December 12, 2017

The Honorable Demetrios Kouzoukas
Principal Deputy Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Principal Deputy Administrator Kouzoukas:

Over the past year, we have encouraged CMS to work with patients, providers and others as part of its efforts to propose payment changes to the home health care benefit to ensure Medicare beneficiaries will continue to have access to services. We are united in our approach for change as outlined in this letter. We especially appreciate CMS' willingness to listen to our concerns and views regarding the Home Health Groupings Model ("HHGM"). We applaud the Agency's decision to not finalize HHGM as part of the Final Rule for the CY 2018 home health payment rule and to instead take additional time to continue engaging with stakeholders and give further consideration to the comments received on the HHGM proposal. This decision is consistent with the best interests of home health providers and their patients and the Medicare program.

We appreciate and welcome the opportunity now to work with CMS to improve home health payment policy, including HHGM. We view the suggested enhancements and refinements set out below as a first step to this process. Our work is based on data and information collected from the beginning of the prospective payment system enacted in 1997 to now. We also believe that there may be other approaches to payment reform that could provide a better alternative to HHGM.

As a reflection of our commitment to these proposals, we will make this proposal publicly available to demonstrate our unified support in working now with CMS to improve the value of the Medicare home health benefit for beneficiaries.

Proposal for Discussion Purposes:

If the enhancements and refinements to HHGM that are described in this document were adopted, CMS would still accomplish the most significant goals of payment reform as stated in the HHGM technical report and the CY 2018 Proposed Rule, described as follows:

- Removing payments tied directly to the number of therapy visits provided

- Better defining the Medicare home health benefit
- Ensuring payments are determined based upon patient characteristics
- Improving payment accuracy for home health services
- Promoting efficient care that aligns payment with high-quality services
- Allowing for a payment structure that is responsive to changes in utilization patterns and resource use
- Minimizing vulnerabilities that may lead to unintended consequences
- Promoting and protecting access to home health services for eligible beneficiaries
- Supporting the provision of care that meets beneficiaries' clinical needs at home
- Ensuring the benefit is available to and adequately reimburses for care provided to certain vulnerable populations

The home health community recommends that any payment reform, including any version of HHGM, adhere to the following principles:

1. The transition to any new payment model must be fully budget-neutral in relation to the existing payment model.
2. Any new model should not include system changes that incentivize or encourage behavioral changes that are counter to the provision of necessary and timely care.
3. Payment models should provide reasonable and sufficient reimbursement such that the entire scope of the home health benefit is covered.
4. Payment amounts should be based on patient characteristics and clinical needs, not the level of service utilization in order to avoid improper financial incentives to provide unnecessary care.
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 that are needed with a new payment system to avoid unintended consequences that could affect patients and service continuity.
7. Significant changes in payment models should be fully tested and validated through such means as a demonstration program prior full application.

The home health community further recommends that the development of any new payment model adhere to a process that includes:

1. Full stakeholder involvement
2. Two-way dialogue throughout
3. Decision-making transparency
4. Data access and data sharing
5. Use of a Technical Experts Panel (TEP)

6. Public reporting of plan development
7. Model testing for validity and reliability to ensure control over unintended consequences
8. Administrative Procedures Act ("APA") compliant rulemaking

Process Timeline

Below is an example of the steps and timeline needed to address the above recommendations regarding the process by which payment reform would occur:

Process Point	Approximate Timeframe
Initial CMS meeting	**November 2017**
Industry response outlining payment reform recommendations	**December 2017**
Follow-up meetings and core work group discussions with CMS staff	**December 2017/early Q1 2018**
Set up and execute TEP	**January-April 2018**
Evaluate TEP outcomes, develop technical report, design demos	**April-November/December 2018**
Launch voluntary pilot or demonstration projects	**Q4 2018**
Regularly scheduled discussions among core work group and progress reports to Congress throughout entire process	**TBD**
TEP and/or Report to Congress on demo outcomes	**TBD**
Advanced Notice of Proposed Rulemaking	**TBD**
Comment period and election of system design	**TBD**
Proposed Rule	**June/July TBD**
Comment period	**July-August TBD**
Final Rule	**October/November TBD**
New model implementation (>9 months after issuance of final rule)	**January TBD**

Process Revisions

1. Any new payment model must be **budget/revenue/output neutral**

2. Any new payment model **should not include any behavior change assumptions.**
    - The most reasonable way to avoid the need for behavior change assumptions is to avoid modifications such as changing the episode duration which would present the risk of behavior changes.

3. Any new payment model must be **piloted/demonstrated in a smaller cohort of HHAs** on a voluntary basis to ensure there are no unintended consequences prior to being rolled out nationally. If the recommendations above are implemented there are multiple companies that would be willing to volunteer in a demonstration model.
    - In previous times of payment redesign implementation smaller-scale demonstrations have played an important role in the home health and other industries to the overall process
    - The original 60-day PPS episode was developed by HCFA (CMS' predecessor) during a voluntary Phase II demonstration program between 1995 and 2000. (*See*, *Medicare Program; Prospective Payment System for Home Health Agencies*, 65 Federal Register 41128 at 41131, July 3, 2000.)
    - HCFA reached its conclusion that a 60-day episode was the appropriate unit following numerous demonstrations, including a failed per visit prospective payment demonstration, over a 12-year period culminating in the Phase II demonstration. (*See*, United States General Accounting Office, *Report to Congressional Committees, Medicare Home Health Care Prospective Payment System Will Need Refinement as Data Become Available*, Appendix II, HEHS-00-9, April 2000.)

4. The **underlying data, analysis, and results used to develop the ultimate framework for payment reform must be made public** with sufficient time to test and confirm the outputs of the modeling

5. In the development of revisions to HHGM, including consideration of alternative payment model approaches, **CMS should develop a Technical Expert Panel (TEP)** with participants proportionately representative of the home health community, including those that have been most active in the payment redesign conversations and activities to date. At least one representative from the Partnership for Quality Home Healthcare ("PQHH"), the National Association for Home Care & Hospice ("NAHC") and Elevating Home ("EH") should be included on the TEP.

    The TEP should identify and prioritize recommendations with respect to the revised payment system and shall consider alternative case mix models including, but not

limited to, patient-focused risk models with value-based initiatives linking payment success to creating value for beneficiaries and CMS. The TEP should further consider the interaction of home health payment policies with value-based models in regard to hospitals, other post-acute settings, bundled payments and accountable care organizations. Furthermore, the TEP should examine the risk of diverting populations of patients to higher cost settings due to untenable reimbursement structures. At a minimum, the TEP should also specifically discuss and explore the following:

- Expand the HHVBP model (currently being tested by CMMI) nationwide in a budget-neutral manner and embed it into the base payment system. We recommend making certain revisions that would more heavily weight claims and HHCAHPS-based patient outcomes (e.g. hospitalizations, ER utilization, patient satisfaction) over process measures and OASIS-based outcome measures. The existing HHVBP model should be carefully evaluated and modified as necessary to ensure that all home health patients are correctly risk stratified (e.g., post-acute and community referred) and to include a measure regarding socio-economic status. This will strengthen the efficacy of the payment system and more closely align payment with real value. CMS' own projections show substantial savings to Medicare from this program that Congress should be allowed to capture and apply to value-adding programs.
- Consider retaining much of the current payment architecture and revising the case mix adjustment model to incorporate payment for therapy services into the existing infrastructure, including keeping the model intact for LUPA and outlier payments calculations. This approach would accomplish the major goal of moving away from paying for utilization while reducing the complexity and likelihood for unintended consequences as much as possible.
- Explore the Risk-based Grouper Model ("RBGM") as was outlined in the formal comments submitted in response to the 2018 NPRM by Almost Family to determine if it offers elements of a better way forward either in part or in its entirety.
- Evaluate whether there are superior underlying datasets that should be leveraged to develop a better payment model that relies upon existing home health agency practices that are producing the best outcomes across the country for existing patients.
- Re-weight certain payment groups to add more case mix points to payment groups that are at greatest risk of incurring a hospital admission and away from those at lowest risk of doing so.
    - HHGM as proposed raised serious questions as to whether payment for therapy related episodes was adequate to secure access to care. In addition, there is concern that payment for long-stay patients with chronic conditions and/or high personal care needs falls short of the needed levels.

        - This could be done similarly to step 5 in the current annual case mix recalibration exercise and would ensure HHAs have adequate reimbursement to be able to continue care for those patients that are most likely to expend the most Medicare resources (primarily through costly hospitalizations).
    - In revising the case mix adjustment model, consider performing regression on a limited subset of high quality providers to incentivize HHAs to achieve higher quality and efficiency in their operations.

Proposed Enhancements and Refinements to the proposed version of HHGM

1. **Episode payment period**- Retain 60-day episodes and 60-day payment periods
    - Any change to the episode length would create major ripple effects that are impossible to predict and adequately plan for. Certain providers will elect to alter their behaviors by extending care unnecessarily to the detriment of CMS and, in some cases, patient care.
    - The total cost home health providers incur to provide care to patients is essentially the same regardless of the actual length of stay within a 60-day episode. A patient that receives 15 visits over 30 days creates the same amount of cost incurred by the home health agency as a patient that receives the same 15 visits spread across 60 days.
    - Patient care and physician decision-making relative to the patient care plan should not be affected by the challenges 30-day payment periods would create. In instances where frontloading of visits is better for patient care and outcomes home health providers should not be harmed or dis-incentivized to deliver care in that manner.
    - The creation of new groupings for home health payment would be a major payment system change. To alter the payment periods at the same time as a major payment system overhaul would heighten the complexity of the implementation for providers. Retaining 60-day episodes and payment periods allows for a more expeditious timeline for implementation, simplifies the technological adaptations that need to be made by both the providers and the payor, greatly reduces the risk of unintended consequences, aligns with the statutes governing the HHPPS and still allows for the overarching goals of payment reform to be realized.
    - Retaining 60 day episodes will also prevent unnecessary additional administrative burden associated with billing twice as often (every 30 days) and is contrary to the Patients over Paperwork initiative CMS is pursuing.

2. **Resource Utilization Basis**- CMS should provide detailed analyses around how HHGM, or any other alternative-payment model, would operate using Bureau of Labor Statistics

("BLS") data vs Medicare home health cost report data and allow the process outlined above to reach the best conclusion on a path forward.

- Medicare cost reports are not a reliable source to determine home health reimbursement amount. Using current cost reports creates an incentive to provide inefficient care and reallocates reimbursement dollars to those lacking efficiency, rather than putting them toward those providers delivering the greatest value and conflicts with no less than 3 of the payment reform goals outlined above.
- Basing HHA costs off of Medicare cost reports introduces elements of cost structures that vary from agency to agency, such as: productivity of the direct care workforce, efficiency of back office operations and investments (or lack thereof) in innovative technologies. Using a standardized approach to determine HHA cost that does not vary among HHAs and is focused on direct care expenses is the superior approach.
- There may be alternative datasets by which to base the underlying resource use/case mix allocation process upon that should be explored further.

3. **There are 6 primary clinical categories**
    - A TEP process should be leveraged, utilizing home health industry clinical and coding experts, to refine the clinical categories to ensure appropriate reimbursement and to minimize the number of questionable encounters.
    - The six clinical category construct in HHGM fails to address the projected therapy visit utilization by patient episode.
    - Placing patients into Hierarchical Condition Categories (HCC) score categories (as the Risk-based Grouper Model ("RBGM") does) may be a better approach.
    - At a minimum, more clinical categories should be developed to more accurately align payment amount with resource utilization.
    - A smaller percentage of diagnoses codes should fall into MMTA (or any other clinical category bucket) than is currently in MMTA (57%) in order to make the payment model more accurate. Having more than half of all episodes in a single clinical category is too restrictive in ensuring accuracy in reimbursement.

4. **Questionable Encounters**
    - CMS should ensure the Medicare home health benefit will not be stripped from patients who qualify for and benefit from home health services. CMS should greatly reduce the number of patient episodes that fall into the "questionable encounter" category and create a streamlined process to remedy those that do.

5. **NRS (Non-routine Supplies) Payments**- Retain current method of adding on these payments to the base rate
    - Supplies do not cost more or less in areas of varying wage indexes. Including them in the base rate will inappropriately subject supplies to the wage index

adjustment process, further penalizing rural providers that have a very low wage index and unnecessarily rewarding providers in high wage index areas of the country.

We appreciate and welcome the opportunity now to work with CMS on a distinct new proposal to improve home health payment policy. We view this as a first step to these discussions. Our proposed enhancements and refinements will achieve a successful and well-designed payment model for the future of home health care. By following a staged implementation process and a timeline that seeks to avoid unintended consequences, CMS can achieve full implementation without unnecessary disruptions to patient care. We look forward to your feedback, please do not hesitate to call us for clarification on any issues.

Sincerely,

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