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Gaithersburg, MD 20878

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1672-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically

RE: 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 (CMS-1672-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 28, 2017.

Home Health Groupings Model (HHGM)

The HHGM plans as defined in the proposed rule raise several concerns for the home care industry.

Proposal: The proposed HHGM relies on clinical characteristics and other patient information to place patients into payment categories and eliminates the therapy service use thresholds currently used to adjust payments for case-mix under the HH PPS.

Response: CMS has expressed concern for some time over the possibility that the existing HH PPS therapy service thresholds create an improper incentive to provide therapy. However, the HHGM proposes to eliminate these therapy payments, without considering therapy costs in the revised payment methodology. For a prospective payment system that links cost to reimbursement, failing to consider an entire category of costs appears to be a major flaw.

Eliminating the case mix points for therapy will force some patients back into hospitals or to longer stays in rehab centers where care is costlier. We urge CMS to find a way to include therapy costs in the new payment calculation system.

Proposal: Clinical Grouping

As part of the HHGM payment system, patients will be grouped into one of six clinical groups based on the principal diagnosis listed on the claim. According to the proposed rule, if a 30-day period of care can't be grouped based on principal diagnosis due to reasons such as code vagueness, incorrect sequencing, or codes for conditions unlikely to require skilled care (among other reasons), the claim will be deemed a questionable encounter and be returned to the provider for more accurate or definitive coding.

We're concerned that agencies will find a significant portion of their claims returned to provider because the principal diagnosis doesn't place the claim into one of the clinical categories. CMS points out in the proposed rule that nearly 20% of claims reviewed during rule development would have qualified as questionable encounters. When providers use a principal diagnosis code that doesn't map to a clinical category, they'll face delays in payment. If the 20% figure holds true in practice, the cost to agencies could be significant.

If nearly 20% of claims don't fit into one of the new clinical categories, will that place beneficiaries at risk of being ineligible for admission to home health?

Additionally, the HHGM system will likely add a heavy burden of additional paperwork for providers.

For example: If a provider clarifies a claim returned as a questionable encounter by changing the principal diagnosis from one that was not billable to one that corresponds to a clinical category, there may be situations where an auditor views this as upcoding. This will lead to increased use of 100% pre-submission audits in an effort to avoid submitting claims that become "questionable encounters."

Claims returned as questionable encounters will also create a wrinkle in the Plan of Care (POC) submission process. Will agencies need to return signed POCs to physicians for correction?

Also, 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.

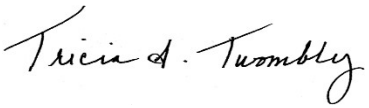
For example: A40 (Sepsis due to streptococcus, group A) is designated as a "questionable encounter" code. Home health agencies are seeing increasing numbers of patients admitted on IV antibiotics to treat this condition. Why is this diagnosis questionable? Yet Z45.2 (Encounter for adjustment and management 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.

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.

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 HHGM as currently proposed.

Sincerely,

The Association of Home Care Coding and Compliance



Tricia A. Twombly

Chief Executive Officer
Board of Medical Specialty Coding and Compliance
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