and validated

Overall, while PDGM presents significant improvements over the 2017 proposed Home Health Groupings Model (HHGM), it falls somewhat short of meeting the guiding principles. We remain concerned that, as with HHGM, the PDGM does not achieve the goals set out in in principles 2, 3, and 4. Each of these areas of weakness is discussed below. Also, given the PDGM proposal schedule, it would not be tested or validated as a reliable payment model at all prior to its nationwide implementation. With changes of the magnitude presented in PDGM, an untested model creates great risk of unintended consequences.

There are several specific areas of concern that should be addressed before it is ready for implementation. With the needed modifications and the need for all stakeholders to have sufficient time to initiate any required modifications in operations, NAHC recommends that CMS look to a later effective date than proposed. Addressing the concerns expressed herein, as well as those previously offered at the February Technical Experts Panel (TEP) review, warrants a minimum of a twelve month extension of the effective date. It would be unfortunate to prematurely implement a new payment model that can be expected to have significant impact on Medicare patients and providers along with the Medicare as a whole.

A postponement in the effective date would not have a Medicare spending impact as the Bipartisan Budget Act requires any new model to be budget neutral. Further, with such a significant change in the reimbursement model it is crucial that the model be as close to perfect as possible at the start rather than relying upon later modifications. The home health patient population is highly vulnerable and generally of advanced age relative to the Medicare population. They deserve CMS's best effort from the beginning.

One of the most significant changes in the payment model is the elimination of the Utilization Domain measure that is part of the current HHPPS HHRG model. NAHC fully supports such a change and has consistently advocated against that measure beginning with the early unveiling of the proposed model in 1999. Most recently, NAHC strongly supported Medicare amendments in the Bipartisan Budget Act of 2018 that mandated the development of a new home health payment model that did not include the volume of therapy services as a measure for the payment level. While we are very encouraged by CMS's efforts to develop a valid and reliable case mix adjustment model that relies on patient characteristics rather than resource use to determine the amount of payment in individual service claims, we are

concerned, as detailed below, that the PDGM design will have a negative impact on patients who need therapy services and the HHAs that provide it. Therapy services are extraordinarily valuable in the care of Medicare home health beneficiaries and should be supported to the greatest degree possible. At the same time, we agree that, a prospective payment system should not be relegated to rely upon the volume of services utilized to determine payment amounts. Patient characteristics, not resource use should be the core focus of any prospective payment model.

NAHC further supports CMS's recognition that the current payment model has created risks that patient populations that are duly entitled to the Medicare home health benefit have problems accessing needed services because of weaknesses in the current payment model. The Medicare home health benefit was a brilliant design when Medicare began in 1965. It has stood the test of time better than any other Medicare benefits as patients and care needs changed over the next 50+ years to where it is a perfect fit for the broad array of patient needs within a population of individuals with acute, post-acute, chronic, and end of life needs. However, the current payment model has created an environment where classes of Medicare beneficiaries with complex nursing, therapy, home health aide, and non-routine medical supply needs face obstacles to care triggered by the payment model. It is sincerely hoped that the new model eliminates or mitigates these risks to a great degree.

We do have some doubt that such will occur since CMS relied upon a regression analysis in crafting PDGM. Accordingly, it would be helpful if CMS could provide some explanation as to how the new model actually addresses the access concerns that it recognizes. For example, CMS references a patient with ALS and offers an extensive review of how such patient fits within Medicare coverage standards and the resultant reimbursement amount. CMS recognizes that such patients have access problems. CMS also indicates that the resulting reimbursement with outlier payment would be more than $5000 short of imputed costs for a 60 day episode of care. If these patients are rarely admitted to home health because of reimbursement barriers, how does the PDGM model address these concerns?

NAHC is heartened by CMS's stated recognition that the scope of the home health benefit is based on the individual's need for skilled care, not on the myth that Medicare coverage is based on a patient's ability to improve from nursing or therapy care. However, given the acknowledgement that such patients have been either wrongly blocked from the home health benefit or faced significant barriers to access to the benefit, how does CMS overcome the problem of relying on a regression analysis for the establishment of PDGM that does not adequately include these patients in the data universe?

While NAHC resoundingly supports the CMS statements that the home health benefit covers individuals with conditions that are acute, chronic, or terminal based on the need for skilled care, there is

a high risk that formulating a payment model in the absence of the full population of patients eligible for the home health benefit will perpetuate the barriers to care access that CMS has recognized. A regression analysis can only reflect the patient population at the time and cannot consider a population that has been wrongly outside the home health benefit.

Finally, as a general comment, NAHC is concerned that the home health workforce needs support from CMS. With multiple years of rate reductions, staffing pressures continue to mount as other health sectors and the workforce at large are getting increased compensation while the home health workforce has not had the ability to follow suit and compete for the best clinicians, executives, and administrative personnel. Further, state and local governments are increasing the minimum wage levels while Medicare rates are at the lowest level in many years. The annual Market Basket Index and the wage index do not reflect these changes on a timely basis. More importantly, HHAs have received on one positive inflation update since 2011, leaving them behind in competing for a shrinking workforce that is available. CMS must consider these factors as it approaches PDGM and not add to the financial pressures facing HHAs with the essential workforce. NAHC recommends that CMS build into the Market Basket Index for 2019 an increase to reflect general health care wage increases. .

PDGM Case Mix Model Concerns and Comments

CMS has proclaimed that among its goals with a reformed payment model is to achieve fair compensation and increased accuracy of reimbursement for the resources employed in caring for the variety of patients served in Medicare home health. NAHC fully supports these goals as central tenets of any reimbursement model. We recommend that CMS provide a full public evaluation as to whether the proposal meets these goals as part of the rulemaking process. NAHC has conducted such of an evaluation and concludes that PDGM results in little or no improvement in reimbursement fairness or payment accuracy.

NAHC analyzed the Medicare margins of HHAs in 2016 (most recent data available) in comparison to the CMS impact analysis that is part of the tools CMS has made available for review of the proposed rule. In theory, improved payment accuracy and fairness would redistribute payments such that low-reimbursed HHAs would receive increased payment and high-reimbursed HHAs would receive lower

payments. However, that does not occur with PDGM. The payment redistribution does little to improve fairness and makes matters worse in terms of accuracy.

Of the HHAs displayed in the CMS HHA-specific impact estimates, the CMS cost report database provides 8442 HHAs with usable reports. These data, in combination with the CMS impact estimates, show that nearly one-half of HHAs have the reverse impact that should occur through payment model reforms that are intended to improve payment accuracy and fairness of compensation.

As noted in TABLE 1, 41% of HHAs with below average Medicare margins (<15%) will be paid less under PDGM than under the current payment model.[i] Likewise, a significant number of HHAs with above average Medicare margins, 49.87%, will receive increased Medicare revenues under CMS estimates.[1] If the CMS goals of improving payment accuracy and providing fair compensation are met, such an outcome would not occur. Generally, below average Medicare margin HHAs would receive increased payments while those with above average margins would receive decreased payments. NAHC recognizes that many factors, especially efficiencies, affect the level of Medicare margins. However, improved payment accuracy and fairer payment distribution is not achieved when nearly half of the HHAs experience the reverse of expected outcomes under a new payment model.

TABLE 1

Medicare Margin/PDGM Outcome	**Number of HHAs**	**% of Below Average**	**% of Above Average**	**% of all HHAs**
Below Average Medicare Margin with Increased Revenue in PDGM	2626	58.94%		31.11%
Below Average Medicare Margin with Decreased Revenue in PDGM	1830	41.06%		21.68%
Above Average Medicare Margin with Increased Revenue in PDGM	1988		49.87%	23.55%
Above Average Medicare Margin with Decreased Revenue in PDGM	1998		50.13%	23.67%

[1] It should be noted that the overall margin for these HHAs is less than 1.95% with resources applied to Medicare Advantage and Medicaid patient reimbursement shortfalls. This also reflects the Medicare margin resulting from traditional Medicare Fee-For-Service (FFS) payment in 2016 that preceded rate cuts in 2017, 2018, and scheduled for 2020. Under PDGM, nearly half of those HHAs with lower than average Medicare FFS margins are increasingly in financial jeopardy.

TABLE 2 further highlights the inequities of PDGM. At all segments of HHAs with Medicare margins lower than the average, over 40% of the HHAs are estimated to receive less Medicare reimbursement under PDGM than under the current HHPPS. Correspondingly, virtually 50% of HHAs with Medicare margins higher than the average receive more Medicare reimbursement under PDGM.

TABLE 2

Medicare Margin 2016	**HHAs w/ Increased Revenue in PDGM**	**HHAs w/ Decreased Revenue in PDGM**
< 0%	1371	859
0-5%	356	275
5-10%	413	334
10-15%	450	326
15-20%	459	401
>20%	1565	1633

CMS must move forward with a responsible payment model reform that does not increase risks of care access by financially destabilizing the home health agency infrastructure. The analyses presented in Tables 1 and 2 demonstrate that PDGM triggers such a risk at a high level.

RECOMMENDATION: CMS should develop a payment model that results in both improved payment accuracy and fair reimbursement. PDGM somewhat achieves those goals, but not to a sufficient extent.

Admission Source Measure

It is not possible for NAHC to fully discern the root cause with PDGM for the inequitable payment redistribution resulting from the proposed reimbursement model. However, there are some indications that it may be centered in the case mix adjustment model that relies on patient characteristics that provide limited explanation on resources used by patients, combined with an undue reliance on an admission source measure. With PDGM, CMS uses certain clinical and functional measures reflecting individual patient characteristics. However, significant weight is given to another measure-- admission source-- that easily overwhelms the impact of all other measures.

While data demonstrates that patients discharged to home health services from an inpatient setting utilize higher levels of services that patients admitted from the community, the level of impact from that measure in PDGM indicates that the remaining measures have extremely limited explanatory power on resource needs. Where patients are identical in all PDGM measures other than admission source, the reimbursements rates are generally $200-$350 per 30 day unit higher for patients coming from an institutional setting. For example, Group 1AA11 and 2AA11 have nearly an 18% payment rate difference. Similarly, 1CC21 and 2CC21 have nearly an 11.3% rate difference. Each of the 216 patient classifications show comparable difference all based solely on the source of admission.

NAHC has previously expressed with comments on HHGM, that the application of an admission source measure may seem warranted given data demonstrating different resource use, but that doing so raises the specter of incentivizing HHAs to give priority to post-acute patients over those who are admitted from the community. Incentivizing discriminatory action should not be built into any Medicare payment model. However, 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. As conveyed uniformly at the Technical Expert Panel discussion, CMS should guard against substituting one bad incentive in the payment model with another.

RECOMMENDATION: CMS should re-evaluate the model and the measures used in designing PDGM to eliminate the use of the admission source measure and limit measure that focus on patients' clinical and functional status.

Availability of caregiver assistance

The availability of caregiver assistance is a critical element in determining resource use for home health patients. Research has demonstrated that home health patients who lacked caregiver assistance required more nursing services. In addition, the lack of caregiver assistance leads to lower Medicare margins for service provided to those patients than for patients where caregiver assistance is available.[2]

RECOMMENDATION: CMS should include into the case mix model the OASIS data set item M02102: Types and Sources of Assistance.

Bundling of Non-Routine Supplies in 30-day Payment Unit

A perennial problem with the current HHPPS is the inadequate reimbursement of medical supplies, particularly for wound care patients. Originally, HHPPS bundled reimbursement for non-routine medical supplies (NRS) in with the 60-episodic payment rate. After several years, CMS concluded that separate reimbursement for NRS made more sense. Out of that conclusion was borne the Severity Level Index that classified patients into one of 6 categories with episodic reimbursement varying from $14.31 to $558.16. With PDGM, CMS now proposes to return to the previously abandoned approach of bundling NRS with home health services into a single, case mix weight adjusted payment rate for a 30-day unit.

[2] Rosati, R. J.et al. "Medicare Home Health Payment Reform May Jeopardize Access for Clinically Complex And Socially Vulnerable Patents" *Health Affairs*, vol.33, no.6, Jan. 2014 pp.946-956

For the same reasons that NAHC advocated for separate NRS reimbursement in the early 2000s, we again caution CMS relative to the manner of addressing the costs of NRS within the care of a home health patient. The current NRS Severity Level method is not without concern. However, bundling NRS with services once again creates a high risk of under and over reimbursement.

Wound care NRS continues to present reimbursement concerns in the current HHPPS. For example, a diabetic patient with lymphedema on Lasix needing 3M wraps with Aqcel Ag on open wounds involving almost both entire lower legs needing dressings daily at a cost of $100 a day with only $8 a day in reimbursement.

Under the PDGM proposal, reimbursement for such a patient will not come close to cover the costs to the home health agency. PDGM does not respect that level of costs in the case mix weights assigned to wound care patients.

RECOMMENDATIONS:

1. **CMS should design and evaluate a reimbursement model that accurately pays for NRS separately within the home health benefit**
2. **CMS should include NRS costs in any outlier payment model used in home health services**

Cost Analysis of Therapy Services

One of the most notable changes coming out of PDGM is CMS's shift from evaluating the cost of therapy using wage data from the Bureau of Labor Statistics (BLS) to an evaluation based on Medicare cost report data. The differences are stark. The cost per minute ratio compared to skilled nursing costs drops from 136% to 114% for physical therapy, 138% to 115% for occupational therapy, and 156% to 125% for speech language pathology. As a result, case mix weights for patient groups that include therapy services are significantly depressed from the weights that would be assigned if CMS continued its longstanding use of BLS data.

The central feature of NAHC's concern with this shift is that the significant reduction in payment rates of therapy-included care units is likely to create barriers to care for patients needing therapy. For some HHAs, the matter presents itself as a very simple calculation: We were paid X for these services in 2019 and we will be paid X minus 20% or more in 2020. CMS must appreciate that dynamic in the world of health care economics.

A second concern is that the discipline specific costs of therapy services as reported on a Medicare cost report have not been established as more reliable than the outcome of using BLS wage data. Since 1999, Medicare cost reports have not had a bearing on payment to home health agencies except for the 2014-2017 episode rate rebasing. Likewise, Medicare has essentially conducted no cost report audits beyond those with fiscal years ending in 1999. While NAHC believes that with proper data trims, cost reports can present reasonably reliable displays of overall costs, discipline-specific cost accuracy is another matter altogether.

NAHC has noted several areas of weakness in discipline-specific cost data. These include: the reporting of travel costs; proper classification of patient assessment costs (OASIS); care management costs; and home health aide supervisory visit costs.

BLS data itself is not a perfect alternative as it does not include costs beyond wages.

Given that neither data source should be considered fully accurate or reliable, NAHC looks to the potential impact of rate changes on affecting care access and provider behavior. Already, the home health community is buzzing that the financial consequences of PDGM effectively eliminates or significantly reduces the ability to use therapy under the home health benefit. NAHC continues to educate HHAs that CMS's use of a regression analysis to calculate PDGM case mix weights leads to the model reflecting actual therapy use. However, deep cuts in the reimbursement levels for therapy patients triggered by the shift away from a BLS data-based calculation of cost are more likely to control perceptions and behavior than the mind-numbing science of regression analyses.

RECOMMENDATIONS:

1. **Prior to moving forward with PDGM, CMS should fully validate the accuracy and reliability of cost data to determine case mix weights. CMS should utilize the data source that is determined to have the highest degree of accuracy and reliability.**

2. **In the event that the data source determined to be used results in a marked difference from the outcome that would occur through continued use of BLS data, CMS should consider a blending of the outcomes of the two data sources as a phase-in approach in order to mitigate any disruption in care access. NAHC considers the proposed PDGM to present cause for a blended phase-in approach.**

Clinical Diagnosis Categories

At the Technical Expert Panel (TEP) in February, Abt Associates information revealed that there are available and sensible subsets to the Medicare Management Teaching and Assessment (MMTA) diagnosis category that would permit a more accurate assignment of case mix weights than through the application of a single MMTA category. With payment accuracy a fundamental goal of CMS in payment reform, NAHC sees it as appropriate to consider an expanded group of diagnosis categories wherever possible. It is recognized that such expansion may add complexity to the payment model through a substantial increase in case mix categories beyond the 216 proposed. Nevertheless, since PDGM is not a simple system at any point, adding more categories for the sake of accuracy appears prudent. No single diagnostic category should encompass nearly 50% of all the patients served in home health care. The patient population is too diverse to accept that result.

RECOMMENDATION: Modify PDGM to recognize subsets of diagnosis under the MMTA classification to the extent that payment accuracy is improved to a material degree.[3]

[3] NAHC would appreciate CMS providing information about the incidence of "questionable encounters" in the development of PDGM. To the extent that patient claims were excluded from the regression analysis due to a status of "questionable encounter," NAHC requests CMS display its evaluation of the potential impacts of such exclusions on the reliability of PDGM.

PDGM Rate Setting: Behavioral Adjustments

NAHC recognizes and appreciates CMS's display of potential behavioral adjustments to the base 30-day unit rate in 2020. The specificity of the adjustment information is helpful. However, what is notably absent is the rationale used to calculate these adjustments so precisely. CMS cites to no experiential data. Further, no connection with specificity is made to the PDGM itself other than the conclusory calculations. Further, CMS does not explain what other areas of potential behavioral change were examined, but not included. In the absence of such information, NAHC finds it impossible to provide focused comments on the specific proposed adjustments beyond the following:

1. Of the 6.42% proposed behavioral adjustment, 4.28 points relate to anticipated diagnosis up-coding. HHAs have been reporting diagnosis for many years under HHPPS. CMS has adjusted rates frequently for improved coding accuracy and/or up-coding. At this point, it is unrealistic to expect that there is much if any room for either improved coding accuracy or up-coding on diagnosis.
2. LUPA avoidance accounts for 1.75 points of the proposed 6.42% adjustment. However, CMS has set a LUPA formula that reflects the present rate of LUPAs under HHPPS. After 18 years under a 4 visit threshold for LUPA status, it should be expected that care adjustment flexibility is highly limited.
3. Comorbidity coding has not been relevant to home health services payment. Still, it is perplexing to discern how CMS calculated a 0.38% behavioral change impact so precisely.

Overall, NAHC has serious concerns about CMS's approach to behavioral adjustment. As CMS is well aware, the history of accurate adjustments involving HHA assumed behavioral change has been far short of a success. With the Balanced Budget Act of 1997, the Congressional Budget Office assumed HHAs would increase patient volume to offset revenue losses due to reduced rates. In fact, HHAs went the opposite direction and the Medicare home health patient population dropped from 3.5 million to 2.1 million in less than 2 years.

Under the Bipartisan Budget Act, CMS is permitted, but not required, to set 2020 payment rates based on assumed behavioral changes triggered in response to a shift to a 30-day unit of payment. CMS is also permitted to make temporary and permanent rate adjustments to address behavioral changes that actually occur as a result of payment model reform in order to ensure overall budget neutrality. NAHC 's

interpretation of the provision is that no adjustments are authorized other than those directly related to payment reform system behavioral change that lead to higher or lower Medicare spending on home health services that would otherwise occur if no changes are made to the payment model. Accordingly, NAHC offers the following recommendations.

RECOMMENDATIONS:

1. **CMS should resolve any existing confusion among stakeholders and affirmatively state that its behavioral adjustment authority relates solely to Medicare spending changes as a direct consequence of payment model reform.**
2. **CMS should exercise its discretion and apply behavioral change adjustments to payment rates only after actual changes have occurred and can be demonstrated as related to the payment model reform. Adjustments based on assumptions can lead to the tragic results that occurred following the Balanced Budget Act of 1997. This is consistent with the CMS action on SNF payment reform.**
3. **CMS should fully display its rationale and supporting evidence for any proposed adjustments whether the adjustments are based on pre-change assumptions or post-change evaluation of evidence**
4. **To the extent that CMS employs a reconciliation process to address Medicare spending that is short of or in excess of budget neutral, CMS should fully display the reconciliation process with public notice and an opportunity to comment in advance of its application.**
5. **In the event that budget neutrality reconciliation necessitates a rate change of 2% or more, CMS should phase-in the reconciliation of two or more years depending on the level of rate change needed.**
6. **CMs should evaluate the extent to which behavioral changes occur with individual HHAs in contrast to HHAs in the aggregate and determine whether an adjustment can be HHA-specific. Otherwise, HHAs that do not experience change may share reduced rates with those HHAs that are responsible for Medicare exceeding budget neutrality.**

PDGM Structure Concerns and Comments

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 1-5 visits over a 30 day period can have unintended consequences. Within the PDGM framework, patients that would have led to a LUPA over 60 days will now qualify for a full payment unit. Likewise, patients who would have meant a full episodic payment to the HHA will now mean per visit payment to the HHA.

Generally, a LUPA presents a financial loss to the HHA. The PDGM proposal will perpetuate that loss outcome unless per visit rates are increased significantly. CMS recognized the shortfall as part of the 2014-2017 rate rebasing process. The combination of a rate that virtually ensures losses with a LUPA and a new model that is wholly different that the single threshold model in use since the inception of HHPPS warrants a cautious approach by CMS. 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.

RECOMMENDATION:

CMS should consider maintaining a single LUPA threshold in the initial stages of payment model reform. Such is more likely to bring an outcome consistent with the current model thereby minimizing any impact risks.

PDGM Request for Anticipated Payment (RAP)

CMS proposes to modify the RAP standards by excluding new HHAs and reducing the amount payable as a RAP to 50% at the start of care. NAHC supports this proposal with the exception of denying RAP status to new providers. Certification as a new HHA is subject to a capitalization requirement that

was formulated with consideration of RAP eligibility. New HHAs have as much of a need for cash flow support as do existing HHAs. CMS also has significant control over RAP payments to HHAS that may be abusive or pose an overpayment risk.

PDGM Outliers

NAHC supports the CMS proposal to continue an outlier payment within a budget of 2.5% of total Medicare home health spending. However, **NAHC recommends** that eligibility for an outlier payment be calculated by including NRS costs not just imputed costs of service visits.

Rural Add-On

The NPRM includes the revised targeted rural add-on for CY 2019 with a display as to its phase-down. NAHC recognizes that the rural add-on design stems from the Bipartisan Budget Act amendments to Medicare home health payment standards. NAHC is on record as having opposed the BBA changes to the rural add-on and continues to strongly support a continuation. We will be seeking legislative action in that regard.

Data from FYE2016 cost reports indicate that 45.5% of HHAs based in rural areas had Medicare FFS margins of 5% or below. A full 38% had margins below 0%. These margins include the 3% rural add-on at the time. There is clear justification in nationwide cost report data for continuing it for the vast majority of rural HHAs.

The add-on targeting required by BiBA does not fit. For example, it is not logical to conclude that rural HHAs with utilization levels in the top quartile do not need the add-on. High volume does not automatically translate in low costs or high Medicare margins. Notably, an HHA is often the only source of care in may rural areas. The absence of alternative sources of care can explain the high volume of home health use. Those HHAs providing such volume still need the add-on because of the higher cost of care in rural areas. Reducing or eliminating the rural add-on will cause harm.

In a similar vein, the BiBA add-on is premised on the assumption that HHAs in low density areas need a greater add-on, presumably for higher costs of travel and lower staff productivity due to travel time between patients. However, a significant portion of the HHAs in such areas are also high utilization HHAs. It is a bit illogical to have conflicting premises in play.

RECOMMENDATION: CMS should establish a workgroup to examine the costs of rural home care to determine the best way to address the cost differentials that warrant an add-on payment. It is hoped that CMS and the home health community can then go to Congress together to support the continuation of a rural add-on.

III. Payment Under the Home Health Prospective Payment System
F. Implementation of the Patient Driven Groupings Model (PDGM) for 2020

Split Percentage Payment Approach for a 30-Day Unit of Payment

CMS is seeking comments on its proposal to require agencies submit a notice of admission (NOA) within 5 days of the start of care (SOC) if RAPs are eliminated. The NOA would establish the primary agency and open the home health episode in the claims processing system.
NAHC does not support a NOA in light of issues hospice providers have experience with the notice of election. Additionally, the five day submission time frame would require burdensome operations and tracking changes for agencies. There is not a prescribed time frame for the RAP submission, other than prior to the final claim.

RECOMMENDATION: CMS should not require a NOA. Alternately, if a NOA is required, CMS should eliminate the requirement for submission within 5 days of the SOC. Permitting a NOA to be submitted any time prior to the final claim allows the NOA to function the same as the RAP for identifying the primary agency and opening the home health episode without potential claims processing delays or undue burden for agencies.

Clinical Groupings

NAHC has concerns regarding the diagnosis codes listed in the Grouper tool for the clinical groupings. Coding expects have informed NAHC that there are numerous errors in this list. For example, the "Complex Nursing" group includes Z45.2 (the code for the care of the infusion catheter) as a primary diagnosis code. It is only appropriate to use a Z code as primary diagnosis when an acute condition is present. Agencies would code the condition being treated first (i.e. the infection). In addition, sepsis codes are not on the primary list and should be included in the "Complex Nursing" group. Patients with sepsis are frequently discharged to home care with IV antibiotics. The codes for Parkinson's and Multiple Sclerosis, which should be included as a primary diagnosis for the PDGM in either the "Neuro/Stroke Rehabilitaion" group is not in list at all. These are just a few issues with the clinical grouping diagnosis list that NAHC is hearing.

RECOMMENDATION: CMS should re-evaluate the entire ICD-10 diagnosis code list for accuracy in diagnosis selection for the clinical grouping. The selection of codes must take into consideration ICD 10 coding guidelines and ensure accurate diagnosis assignment for the clinical grouping prior to implementation of the PDGM.

Comorbidity Adjustment

The PDGM includes a comorbidity adjustment for select diagnoses and their interaction with other listed diagnoses. Agencies list the primary and secondary diagnoses on the OASIS assessment in accord the OASIS manual instructions. CMS requires that the diagnoses on the claim match the diagnoses on the OASIS. However, the OASIS is limited to five secondary diagnoses that can be listed regardless of the number of comorbidities the patient may have, while the claim allows up to 20 diagnoses that can be listed. Therefore, there is potential for agencies to have diagnoses listed on the claim that cannot be added to the OASIS assessment.

RECOMMENDATION: **CMS should apply to the comorbidity adjustment to any selected PDGM comorbid diagnosis that is listed on the claim.**

HH PPS Case-Mix Weights Under the PDGM

CMS proposes to discontinue the October release of the home health home Grouper and issue only one release in January of each year beginning in 2020. The second Grouper that CMS currently releases includes revisions to the International Classification of Diseases (ICD) coding system that are implemented each October. Under this proposal, HHAs would continue to use the ICD–10 codes and reporting guidelines during the forth quarter of each year that they would have used for the first three calendar quarters. HHAs would begin using the most recent ICD–10 codes and reporting guidelines on home health claims beginning on January 1 of each calendar year.

NAHC has concerns that HHAs will be out of compliance with Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules if the Grouper is not updated in accord with ICD revisions. HIPAA requires usage of the ICD code set that is valid at the time the service is provided. Under CMS' proposal, HHAs could potentially use an incorrect ICD-10 code on claims for the last quarter of each year.

RECOMMENDATIONS: CMS should ensure that the decision to release only one Grouper version per year in January does not place HHAs at risk for violating HIPAA rules.

G. Proposed Changes Regarding Certifying and Recertifying Patient Eligibility for Medicare Home Health Services

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

CMS proposes to codify into the regulation its policy for documentation requirements to support eligibility for home health services. CMS has issued sub-regulatory guidance which permits the physician to incorporate documentation from HHAs medical record that supports eligibility for home health services into his/her own medical record. The physician must sign the documentation as evidence of incorporating the information into his/her medical record. In the guidance, CMS states that the

documentation can include, but is not limited to, the patient's plan of care (POC) and the initial and/or the comprehensive assessment.

It is unclear, and cannot be inferred, from CMS' policy that a patient's POC that includes information to support eligibility can be the sole document used for the physician to sign and incorporate into the medical record to support eligibility for home health services.

RECOMMENDATION: CMS should clarify that the patient's POC, with sufficient information to support eligibility, signed by the physician may be used as documentation from the physician's medical record to support eligibility for home health services. CMS might consider revising the regulatory text to read: "…..documentation can include, but is not limited to, the patient's plan of care and/or the initial or the comprehensive assessment".

Proposed Elimination of Recertification Requirement To Estimate How Much Longer Home Health Services Will Be Required

NAHC supports the proposed change to eliminate the recertification statement for how much longer the home health services are needed and is grateful that CMS has reconsidered its position on this requirement.

IV. Home Health Value-Based Purchasing (HHVBP) Model

B. Quality Measures

Proposal To Replace Three OASIS Based Measures With Two Composite Measures Beginning With Performance Year 4

CMS proposes to add to the HHVBP model two new composite measures: Total Normalized Composite Change in Mobility and Total Normalized Composite Change in Self-Care.

The composite measure for change in mobility uses three existing OASIS based outcome measures currently included in the HHVBP model (improvement in bathing, transfer and ambulation). While the composite measure for change in self-care uses six OASIS based measures not currently included in the HHVBP model (Improvement in Grooming (M1800), Improvement in Upper Body Dressing (M1810); Improvement in Lower Body Dressing (M1820); Improvement in Bathing (M1830); Improvement in Toileting Hygiene (M1845); Improvement in Eating (M1870)). In addition, only the improvement in bathing measure is publically reported and included in the Quality of Patient Care Star Ratings. CMS propose that the two composite measures will carry a maximum possible score of 15 points each for a total of 30 points. The changes apply to performance year 4.

NAHC has concerns with incorporating into the HHVBP model a composite self-care measure that uses outcome measures that are not currently included in the HHVBP model and have not been a priority focus for quality improvement for agencies participating in the HHVBP program.

CMS in essence is adding six new quality measures to the HHVBP model. Although agencies look at all the quality measures when assessing quality of care delivery, priority is given to those measures that impact the public perception of high quality of care provided by the agency, and for agencies participating in the HHVBP model, measures that also impact the TPS.

Proposal To Reweight the OASIS Based, Claims-Based, and HHCAHPS Measures

CMS is proposing to change the methodology for calculating the Total Performance Score (TPS) by weighting the measure categories so that the OASIS-based measure category and the claims-based measures would each count for 35 percent and the HHCAHPS measures would count for 30 percent of 90 percent of the TPS. In addition, CMS is proposing to revise the weight of the Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health claims-based measure by increasing the weight so that it has three times the weight of the Emergency Department Use without Hospitalization claims-based measure,

The acute care hospitalization measure would account for 26.25 % score while the ED use measure would account for 8.75 % of the score (90 % of the TPS). Furthermore, CMS proposes to

weight categories of measures equally if one category is not reported. This scenario would most likely occur when an agency is exempt for the HHCAHPS reporting requirements. The OASIS based measure scores and the claims based measures scores would each equal 50 % of the score (90% of the TPS).

These proposed changes to the HHVBP model could have significant impact on the reimbursement for agencies participating in the HHVBP model. Agencies are at risk for as much as a 7% payment adjustment in payment year 4, which reflects their performance under the HHVBP model for CY 2019. Agencies will need sufficient time to understand the impact these proposals will have the on their reimbursement and to revise their strategies for successful behavior change that CMS compels agencies to attain. Implementation that begins January 1, 2019 will not provide agencies with sufficient time to conduct the necessary analysis and adopt the required operational changes.

These concerns are heightened with CMS' proposal to weight the acute care hospitalization measure 26.25 %. The emphasis on the acute care hospitalization measure is too dramatic for the amount of time agencies will have to implement strategies to affect change in this measure during the remainder of the HHVBP program, much less for performance year 4. Agencies are unfairly at risk for significant negative reimbursement adjustments. Additionally, such an emphasis to reduce acute care hospitalizations could create barriers to care for complex and vulnerable patents in the HHVBP states.

RECOMMENDATIONS:

1. **Adopt only the Total Normalized Composite Change in Mobility that uses measures currently in the HHVBP model.**
2. **Maintain the current weighting methodology that weights each of the measures equally.**
3. **Alternately, delay implementation of the proposed weighing methodology for one year to allow agencies time for adequate preparations and apply a more reasonable weighting methodology to the claims based measures.**

D. Update on the Public Display of Total Performance Scores

CMS is soliciting further public comment on what information, from the Annual Total Performance Score and Payment Adjustment Reports and subsequent annual reports, should be made publicly available.

It is unclear how this information will be reported. Either as a separate report or as part of the Home Health Compare web page.

RECOMMENDATIONS: Regardless of the manner CMS reports the performance of agencies participating under the HHVBP model, NAHC urges CMS to ensure that it does not unfairly disadvantage agencies in states not participating in HHVBP model. This has important implications for agencies in non-HHVBP model states that service patients in areas within the HHVBP model states. Agencies in the non-participating states will not have the same quality information posted as the participating agencies, which could be confusing to consumers and referral sources when selecting an agency. CMS should ensure all agencies servicing selected areas are represented and clearly define the differences in the quality information reported.

V. Proposed Updates to the Home Health Quality Reporting Program (HH QRP)

C. Proposed Removal Factors for Previously Adopted HH QRP Measures

CMS is proposing to replace the six criteria used when considering a quality measure for removal with the following seven measure removal factors. CMS is also proposing to adopt an additional factor to consider when evaluating potential measures for removal from the HH QRP that addresses cost associated with the measure.

E. Proposed Removal of HH QRP Measures Beginning With the CY 2021HH QRP

CMS is proposing to remove the following seven measures from the HHQRP

- Depression assessment conducted-
- Diabetic foot care and PT/CG education
- Fall risk assessment conducted
- Pneumococcal Polysaccharide Vaccine ever received
- Improvement of status of surgical wounds
- ED use without hosp. readmission 30 days

- Re-hospitalization first 30 days

RECOMMENDATION: **NAHC supports the proposed changes to the HHQRP**

VI. Medicare Coverage of Home Infusion Therapy Services

C.2.f. Home Infusion Therapy and the Relationship to/Interaction with Home Health

CMS proposes to permit a beneficiary to receive the home health benefit and the home infusion therapy benefit concurrently and further describes how HHAs would submit claims when a beneficiary is receiving services under both benefits during a spell of illness.

NAHC has serious concerns with CMS' proposal since it fails to recognize how home infusion therapy is currently provided to eligible beneficiaries under the home health benefit.

Currently, a beneficiary may receive home infusion therapy by combining the DME benefit for the pump, supplies and covered infusion drug with the skilled professional services covered under the home health benefit. The DME supplier bills Part B DME for the supplies, pump and infusion drugs, while the HHA bills Medicare for the professional services under the home health benefit.

If the home infusion therapy benefit is implemented as proposed, HHAs will not be able to bill for the professional services associated with the new benefit for home infusion therapy under the home health benefit, rather, these services will need to be provided and billed by a home infusion therapy supplier under Medicare Part B, whether or not the home infusion therapy supplier is also the Medicare certified HHA. This benefit structure disadvantages beneficiaries in terms of cost to the beneficiary, restricting entitled benefits, and fragmenting care.

Eligible beneficiaries are able to receive the professional services associated with infusion therapy under the home health benefit without incurring out of pocket costs. The new Part B home infusion therapy benefit will require 20 % beneficiary co-pay for the professional services that are otherwise covered in full under the home health benefit.

Additionally, some beneficiaries could see limitations in eligibility for home health services. For example, if a beneficiary is otherwise eligible for home health services and the only needed skilled service is nursing for infusion therapy, but also needs a dependent home health service(s)(occupational therapy, home care aide, social worker), the beneficiary will be precluded from receiving the other support services under the home health benefit. The qualifying service for Medicare home health services will be shifted to the home infusion therapy supplier. The home infusion therapy supplier will not be eligible to provide the support services nor will the beneficiary be eligible to receive the services under the home health benefit. Therefore, the beneficiary will be forced to go without the needed support services or pay for the care privately.

Furthermore, the proposal for the home infusion therapy benefit and the home health benefit to run concurrently could require two distinct service providers in the home under separate plans of care during the same spell of illness. For example, a beneficiary that requires skilled nursing for wound care and infusion services could potentially be required to receive skilled nursing for the wound care from the home health agency and receive skilled nursing for the infusion from the home infusion therapy supplier. This fragmentation of care poses a clear risk to the quality of care provided to the beneficiary. Additionally, the burden of coordinating care to assure beneficiary safety will be the responsibility of the home health agency since the home infusion therapy benefit is more limited in scope.

C.1.c. Eligible Home Infusion Suppliers, Eligible Individuals, And Relationship to Home Health

Section 50401 of the BBA of 2018 provides for a transitional payment for home infusion therapy services to select suppliers. CMS proposes to coordinate the home infusion therapy benefit and home health benefit during the CY2019-2020 transitional payment the same as when the program becomes permanent in 2021 as described in section VI.C.2.f in the proposed rule. NAHC has concerns, as described above, with the provision of these two benefits in accord with section VI.C.2.f.

NAHC does not believe section 50401 of the BBA of 2018 requires CMS to implement concurrent benefits during the 2019 -2020 transition period. Therefore, NAHC does not support CMS implementing the payment arrangement described in VI.C.2.f.during the transition payment period.

RECOMMENDATION: **CMS should limit the new Part B home infusion therapy benefit for the professional services to beneficiaries not eligible for the home health benefit during 2019-2020 transitional payment periods and when the benefit becomes permanent in 2021. Limiting the home infusion therapy benefit to beneficiaries not eligible for the home health benefit ensures beneficiary protections related to unnecessary beneficiary cost, full benefit entitlement, and quality home health care.**

C.2.c Payment Basis, Limitation on Payment, Required and Discretionary Adjustments and Billing Procedures

CMS proposes that all home infusion therapy suppliers be enrolled in Medicare as Part B supplier and bill the home infusion therapy services on a supplier and professional claim 837P/CMS-1500. Home health agencies are eligible to enroll as home infusion therapy supplies beginning 2021 when the benefit becomes permanent.

Home health agencies may currently bill for select Part B items and services under the agency's provider number using a Type of Bill (TOB) 34x. For example, HHAs may bill for outpatient Part B therapy and DME without enrolling as Medicare Part B supplier.

RECOMMENDATION: CMS should not require HHAs to enroll in Medicare as Part B suppliers in order to furnish home infusion therapy services under the new benefit. Rather, CMS should permit home health agencies that are accredited home infusion therapy suppliers to bill for the home infusion services under the home health provider number on a TOB 34x.

VIII. Requests for Information:

A. Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

NAHC has established an affiliated Home Care Technology Association of America (HCTAA) that is comprised of home care and hospice vendor partners as well as provider representatives. The HCTAA Advisory Board has analyzed the RFI included in the proposed home health payment rule and has developed comments responding to it. Those comments and perspectives are contained in a separate letter that we have enclosed with this submission.

B. Request for Information on Price Transparency: Improving Beneficiary Access to Home Health Agency Charge Information

CMS is seeking information on how to achieve its objective of having providers undertake efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain from the provider and to enable patients to compare charges for similar services across providers and suppliers.

Specifically, CMS is seeking information on the following:

• How should ‘‘standard charges’’ in the home health setting be defined? Is there one definition for those settings that maintain charge masters, and potentially a different definition for those settings that do not maintain charge masters? Should ‘‘standard charges’’ be defined to mean: average or median rates for the items on a charge master or other price list or charge list; average or median rates for groups of items and/or services commonly billed together, as determined by the HHA based on its billing patterns; or the average discount off the charge master, price list or charge list amount across all payers, either for each separately enumerated item or for groups of services commonly billed together? Should ‘‘standard charges’’ be defined and reported for both some measure of the average contracted rate and the charge master, price list or charge list? Or is the best measure of a HHA’s standard charges its charge master, price list or charge list?

• What types of information would be most beneficial to patients, how can HHAs best enable patients to use charge and cost information in their decision making, and how can CMS and HHAs help third parties create patient-friendly interfaces with these data?

Comments: HHAs currently provide patients, as part of the admission process, the agency charges for services equivalent to a charge master. NAHC does not support requiring agencies to include as part of a

charge master a price list or charge list amount across all payers. This would be prohibitively burdensome for agencies and should be the responsibility of the individual payers to provide this information. Additionally, consumers and referral sources do not choose home health providers based on charges but on the quality of care the agency provides. Any out of pocket costs for home health services is determined by the payer not the home health agency.

• Should HHAs be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service? How can information on out-of-pocket costs be provided to better support patients' choice and decision-making? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs?

How can CMS help beneficiaries to better understand how co-pays and coinsurance are applied to each service covered by Medicare? What can be done to better inform patients of their financial obligations? Should HHAs play any role in helping to inform patients of what their out-of-pocket obligations will be?

• If HHAs were required to provide patients with information on what Medicare pays for a particular service performed by that HHA, what changes would need to be made by HHAs? What burden would be added as a result of such a requirement?

In addition, CMS is seeking public comment on improving a Medigap patient's understand of his or her out-of-pocket costs prior to receiving services, especially with respect to the following particular questions:

• How does Medigap coverage affect patients' understanding of their out-of-pocket costs before they receive care? What challenges do HHAs face in providing information about out-of pocket costs to patients with Medigap?

- What changes can Medicare make to support HHAs that share out-of-pocket cost information with patients that reflects the patient's Medigap coverage? Who is best situated to provide patients with clear Medigap coverage information on their out-of-pocket costs prior to receipt of care? What role can Medigap plans play in providing information to patients on their expected out-of-pocket costs for a service? What state-specific requirements or programs help educate Medigap patients about their out-of-pocket costs prior to receipt of care?

Comments: NAHC believes HHAs are currently providing this information. In accord with federal regulations, HHAs are required to inform all patients served by the agency, in writing, of their out of pocket costs, regardless of payer, and for Medicare beneficiaries, what services are covered by Medicare prior to the initiation of care. In addition, there is no cost sharing (co-payments or coinsurance) for Medicare fee- for-services beneficiaries under the home health benefit. Therefore, Medigap coverage policies do not apply to HHAs. Although, cost sharing is permissible for beneficiaries under Medicare Advantage (MA) plans, Medigap policies do not apply to cost sharing related to MA plan coverage.

VII. Collection of Information Requirements

B. ICRs Regarding the OASIS

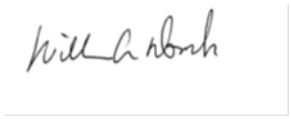
CMS proposes to make 19 current OASIS items (48 data elements) optional at the follow-up time point once PDGM is implemented. Two of the items proposed to be optional are M1021: Primary Diagnosis and M1023: Other Diagnosis. Since the diagnosis will be required for the PDGM case mix calculation and the claim must reflect the diagnoses as reported on the OASIS assessment, it is unclear why CMS proposes to make these two items optional at recertification.

RECOMMENDATION: CMS should clarify why it is proposing the OASIS items for primary and other diagnosis are to be option at recertification with the implementation of the PDGM.

CONCLUSION

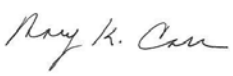
Thank you for the opportunity to submit these comments. Please free to contact the undersigned if further information is needed.

Very truly yours



William A. Dombi, Esq.

President



Mary K. Carr
Vice President for Regulatory Affairs

State Associations

Arizona Association for Home Care
California Association for Health Services at Home
Home Care Association of Colorado
Connecticut Association for Healthcare at Home
Kansas Home Care & Hospice Association
Home Care Association of Florida
Georgia Association for Home Health Agencies
Healthcare Association of Hawaii
Illinois HomeCare & Hospice Council
Indiana Association for Home and Hospice Care
Iowa Health Care Association
Kentucky Home Care Association
HomeCare Association of Louisiana
Home Care & Hospice Alliance of Maine
Maryland National Capital Home Care Association
Michigan HomeCare & Hospice Association

Minnesota HomeCare Association

Mississippi Association for Home Care

Missouri Alliance for Home Care

Montana Hospital Association

Nebraska Home Care Association

New Mexico Association for Home & Hospice Care

Home Care Association of New York State

New York State Association of Health Care Providers

Association for Home & Hospice Care of North Carolina

Ohio Council for Home Care & Hospice

Oklahoma Assoc. for Home Care & Hospice

Oregon Association for Home Care

Pennsylvania Homecare Association

Asociación de Agencias de Servicios de Salud en el Hogar y Hospicios de Puerto Rico

Rhode Island Partnership for Home Care

South Carolina Home Care & Hospice Association

Tennessee Association for Home Care

Texas Association for Home Care & Hospice

Utah Association for Home Care

Virginia Association for Home Care and Hospice.

Home Care Association of Washington

West Virginia Council of Home Care Agencies

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