



September 22, 2017

VIA ELECTRONIC SUBMISSION

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 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

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR), as well as additional signatories, appreciate the opportunity to comment on the proposed rule entitled, *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 Proposed Rule). CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

Overview

The proposed rule updates the home health prospective payment system (HH PPS) payment rates, including the national, standardized 60-day episode payment rates and the national per-visit rates, effective for home health episodes of care ending on or after January 1, 2018. The proposed rule also makes case-mix methodology refinements, and changes the unit of payment from 60-day to 30-day episodes of care, to be implemented for home health services beginning on or after January 1, 2019. The proposed rule would also change the Home Health Value-Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP), among other things.

CPR offers these comments to CMS' revision of the Home Health Groupings Model (HHGM), including the change in the length of the episode of care from 60-day to 30-day episodes of care. This is a fundamental change to the home health payment model that will create major incentives to

underserve Medicare beneficiaries with disabilities, longer-term, and chronic conditions. The proposed rule will also create incentives to serve beneficiaries who are admitted to homecare from hospitals and other institutions, and disincentives for those who have avoided institutional care while living at home and being served by home and community-based providers.

In addition, the proposed rule would undercut the gains achieved under the *Jimmo v. Sebelius* Settlement, which reaffirms that skilled services are covered under the Medicare home health benefit even if the patient does not show signs of improvement. The *Jimmo* Settlement, and a recently completed CMS.gov *Jimmo* webpage, clarify that Medicare coverage should be equally available for skilled home health therapy and nursing needed to maintain, prevent, or slow deterioration of a Medicare beneficiary's condition. Regrettably, the proposed rule conflicts with both the Medicare law and *Jimmo* standards.

These are troubling proposals. We seriously question CMS's authority to enact such significant changes to the home health benefit without Congressional action. These issues are discussed further below.

Initial Reaction from the Home Health Community

CPR has serious concerns with the proposed rule. If finalized as proposed, the rule would lead to a home health benefit that caters to beneficiaries with more intensive, short-term needs at the expense of beneficiaries with chronic illnesses, disabilities and longer term or ongoing needs, and those needing extensive rehabilitation. The impact will be severe for people who will not necessarily improve with home care, but who need skilled services to maintain their condition or slow decline, including those with rehabilitation needs. These vulnerable beneficiaries, who already struggle to obtain needed care, will face even greater access barriers.

Change from 60-Day Billing to 30-Day Billing Will Negatively Impact Rehabilitation

CMS proposes to change the unit of payment from 60-day to 30-day episodes of care. CMS stated in the proposed rule that when it examined the resources used within a 60-day episode of care, it identified differences in resource utilization between the first and second 30-day periods within the 60-day episode. CMS noted that there were on average more visits, and higher costs, during the first 30 days. There were more visits for not only skilled nursing and home health aide services, but physical therapy, occupational therapy, and speech language pathology as well.

CMS thus reasoned that dividing a 60-day episode into two 30-day periods would more accurately apportion payments. In fact, CMS found that approximately 25 percent of episodes were 30 days or less in length, and therefore a second 30-day payment period would not be needed for these cases. CMS also proposes a switch to a 30-day payment period to align with other Medicare settings such as hospices and SNFs. This proposed change accounts for a large percentage of the cost savings expected from this proposal. In fact, CMS forecasts that it will save nearly a billion dollars in the first year of implementation alone. There is only one way to reduce the costs of home care so quickly and dramatically: further restrict services that are currently being provided to Medicare beneficiaries. Services, particularly nursing and home health aide care services, are already difficult to obtain for longer-term patients.

CPR believes that truncating payment periods to 30-day episodes, coupled with the new health resource groupings discussed below, will create financial incentives that will likely create access issues for Medicare beneficiaries who need ongoing or longer-term, home health services to meet their needs.

A large majority of home health episodes are greater than 30 days in length. Patients with significant longer-term needs, including those with MS, Parkinson's, spinal injuries, and paralysis, who meet the legal criteria for Medicare home health coverage, are already disfavored by home care providers. These patients will be left behind by the proposed system that further encourages providers to care for short-term, acute care patients.

Yet, this policy proposal would create incentives for home health agencies to provide more intensive therapy in the first 30-day episode, and less following that time period. In addition, the proposed system will reward agencies for serving healthier patients with fewer, long term rehabilitation needs. ***CPR therefore requests that CMS withdraw this proposed rule, including its proposed change from 60-day billing to 30-day billing, as it will establish incentives that are likely to harm Medicare patients, especially those needing rehabilitation and long term services and supports in the home.***

Shorter Payment Periods Conflict with the *Jimmo* Settlement

A shorter payment period is particularly inappropriate given the recent *Jimmo v. Sebelius* Settlement and CMS Corrective Action Plan that confirm the availability of Medicare coverage for skilled home health care to maintain an individual's function, not only to improve it. Pursuant to *Jimmo*, medically necessary skilled nursing and skilled therapy services provided by or under the supervision of skilled personnel are covered services by Medicare if the services are needed to improve a beneficiary's condition, maintain the individual's condition, or prevent or slow their decline.

By truncating the payment period, access to essential, ongoing skilled home care for longer-term patients will be compromised. Under *Jimmo*, patients need not demonstrate improvement in order for skilled services to be covered as reasonable and necessary. A 30-day payment period, however, will create a payment system in which providers will have further financial incentives to "cherry pick" patients who are more likely to improve and who have rehabilitation or skilled care needs that are more intensive and shorter in duration. This will significantly interfere with the *Jimmo* Settlement for Medicare beneficiaries in need of greater-than-average or prolonged home health services. For these reasons and those listed above, ***CPR requests that CMS withdraw this proposed rule; it should not change the current 60-day billing cycle to a 30-day billing period.***

Existing Therapy Thresholds and CMS Proposal to Eliminate Them

Under the existing HH PPS, home health agencies receive higher payments for providing more therapy visits once certain thresholds are reached. But CMS argues in the proposed rule that this has caused a higher average number of therapy visits per 60-day episode of care. CMS also pointed to a study that showed a sharp increase in the percentage of episodes just above payment thresholds, which suggests that some home health providers may be responding to the financial payment incentives of the thresholds.

CMS also cited an investigation conducted by the Senate Committee on Finance in 2010 that examined the therapy practices of the four largest publically-traded home health companies. This investigation found that three of these companies "encouraged therapists to target the most profitable number of therapy visits, even when patient need alone may not have justified such patterns." CMS further cited this investigation as highlighting the responses the home health industry has taken to maximize reimbursement under the therapy threshold models. CMS also cited MedPAC as continuing to advocate for the removal of the therapy thresholds as a way to counter over-utilization of therapy that is not clinically necessary.

In response to these concerns, CMS proposes to eliminate the therapy thresholds in the case-mix system. *CMS should not eliminate the therapy thresholds unless it can do so in a way that will ensure all beneficiaries' equal access to medically necessary therapy.*

New Home Health Resource Groupings Favor Hospitalization and Institutional Care

Under the proposed rule, CMS will pay more for home health care for patients who are referred from an institution (i.e. a hospital, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF) or long-term care hospital (LTCH)), than for those who seek to begin care from home, without a prior institutional stay. As an example, the payment weights for the neuro clinical group, with a low functional level, with a comorbidity adjustment, with variable timing (either “early” or “late,” where “early” is the first 30 days of care) and admission sources (either community or institution) are as follows:

- Early, Community = 1.3458
- Early, Institutional = 1.5167
- Late, Community = 0.9555
- Late, Institutional = 1.3985

This proposed revision clearly values short-term, institutional referrals more than longer term, community provider referrals to home health agencies. The proposal provides a financial incentive for home health agencies to select patients coming from institutions like hospitals because the payment weight favors these patients. Since “institutions” will largely include acute care hospitals, there may be incentives for such hospitals to bypass necessary IRF and SNF care altogether and send some patients directly home, with home care agencies expected to provide sufficient therapy and medical management under the respective payment weight.

CPR is concerned that, over time, patients will have to be admitted to an inpatient setting before gaining access to home health services. The proposed rule will create unnecessary institutional care for many individuals who could otherwise stay home, because they will be less able to obtain access to home health care based on the relatively low payment weights in the proposed rule. CPR is also concerned that the proposed payment weights will create incentives for providers to select patients with relatively intensive, short-term therapy needs, not patients who require skilled services on an ongoing basis in order to remain at home, living in the community.

Comorbidity Adjustment May Not Be Adequate

The proposed rule does not fully capture the impact of comorbidities or complex rehabilitation needs, which can require additional resources, time, and intensity in service delivery. We are concerned that whether a patient has 1 or 5 comorbidities, the HHA would receive the same comorbidity adjustment amount.¹ If a HHA believes it would not receive adequate payment for a patient with multiple comorbidities, they may be disinclined to take that patient and instead accept a patient with fewer conditions.

More is needed to address and adequately adjust payment for the complex patients admitted to HHAs for purposes of rehabilitation. CMS must better account for all types of patients in a revised payment system.

¹ *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*, Vol. 82, No. 144 (July 28, 2017), at 35,324. Accessible at: <https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf>.

Conclusion

CPR urges CMS to withdraw this proposed rule. The proposed change from a 60-day to 30-day billing period and the incentives to serve acute care patients undercut the *Jimmo* Settlement. The proposed rule will establish financial incentives that will harm Medicare patients, especially those needing rehabilitation and longer term skilled care in order to remain in the home. CPR is further concerned that the proposed rule may lead to discrimination against patients living at home who develop, or continue, a need for home health care without first requiring admission to a hospital or post-acute care institution.

CMS should rescind this proposed rule and seek input from patients, providers and other stakeholders to develop a payment system that is “margin neutral,” so that all beneficiaries who qualify have equal access to necessary home care.

We greatly appreciate your attention to our concerns and your interest in our comments. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, CPR staff, at (202) 466-6550 or by emailing Peter.Thomas@powerslaw.com or Steve.Postal@powerslaw.com.

Sincerely,

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Supporting Organizations

Academy of Spinal Cord Injury Professionals
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
ACCSES

Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Easterseals
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
Lupus Foundation of America
The Michael J. Fox Foundation for Parkinson's Research
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Association of State Head Injury Administrators
National Disability Rights Network
National Multiple Sclerosis Society
National Rehabilitation Association
National Stroke Association
Paralyzed Veterans of America
United Cerebral Palsy
United Spinal Association