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September 25, 2017

VIA ELECTONIC FILING:
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Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1672-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Request for Comments: CMS-1672-P – 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:

Corridor appreciates the opportunity to provide comments on the proposed Home Health 2018 rules and 2019 refinements provided to the industry in July. CMS proposed a major change to the payment methodology, effective January 1, 2019 when the current payment model is set to be replaced by the Home health groupings model (HHGM).

Corridor is a leading provider of home health business services to agencies across the country. Founded in 1989, Corridor has served the home health industry and is a key partner to profit and not-for profit certified agencies in all 50 states, and in all different types of community settings including rural markets. Our solutions include industry leading subject matter experts, proprietary technology, educational and outsourced operating solutions. We specialize in coding, OASIS and revenue cycle management services, including documentation review, pre-claim review, billing process assessments, invoicing and collections with all MACs. The combined footprint of the home health documentation reviews we do is equal to the total volumes of some of the largest home health providers in the country. Importantly, we deliver solutions which support all of CMS' requirements and innovative programs in a compliant manner.

A big part of our work includes helping home health agencies understand and determine the impact of proposed reimbursement measures, quality requirements and many of the innovations and new initiatives that CMS has put forth.

We are a member of the National Association for Homecare and Hospice ("NAHC"), the Partnership for Quality Home HealthCare ("PQHH"), the Alliance for Home Health Quality and Innovation ("AHHQI"), Elevating Home, the Visiting Nurses Association of America ("VNAA") and also sit on the board of directors and a member of the Governance Committee and Strategic Planning Committee for the VNAA.

III. E. 1. Overview, Data, and File Construction

The Report to Congress, required by section 3131(d) of the Affordable Care Act (ACA), proposed that payment accuracy could be improved under the current payment system, particularly for patients of certain clinical characteristics. This section further notes that MedPAC believes that the Medicare home health benefit is ill-defined and the current reliance on therapy service thresholds for determining payment is counter to the goals of a prospective payment system.

MedPAC's beliefs on the home health benefit being ill-defined is irrelevant in discussing a new payment model. The home health benefit establishes medical necessity, not payment. Implementation of a new payment model is just that, the payment model. These are two separate issues and the new proposed HHGM model as is, will not improve access but further lead to agencies staying away from patients of certain characteristics.

It would be less administratively and financially burdensome, both for the government and home health agencies, to <u>expand</u> the home health benefit (i.e. allow some high rehospitalization risk non-homebound populations to receive short term home care services) than attempting to initiate a new, untested payment model, in the hope of driving certain patient populations to low cost, high quality home health services.

Furthermore, if it is CMS' and MedPAC's desire to decrease the amount of therapy within home health, this could be done by modifying the current system and not by implementing a new, untested payment model.

CMS is proposing to implement the HHGM for home health periods of care beginning on or after January 1, 2019.

Assuming that the final rules are published at the end of November, thirteen (13) months is not enough time to accomplish successful national implementation across the home health industry. CMS acknowledges that HHGM will require education and training, updating and revising relevant manuals, along with changing claims processing systems. This set of changes will be the largest home health program update since implementation of PPS in 2000. Since then, the amount of computer systems – both claims processing systems as well as agency electronic medical record (EMR) systems – and complexity of operations has grown dramatically. Multiple delays of ICD-10 and HIPAA 5010 implementations are good indicators that more time is necessary to prepare for a change of this magnitude, which is much more broadly impactful to the industry than those prior regulatory changes.

CMS notes that the analyses and the ultimate development of the HHGM has been shared with both internal and external stakeholders via technical expert panels, clinical workgroups, special open door forums and in the CY 2017 HH PPS final rule (81 FR 76702) **however** no pilots have been completed or are scheduled to be completed and analyzed prior to the national roll out.

Corridor recommends several pilots be completed like those completed in 1998/99 prior to the rollout of the current prospective payment system (PPS). CMS is accustomed to trialing programs with geographic demonstrations to determine feasibility and establish success criteria. A "big bang" national rollout without preliminary trials and testing of the new systems would be disastrous for patients and their families by agencies across the country. CMS's past demonstrations have led to successful national rollouts with slight modifications to the pilot. These demonstrations have also identified programs that need to be halted such as the Pre-Claims Review Demonstration to potentially revise criteria and workflow processes. No success criteria has been established with the HHGM.

III. E. 2. Methodology Used To Calculate the Cost of Care

For the HHGM, CMS props shifting to a Cost-Per-Minute plus Non-Routine Supplies (CPM+NRS) approach, which uses information from the Medicare Cost Report.

Cost reports are not consistently and correctly completed across all agencies and should not be considered accurate unless audited. Auditing of cost reports has not been required since before the PPS implementation in 2000. There are also significant differences on how agencies complete the reports (for examples, differences

between hospital-based and independent agency cost reports).

One or more demonstration pilots of HHGM could adjust the requirements for cost report submissions and allow for testing of the CPM+NRS approach, as well as give time for home health agencies to adapt to this new approach and improve their cost report submissions.

Without changes in the current cost reporting process, Corridor recommends continuing to use the WWMC approach to calculate the cost of resources as it is based on more reliable data.

III. E. 3. Change From 60-Day Billing to 30-Day Billing Under the HHGM

CMS is proposing 30-day units of payment using justification that the first 30 days require high utilization of services than the subsequent 30 days.

The home health industry has been focused on several quality initiatives over the past fourteen years since Home Health Compare was launched. The primary national focus has been decreasing re-hospitalizations. To address this and other key areas for improvement, home health agencies have implemented many best practices, including front loading visits in the first several weeks and then stretching out visits over the remaining 60-days to continue monitor the patients; and identifying potential avoidable exacerbations of conditions which may lead to a costly rehospitalization. These best practices are slightly modified geographically due to challenges presented by differences in community populations and availability of resources. It appears that CMS's analyses of home health's visit frequencies are not taking into account what is now one of the broader healthcare industry's key focuses - preventing re-hospitalizations for 60 days after acute stay. Reducing payment cycles to 30-day increments may discourage agencies from continuing observing and assessing the patient for the 2nd 30-day period.

Corridor recommends against changing to a 30-day reimbursement system unless preparatory demonstrations show that there will not be any impact on costly rehospitalization rates.

III. E. 5. Admission Source Category

CMS proposes using admission source as one of the key determinants of payment in the new HHGM model.

CMS has prior acknowledged the challenges with agencies obtaining consistent information regarding the patient's preadmission location while performing the initial home health assessment and scoring the OASIS question M1000. Yet, CMS continues to implement this question despite its unreliability.

Previously, this question led to case mix adjustment resulting in millions of dollars of improper payments. CMS is now proposing to re-implement payment adjustment based on admission source category.

Under the HHGM, each episode is classified into one or two admission source categories Institutional or Community, depending on certain services the beneficiary received in the last 14 days prior to being admitted to home health. Claims data will be used to determine the admission source although for non-Medicare admissions, an occurrence code could be used to manually indicate on Medicare home health claims an institutional admission source prior to an acute/post-acute Medicare claim.

This is another area that needs extensive testing. Previous failures leading to over payments should indicate enough concern requiring a demonstration project prior to national roll out.

III. E. 6. Proposed Clinical Groupings

It is noted that the Home Health Study Report to Congress, the current payment system **may encourage** HHAs to select certain types of patients over others but does not state this is proven. MedPAC also has **expressed concerns** that the HH PPS creates disincentives to care for patients needing skilled nursing visits, thereby limiting access of care to the most clinically vulnerable patient populations but does not state this is proven. CMS's response is the creation of six clinical domains based off the primary reason for home health services under the Medicare home health benefit.

Certain patient populations cared for under current payment system will not be allowed under HHGM as they do not qualify for one of the six clinical domains per the questionable encounters list. It does not appear that the questionable encounter list was full vetted out by industry experts.

We encourage for CMS to conduct demonstration program to determine if the creation of six clinical domains will limit access to the home health beneficiary.

Following is a list of several examples of codes that are listed as questionable encounters which would lead the claims being returned to the provider (RTP). This would force the agency either to have to not accept these patients under HHGM (and have the patient seek a costlier alternative such as skilled nursing facility), or incorrectly code the claim in order for the RTP not to occur which leads to incorrect coding per guidelines.

ICD-10 QE	Short Description	Notes
A41.59	**Other Gram-negative sepsis**	If sepsis is present at admission, it is the focus of care and sepsis is caused by specific gram-negative organism, this code might be used and is required to be coded first per guidelines
A41.9	**Sepsis, unspecified organism**	If sepsis is present at admission, it is the focus of care and sepsis is caused by specific gram-negative organism, this code might be used and is required to be coded first per guidelines
C34.90	**Malignant neoplasm of unsp part of unsp bronchus or lung**	This code is used often, pending results of test
E09.22	**Drug/chem diabetes w diabetic chronic kidney disease**	Not frequently seen in home health but is appropriate
E09.65	**Drug or chemical induced diabetes mellitus w hyperglycemia**	Frequently seen in home health. Patient can suffer from this type of diabetes due to the need for steroids as well as other medication leading to diabetes
E11.3599	**Type 2 diab with prolif diab rtnop without mclr edema, unsp**	A patient who only had macular edema with diabetes would need this as primary when home health was addressing diabetes
G23.9	**Degenerative disease of basal ganglia, unspecified**	A specificity to this diagnosis would most likely require neurologist to confirm type of disease process which might not be available prior to home care episode
G61.9	**Inflammatory polyneuropathy, unspecified**	The cause might not be known
I12.0	**Hyp chr kidney disease w stage 5 chr kidney disease or ESRD**	Coding guidelines require to code this before CKD
I13.2	**Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD**	Coding guidelines require to code this before heart failure and CKD
I95.9	**Hypotension, unspecified**	Specific cause of Hypotension may not be identified by physician
J06.9	**Acute upper respiratory infection, unspecified**	Specific location may not be identified
K50.819	**Crohn's disease of both small and lg int w unsp comp**	Specific diagnosis referred to home health for observation and assessment and/or teaching and training

CMS needs to work with experienced experts in the industry to develop comprehensive questionable encounter list and test during demonstration program.

It is also noted that CMS feels that the creation of the questionable encounter list will encourage agencies to further obtain clinical documentation such as discharge summaries from acute facilities. Obtaining discharge summaries has been a huge challenge for home health across the country, and not because home health

agencies haven't spent an enormous amount of time and money requesting this documentation. This is especially true for non-facility based home health agencies. Facilities/providers are not incentivized to provide comprehensive clinical documentation to home health agencies – it is simply an added administrative burden for them. Most agencies are fortunate to obtain an H&P which is completed at admission and may not have a complete summary of the patient due to pending treatments and test. Continuing to place the full burden to obtain comprehensive clinical documentation from the referral source on the home health agency will lead to facilities/provides being dis-incentivized to refer to home health due to frequent documentation request leading to increase administrative cost.

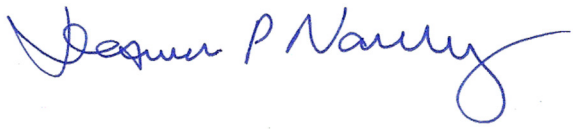
In order to be certain that home health agencies have the full set of documentation they need, CMS should incentivize referring facilities/providers to provide comprehensive clinical documentation.

Conclusion

In conclusion, for multiple reasons stated in this letter, we respectfully urge CMS to refrain from finalizing the HHGM as part of the CY 2018 Final Rule until demonstration programs are conducted and refinements to the model are made. We welcome the opportunity to work with CMS to develop these needed improvements and refinements to the HHGM model to ensure home health agencies can continue provide access to medically complex patients.

We thank you for careful consideration of these concerns and issues. We look forward to working with CMS to ensure that patients' access to skilled home health services is not compromised as a result of the HHGM. Please contact me at (866) 263-3795 or by email at: dvarady@corridorgroup.com if you have any questions regarding our comments.

Sincerely,



Desmond P. Varady
Chief Executive Officer
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