



Charles N. Kahn III
President & CEO

September 25, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW Room 445-G
Washington, DC 20201

CMS-1672-P: Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Dear Administrator Verma:

The Federation of American Hospitals (“FAH”) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, ambulatory and post-acute care, including home health, for which two of our member companies are among the largest providers in the nation. The FAH appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (“CMS”) on the above proposed rule (“proposed rule”).

The proposed rule providing for the 2018 home health prospective payment system (HH PPS) rate update also includes proposed refinements to the case-mix adjustment methodology that would begin in 2019. Specifically, the proposed home health grouping model (HHGM) would group patients into payment categories using primarily clinical characteristics and other patient information as a replacement for the five current categories, which are based on the number of therapy services provided and the episode’s timing in a sequence of episodes. In addition, the unit of payment would be changed from 60-day to 30-day episodes of care. The changes would not be implemented in a budget-neutral manner, and CMS estimates that this will result in a \$950 million (4.3 percent) reduction in aggregate payments to home health agencies in 2019.

The FAH supports continued work on developing a HHGM-based case-mix adjustment for use in the HH PPS, but the system described in the proposed rule is not ready for implementation in 2019, and

we urge CMS not to finalize the proposed adoption of the HHGM. The proposed new case mix system represents a major departure from how home health agencies are currently paid by Medicare. It is untested, its details are not transparent, and if implemented as proposed, the new HHGM could result in unintended consequences for Medicare beneficiaries, the Medicare program, and home health service providers, as well as hospitals and the broader health care system if, for example, patients are diverted to higher cost settings because the coding issues associated with the model result in a home health agency not admitting a patient it otherwise would.

CMS should continue to work with all stakeholders to develop a home health case mix system that is clinically coherent and transparent, results in appropriate payment for services rendered, and ensures continued access to needed home health services. To maximize the potential for the successful implementation of a HHGM, CMS should:

- Defer implementation of the proposed 2019 HHGM, and establish a process for continued dialogue with stakeholders in anticipation of a re-proposal of an HHGM in the future
- Make all data used in preparing the proposed rule groupings and impact analysis available to stakeholders to further understanding and replication of the proposed system
- Propose any subsequent HHGM with a multi-year transition in order to minimize disruptions
- Make conversion to the HHGM budget neutral

Defer adoption of the HHGM. As noted above, the FAH believes that the proposed policy represents a major restructuring of Medicare payment for home health services, and is not ready for implementation in 2019. The potential redistributive impact of the changes and the associated incentives for patient selection need to be fully understood and addressed to the fullest extent possible to ensure that all beneficiaries maintain access to needed services.

Data and transparency. The data used in modeling the HHGM for the proposed rule are from 2016; these data are not yet publicly available and stakeholders are therefore unable to fully replicate and analyze the proposed new payment system. As the FAH has learned over the years with respect to hospital payment policy, such payment modeling is a critical step in helping the field understand the payment system, developing thorough and meaningful comments on the proposed rule, and on occasion in identifying inadvertent errors in the CMS analysis.

Given the major payment policy change proposed in this case it is especially important that the underlying data be fully available to the public. In particular, the analysis and behavioral assumptions underlying the estimated 4.4 percent reduction in aggregate payments need to be discussed in detail. The proposed rule, however, is materially deficient in this regard. Assumptions on behavioral responses resulting from the new case-mix adjustment methodology are central to understanding the broad impact of the HHGM model, yet they appear in the proposed rule only as a brief mention in a footnote to a table, with no discussion in the text of how they affect the overall impact calculations nor any specificity about the nature of the assumptions. Other areas for which more information is needed include projected expenditures under the current system and the inclusion/exclusion of 30-day episodes under the proposed rule.

Transition to HHGM. The shift from current payment policy to a new HHGM-based payment could result in a significant redistribution of payments across types of patients and across home health agencies. In order to provide HHAs with sufficient time to adapt to the new payment structure, CMS should adopt a gradual transition to the HHGM model. Doing so would reduce the likelihood that some HHAs fail to manage the transition and abruptly leave the marketplace, which could limit access to needed services for

some beneficiaries. It would also provide time to assess the real world impact of the revised policies and make adjustments if unintended consequences occur.

Budget neutrality. Implementation of the HHGB or any changes to the case mix system used to pay for home health services should not impact the aggregate payments for these services under the home health PPS. Beginning with the first prospective payment system, which was adopted for inpatient hospital services more than 30 years ago, the underlying structure of prospective payment provides by design that only changes to the base rate (e.g., update factors) are used to adjust the aggregate level of payments. Patient classification or case mix systems have been used to distinguish payment rates among patients with different healthcare needs and resource use requirements, not to establish the aggregate level of Medicare payment. The annual budget neutral recalibration of the inpatient MS DRG weights, for example, reflects CMS' commitment to ensuring that the patient classification system serves its purpose without affecting aggregate program payments.

Indeed, the statute does not specifically authorize the Secretary to undertake to revise the HH PPS standardized payment amounts and the case-mix adjustment in a non-budget neutral manner, as CMS has proposed. The initial language directing the Secretary to establish a HH PPS clearly required that the payment rates be set to result in budget neutrality with respect to under prior policies (§1895(b)(3)(A)(i)(I)). A subsequent rebasing of the payment amounts was not budget neutral, but this policy was specified in the statute (§1895(b)(3)(A)(iii)). In addition, in describing the annual updates to the home health payment rates, the statute anticipates adjustments to the HH PPS payment rates to eliminate any effect the case mix adjustment may have on aggregates payments (§1895(b)(3)(B)(iv)).

Additional, more technical concerns with the proposed approach involve moving from a 60-day to 30-day payment episode, which will require additional billing resources; replacing the current wage-weighted minutes of care method of measuring the cost of care with cost report data that involve definitions that are not standardized and which are not uniformly audited; and inclusion of non-routine supplies in the base rate, which results in these costs being inappropriately adjusted by the wage index, disadvantaging rural providers.

The FAH appreciates the opportunity to submit these comments. If you have any questions, please contact me at 202-624-1534, or Steve Speil, Executive Vice President, at 202-624-1529.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve Speil", written in a cursive style.