



UnityPoint at Home

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August 31, 2018

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

RE: **CMS-1689-P** – Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and Proposed 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; published at Federal Register, Vol. 83, No. 134, July 12, 2018.

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

Dear Ms. Verma,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Home Health rules for calendar year 2019. UnityPoint at Home is the Home Health Agency affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment (DME), pharmacy, palliative care, hospice care, and (in certain locales) public health. In 2017, UnityPoint at Home provided more than 610,000 visits to consumers in Iowa and Illinois. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMMI Next Generation ACO Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa, and is a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. We respectfully offer the following comments to the proposed Home Health regulatory framework.

## I. PAYMENTS UNDER THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

**Proposed CY 2019 HH PPS Payment Adjustment:** Medicare payments to Home Health Agencies (HHAs) in CY 2019 are proposed to be increased by 2.1% or an estimated \$400 million.

*Comment:* **We support this rate increase.** Past adjustments have not kept pace with increased costs attributable to labor, technology and mileage. This increase will assist in maintaining healthcare access for Medicare beneficiaries that live in areas of the country where most HHAs are already experiencing very small operating margins.

**Rural Health Add-On Payments for CYs 2019 through 2022:** The Bipartisan Budget Act of 2018 imposed a -0.1 percent decrease in payments and established a classification system for rural counties: high utilization; low population density; and all others.

*Comment:* In Iowa and central Illinois, we have a significant rural population. Collectively, our HHAs serve 47 counties, which are all classified in the “all other” category as defined in the proposed rule, and two of our Iowa HHAs serve only rural counties. **We are extremely concerned about the impact this policy will have on our ability to continue to provide services to rural beneficiaries.** This reduction will negatively impact access to care in low population density areas, where beneficiaries are older, have more chronic conditions, and face provider shortages. To compound matters, areas that receive rural add-on payments typically have much lower wage indices, and therefore are already faced with providing the same level of care as other HHAs but with less Medicare reimbursement. To put this in perspective, the 3 percent add-on is the approximate equivalent of a full-time nurse’s (RN) salary. For one of our rural HHAs serving an average of 235 patients per day, the loss of this rural add-on equates to about \$75,000 annually (i.e. the equivalent to one RN FTE). Reductions in the add-on similarly tighten margins which are already razor thin. For our HHAs serving rural areas, this proposal will force us to re-evaluate these service areas and may require a reduction or discontinuation of coverage.

**Proposed Implementation of the Patient-Driven Groupings Model (PDGM) for CY 2020:** The Bipartisan Budget Act of 2018 required a change in the unit of payment from 60-day episodes of care to 30-day periods of care to be implemented in a budget neutral manner on January 1, 2020. Also for 2020, Congress mandated that Medicare stop using the number of therapy visits provided to determine payment.

*Comment:* Most importantly, **we want to thank CMS for listening and incorporating stakeholder feedback from last year’s notice and comment period.** We are especially appreciative of the initial delay to allow the proposed framework to become more detailed and to enable a more thorough analysis. We also want to recognize CMS’s posting of the PDGM Agency-Level Impacts, Estimated for CY 2019, that has aided our ability to make baseline financial projections. That said, we are still concerned with the short implementation timeframe associated with this re-visioning of the HH PPS and that this fundamental change has been modeled only on paper and has never been tested by any HHA in any area of the country.

**Implementation scope and timeframe:** We will reiterate our request from last year<sup>1</sup> and **urge CMS to reconsider national implementation in favor of a small pilot**, like the process used by CMS to test the

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<sup>1</sup> 2018HHPPS\_UnityPointatHome\_092517.pdf found at Regulations.gov comment tracking number 1k1-8yva-2pzz

Home Health Value-Based Purchasing Model (HVBPM). A measured phased approach will give providers, MACs and CMS time to evaluate if all needed elements are in place and working as intended prior to national implementation. Specifically, we would recommend that 5 or 6 states be selected for this pilot; that selected states exclude those currently participating in the HVBPM; that implementation begin in CY 2021 to allow for corresponding EHR infrastructure to be put in place as well as technical assistance and staff training to occur for those participating states; and that the remainder of states begin implementation in CY 2023 to allow for more seamless implementation given the benefit of a pilot evaluation and subsequent improvement efforts. In addition, we cannot overstate the magnitude of operational impact, including OASIS, risk adjustment, HHVBP, IMPACT, and HH QRP, which are all changing concurrently but independently of each other. More time and a phased approach will facilitate a successful transition and enable HHAs, MACs and CMS to better predict quality outcomes and financial impact. Should CMS elect to move forward on a national scale, ***we request that implementation be delayed at least until CY 2021 to enable EHR infrastructure builds and appropriate training, as well as added time for HHAs to understand and appropriately implement the multitude of new regulatory requirements.***

Decrease length of payment episode. ***We are generally supportive of the concept to shorten payment to 30-day periods of care.*** We also agree that the elimination of the split percentage would align better with a 30-day payment. Although we support a 30-day period of care, ***we would suggest that CMS establish a carve-out or outlier policy to encompass high cost and/or recurring supplies.*** A patient with a thoracostomy would be an example. The drainage kit for that patient usually needs to be replaced about every 3 days with a cost between \$50-60 per kit. Another example is a new ostomy patient that is having complications with fitting. In this instance, we may be buying boxes of supplies at \$70-80 per box until we find an appropriate solution for that individual patient.

Proposed case-mix adjustment. From a policy perspective, ***we fully support elimination of a therapy-utilization-driven payment model.*** Today, the most complex and costly beneficiaries for a HHA are those that require intensive nursing care in comparison to those beneficiaries that require intensive therapy services. The Medicare payment structure should not create perverse incentives – to increase visits to surpass outlier thresholds or to avoid serving medically complex patients who require less but longer visits. We agree that payment based on service volume, rather than patient characteristics and needs, is flawed and does not drive high-quality care.

While we support the elimination of therapy thresholds, we are alarmed by the wide case mix weight gap in the “Referral Source with Timing” category, which distinguishes community from institutional referrals. We fully support institutional being higher than community and appreciate that this is one of the elements that better reflects the complexity and cost of taking care of highly acute hospital discharges. At issue is that the long-term goal of all health systems and providers, as encouraged by CMS, is enhanced population health – to lower total overall beneficiary spending while maintaining access and improving quality. One important strategy to achieve this goal is to work with primary care providers on upstream interventions to avoid preventable inpatient admissions. As a result, when a patient is seen in the provider’s office and needs more intervention for an acute exacerbation of a chronic illness or other condition manageable at home, evidence-based protocols are in place for providers to arrange for a same-day admission with nursing intervention to HHAs instead of sending the

patient to the hospital. We are also concerned that CMS has excluded the “community early” category from Table 48 (excerpt shown below), as this is likely show an even greater disparity. ***We urge your reconsideration of how community referrals are valued for purposes of the case-mix rate.***

Referral Source With Timing (Community Early excluded)		
Community - Late	-\$646.84	-0.4118
Institutional - Early	\$278.85	0.1775
Institutional - Late	\$45.71	0.0291

**Proposed Changes for Certifying and Recertifying Patient Eligibility for Medicare Home Health Services:**

CMS is eliminating the requirement that the certifying physician estimate how much longer skilled services are required when recertifying the need for continued home health care. Also, medical record documentation from the HHA is proposed to be used to support the basis for certification of home health eligibility.

*Comment:* ***We want to thank CMS for this proposal*** to reduce administrative burden and enable more beneficiaries to access home health services. This is a great first step. Along the same rationale, we request that CMS consider:

- ***Eliminating the requirement for the Home Health face-to-face encounter for certification/recertification for post-acute or skilled discharges.*** In situations in which a home health referral is made as part of a post-acute or skilled nursing facility discharge, a mandatory face-to-face encounter for purposes of certification is not necessary and a poor use of physician time and associated costs. We would recommend that CMS permit these certifications to be claims based and to rely upon the medical record of the patient to determine need. In our view, this recommendation is an extension of PDGM framework, in which CMS will be verifying that the home health episode is post-institutional versus community-based, and correlates nicely to the PDGM referral source provisions.
- Recognizing efficient patient home health transitions between traditional Medicare and Medicare Advantage. Presently, when a home health beneficiary switches between Fee-for-Service Medicare and Medicare Advantage, the HHA must re-establish the beneficiary’s home health eligibility to continue home health services. To avoid gaps in service and reduce HHA administrative and clinical documentation burden, we recommend that CMS simply ***enable home health eligibility to continue regardless of Medicare payment source.*** Current policy does not promote seamless and timely care and is not patient-centric. If a patient has not seen their primary care provider in the 90 days prior to the new Medicare-payer episode, this policy creates a potential delay in home health services, requires an otherwise-unnecessary physician visit, and increases beneficiary costs.

**Remote Patient Monitoring Under the Medicare Home Health Benefit:** CMS is defining remote patient monitoring under the Medicare home health benefit as “the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the HHA.” Remote patient monitoring will be an allowable administrative cost on the HHA cost report, if remote patient monitoring is used by the HHA to augment the care planning process.

*Comment:* UnityPoint at Home is proud to be an early HIT adopter (telehealth, video, remote wound care, I-phones) and has historically been supportive of CMS efforts to facilitate the expanded use of technology in health care. **We support CMS' recognition of remote patient monitoring;** however, its classification as an "allowable expense" does not necessarily promote its use within the constructs of the current global payment environment. Instead **we would recommend that CMS include remote patient monitoring as an add-on expense in the HH PPS.**

## II. HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

**Iowa is one of the nine states participating in the Home Health Value-Based Purchasing Model pilot, a five-year demonstration project. UnityPoint at Home has 13 locations within Iowa.** Quality measurement and performance scoring methodology are among the topics for which CMS is proposing revisions.

**Quality Measures:** For CY 2019, two OASIS-based measures (Influenza Immunization Received for Current Flu Season Measure and Pneumococcal Polysaccharide Vaccine Ever Received) are being removed and three OASIS-based measures are being replaced with two composite measures on total change in self-care and mobility. Also OASIS-based, claims-based, and HHCAHPS measures within the Clinical Quality of Care, Care Coordination and Efficiency, and Person and Caregiver-Centered Experience classifications are being reweighted. It is proposed that the total performance score would be calculated as follows: OASIS-based measures would account for 35 percent; Claims-based measures would account for 35 percent; and HHCAHPS would account for 30 percent.

*Comment:* UnityPoint at Home is supportive of the Meaningful Measures initiative and applauds efforts to streamline data collection and reporting. As such, **we support the elimination of redundant OASIS-based measures.** We do have concerns with the two proposed composite measures, which replace three OASIS-based measures. In particular, **we question the methodology for the "maximum possible change" calculation for each measure.** Each patient's maximum score for a specific question will be based upon the total number of responses possible for that OASIS question. This methodology does not create an equal ability for HHAs to improve certain populations of patients. For example, for Activities of Daily Living/Instrumental Activities of Daily Living: M1860 (Ambulation/Locomotion), a patient this is temporarily in a wheelchair following a lower extremity injury, surgery or other reason for immobilization would be scored a 4 at SOC and has the potential to move to a 0 prior to HHA discharge. However, a patient who has a chronic musculoskeletal or neurological condition that will never be ambulatory again, but needs home health physical therapy to improve on transfers, would be scored a 4 at SOC but would still be a 4 at HHA discharge. In addition, **we believe that CMS adds complexity to the HHVBP model by using a CY 2017 baseline year for these new composites,** which differs from the CY 2015 baseline year used for the remainder of the measures.

**We also support the proposed reweighting of the total performance score and would like to see these weights trend even more towards claims-based measures (i.e. 60 percent).** As a general rule, claims-based measures are less likely to be the subject of data manipulation, as opposed to OASIS-based measures. Also we believe that the OASIS-based outcomes measures may not reflect best practices. For instance, the Discharge to Community measure may incentivize inappropriate discharges and **we would encourage CMS to evaluate the removal of the Discharge to Community measure** during next year's

review of the HHVBP model. This measure fails to recognize that keeping a patient in the community is not always the best outcome for that patient. Furthermore, this measure undermines the provision of appropriate care – if a HHA believes a patient will not remain in the community at discharge despite the need for services, this measure would support HHA decisions to not serve the patient entirely or to discharge the patient at time of transfer to an inpatient facility rather than accepting the resumption of care orders. For instance, this measure may encourage some HHAs to cherry pick orthopedic surgical patients and discourage some HHAs from serving rural patients.

**Performance Scoring Methodology:** Performance scoring is being retooled to reduce the maximum improvement points to 9 points from 10 points starting in performance year 4.

*Comment:* While we are pleased that CMS is attempting to “encourage HHAs to focus on achieving higher performance levels and incentivizing in this manner would encourage HHAs to rely less on their improvement and more on their achievement,” the proposed scoring structure still penalizes high-performing HHAs. Even under this structure, low-performing HHAs who are improving can earn more points than HHAs who consistently perform at higher levels. ***We encourage CMS to revisit performance scoring methodology so that high-performing HHAs are not disincentivized and offer two options for further consideration:***

- ***Revisit improvement points in comparison to achievement points*** as we believe that HHAs with high achievement should always score better than those with improvements. This could be accomplished by reweighting the CMS improvement scores, reducing the available points or establishing a bonus system.
- ***Reset the baseline year of all measures to 2017.*** As stated in this proposed rule, all HHAs in performance and non-performance states continue to improve in OASIS-based measures while claims-based measures have remained flat, and HHAs currently in the HHVBP model should have had adequate time to make necessary changes to the quality of care delivery. By resetting the baseline performance year, the improvement points baseline period would correspond to the timeframe in which each HHA was being incentivized to perform well in all the same areas of patient care delivery. This would also help eliminate the confusion that will come with having two different performance year baselines assuming the two new composite measures are finalized.

**Public Display of Total Performance Scores:** CMS is considering public reporting for the HHVBP Model after allowing analysis of at least eight quarters of performance data for the Model and the opportunity to compare how these results align with other publicly reported quality data. CMS is seeking comment of what information should be made publicly available for inclusion in future rulemaking.

*Comment:* We support public reporting of the Annual Total Performance Score and Payment Adjustments Reports. ***We would also suggest that CMS consider providing an actual percentile ranking for HHAs along with their Total Performance Score.*** Currently CMS only provides HHAs with percentile ranking (i.e. 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup> or 90<sup>th</sup>) and more specific percentiles would inform both HHAs and the public.

### III. HOME HEALTH CARE QUALITY REPORTING PROGRAM (HH QRP)

**Removal of HH QRP Measures:** CMS proposing to adopt an additional factor to rationalize removal of measures from the measure set – Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program. In addition, CMS is proposing to remove seven quality measures: (1) OASIS Item M1730, Depression Screening at SOC/ROC; (2) OASIS Item M2401 row a, Intervention Synopsis: Diabetic foot care at the time point of Transfer to an Inpatient Facility (TOC) and Discharge from Agency—Not to an Inpatient Facility (Discharge); (3) OASIS Item M1910, Falls Risk Assessment at SOC/ROC; (4) OASIS Items M1051, Pneumococcal Vaccine and M1056, Reason Pneumococcal Vaccine not received at the time point of TOC and Discharge; (5) OASIS Items M1340, Does this patient have a Surgical Wound? and M1342, Status of Most Problematic Surgical Wound that is Observable at the time points of SOC/ROC and Discharge; (6) ED Use without Hospital Readmission During the First 30 Days of HH (NQF #2505); and (7) Rehospitalization during the First 30 Days of HH (NQF #2380).

**Comment:** *We support the addition of Factor 8 and the proposal to remove seven measures from the HH QRP. We offer the following suggestions:*

- **Scope of Factor 8** – We believe that CMS has correctly identified that Factor 8 invokes and should consider a variety of costs, including “provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs.” Using this underpinning, we would suggest that **Factor 8 be incorporated when evaluating measures in all programs** that are concurrently, yet independently, making changes to the input items of OASIS as well as resulting outputs. For instance, HH QRP, HHVBP, IMPACT, ICD coding conventions, survey/accreditation, and risk adjustment calculations are all making changes to the OASIS item set inputs while HHA performance is tied to OASIS outputs relative to case mix, risk adjustment, PDGM, HH QRP and HHVBP.
- **IMPACT Act measures** – The pace of removal of historical OASIS items has not matched the addition of new measures to meet IMPACT Act requirements. We would request that **as IMPACT Act measures are added that, along with the burden of duplicative data collection, the applicability to all three care settings be taken into consideration.** For example, for CY 2020, the Application of Falls (NQF #0674) and the Application of Functional Assessment (NQF #02631) measures are worded and established for patients residing in a facility (appropriate for SNFs and LTACHs, but not HHAs).

**IMPACT Act Implementation:** CMS is proposing to delay the implementation of two measures that would satisfy the IMPACT Act domain of accurately communicating the existence and provision of the transfer of health information and care preferences. The new proposed timeframe to specify the measures is no later than January 1, 2020, with an intent to adopt them beginning the CY 2022 HH QRP and data collection at the time point of SOC, ROC and Discharge beginning January 1, 2021

**Comment:** In general, **we believe that IMPACT Act measures have not appropriately captured HHA assessments.** Aside from the example in our comment to the “Removal of HH QRP Measures” above, some measures require manual extraction of information from various sources for every home health

admission. We urge CMS to consider the collection of data elements and the burden imposed across settings prior to adoption.

**Form, Manner, and Timing of OASIS Data Submission:** CMS is clarifying that not all OASIS data described in §484.55(b) and (d) are needed for purposes of complying with the HH QRP reporting requirements.

*Comment:* Thank you. ***This clarification aligns with our understanding.***

**Public Display for the HH QRP:** CMS is proposing to increase the number of years of data used to calculate the Medicare Spending Per Beneficiary (MSPB)–PAC HH QRP for purposes of public display from 1 year to 2 years beginning in CY 2019.

*Comment:* ***We support*** this recommendation.

**Home Health Care Consumer Assessment of Healthcare Providers and Systems® (HCAHPS):** No changes are proposed for CY 2019.

*Comment:* ***We appreciate*** that CMS is continually monitoring Home Health measures and has not recommended further changes this year.

#### **IV. MEDICARE COVERAGE OF HOME INFUSION THERAPY SERVICES**

CMS is proposing regulations in support of the new home infusion therapy benefit that was established in section 5012 of the 21st Century Cures Act.

**Health and Safety Standards for Home Infusion Therapy:** CMS is limiting its proposed requirements to those elements specifically identified in section 1861(iii) of the Act. For home infusion therapy suppliers, standards are proposed for a plan of care and required services.

*Comment:* Among the required services, professional services must be available on a 7-day-a-week, 24-hour-a-day basis in order to ensure that patients have access to expert clinical knowledge and advice in the event of an urgent or emergent infusion-related situation. ***We request that CMS further clarify this availability of professional services requirement with examples.*** As used in this context, does professional services extend beyond nursing services? Would “on-call” capacity be sufficient to meet this requirement?

**Approval and Oversight of Accrediting Organizations for Home Infusion Therapy (HIT) Suppliers:** CMS is proposing accreditation process and standards, which are separate from the home health accreditation program.

*Comment:* Both the Accrediting Organizations (AOs) and suppliers will incur accreditation costs. Due the large extent of unknowns, it is difficult to provide specific guidance on this subject except to express that ***we are concerned that this will create undue costs and administrative burdens on home infusion agencies outside of direct patient care.*** In general, home infusion agency costs and time and effort expenses will be incurred for:

- Additional AO accreditation and administrative/compliance costs related to the accreditation process itself.
- Additional AO costs related to the CMS application and certification process that will pass through to regulated providers from the AOs.
- Additional training and operational costs for home infusion agencies to meet new and/or different accreditation standards from the AO. It is likely that these standards and associated costs will vary among AOs.

**Payment for Home Infusion Therapy Services:** CMS is proposing a temporary transitional payment to begin on January 1, 2019 and end the day before the full implementation of the home infusion therapy benefit on January 1, 2021. This payment is based on an infusion drug administration calendar day with rates assigned to three payment categories. CMS estimates a \$60 million increase in Medicare payments to home infusion suppliers in CY 2019. This increase reflects the cost of providing infusion therapy services to existing DME home infusion therapy beneficiaries.

Comment:

**Infusion Drug Administration Calendar Day:** We request that CMS revisit this definition, which triggers when a supplier can bill for home infusion therapy services. While we agree with the concept that payment should be limited to the date on which professional services were furnished, we believe that CMS has misinterpreted this to require that skilled professionals (i.e. nurses) be physically present in an individual's home on the day the infusion drug is administered for payment to occur. This interpretation is flawed in several respects. First, CMS incorrectly equates professional services to skilled services as set forth in 42 CFR 409.32. We are uncertain why CMS would reference regulations related to the coverage of posthospital SNF care as the equivalent of care in the home setting. Second, limiting reimbursement for professional services to those instances when a nurse has a physical presence in the home appears contrary to the statute's plain language, which authorizes "*professional services, including nursing services, furnished in accordance with the plan.*" It is clear from this language that nursing services are a subset of professional services. Third, the CMS requirement of in-person nursing services seems to overstep the Congressional intent that professional services are furnished according to the provider's plan of care. We do not believe that Congress intended CMS to offer clinical judgment related to how home infusion drugs are furnished. In many instances, the plans of care for home infusion therapy have goals of promoting and teaching patients to be independent. Fourth, for decades, private insurances have required patients to perform their own administration of their IV medications without the physical presence of a nurse. Fifth, this exacerbates a nursing shortage, particularly in rural areas. To make matter worse, this shortage is predicted to worsen as the baby boomers retire. ***We urge your reconsideration and offer this revised definition: Infusion drug administration calendar day means the day on which home infusion therapy services are furnished in the individual's home on the day of infusion drug administration.***

**Overlap with Medicare Part A:** As proposed, a nursing visit triggers the supplier billing. Currently coverage for nursing is under the Medicare Part A benefit and is performed by a Medicare Certified Home Health Agency. ***Is it the intend of CMS to change the current Home Health Agency Part A billing?***

**Calculation of Cost Estimate:** In Table 66, CMS estimates \$58.6 million in increased costs for existing DME home infusion patients. This was calculated using CY 2017 data for duration and then assumed monthly nursing visits for category 2 and weekly nursing visits (with the exception of two nursing visits in the initial week) for categories 1 and 3. ***We concur with the visit frequencies used for this calculation.***

**Home Infusion Drug:** ***We seek clarification related to the timeframe within this definition.*** Both statute and regulation define this term as “a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment.”

- Does the 15-minute duration reference both intravenous and subcutaneous administration?
- What is the impact if the 15-minute administration duration is not met? Will the supplier receive a lower reimbursement or no reimbursement at all?
- While the billing commentary states “Each visit reported would include the length of time in which professional services were provided (in 15 minute increments),” must the visit time correspond to the time needed for drug administration?

## V. ACCREDITATION REQUIREMENTS FOR CERTAIN MEDICARE CERTIFIED PROVIDERES AND SUPPLIERS

CMS is proposing to require that AOs continue the accreditation term when a Medicare-certified provider or supplier decides to voluntarily terminate the AO’s service contract. In addition, CMS is proposing that all AO surveyors be required to take the CMS online surveyor training offered on the CMS website.

**Comment:** We are generally supportive of these proposals. In terms of the AO surveyor training, ***we would urge CMS to consider including a corresponding decrease in CMS validation surveys for those AOs whose surveyors have completed the training.*** With an uptick in training, CMS resources devoted to validation surveys could be reduced, saving taxpayer dollars and lessening HHA time and effort spend on largely redundant surveys.

Validation surveys are just one example of duplicative and administratively burdensome audit processes targeted at HHAs. Other administrative reviews include RAC, Pre Claim Review, Probe & Educate, and routine MAC ADR probes. While there are ample enforcement tools, CMS has not clearly targeted these efforts to bad actors and high-value HHAs have had to divert resources from direct care to administrative functions. ***We would reiterate the request from our CY 2018 comment letter<sup>2</sup> for CMS to establish controls, limits, and timeframes over audit volume and clearly define audit scope (i.e. who and what can be audited). We suggest that audit frequency should be determined using current data along with PEPPER reports to identify underperforming and/or noncompliant agencies. In addition, audits should be limited to topics within statutory and regulatory parameters.***

## VI. REQUESTS FOR INFORMATION

CMS is requesting input related Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals

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<sup>2</sup> 2018HHPPS\_UnityPointatHome\_092517.pdf found at Regulations.gov comment tracking number 1k1-8yva-2pzz

and Other Medicare- and Medicaid-Participating Providers and Suppliers and Price Transparency: Improving Beneficiary Access to Home Health Agency Charge Information.

*Comment:* We are pleased that CMS is prioritizing interoperability across sites and settings of care. While certain providers have been provided with financial incentives to promote HIT adoption, HHAs were not included. As CMS considers interoperability, a phased approach should be considered to reflect the state of EHR adoption and the need for financial assistance. ***Although the idea of requiring the electronic exchange of medically necessary information within CoPs/CfCs/RfPs is interesting, we believe this is premature as the state of EHR adoption across sites and settings of care has not uniformly advanced or been incentivized.***

*In terms of Price Transparency, UnityPoint at Home would consider “standard charges” to be our price list.* The only thing we bill any payer or patient for is visits (or episodes for Medicare and most MA plans) or hours. Each year we establish a visit rate by discipline and an hourly rate by discipline. That is what we use to provide advance notice to patients as required by our CoPs. This includes notice to patients of out-of-pocket costs for a service before it is furnished, even if it is \$0, which is also required by our CoPs.

## VII. ADDITIONAL REGULATORY RELIEF

Although these items were not addressed in the proposed rules, we would like to take this opportunity to offer the following suggestions to remove barriers that hamper our efficient and effective delivery of home health services to our Medicare beneficiaries.

- **Eliminate the Pre-Claim Review Demonstration for Home Health Services (CMS–10599).** UnityPoint at Home has submitted a separate comment letter<sup>3</sup> to CMS on this issue dated July 30, 2018, which details our concerns. We request that this Demonstration be eliminated altogether or, in the alternative, be more narrowly targeted to HHAs with a record of compliance issues. Casting the Demonstration to entire states is overly broad and burdens high-value HHAs without evidence of added value to the overall care of beneficiaries.
- **Electronic Visit Verification (EVV) Delay and flexibility.** We appreciate the delay of EVV until 2020<sup>4</sup> and would request that CMS adopt a pro-HHA approach by encouraging open models in states. This would allow each HHA to choose an individualized solution that meets their needs as well as minimum federal requirements. As an organization that has HHAs in several states, including border communities, it would allow us to choose one solution and minimize compliance efforts.
- **Remove the regulation for home bound status for home health beneficiaries in a risk-bearing Medicare ACO.** With the shift to value-based payment, CMS should permit providers that are in risk-bearing relationships the ability to determine whether a patient needs a home care episode

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<sup>3</sup> PreClaimReviewDemo\_UPATH\_07302018.pdf found at Regulations.gov comment tracking number 1k2-94km-n9hb

<sup>4</sup> The Guthrie Act, H.R. 6042, became Public Law 115-222 on July 30, 2018

even if the beneficiary is able to ambulate and does not require a taxing effort to leave the home. Effectively, this permits providers and beneficiaries, and not a regulator/payer, to determine the preferred course and setting for service delivery.

- **Authorize Nurse Practitioners and Physician Assistants to sign home care orders.** Presently this authorization is limited to physicians and delays services in areas with provider shortages.
- **Authorize Occupational Therapy to be a qualifying skilled service to independently meet eligibility requirements for admitting patients into the Medicare program.** This change would promote operational flexibility and efficiency by allowing HHAs to deliver the right care for the beneficiary without having to send a nurse or physical therapist to "start" the visit. It is a common practice of occupational therapists to perform the initial assessment for admission for commercial payers.

We appreciate the opportunity to provide comments to the proposed Home Health rules and their impact on our home health agency and beneficiaries. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at [sabra.rosener@unitypoint.org](mailto:sabra.rosener@unitypoint.org) or 515-205-1206.

Sincerely,



Margaret VanOosten, RN, BSN  
President & Chief Clinical Officer  
UnityPoint at Home



Sabra Rosener, JD  
VP, Government & External Affairs  
UnityPoint Health