201 West Lake Street # 226
Chicago, IL 60606

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1844-P
P.O. Box 8013
Baltimore, MD 21244-8013.
Submitted electronically

RE: Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies (CMS-1844-P, 91 FR 41216)

Dear Administrator Oz,

The Association of Home Care Coding and Compliance (AHCC), the national membership organization for home health coding and OASIS review and compliance professionals appreciates the opportunity to comment on changes to the Home Health Prospective Payment System as outlined by the Centers for Medicare and Medicaid Services Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model.

Our members are the coders, the OASIS reviewers, and the compliance officers who sit between what the clinician saw in somebody's living room and what finally goes out on the claim.

There is a lot in this rule to be glad about.

Home Health Wage Index:

AHCC appreciates CMS's request for information regarding the development of a home health-specific wage index. We agree that the home health industry has a unique workforce and operating characteristics that may not be fully reflected through the continued use of inpatient hospital wage data.

As CMS considers alternative methodologies, we encourage careful evaluation of the factors that drive the actual cost of delivering care in the home. Unlike facility-based providers, home health agencies incur substantial expenses that extend beyond wage rates alone. Clinicians spend significant time traveling between patient homes, often across large geographic areas, and agencies absorb increasing costs related to milage reimbursement, vehicle expenses, scheduling inefficiencies, and non-billable travel time. These costs are fundamental to care delivery and directly affect an agency's ability to recruit and retain qualified clinicians.

We are concerned that a home health-specific wage index based primarily on wage data could inadvertently understate the true cost of providing care, particularly in rural and geographically dispersed communities. Direct wage rates alone do not capture the operational burden associated with

delivering care across large service territories where travel time may consume a substantial portion of a clinician's workday.

We encourage CMS to further evaluate whether areas experiencing the greatest workforce shortages and longest travel distances face cost pressures that are not adequately reflected under current wage index methodologies. In many rural markets, agencies compete aggressively for a limited clinical workforce while simultaneously absorbing higher travel-related costs. These realities can result in actual labor costs that exceed those suggested by local wage data alone.

We urge CMS to ensure that any future methodologies reflect both the clinical work performed in the home and the substantial resources required to get clinicians there.

Aligning the HH QRP, the QoPC Star Ratings, and the expanded HHVBP Model:

This alignment is overdue, and we agree with CMS that the differences between the HH QRP, the QoPC Star Ratings, and the expanded HHVBP Model create complexity that does nothing for the patient. Moving the reporting periods to a calendar year is a burden reduction that our members will feel.

First, we support alignment, but one of the six items on page 41277 is not a scheduling change. CMS says it is looking at "[u]pdating scoring methodology to incorporate HH QRP APU penalties in expanded HHVBP Model payment adjustments and factoring HH QRP Quality Assessments Only (QAO) values into QoPC Star Ratings scoring." This changes how the score is built.

When the score changes, the money changes, and so does the number families see on Care Compare. We know CMS is not seeking comment on that list and is not proposing Model changes here (page 41282), but this is the only place we have to say it: Please run these model changes through the public notice and comment process, and publish the arithmetic first. Please outline the measure weights, the star cut points, the normalization and scoring steps, how cohorts are assigned, and the risk adjustment coefficients. Our members are the professionals who will be asked to validate these numbers for auditors and boards, and you cannot show your work on a calculation you were never given.

Second, the measures still run on improvement, and some agencies with heavy assisted living and memory care census cannot get past 3 stars no matter how well they perform.

These are older, medically complex patients with progressive decline, and for most of them stabilization and preventing further deterioration is an excellent outcome. CMS says as much on page 41275 of this rule: "the restoration potential of a patient is not the deciding factor in deciding whether skilled services are needed." As noted in CMS's FAQ on the Jimmo Settlement Agreement, Medicare coverage for skilled nursing and therapy services "does not 'turn on' the presence or absence of a beneficiary's potential for improvement, *i.e.*, it does not matter whether such care is expected to improve or maintain the patient's clinical condition."

We know M1100 and the OASIS cognitive items are already in the risk adjustment models and we appreciate that. But "lives in congregate situation" puts an assisted living apartment, a memory care unit, and a group home in one bucket, and the assistance categories describe hours of coverage rather than who is providing the care. Both around-the-clock aide coverage in a facility and an exhausted spouse at home fall in the same place. Being in the model is not the same as being weighted enough to matter.

How does a woman with Lewy body dementia show a better score on medication management in 60 days? She does not, and she should not have to. The home health agency did their job when she was still home at the end of the episode instead of in a hospital bed. As it stands, stable counts as a failure, and that is backwards. We ask CMS for four things:

- Publish the coefficients on the congregate and assistance variables;
- Break that congregate category into something meaningful;
- Show us how star ratings and TPS scores actually spread out by assisted living census; and
- Give scoring credit for keeping a patient stable.

Stratification or peer grouping could also work, so agencies are compared against clinically similar populations. If we are wrong about the plateau, your own data will show it.

Palliative care:

We also agree with CMS that the home is where palliative care belongs. We are grateful the agency is taking that question up.

Our concern here is simple: How will this work with the star ratings? There is no way to tell CMS that an episode was palliative. In the data it looks like every other MMTA case.

We have an ICD-10 code for an encounter for palliative care, but it does nothing here. It does not drive the clinical group, adjust the payment, or reach a single quality measure. So, when the patient does not improve, it counts against the agency, and when she elects hospice or dies at home, which is exactly what she asked for, we cannot tell our members how CMS is counting the outcomes.

If CMS asks home health agencies to take these patients, the measures must count symptoms controlled, deterioration avoided, and patient-chosen goals met. That could mean stratifying these episodes, pulling them out of selected improvement measures when clinically appropriate, or building measures that recognize those outcomes.

Or will there be a different HIPPS code for these patients? The rule does not create a separate payment classification for palliative care, and we think it must. Whether that takes the form of a palliative clinical group with its own case mix weights and its own HIPPS codes, a condition code or modifier on the claim, or an OASIS item on goals of care, we do not have a preference among the three. We care that there is one, and that it works for payment and for scoring these episodes fairly.

Please also take a look at the MMTA weights. These episodes are visit heavy, nursing and social work heavy, and many end early in hospice or death, so the agency takes a LUPA and swallows the cost of the front-loaded assessment and teaching.

We are glad CMS is moving on both the alignment and palliative care issues, and we want these shifts to work. Our members can tell you quickly whether a proposed code or a new OASIS item will hold up in the field, because they are the ones who will apply it, audit it, and defend it. AHCC would welcome the chance to help build it.

Our members have been walking into people's homes for many decades and know what good care looks like at somebody's kitchen table at 7 o'clock at night. We would just like the report card, and the claim, to know it too.

Adding Endocrine 3 to the comorbidity adjustment codes:

We support the proposal to add the Endocrine 3 group to the comorbidity adjustment subgroups.

The Endocrine 3 group includes our diabetic patients. As a medical industry we know that diabetic patients require more care.

Diabetic patients are more likely to have delayed healing and infection after a surgical procedure. Diabetic patients often struggle with diabetic ulcers that are also difficult to heal. Diabetes can affect the majority of the body systems if not treated correctly. The high level of blood sugar in a diabetic patient's system can cause heart disease, CKD, nerve damage, gum disease, hearing loss, blindness, gastroparesis, liver disease, weaken white blood cells that help to fight infection, damage blood vessels in the brain, etc.

Diabetic patients have increased risk of getting sick, staying sick longer, or getting more severe infections. This makes it hard to fight off infectious disease and illness caused by germs. Diabetes is a very complex disease that has many risk factors and complications involved.

Diabetes is the number one cause of surgical amputation. This decreases our patient's quality of life and causes long-term functional disabilities. All of this information supports including diabetes in the comorbidity adjustment group.

0 points proposed for an M1860 score of 3:

We understand that Medicare utilizes data from our OASIS submissions to determine the cost of caring for each type of patient.

"3. Able to walk only with the supervision or assistance of another person at all times" is the most common response for OASIS item M1860: Ambulation/Locomotion.

Last year, CMS decreased points for an M1860 answer marked as "3 " to 1 point. Now CMS proposes that selecting response “3” earns zero points.

This is an unfortunate proposal. The patients who are truly a "3" on M1860 are those who are only safe walking with supervision or assistance of another person at all times. OASIS manual instructions tell us to mark "3" if the patient does not have a walking device but is clearly not safe walking alone, unless the patient is chairfast. The manual also instructs that if the patient requires hands-on assistance (hands-on, supervision, and/or verbal cueing) to safely ambulate continuously, they should be marked as a "3."

The question also takes into account a variety of surfaces that the patient typically encounters. We are asked to select the answer where the patient's ability best supports safe ambulation on all surfaces the patient routinely encounters. With all the OASIS guidance as it stands, you can see why response "3" is so frequently selected by home health agencies.

We would like to better understand the rationale behind this removal of points for M1860 response “3.”

Grouper category for new nipple/areola necrosis ICD-10 codes:

As of Oct. 1, ICD-10-CM will include two new codes for nipple/areola necrosis after nipple-sparing mastectomy:

- N99.860 (Intraoperative and postprocedural nipple ischemia) and
- N99.861 (Intraoperative and postprocedural nipple necrosis)

While these codes have been added to the genitourinary system section of the ICD-10-CM code set, these codes would be more appropriate for inclusion in the wound grouper.

These complications can result in gaping wounds that have difficulty healing. They require wound care either through a wound clinic for non-homebound patients or home health for those that are homebound and meet eligibility for Medicare home health.

These codes should be included under the wound grouper to support the type of care agencies will provide for patients who have these complications. Agencies will require additional revenue to support the costly supplies needed to treat these kinds of wounds.

CMS Transition to the exclusive use of the GG items to measure functional performance:

We support CMS's exploration of a transition to the exclusive use of Section GG functional items for home health payment and outcome measurement. The movement to exclusive use of the GG items within home health furthers CMS's broader goals of alignment across quality initiatives, quality reporting programs, value-based purchasing, and post-acute care settings. The use of a common functional language across the continuum promotes consistency, facilitates comparison of outcomes, and supports more coordinated care delivery. CMS has identified opportunities to further align the Home Health Quality Reporting Program and the Expanded Home Health Value-Based Purchasing Model, and the addition of Section GG provides a logical foundation for that alignment. [federalregister.gov], [cms.gov]

A GG-based framework would also eliminate the duplication of functional assessment currently required within home health. Clinicians often collect similar functional information multiple times using different assessment constructs. Moving to a single functional framework would reduce documentation burden, improve efficiency, and allow clinicians to devote more time to patient care rather than redundant data collection. In addition, using the same functional items for payment, quality measurement, and benchmarking creates a more transparent and understandable methodology for providers.

Continued efforts to improve inter-rater reliability will also be essential. Because GG items may ultimately have significant implications for payment and outcomes measurement, agencies and clinicians should receive ongoing education and guidance to promote consistent scoring practices across disciplines and organizations.

Overall, we believe the benefits of moving toward an exclusive GG-based functional assessment framework outweigh the challenges. With appropriate testing, risk adjustment, education, and phased implementation, CMS can reduce provider burden, eliminate duplicative functional assessment requirements, improve standardization, and further advance the long-term goal of alignment across home health quality and payment programs.

Thank you for the opportunity to comment.

Respectfully submitted,

The Association of Home Care Coding and Compliance

Jan Milliman, HCS-D

Director

Association of Home Care Coding and Compliance