September 25, 2017

Submitted via www.regulations.com

The Honorable Seema Verma
Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: **CMS-1672-P**
PO Box 8016
Baltimore, MD 21244-8016

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,

The Home Care & Hospice Association of NJ represents home health and hospice agencies that embody over 36,600 visiting nurses, home health aides and other health care industry agencies and employees. Our services reach more than 100,000 Medicare beneficiaries across the state.

On behalf of the Association, thank you for the opportunity to comment on the following components of the 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.

According to the National Association for Home Care and Hospice, Medicare home health has experienced more rate cuts over the last decade than any other health care sector in the Medicare program and is the only provider type that has not had an increase in Medicare reimbursement since 2009. Cuts to the home health program

would result in the loss of available home health services and will also threaten important health care jobs.

For the millions of people who receive home care services, and the millions more projected to need it in the near future, protecting and improving the home health benefit for beneficiaries is paramount. However, ensuring that the models proposed for reimbursement are sustainable, equitable and dependable is even more critical if home health providers are to stay in business and have the resources to provide high quality care to enable people to remain at home.

Annual Home Health Payment-Rate Update

The proposed rate update would result in a 0.4% (-$80 million) decrease in payments in 2018 as the result of the 3rd and final year of case mix adjustments and the annual market basket increase. Further, an additional 2% reduction for HHAs that do not submit quality data would continue. The most significant change in the rate update for 2018 is the scheduled sunset of the 3% rural add-on provision for agencies serving rural and hard to service geographical territories. Although New Jersey is not classified as a rural state, we do recognize and appreciate the financial, staffing, clinical oversight and transportation challenges that HHAs face in serving beneficiaries in rural areas. We strongly support any legislation that would extend the rural add-on provision which is a crucial protection for providers and prevents access to care challenges for Medicare beneficiaries living in rural America.

With respect to New Jersey home health providers, while not classified as a rural state, we serve many high risk urban areas including Camden, Vineland, Atlantic City, Elizabeth, Trenton, Newark, Irvington, East Orange, Paterson and more. The need for security services to escort visiting staff and ensure their safety has risen dramatically. The cost of providing this security service, to ensure that patients have access to care and staff are safe, is a tremendous expense and one that continues to rise. With ongoing cuts to reimbursement, agencies that provide essential home health services to some of the state's poorest and most disabled residents will need to revisit whether they can continue to afford to safely provide care in these urban areas of New Jersey.

Value Based Purchasing

New Jersey providers support improving the quality and delivery of home care services to Medicare beneficiaries and evaluating and updating the quality standards that measure overall value of service delivery.

Future VBP measures for consideration should be tested and evaluated thoroughly before implementation, be risk adjusted and allow consideration for stabilization of patient outcomes. The future inclusion of behavioral-mental health measures is significantly important. Behavioral-mental health factors impact the success or progress made with a home health plan of care. Behavioral health conditions are often the primary factor influencing patient and caregiver participation, compliance and eventual outcomes of care. Identifying behavioral health conditions and the availability of behavioral health supervision could improve a patient's access to other types of mental health care providers and improve health outcomes.

Home Health Quality Reporting Program

Quality improvement is a progressive evolving process required to change and improve patient care. The proposed changes to the Home Health Quality Reporting Program (HHQRP) for collection starting in 2019 include:

- The redesign of several quality measures to comply with the IMPACT Act of 2014 which focuses on post-acute care cross setting quality measures and standardized assessment items.
  Comment: Agencies will incur significant costs to change EHR systems, patient documentation procedures and provide extensive staff and administrative education and training. All proposed changes to the HHQRP must be endorsed by the National Quality Forum (NQF) before implementation.

- Consider accounting for social risk factors in the quality reporting program.
  Comment: There is no doubt that social risk factors affect outcomes and the measurement of quality care. We believe it is every clinician's intent to provide the same standard of care to all patients, but social risk factors can influence participation in a plan of care and must be taken into consideration when measuring quality and patient outcomes.

- Removal of OASIS data elements that are not used in quality measure or payment calculations.
  Comment: We support the changes proposed in the OASIS change table (table 45). These exclusions will reduce burden for HHAs and do not collect impactful or valuable data. The additions proposed to the OASIS assessment tool are comprised of several new/combined items in line with the objectives of the IMPACT Act.

- Collection of standardized patient assessment data items across post-acute care settings.
  Comment: Standardizing assessment items across post-acute care settings will allow for improved communication, continuity of care and the determination of quality care outcomes along a patient's healthcare trajectory. These cross setting assessment items, once designed, must be tested and validated for use in all four PAC settings before implementation.

- New/Changed (*) HHQRP Quality Measures for 2020.
  - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury*- quality measure that would be a modification of the existing pressure ulcer measure.
  - Application of an Admission and Discharge Functional Assessment and Care Plan that Addresses Function- process measure that would require new/added OASIS assessment and the completion of an additional data set specific to this measure.
  - Application of the Percent of Patients Experiencing One or More Falls with Major Injury- outcome measure

Comment: Revision of quality measure assessment items is a necessary performance improvement process. All quality measure and assessment item changes that occur as a result of the IMPACT Act must be first tested then endorsed by NQF. These changes will require intensive education and training, EHR and other administrative procedure changes, and system upgrades that will all have a significant impact on a HHA's resource utilization and clinical operations.

Home Health Case Mix Redesign with Home Health Group Model

The most dramatic proposed change in the CY2018 HHPPS Proposed Rule is the introduction of a completely new payment model that is not budget neutral, named the Home Health Grouper Model (HHGM). This payment system proposed to go into effect in 2019, is estimated to cut Medicare home health spending by $950 million (4.3%) and does not comply with the laws of Home Health Prospective Payment System which require any changes or new reimbursement models for Medicare Home Health services to be done in a budget neutral manner. This proposed grouper model would also change the episode payment structure (from 60 to 30 days) which contradicts the statutory requirements of the ACA and the Social Security Act. Historically, this is the largest, most risky and most dramatic payment reform proposal since the inception of PPS in 1999-2000.

Issues/Comments:

The HHGM was created without input from home health industry experts/leaders and it proposes to change an entire health care system into an untested payment model. Being an untested model, there is a high probability that it would cause severe agency financial loss with consequences that would put beneficiaries at risk. A non budget neutral payment system would cause significant access to care issues especially for beneficiaries residing in more rural areas.

The goal of the model appears to set payments equal to costs which would rebase the entire PPS system to a lower level. The proposed change to a 30 day payment model would leave the 60 day episode of care intact including the current OASIS collection requirements, RAP submissions, physician certifications and the patient's plan of care and goals. A payment structure that is inconsistent with the rest of the Medicare home health structure will cause confusion, increase administrative burdens, change billing practices, risk cash flow, complicate existing clinical operations and increase costs.

Therapy home health services are producing savings in innovative value based care, alternative payment systems and bundled payment models. Elimination of the therapy visit volume payment determinant would penalize agencies providing high levels of skilled therapy usually associated with joint replacements with the need for high volume, high acuity therapy interventions in the immediate post-op period. These patients are discharged to the community, bypassing more costly post-acute settings (SNF, IRF) because they *can* receive high quality, intensive therapy in a lower cost setting at home. These highly skilled services remain costly but nowhere near what inpatient care of these same services would cost! Failure to recognize the need for appropriate therapy utilization reimbursement could force Medicare patients to seek more costly rehabilitation in institutions rather than receive care at home.

LUPA and Outlier payment calculations would change from a 60 day episode calculation to a 30 day period timeframe, meaning that each of the 30 day payment periods in a 60 day episode of care could be calculated as a LUPA decreasing the episodic payment. The low utilization payment adjustment calculated for 30 day periods should not vary based on proposed clinical or case mix groups, but instead simply be set at 2 visits- half of the original LUPA threshold of 4 visits established for 60 day episodes.

HHGM Components:

- Admission Source & Timing of the Episode- acuity and higher resource utilization does not always align with institutional referral sources. The practice of 'front-

loading' (higher service provision at the beginning of care) a patient admitted to home health from an acute care setting is accepted best practice to assess changes in condition and establish a thoroughly reconciled plan of care to prevent acute care readmission. However, this practice is not unique to institutional referrals and can be applied to community referrals depending on the diagnosis, care planning needs, risk for acute care interventions and comorbidities. Admission source is not always an indicator of acuity or resource utilization.

- Clinical Groupings- based on clinical characteristics of the primary home health diagnosis, these clinical groupings illustrate expected resource utilization and fall into 6 categories. The MMTA (medication management, teaching & assessment) and Behavioral Health clinical groups are considered a lower resource category despite the fact that a majority (projected 56.77%) of chronically ill, complex patients with complicating co-morbidities fall into these groups. The skilled assessment, teaching and case management of these clinically complex and challenging groups is what helps to prevent acute care hospitalizations, adverse events and decline in functional status. These clinical groups may not need multidisciplinary intervention, non-routine supplies or high tech interventions, but the skilled care they do require and the outcomes achieved cannot be undervalued based on diagnosis alone.

- Functional Status- this is one area of the payment model that has not changed. Functional status (collected thru OASIS items) is a requirement of the IMPACT Act and is a valuable component of determining need for therapy services. Functional status assessment and outcome measurements should also allow for stabilization, not just an improvement or decline in status.

- Comorbidity Adjustment- all secondary diagnoses will be considered for inclusion into qualifying comorbidity adjustment groups. Financial adjustments will be added if a qualified comorbid diagnosis exists. The proposed rule illustrates in table 39 that only 14.7% of the episodes qualified for comorbidity adjustments. Without proof of how this model designed and tested, but knowing that a majority of home health beneficiaries have between 2-5 comorbid conditions, it seems illogical that only 14.7% of episodes had a qualifying comorbidity factor! More information and education is needed on the determination and inclusion of comorbidity diagnoses in the calculation of the HHGM.

Dobson DaVanzo & Associates, LLC, compared current data using the proposed HHGM and were able to demonstrate that 27% of HHAs would experience a revenue shift of at least +/-20% for the same cases under HHGM. Historically, changes of this

magnitude have placed agencies in jeopardy, with negative impacts on beneficiaries, providers, and the post-acute care landscape. All of the changes in the proposed HHPPS rule and its projected risk is contradictory to CMS's goal of reducing burden and regulation restrictions and investing more resources into delivering quality care in the most cost effective setting.

We urge CMS to withdraw the HHGM proposed payment model and work with stakeholders in a more inclusive process that will enable policy changes that comply with statute, not limit access to beneficiaries, reduce provider resources or negatively impact the health care workforce thereby risking the health care sector that is best positioned to achieve the triple aim.

Medicare home health services are proven to save health care dollars, provide quality care with positive health outcomes, keep patients and families safe in their own homes, reduce health care expenditures over time and improve the quality of patient's lives. We believe that it is imperative that the Home Health Grouper Model (HHGM) proposed for 2019 be withdrawn as we require more information to fully assess the impact this drastically different payment model will have on the home health industry. We encourage CMS to convene a workgroup and educate all members on the impact of the HHGM before considering it in a future proposed rule.

On behalf of our members and the Medicare beneficiaries they serve, thank you for the opportunity to comment on the 2018 HHPPS Proposed Rule. We look forward to our continued innovative and collaborative relationship with CMS and the post-acute care community of quality focused providers.

Sincerely,

Chrissy Buteas
President & CEO