

Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME



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Submitted via regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare & 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

The Centers for Medicare & Medicaid Services (“CMS”) has proposed to establish and implement a completely new payment system for Medicare home health services beginning in calendar year (CY) 2019. 82 Fed. Reg. 35,270 (July 28, 2017). The proposed new model is known as the Home Health Groupings Model (“HHGM”). It completely replaces the patient classification system with a new model that classifies patients for purposes of determining payment amounts based on the patient’s diagnoses, clinical condition, functional status, pre-home healthcare setting, and the time point when care is rendered in relation to the start of home health services. The proposed model also would institute a 30-day unit of payment in place of the 60-day unit of payment. Finally, this new model is not implemented in a budget neutral manner. We believe that the statutory language does not permit this wholesale revision of the law absent Congressional action.

The HHGM proposal to establish a wholly new, non-budget neutral payment amount without authorization by Congress violates Section 1895(b)(3) of the Social Security Act, 42 USC 1395fff(b)(3). Further, the proposal to replace the 60-day “episode” unit of payment with a 30-day payment “period” violates Section 1895(b)(2) of the Social Security Act, 42 USC 1395fff(b)(2). Accordingly, this proposal must be withdrawn.

The following is a summary presentation of the limitations on the Secretary’s authority to change the standardized payment amount in a non-budget neutral manner along with the limitations in power to substitute a new “unit of payment.” While this letter is not intended to be an exhaustive legal review, the Secretary lacks the authority to implement these changes. The statutory framework establishes an unambiguous limit on the Secretary’s discretion to make changes in the Medicare home health payment system in the absence of direct authorization and/or mandate from Congress. Neither the language of Section 1895 nor CMS’s numerous past interpretations of Section 1895 support the claimed authority to implement a changed payment amount or new unit of payment.

“The starting point for [determining the scope of an agency’s rulemaking authority is], of course, the language of the delegation provision itself.” *Gonzales v. Oregon*, 546 U.S. 243, 259 (2006). The language of Section 1895(b)(3) and 1895(b)(2) unambiguously indicates that any modifications by CMS to the prospective payment system for home health must be budget neutral unless Congress indicates otherwise. Similarly, there is no authority to alter the 60-day episode unit of payment once it was established.

The Secretary Must Implement Any Changes in the Payment Model as Budget Neutral

The Balanced Budget Act of 1997 (“BBA”), Pub. L. No. 105-33, mandated the development and implementation effective October 1, 2000 of a prospective payment system (“PPS”) for home health services. *See* BBA, § 4603(a), adding a new section 1895 to the Social Security Act. On July 3, 2000, CMS predecessor issued its final rule implementing the Home Health Prospective Payment System (“HH PPS”) effective October 1, 2000, as required by the Balanced Budget Act of 1997. *See* Medicare Program: Prospective Payment System for Home Health Agencies, 65 Fed. Reg. 41,128 (Jul. 3, 2000) (codified at 42 C.F.R. pts. 409, 410, 411, 413, 424, and 484); *see also* Social Security Act § 1895(a), 42 U.S.C. § 1395fff(a); 42 C.F.R. pt. 484.200. The new rule “establishe[d] requirements for the new prospective payment system for home health agencies,” which include “the implementation of a prospective payment system for home health agencies, consolidated billing requirements, and a number of other related changes.” *Id.* at 41,128.

For CY 2019 and subsequent years, the agency proposes to establish a new standard payment amount that is not budget neutral in comparison to the current amount that was established in October 2000 with only statutorily authorized reductions and adjustments since that point. According to CMS,

[t]he overall impact of the proposed HH PPS case-mix adjustment methodology refinements, including a change in the unit of payment from 60-day episodes to 30-day

periods of care, is an estimated -\$950 million (-4.3 percent) in payments to HHAs in CY 2019 if the refinements are implemented in a non-budget neutral manner for 30-day periods of care beginning on or after January 1, 2019.

82 Fed. Reg. at 35,273 (Table 1).

Under Section 1895(b)(1), the Secretary is empowered to establish “a prospective payment amount.” The authorization for the Medicare prospective payment amount, as originally enacted, provided that

[u]nder such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in **a budget neutral manner** consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

Social Security Act § 1895(b)(3)(A)(i) (West 1998) (emphasis added).

When Section 1895(b)(3)(A)(i) was amended, the concept of budget neutrality was continued in its current form:

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a **budget neutral** manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A) (emphasis added).

In terms of specific implementation of the budget neutrality requirement, Section 1895(b)(3)(A)(i)(I) authorizes the Secretary to compute the standard prospective payment amount based on audited cost data

so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect and if section 1895(v)(1)(L)(ix) had not been enacted.

These directives are unambiguous budget neutrality mandates regarding the standard payment amount.

Section 1895(b)(3) proceeds with a year-by-year sequence of limited mandates authorizing changes in the standard payment amount established as of October 2000. These changes in the standard amount include:

1. 2001—A 12-month update calculated by applying the annual Market Basket applicable increase percentage, Section 1895(b)(3)(A)(i)(II).
2. Beginning 2002—A reduction in the standard payment amount equal to “a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L).
3. For “**2014 and subsequent years**”—The “amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary...” subject to a 4-year phase-in period with a 3.5 percent limit annually during the phase-in period, Section 1895(b)(3)(A)(iii) (emphasis added).

No further non-budget neutral adjustments in the standard payment amount are authorized by the statute. CY 2019 is a “subsequent year” subject to the statutorily mandated standard payment amount determined following application of Section 1895(b)(3)(A)(iii). The statute only permits changes in the payment amount that reflects the Market Basket Percentage Increase [1895(b)(3)(B)(i)-(iii)], the Adjustment for Case Mix Changes [1895(b)(3)(B)(iv)], the Adjustment for Quality Data Not Submitted [1895(b)(3)(B)(v)], the Productivity Adjustment [1895(b)(3)(B)(vi)], and the Outlier Adjustment [1895(b)(3)(C)]. The Secretary has no authority to alter or change the standard payment amount that is required by the statute unless such alteration or change is specifically authorized by the statute, yet this is precisely what HHGM would achieve if it is implemented.

The budget neutrality mandate is further supported by Section 3131(d) of the Patient Protection and Affordable Care Act (“ACA”), P.L. 111-148, which required a study of low-income patients’ access to home health services and directed CMS to furnish Congress with a report of its work, along with any legislative or regulatory recommendations. Section 3131(d) also permitted CMS to establish a 4-year demonstration based on the findings of the study. Nothing in Section 3131(d) authorized CMS to establish a process by which the current home health payment system could be comprehensively, permanently altered, and nothing within Section 3131(d) authorized CMS to implement any of the legislative or regulatory recommendations that accompanied the aforementioned study and report. Moreover, and quite significantly, while Congress did authorize CMS to conduct a 4-year demonstration to test any of the concepts or findings derived from the aforementioned study, it contemplated the possibility that CMS might have devised the standardized payment amount of such a demonstration in a non-budget neutral fashion – but clearly and unequivocally prohibited the Agency from doing so. Section 3131(d)(5)(B) states as follows:

WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

(emphasis added).

Section 3131(d) permits CMS to modify the payment model in a demonstration program, but only if it is budget neutral. It is illogical then for CMS to claim that it can implement comparable modifications outside of a demonstration project in a non-budget neutral manner. Medicare laws must be read in a consistent and logical manner. As such, it is in violation of Medicare law, specifically Section 1895(b)(3), for CMS to implement the proposed payment model changes in a non-budget neutral manner when CMS is unambiguously prohibited from doing such in a demonstration project.

The Secretary Must Maintain the Originally Established Unit of Payment

Section 1895(b)(2) provides that:

In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

The linchpin of the home health payment has been, since 2000, the sixty-day episode of care. *See* 42 C.F.R. § 484.205(a). The 60-day episode for payment purposes is also consistent with the plan of care and patient assessment requirements that are based on a 60-day period, 42 C.F.R. § 484.18(a); 484.55 and the physician certification and recertification standards, 42 C.F.R. § 424.22.

In establishing the prospective payment system, the Secretary is required to select an appropriate payment unit that includes all costs in its duration. *See* Social Security Act § 1895(b)(2). Once that has been completed and following a four-year transition period, the only changes to the payment unit that are permitted are the annual updates to adjust the case mix, the wage index and certain other modifications as expressly permitted or required by statute. No other changes are authorized.

In that regard, the ACA established a process by which the original model could be altered, but those alterations contemplated a study, a possible demonstration project, and then congressional action. *See* ACA § 3131(d). There has been no such congressional action to date and the unilateral agency action to modify the initial model by altering the unit (*i.e.*, length of episode) is not authorized by section 1895 or by section 3131 of the ACA. If CMS has the authority to change the unit of payment unilaterally, there would be no need for Congress to authorize CMS to do so in a demonstration project. Accordingly, CMS's proposal to change the unit of payment is neither logical nor authorized in Medicare law.

Most notably, the ACA codified into the statute the unit of payment that the Secretary must use for 2014 and subsequent years. Under Section 1895(b)(3)(A)(iii), the authorized

adjustments are to be made only to the standard payment amount based on the continued use of an episode unit of payment as it existed at the time of the ACA enactment. That provision provides in part:

Adjustment for 2014 and subsequent years.—

(I) In general.—Subject to subclause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits **in an episode**, the mix of services **in an episode**, the level of intensity of services **in an episode**, the average cost of providing care **per episode**, and other factors that the Secretary considers to be relevant...

Section 1895(b)(3)(A)(iii)(I) (emphasis added).

By proposing to change the unit of payment from a 60-day episode to a 30-day payment period, the Secretary ignores the statutory directive under Section 1895 that the standard payment amount be based upon the continued use of the episode of payment subject to the 4-year phase-in of the standard payment rate reduction. Accordingly, the Secretary would directly violate the statutory mandate to alter the unit of payment that is in effect.

The Budget Neutrality and the 60-day Episodic Payment Model Is Better Policy

Beyond absence of legal authority to institute the proposed changes, instituting any new reimbursement model for Medicare home health services warrants a budget neutral transition and maintenance of the 60-day episode unit of payment approach.

The proposed system is untested with a high risk of adverse unintended consequences given the radical changes proposed. Further, home health agencies are navigating through multiple consecutive years of payment rate reductions including a 4-year rate rebasing, productivity adjustments, case mix weight adjustments, market basket index limitations, and sequestration that have, in combination, reduced rates by over 20% in the past five years. Stabilization of the delivery system has yet to occur. As such, a non-budget neutral policy, such as HHGM, poses serious risks to Medicare patients, home health agencies, and Medicare itself. Those consequences are not merely speculative. Instead, the transition to the Interim Payment System and HH PPS between 1998 and 2000 is a historical lesson that should not be ignored. Over 4,000 home health agencies closed during that period with nearly 1.5 million fewer Medicare beneficiaries finding access to care in 2001 than in 1997.

With respect to the proposed replacement of the 60-day episode with a 30-day payment period, smart policy would dictate recognition that Medicare home health services remains a 60-day model. The patient plan of care will remain a 60-day plan. Physician certifications of eligibility will stay at 60 days. Patient assessments using OASIS will continue on a 60 day schedule. A payment period that is inconsistent with the rest of Medicare home health services architecture will only create unnecessary administrative burdens and confusion among caregivers. Doubling the number of billings is just one big part of that increased administrative

burden and is inconsistent with the Secretary's priority goal of reducing administrative burden on providers so that more time and resources can be devoted to providing high quality care.

CONCLUSION

The Secretary must withdraw in its entirety, the Home Health Groupings Model included in the CY 2018 Proposed Rule. This proposal seeks to alter the Medicare home health payment model through the establishment of a standard payment amount that is not budget neutral in comparison to the effect of the current standard payment amount as the Secretary is prohibited from making any non-budget neutral changes unless specifically authorized by statute. Similarly, the Secretary must continue the use of a 60-day episode as the unit of payment as such is mandated by statute.

Please direct any questions to William A. Dombi at wad@nahc.org.

Sincerely,



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