Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

July 29, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Initial Review of the CY 2020 Medicare Home Health Care Proposed Rule

Dear Administrator Verma:

I am writing to you on behalf of the Partnership for Quality Home Healthcare ("PQHH"), a national coalition of skilled home healthcare providers with a proud track record of offering excellent skilled homecare services to millions of Medicare beneficiaries. Every year, 3.5 million patients rely on skilled health care services delivered in their own home to recover after an illness or injury. Our patients and their families count on us for exceptional care and unparalleled service. We take seriously the trust patients and families have placed in us and our skilled nurses, therapists and aides to help them with dignity and compassion.

We are also proud that the Centers for Medicare and Medicaid Services ("CMS") has consistently recognized the quality and importance of this benefit to patients, and the value it creates through savings for the Medicare program. The Medicare home healthcare benefit is particularly important to the vulnerable population of seniors who tend to be older, sicker, and poorer than the general Medicare population.

Retaining value for all communities served is always critically important. However, as home health providers, on behalf of the physicians and patients we serve, we are offering suggestions on how to improve and implement CMS's significant new payment reform for the home health benefit. While many components were finalized last year, we believe there are remaining issues and concerns as well as new issues, that we would like addressed. Our goal is to offer our recommendations and comments in the spirit of improvement, as our organizations have decades of experience in transitioning to new models and payment systems that would add important insights to changes on the horizon for home health. Now is the time to carefully evaluate any requirement or action that can improve the Medicare program payment model to ensure patients can be cared for in their home as an alternative to institutional services. We believe that home health care services can save money for the Medicare program – including

reducing the number of unnecessary readmissions, as well as caring for patients in their home to avoid unnecessary hospitalizations or skilled nursing stays.

Five Recommendations in Adjusting the New Model

1. We encourage CMS to carefully reevaluate the impact of the 8.01% reduction in payment that is based on perceived changes that providers may make when this new payment model is implemented. An 8.01% reduction is one of the most significant reductions taken in any new or existing Medicare payment system to date and will certainly have far-reaching negative consequences.

2. We continue to be concerned that this new payment model incentivizes reduced therapy services. We intend to offer recommendations in this area.

3. We are also concerned about certain coding-related policy changes that may have the result of narrowing the home health benefit. Medicare beneficiaries who are homebound and in need of skilled, intermittent services (subject to a physician established plan of care) are entitled to receive services under the Medicare home health benefit. We are concerned about the legal implications of CMS's coding-related policies and will discuss this in detail in our complete comments that will be submitted this summer.

4. We believe that adequate and intensive preparation must begin to implement the new payment program with clear guidance to physicians, hospitals and other facilities, home health agencies, and Medicare contractors, as this new model relies on coding and documentation accuracy and access to claims. Success of this new payment model relies on preparation of all partners involved in the Medicare home health payment system.

5. We urge review of new regulatory requirements that potentially place additional burdens on home health agencies during this transition to a new payment model. The creation of "Notice of Admission" may result in increased paperwork burden and cost to providers.

As is our custom, PQHH will file additional detailed and extensive comments on the CY 2020 proposed payment rule. We have also participated in Technical Expert Panels ("TEPs") where we and others with tremendous experience in the post-acute care and home health sector have contributed thoughtful recommendations and suggestions. We note that these recommendations were not included in this year's or last year's proposed rule. We are hopeful that in this final stretch toward implementation of the new payment model, the Administration will seriously and thoughtfully evaluate our recommendations, as well as the TEP recommendations.

I. Concerns with the Patient Driven Groupings Model ("PDGM")

Behavioral Assumptions

The behavioral assumption in the proposed rule – 8.01% – is extremely concerning. PQHH and all of our state and national home health partners are very concerned that this reduction will cause undue harm and instability to the home health delivery system. The proposed behavior change would significantly exceed past actual behaviors exhibited by the industry since the development of the current payment system. For example, included in the assumed behavior change is an assumption that 100% of the time if a secondary diagnosis would result in higher reimbursement, it would be moved to primary on day one. This level of reduction beginning on the first day of the new model is unquestionably too harsh and unnecessary in implementing this new model. We urge caution and ask for a more data-driven approach to rate reductions that are based on behavior changes.

Therapy Services

We continue to be concerned about the impact on the availability of therapy services to patients with intensive therapy needs under this new model. This model is significantly reducing therapy, and we are concerned about the unintended consequences for patient care in deemphasizing therapy. We have worked with CMS on understanding the potential impact of the new model and believe that one solution would be to use more accurate data. We continue to request that BLS data be used as an alternative to cost reports.

Reducing Entitled Benefits

We are also concerned about coding-related policy changes that may narrow the home health benefit that Medicare beneficiaries who are homebound and in need of skilled services are entitled to receive. We believe that the legal implications will address both the underlying entitlement and the *Jimmo* settlement, which states that Medicare covers skilled services when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). We will discuss this area more fully in our longer comments.

Readiness to Implement on January 1, 2020

Implementing this new system requires assurances that all relevant stakeholders and partners are prepared. While PQHH members are planning our readiness, it is our hope that CMS will proactively assist physicians, Medicare contractors and auditors, and hospital discharge teams to understand how to comply with these new requirements.

Regulatory Burdens Contained in the Proposed Rule

We applaud the Administration for eliminating regulatory burdens in many federal programs that only increase costs. We encourage another review of this proposed rule to identify additional requirements that will impose great burdens on home health agencies and Medicare contractors that are unnecessary.

CMS is proposing a phase-out approach to RAP payments, and that beginning in CY 2021, all HHAs must submit a Notice of Admission ("NOA") within 5 days of admission. We are concerned that the NOA will require too much information in too short of a period of time. We encourage CMS to eliminate this and requirements that will be cumbersome and unnecessary, or seek least burdensome approaches, especially at a time when HHAs are transitioning to a new payment model.

II. Home Healthcare Stakeholders are Eager to Work with the Administration on Sensible Solutions

We would greatly appreciate the opportunity to meet with you to discuss ways we can help CMS successfully move forward in payment reform efforts and ensure readiness in implementing a system based on patient characteristics. We are ready and willing to work with CMS to get the policy right by collaborating with CMS in providing data, information, the patient's perspective, and policy options to improve the home healthcare benefit.

Sincerely,

Keith Myers
Chairman
Partnership for Quality Home Healthcare

cc:

Demetrios Kouzoukas
Principal Deputy Administrator & Director of the Center for Medicare

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