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August 27, 2018

Seema Verma, MPH Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1689-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

RE: Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations (CMS-1689- P)

Dear Administrator Verma,

The Association of Home Care Coding and Compliance (AHCC), the national membership organization for home health coding and compliance professionals, together with the Board of Medical Specialty Coding and Compliance (BMSC), the credentialing arm of AHCC, appreciate the opportunity to comment on changes to the Home Health Prospective Payment System as outlined by the Centers for Medicare and Medicaid Services in the proposed rule issued July 12, 2018. Our response to several items contained in the proposed rule follows.

Proposal: Clinical Grouping. As part of the PDGM payment system, patients will be grouped into one of six clinical groups based on the principal diagnosis listed on the claim.

Response: We're concerned that agencies will find that a significant portion of their claims include a principal diagnosis that doesn't place the claim into one of the new clinical categories. CMS pointed out in the 2018 proposed rule that nearly 20% of claims reviewed during rule development would have qualified as questionable encounters, because the principal diagnosis listed on the claim did not map to one of the six clinical categories under HHGM. We understand that PDGM is a modified version of HHGM and that some of the mappings have been addressed, but it appears that there are still a significant number of diagnosis codes that do not map to clinical categories.

Patients whose principal diagnosis does not map to a clinical category will find their care not covered by Medicare, despite the fact that they are homebound and have a medical need for intermittent nursing, PT, or Speech Therapy. Reducing the number of codes that map, effectively changes the eligibility criteria for, potentially, a large number of home health beneficiaries. AHCC and BMSC believe that CMS needs to explain, in much greater detail, the codes that map to clinical categories, the codes that no

longer will result in payment and the rationale for this change. This is, in many respects, a change that will practically impact eligibility and needs to be handled appropriately. The eligibility requirements for home health are set forth in statute and the payment reform process is not the appropriate place to change eligibility.

AHCC and BMSC also think that CMS must create a clear regulatory process for addressing questionable claims. This last point is extremely important. In the HHGM proposal, CMS stated that when a claim was submitted with a diagnosis that did not map to a clinical category, it would be rejected as questionable. CMS advised that the provider could revise the diagnosis on a questionable claim and resubmit it. In simpler terms, AHCC and BMSC understand CMS to have advised providers that, if a claim was denied based upon the principal diagnosis, the provider could resubmit the claim, but alter the principal diagnosis to a code that would result in the claim being paid.

As associations committed to home health coding and compliance, AHCC and BMSC continue to be concerned that changing the coding for the principal diagnosis on a claim in order to receive payment could be viewed as upcoding. This concern was heightened when you included amongst your behavioral assumptions the assumption that home health providers will engage in intentional upcoding under PDGM. Given that assumption, recoding the principal diagnosis for a questionable episode and resubmitting the claim appears to be a problematic response to a denied claim. AHCC and BMSC request that CMS specifically state in the regulations the process for resubmitting a denied claim so that providers will have a clear process to avoid improper claims denial and/or the risk of being perceived to be engaged in a non-compliant practice like upcoding.

Proposal: Behavioral Assumptions. In calculating the budget-neutral 30-day payment amount, CMS proposes assumptions about three behavior changes that could occur in CY 2020 as a result of the implementation of the 30-day unit of payment and the implementation of the PDGM case-mix adjustment methodology. These assumptions include:

1. That HHAs will change their documentation and coding practices and would put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group.
2. That for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold HHAs will provide 1 to 2 extra visits to receive a full 30-day payment.

As a result of these assumptions, in combination with the potential for increased payment due to the new comorbidity adjustments, CMS proposes a 6.42 percent decrease to achieve budget neutrality.

Response: With this adjustment, CMS appears to assume that providers will behave fraudulently to improve reimbursement. That's a troubling assumption. Moreover, to the extent providers engage in such behavior, AHCC and BMSC believe that the correct response to such behavior is to prosecute wrongdoers. Reducing home health reimbursement in response to assumption of criminal conduct in the industry does not stop the misconduct, but simply takes from the numerous hardworking, law abiding providers to fund the fraud committed by others. This is an inappropriate and ineffective way to address fraud.

The industry as a whole will not engage in such misconduct, but all agencies will feel the impact of the 6.42 percent payment decrease. A better course of action would be to establish ways to identify the subset of unethical providers and prosecute them, rather than reducing payment for all providers.

As it stands, the PDGM system could force providers into the very situation it aims to target. If an agency providing care to an eligible patient changes the principal diagnosis from one that was not billable to one that corresponds to a clinical category, will auditors view this as upcoding?

Not only are the assumptions disparaging to the industry, but it is not at all clear that CMS can assume behaviors based upon the current LUPA model will follow in the new model. The behavioral assumptions involving LUPA payment are based on current data and current LUPA thresholds. The proposed LUPA model makes extensive changes to these payments resulting in a wide range of LUPA thresholds. Under the current model, a provider must get to 5 visits in 60 days to avoid a LUPA. Under the new model a provider will need to achieve 3 – 7 visits per 30-day episode, depending upon the group into which the patient is placed. This translates into a range of 6 – 14 visits in a 60-day episode. The assumption that a 6 – 14 day LUPA threshold range will result in similar behavior as a 5-day threshold seems unlikely.

Proposal: Reevaluating the necessity of RAPs. CMS points out that RAP payments can result in program vulnerabilities and mentions two egregious cases in which HHAs billed large amounts of RAPs without submitting final claims.

Response: Again, CMS bases a decision to remove a component upon which the vast majority of providers rely not upon the fiscal realities of these providers, but upon the criminal conduct of a handful of providers. The alleged program vulnerabilities created by the RAP process can be much better addressed by means that do not require eliminating them. CMS has had the tools to suspend an individual provider's ability to submit RAPs for many years. CMS has just recently updated its guidance to the intermediaries regarding this process. Utilizing the RAP suspension process is a much more equitable way to address this issue.

Providers rely upon the RAP, because they are required to provide the patient care before they are ever able to submit the claim, which will be at least thirty (30) days after the start of care. During this period, providers will have at least two payrolls go by, plus other monthly expenses, the RAP provides a way for the provider to obtain some of the reimbursement up front, in order to meet these expenses.

Providers who abuse the RAP in the manner outlined in the comments should have the ability to submit the RAP suspended and should be prosecuted for their fraudulent conduct. Eliminating the RAP will not stop fraudulent actors, they will, as they have done before, simply modify their fraud schemes to pursue other vulnerabilities. Meanwhile, the providers who are striving tirelessly to care for a vulnerable population will be presented with a significant financial challenge. This is an unnecessary burden to place on providers when CMS already has a number of other tools at its disposal that would allow CMS to pursue the wrongdoers directly.

Proposal: CMS proposes placement of each 30-day period of care into a specific clinical group based on the primary reason the patient is receiving home health care as determined by the principal diagnosis reported on the claim.

Response: As part of the clinical grouping model, CMS released a list of ICD-10-CM codes that would assign 30-day periods into the six clinical groupings. The logic behind some of these assignments seems counter-intuitive.

For example: the A41.- (Sepsis due to streptococcus aureus) and A40.- (Streptococcal sepsis) aren't on the list of acceptable principal diagnosis codes. Yet Z45.2 (Encounter for adjustment and management of VAD), which reports IV care, falls under the Complex Nursing Interventions Clinical Grouping as an acceptable primary diagnosis. Are agencies expected to report this Z code as primary rather than the diagnosis itself? The sepsis diagnosis gives a better picture of the complexity of care for such a patient and is more in line with coding guidelines. This is a concrete example as to why much greater transparency and dialog is needed in mapping codes to clinical groups.

Another example: The T87.4- (Infection of amputation stump) codes are assigned to the Medication Management Teaching and Assessment (MMTA) clinical group. This is the lowest paying clinical group, yet in home health, these patients with complicated amputations often also have diabetes, so the wounds don't heal well and require more care.

More clinical grouping questions: Why are some T8x.- (Complications of surgical and medical care, not elsewhere classified) in the Complex clinical group and some in MMTA?

Aftercare situations reported with the Z48.- (Encounter for other postprocedural aftercare) codes often require extensive wound care. Placing these codes in the MMTA clinical group doesn't give an accurate assessment of the care provided. These codes would be more appropriately placed in the Wound clinical group, like Z48.00 (Encounter for change or removal of nonsurgical wound dressing) and Z48.01 (Encounter for change or removal of surgical wound dressing). Otherwise, CMS may see an increase of agencies placing Z48.01 in the primary position!

And why is Z46.6 (Encounter for fitting and adjustment of urinary device) not considered an acceptable primary diagnosis code? For some patients, year over year, that is the focus of care. This puts agencies in the position of needing to change their diagnosis code sequencing, despite what the Coding Guidelines state.

Again, we appreciate the opportunity to comment on the proposed rule. We hope you will consider our concerns before moving forward with plans to roll out the PDGM as currently proposed.

While this isn't a comment directly related to the proposed rule, we understand that CMS convened a Technical Expert Panel ("TEP") earlier this year to gain insight on proposed changes to the Home Health Grouper Model from industry leaders, patient representatives, clinicians, and researchers with experience in home health care and/or experience in home health agency management. The AHCC and BMSC boards would appreciate the opportunity to send a representative to participate in panels of this nature in the future.

Sincerely,

The Association of Home Care Coding and Compliance

Dan Millman

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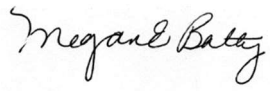
The Board of Medical Specialty Coding & Compliance (BMSC)



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