



September 20, 2017

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1672-P
Post Office Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-1672-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2018

To Whom It May Concern:

The Home Care Association of New York State (HCA), Inc., on behalf of its 200 member agencies who serve approximately 420,000 beneficiaries annually throughout the entire continuum of home care, hospice and managed long term care, appreciates the opportunity to provide comments on the proposed rule for the 2018 Medicare Home Health Prospective Payment System (HHPPS).

This letter will provide HCA's major comments on the 2018 HHPPS proposed rule, addressing elements of the rule that we believe will considerably harm home health agencies (HHAs) and patients, and which we recommend be revised or withdrawn, as well as those proposals which we believe to be positive steps for the system.

Proposed Home Health Groupings Model for CY 2019: Wrong Approach to HHPPS Payment Reform

Background

Of major concern, the rule, if adopted, proposes significant case-mix changes, called the Home Health Groupings Model (HHGM) beginning in Calendar Year (CY) 2019. As part of this HHGM proposal, CMS is also proposing a significant change in the unit of payment from a 60-day episode of care to a 30-day period of care, to be implemented for home health services beginning on or after January 1, 2019. This is estimated to reduce Medicare home health payments nationally by **\$950 million in CY 2019**.

Under the HHGM, CMS proposes to eliminate therapy visit numbers in determining payment, and, rather, rely more heavily on clinical characteristics and other patient information (for example, diagnosis, functional level, comorbid conditions, admission source) to place patients into clinically meaningful payment categories. In total, there are 144 different payment groups in HHGM.

CMS's rationale for 30-day units (rather than the current 60-day episodes) is based on CMS's finding that episodes have more visits, on average, during the first 30 days compared to the last 30 days. CMS also contends that costs are much higher earlier in the episode (and lesser later on). Thus, with the division into two 30-day periods, CMS believes it can more accurately apportion payments. Overall, CMS found that the average length of an episode of care was 47 days, but roughly a quarter of all 60-day episodes lasted 30 days or less.

While the home health provider and industry associations support efforts to better align Medicare payments with patient characteristics and care needs, this policy change is not made with the full understanding of its impact or with the input and guidance of the industry. Further, there is little time for complete industry analysis of the impact on providers and beneficiaries prior to this September 25 comment deadline. Payment reform of this magnitude should be implemented thoughtfully and carefully, with full disclosure of data and ample opportunity for stakeholder participation and input.

The Issue

The HHGM, if implemented, would completely revamp the current home health payment system, cause enormous disruption in the field, and undoubtedly would negatively impact patient access to care. This proposal comes at a time when federal policies continue to support care in the most cost-effective settings, like home health services, yet HHGM is a significant obstacle to delivering the type of quality care that Medicare beneficiaries need in their home.

The HHGM is a wholesale payment reform measure that would replace a 18-year payment model in a **non-budget neutral** manner with dramatic and wide ranging effects at the provider level. The HHGM bases payment amounts on an untested model that relies on certain patient characteristics which have not been determined to be valid or reliable indicators of care needs. It also would replace the historically used 60-day episodes with 30-day "periods" even though Medicare retains a 60-day standard for the patient assessment and plan of care. This change conflicts with CMS's efforts to reduce administrative burdens by requiring providers to bill twice as frequently and manage patient care in a framework inconsistent with the payment system.

CMS's HHGM proposal would:

- Compound five years of Medicare home health rate cuts that total nearly 18% in a benefit that has had essentially flat spending since 2010;
- Potentially create access to care barriers for vulnerable home health patients by reducing reimbursement for more complex patients;
- Significantly cut reimbursement for many types of home health patients without Congressional authorization;
- Impose **non-budget-neutral** changes in home health services at a level that previously caused significant harm to patients under the past Interim Payment System (1998-2000), or IPS, where nearly 1.5 million Medicare beneficiaries lost access to care following the closure of more than 4,000 home health agencies virtually overnight.

The financial distress posed by this model is highlighted in a recent analysis by Dobson DaVanzo & Associates who found parallels between HHGM and past payment overhauls, IPS, noting that “historically, when changes of this magnitude were implemented, the field experienced extreme financial distress ... changes of a similar scale have created unintended effects among agencies and beneficiaries.” Regarding HHGM’s departure from standards of budget-neutrality, the report finds that the proposed HHGM will reduce Medicare revenues by an estimated 15%.

The HHGM would redistribute payments away from medically-necessary home health services such as physical therapy, occupational therapy and speech-language pathology that are currently producing Medicare savings in innovative value-based care, alternative payment systems and bundled payment models. In the long run, HHGM could result in higher Medicare costs as patients are forced to access institutional care rather than receive appropriate care in their own homes. This redistribution is reinforced in the Dobson DaVanzo & Associates analysis, which calls the HHGM “highly redistributive of Medicare payments for home health services,” with 27 percent of HHAs experiencing “a revenue shift of at least +/-20% for some cases under HHGM.” Over 40% of “HHAs serving ACO-attributed beneficiaries would experience a revenue shift of +/-20% for the ACO-attributed case load under HHGM.”

This redistribution of Medicare reimbursement for home health services also varies significantly across states and regions with little explanation. Some states and Congressional districts face greater cuts to Medicare reimbursement than others. This is exactly the case in New York where home care Medicare margins have remained negative for the 15th year in a row, with an un-weighted average margin of -6.97% in 2015 (the most recent year of data available). And unlike other providers, home health has no other payors that can offset these types of losses in Medicare, since Medicaid is the other predominant payor, and Medicaid rates are also consistently inadequate to meet costs.

In fact, an HCA financial analysis from early January 2017 found that over 70% of New York’s Medicare certified home care providers were operating at a loss across *all* payors in 2015, not just Medicare – which leaves no resources for capital to keep pace with increasing regulatory requirements (new mandatory minimum wage increases and physician documentation burdens under the Medicare face-to-face rule) and modernization through technology (i.e. home telehealth and electronic health records).

Before implementing such a massive home health payment change that will reduce Medicare payments by an estimated \$950 million, it is imperative that CMS conduct a more thorough analysis examining the cumulative impact of past payment cuts which have contributed to financial distress industrywide. This includes examining the specific impact of CMS’s most recent rebasing adjustments in CYs 2014 to 2017, along with sequestration cuts and other cost impacts that continue to mount.

HCA Recommendations

Certain baseline considerations in any payment overhaul must be made in order to ensure that access to care is maintained for one of Medicare’s most vulnerable beneficiary populations while also giving

CMS time to analyze the financial viability of home health providers after four years of significant rebasing cuts. HCA's recommendations are as follows:

1. **The HHGM policy must be withdrawn as a part of the HHA CY 2018 Final Rule**, especially given the extraordinarily limited window for providers to assess the impact of the proposed changes on beneficiary access. Essentially, this limited window commits CMS to a fundamental payment system overhaul in 2019 after allowing a mere matter of weeks for stakeholders, providers, and beneficiary advocacy organizations to analyze and recommend changes to HHGM.
2. HHGM must be revised to be implemented in a true **budget-neutral** fashion. Budget neutrality is an essential hallmark of past payment reform policies and is an important protection against system-wide fiscal destabilization. Budget neutrality must be required to ensure that a new payment system does not simultaneously destabilize an entire sector of health care services.
3. CMS should initiate a partnership with industry and beneficiary stakeholders to design, develop and test (through a rigorous demonstration process) a payment model that supports a patient-centered, quality-driven system.
4. HHGM must then be phased-in over a multiple year transition period.

HCA also notes that CMS's proposed HHGM development process was not adequately transparent. Only vague details were provided despite the industry's ongoing requests for data. Additionally, the proposed rule does not provide enough information to accurately estimate the potential impacts of the HHGM on HHAs. Since industry leaders have not been able to fully research, model and provide specific comments on the HHGM, it must **not** be finalized as part of the CY 2018 payment rule and we encourage ongoing stakeholder dialogue and coordination with CMS to improve the HHGM before implementation.

Ongoing "Case-Mix Creep" Cuts Should be Rescinded

As part of the 2016 final rule, CMS implemented a three-year annual reduction of 0.97 percent to the national, standardized 60-day episodic payment rate for CYs 2016 through 2018 to account for "nominal" case-mix coding intensity growth (aka "the case-mix creep adjustment") from 2012 through 2014, which CMS says is unrelated to changes in patient acuity.

This three-year, 0.97-percent reduction will decrease total payment rates to providers by \$160 million annually and was in addition to CMS's four year HHPPS rebasing initiative during CYs 2014 through 2017.

Besides the last four years of rebasing, CMS has also implemented an annual recalibration of the case-mix weights (CMWs) for the past several years that have actually accomplished CMS's long desired goal to fulfill an average case-mix weight score of approximately 1.0 percent. Based on the latest case-mix weight data (4th quarter 2016 and 1st quarter 2017) provided by Strategic Healthcare Programs

(SHP) and Simone Healthcare Consultants' Financial Monitor, the average CMW nationally is approximately 1.049, while, over the same period, it is 0.975 here in New York.

HCA Recommendation

HCA believes CMS's -0.97-percent case-mix creep adjustment for CY 2018 should be rescinded, since CMS's rebasing methodology continues to include another year of recalibrating the case-mix weights, which, after many years of recalibration, has accomplished its intended goal.

The Need for Practical Changes to Face-to-Face Requirement

For the third year in a row, the 2018 proposed rule has made no reference or policy revisions to the current face-to-face (F2F) regulation which remains a duplicative, onerous burden for providers and physicians alike, with little justification in terms of positive impact on patient care, program integrity or effective eligibility oversight.

Indeed, CMS's own proposed rule includes a request for information soliciting ideas for regulatory, sub-regulatory, policy, practice and procedural changes "to improve the health care delivery system, make the delivery system less bureaucratic and complex, and how CMS can reduce the burden for clinicians, providers and patients in a way that increases quality of care and decreases costs." We welcome this invitation, but stress the fact that F2F relief has long been a point of recommendation for bureaucratic and regulatory relief. It could – and should – be addressed immediately in the 2018 final rulemaking process.

As repeatedly stressed in prior-year comments and other outreach, CMS's implementation of the F2F rule is confusing to all involved, including physicians, HHAs and hospitals. CMS has tried to mitigate the confusion in various ways, but those solutions fail to provide basic clarity, ease of application or sensible application. As a result, the rule is creating an access-to-care barrier, and practitioners find that it is easier to recommend care for patients in alternative settings to home health care.

Following a 2014 lawsuit, CMS (in the CY 2015 final rule) eliminated one specific component of F2F that drew objections from home care providers – a requirement that physicians complete a "narrative." But CMS did not eliminate the rule itself and, in many ways, made the documentation requirements even more fragmented, onerous and confusing.

In place of the physician narrative, CMS requires that physicians have sufficient documentation in their own files to support the certification of a patient's homebound status and skilled care need. After two questionable rounds of the CMS-mandated "Probe and Educate" audit, many HHAs across the country have experienced a high percentage of Medicare eligibility denials due to technicalities in the physician's documentation of the F2F requirement. Fixing the F2F should be a top prerogative for CMS.

HCA Recommendations

HCA believes CMS made the home health F2F physician encounter requirement much more burdensome than the Affordable Care Act (ACA) ever intended and that physicians conducting the

F2F encounter should be able to simply sign and date the beneficiary's plan of care which would serve as an attestation that the F2F encounter has been met.

A F2F solution needs to be workable and amenable to home care providers and physicians alike. We urge CMS to do the following:

- Eliminate or significantly modify the physician documentation requirements so that physicians no longer must spell out why the patient's clinical condition requires Medicare-covered home health services, nor require such an insurmountable level of documentation in their own files.
- Modify this requirement so that the F2F mandate can be met through the completion and collection of the separately signed and modified (if necessary) 485 form.
- Establish F2F exceptions for patients who have been recently discharged from an inpatient setting, individuals in rural areas where access to a physician or non-physician practitioner is limited, and individuals unable to leave home or have a physician perform a home visit.
- Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

HCA also supports H.R. 2663 that would require CMS to consult a home health agency's patient record as supporting material to the medical record of the physician certifying for home health services. This bipartisan bill will ensure that HHAs can focus their resources on providing medically necessary care to beneficiaries in their homes rather than fighting "paperwork" denials.

HCA and many of our other state and national association colleagues have repeatedly made these types of recommendations and it is long past time for CMS to adopt them.

Ongoing Value Based Purchasing Concerns

Another area of concern is CMS's continuation of its Home Health Value-Based Purchasing (VBP) pilot program, which began on January 1, 2016 in nine randomly selected states.

While New York was not one of the nine states selected to participate in CMS's pilot program, our state Department of Health (DOH) has released a "Draft Medicare Alignment Paper" with proposals to integrate Medicare and Medicaid VBP efforts. The state would incorporate Medicare payment reform models, such as ACOs and bundled payments, into its Medicaid VBP efforts. In addition, the state would include Medicare beneficiaries in the Medicaid VBP models implemented under the state's VBP Roadmap (e.g., global payment for a population, integrated primary care, bundled payments, and total care for a subpopulation).

Because New York is vigorously pursuing VBP from the Medicaid payment perspective, we are pleased that CMS did not include New York as one of the nine states to participate in its home health VBP program mainly because we believe it is critical for HHAs to be able to invest in the infrastructure necessary to successfully participate in any proposed Home Health VBP program. Also

New York providers are already struggling to prepare for the New York-initiated VBP project without the added focus of a federal project.

But more generally we have ongoing concerns about the design of VBP, particularly CMS's approach to mandating participation by all HHAs in a state, which departs from CMS's routine procedure of inviting interested agencies to participate. Also, this mandatory participation in VBP is contrary to recent actions by CMS to pursue a more voluntary approach when testing new payment models for other sectors. This includes CMS's recent reduction in the number of mandatory geographic areas participating in its Comprehensive Care for Joint Replacement (CJR) model. As CMS explained in its August 2017 decision on the CJR model, "We are concerned that engaging in large mandatory episode payment model efforts at this time may impede our ability to engage providers, such as hospitals, in future voluntary efforts." If this is true for hospitals, the same logic should apply for home care.

HCA Recommendations

As a whole, we believe that this pilot project should be voluntary, shorter in duration and with a more moderate risk corridor. As such, we encourage CMS to consider revisions that would expedite the implementation and completion of the program such that the entire industry can begin to move forward.

We recommend that CMS develop an application process so that interested HHAs can apply for the VBP program rather than require all agencies in the pilot states to participate. CMS could document the characteristics of these volunteer agencies and select a similar set of agencies for comparison in order to assess the success of the program.

HCA also believes that CMS needs to expedite its VBP pilot program so that it is concluded in no more than 4 to 5 years. While HCA appreciates the fact that New York is not included in the pilot – so our providers can focus on state-level, Medicaid VBP projects – the extensive time devoted to Medicare VBP in the pilot regions does put agencies in New York and in other states at risk of falling behind the pilot states as the pilot agencies acclimate to Medicare VBP principles and payment. HCA believes it will be a challenge for agencies not currently participating in the VBP project to catch up to those that are participating after seven years, especially if CMS decides to roll-out VBP nationally after the seven-year period. A shorter testing phase with a more selective volunteer base of participants will give CMS enough time to evaluate the program without the pilot entering a condition of near-permanency for those providers who are obligated to participate, thus putting these providers in a different functioning capacity from the rest of the country, and providing them a much longer head-start on what may likely become a national initiative in the future.

Additionally, over this extensive time period, more and more states that are excluded from the pilot are likely to follow New York's example by pursuing VBP arrangements with other payors (Medicaid and Managed Care). This may challenge CMS's ability to evaluate the performance of its program, as agencies in these states will not be suitable to serve as part of the control group for Medicare VBP, and this control group will decrease as more states implement VBP projects of their own.

Furthermore, while the home health VBP pilot is intended to be similar to the Hospital VBP program and the Skilled Nursing Facility (SNF) VBP program, there is significant variation. **Of**

major concern is the incentive/penalty ranges: a minimum of three to a maximum of eight percent. A range of this size is unprecedented in a new and untested program. By contrast, the Hospital and SNF VBP programs utilize an incentive/penalty mechanism that is statutorily limited at 2 percent. The range of penalties/rewards in VBP should relate to the level of risk needed to affect provider behavior. CMS has not provided any analysis that supports using a 5 to 8 percent level of risk for changing HHA behavior, especially for HHAs that are experiencing negative operating margins. **We believe CMS should modify its incentive/penalty ranges to establish a more moderate risk corridor.**

Lastly, HCA is supportive of the following revisions CMS outlined to its VBP project in the CY 2018 proposed rule:

- Revise the definition of “applicable measure” to specify that the HHA would have to submit a minimum of 40 completed Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) surveys.
- For performance year (PY) 3 and subsequent years, CMS proposes to remove the Outcome and Assessment Information Set (OASIS)-based measure “Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care.”

Other Elements of CMS’s CY 2018 Proposed Rule

HCA also offers the following comments and recommendations to other critical components of the 2018 HHPPS proposed rule.

Outlier Policy

CMS is proposing no changes to the outlier methodology for CY 2018.

In its CY 2017 final rule, CMS finalized significant (but budget-neutral) changes to its outlier methodology while maintaining that the total outlier fund will remain at 2.5 percent of the total home health services estimated expenditures. This total allowance is 2.5 percent of all HHPPS revenues (nationally). CMS’s 2017 final rule also continued to impose a per-provider outlier cap of no more than 10 percent of total Medicare revenues.

One key component of CMS’s outlier policy, finalized last year, was to keep the same 80 percent outlier loss ratio but to increase the fixed dollar loss (FDL) ratio from 0.45 to 0.56. By doing this, CMS is reducing the number of episodes that would qualify for outlier payment. CMS indicated that such a change was needed to keep outlier spending within the 2.5% national spending limit. These overall changes have had a distributional impact, with some HHAs receiving higher outlier payments due to the nature of their patient service time utilization, while other HHAs have received lower outlier payment or no outlier payment at all.

HCA Comments & Recommendations

HCA remains very concerned with CMS's outlier policy change last year which increased the FDL ratio from 0.45 to 0.56 as well as CMS's decision to maintain the existing 10 percent outlier therapy cap on HHAs.

Increasing the FDL ratio has reduced the number of episodes that would qualify for outlier payment, which is a significant concern for HHAs in New York that serve a disproportionately high number of patients who are dually eligible beneficiaries (Medicare and Medicaid) and tend to have extensive and clinically complex care needs.

HCA also disagrees with CMS's decision to maintain the existing 10-percent threshold cap on outlier payments to HHAs as a purported fraud-fighting initiative. While we recognize that CMS established the outlier policy to address abuse, CMS should realize that the vast majority of HHAs who are receiving proper outlier payments are in reality losing significant funds from their episodic payment due to serving high-need and high-cost beneficiaries. **HCA believes a more appropriate and targeted fraud-fighting initiative would include a possible minimum provider-specific number or percent of episodes that result in LUPAs.** We would be more concerned with HHAs that are shown to have zero LUPAs during a reporting period rather than HHAs having 10 percent or more of outliers, given that, for most HHAs, such an outlier threshold means incurring significant financial losses.

Considering all of the rebasing and analysis CMS has done with the HHPPS over the past 4 to 6 years, **HCA recommends that CMS conduct a more detailed analysis to determine whether the total outlier cap of 2.5 percent is adequate or whether it needs to be increased for future years.**

HCA understands that if CMS increases the 2.5 percent cap of total outlier payments, then another area within HHPPS will have to be decreased, given CMS's long-standing history of keeping the HHPPS methodology budget-neutral (unlike the newly proposed HHGM model). However, CMS has made revisions to many key areas within the HHPPS throughout the years (wage index, case-mix recalibrations, base rate revisions, etc). With an increased number of baby boomers becoming Medicare eligible every year, along with the increasing intensity and complexity of dual-eligible beneficiary needs, CMS should re-examine the overall outlier payment cap of 2.5 percent.

Proposed CY 2018 Wage Index

CMS's decision twelve years ago to switch from Metropolitan Statistical Areas (MSAs) to the Core Based Statistical Areas (CBSAs) for the wage index calculation has had serious financial ramifications for New York HHAs. Unlike past MSA designations – where all of the counties in the New York City (NYC) designation were from New York State – the 2006 CBSA wage index designation added Bergen, Hudson and Passaic counties from New Jersey into the NYC wage index area. With the CY 2015 final rule, CMS added three more New Jersey counties (Middlesex, Monmouth and Ocean) to the NYC area wage index.

HCA estimates that this twelve-year shift – from MSAs to CBSAs – has resulted in an estimated \$80 million cut in Medicare home health reimbursement in New York State and over \$60 million in cuts

for HHAs in the New York City (NYC) metropolitan area. Furthermore, HHAs in the NYC metropolitan area have seen their home health wage index decrease almost 1 percent a year since 2005, in a time when New York's state policymakers have implemented a home health wage parity law (establishing a new wage floor for home health aides in this region) and minimum wage statutory increases that have caused costs for HHAs in NYC to increase 7 to 8 percent over the past two years.

The provision of home health care is a local endeavor; thus, the decision to view the current CBSA area designation in the "aggregate" for a large geographic region like NYC fails to represent the actual impact of the change. CMS's shift to the CBSA wage index designation has resulted in below trend reimbursement for NYC agencies since 2007.

HCA has also consistently raised issues with CMS's decision to maintain the current policy of using the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next. We also must question the validity of this data, especially if CMS were to analyze the Albany-Schenectady-Troy (aka, the Capital District) CBSA as an example.

In the past five years, this CBSA has seen its wage index reduced 5.41 percent, going from 0.8647 in 2013 to a proposed CY 2018 wage index of 0.8179. Furthermore, those familiar with the upstate New York labor market and general cost of living would recognize that the Capital District CBSA should not be lower than any of the following other upstate New York CBSAs: Binghamton, Elmira, Glen Falls, Rochester, Syracuse, Watertown-Fort Drum and, most significantly, the "New York Rural Areas CBSA," which is proposed to be 0.8503.

In addition, unlike the hospitals in the Capital District CBSA who are given the opportunity to appeal their annual wage index, HHAs in this CBSA are not given that same privilege. This lack of parity between different health care sectors further exemplifies the inadequacy of CMS's decision to continue to use the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates.

HCA Recommendations

HCA once again requests that CMS explore wholesale revision and reform of the home health wage index. The pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting home health costs, particularly in states like New York, which has among the nation's highest labor costs, now startlingly exacerbated by our state's implementation of a phased-in \$15 per-hour minimum wage hike, which is unfunded by Medicare. This mandate, when fully phased-in, will cost a stunning \$2 billion for New York HHAs across all payors (Medicaid, Medicare, managed care, commercial insurance and private-pay) and will never be adequately addressed due to CMS's ongoing disposition to continue using the pre-floor, pre-reclassified hospital wage index to adjust home health costs.

CMS's reform to the wage index should also consider the following:

- The impact on care access and financial stability of HHAs at the local level;

- The unpredictable year-to-year swings in wage index values that are often based on inaccurate or incomplete hospital cost reports which have negatively impacted New York HHAs throughout the years and jeopardized access to care;
- The inadequacy and inaccuracy of the pre-floor, pre-reclassified hospital wage index for adjusting home health costs; and
- The labor market distortions created by reclassification of hospitals in areas in which home health labor costs are not reclassified.

Existing law permits CMS a nearly unlimited degree of flexibility to utilize a wage index that recognizes the geographic differences in labor costs in the provision of home health services across the country. Section 1895(b)(4)(C) of the Social Security Act (SSA) mandates the establishment of area wage index adjustment factors, provides CMS discretion to determine which factors to consider, and permits the Secretary to utilize the same wage index adjustment factors that are utilized in composing the hospital wage index. However, despite CMS's ongoing recognition that HHAs compete in the labor marketplace for the same health care staff as inpatient hospitals, the wage index employed is comparable in name only.

HCA recommends that CMS reform the home health wage index by instituting a proxy that allows HHAs to receive the same reclassification as hospitals if they provide services in the same service area. This policy change will result in the important goal of parity in the labor marketplace between hospitals and HHAs.

Home Health Quality Reporting Program (HHQRP)

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) requires HHAs, SNFs, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs) to submit standardized patient assessment data, as well as standardized data on quality measures and resource use and other measures. The data reporting requirements and implementation of standardized patient assessment data are intended to enable interoperability and improve quality, payment, and discharge planning, among other purposes.

CMS is proposing in 2018 to adopt three measures in the CY 2020 payment determination to meet the requirements of the IMPACT Act. These three measures are assessment-based and are calculated using OASIS data. The proposed measures are as follows:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury;
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674); and
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).

HCA is most concerned with the proposed measure entitled “Application of Percent of Residents Experiencing One or More Falls with Major Injury”. Major injury is defined as bone fractures, joint dislocation and closed head injuries with altered consciousness or subdural hematoma. The term “application” is used to indicate that the measure will be used in a setting other than the setting for which it was endorsed by the National Quality Forum (NQF). Therefore, the measure has not been endorsed by NQF for the home health setting. In order to collect the data required for the measure, two new assessment items will need to be added to the Outcome and Assessment Information Set (OASIS).

HCA’s main concern about the “falls with major injury” measure is that it is not **risk adjusted**. Although an unadjusted falls-risk measure could provide valuable information regarding the overall rates of falls occurring within the agency, it has limited value when comparisons are made to other HHAs.

HHAs provide intermittent care to patients with varying care needs, living environments and caregiver support. Agencies have limited control over a patient/caregiver’s ability or willingness to comply with falls-prevention strategies. Additionally, home health patients are only permitted to leave the home infrequently or for short duration, and are allowed unlimited absences for medical reasons. Therefore, a home health patient could encounter a falls-risks which the agency could not be expected to mitigate.

Without a risk adjustment, the measure could present a distorted correlation between the rate of major injuries related to falls and the quality of care provided by the agency. Concerns over the inclusion of the measure into CMS’s public reporting system, and potentially in a home health VBP program, will lead to difficulties in caring for patients perceived as high risk for falls.

HCA’s Recommendations & Concerns

CMS should include an unadjusted rate for falls with major injury on the agency’s confidential feedback reports along with a risk-adjusted rate for the measure. This will allow the agency to see its actual “falls” rates, while risk-adjusted rates could be used for public reporting, when required.

HCA is also concerned that the IMPACT Act requires the “falls with major injury” measure to be applied across other Post-Acute Care (PAC) settings, all of which are facility-based with 24/7 supervision and the ability to affect falls-prevention through direct interventions by the facility staff. The standard for falls-risks and prevention that is applied to facility-based care cannot be applied to community care settings.

Upcoming Changes to OASIS Submission & Pay for Reporting

CMS’s proposed rule will continue to reduce home health payment rates by a 2 percent penalty for HHAs that did not report OASIS quality data for episodes beginning on or after July 1, 2016 and before July 1, 2017.

However, CMS’s CY 2015 final rule increased the threshold of OASIS data submissions that an agency must produce in order to avoid the 2 percent rate penalty beginning in CY 2017 (OASIS

submissions for the July 1, 2015 through June 30, 2016 time period). In the first year (CY 2017), CMS imposed a 70 percent compliance standard for the number of OASIS submitted (using a “Quality Assessment Only” formula), which rises to 80 percent in the second year (CY 2018) and caps out at 90 percent in the third year (CY 2019).

The “Quality Assessment Only” formula is an equation comparing the number of quality assessments to the combined number of quality assessments and non-quality assessments. “Quality Assessments” include most start-of-care (SOC), resumption-of-care (ROC), and end-of-care (EOC) assessments of various kinds, but do not include limited SOC, ROC and EOC assessments and follow-up assessments.

HCA Comments

HCA appreciates CMS clarifying in previous final rules that the OASIS assessments considered in the HHQRP include both the OASIS assessments for traditional Medicare fee-for-service (FFS) beneficiaries as well as OASIS assessments for Medicare Advantage and Medicaid home health beneficiaries as well.

We also appreciate that CMS provided education through the MACs on these new standards of OASIS submission which we believe should be attainable for the vast majority, if not all, of our member agencies in New York.

HHCAHPS Survey

CMS’s proposed rule maintains its existing policy to expand the home health quality measures to include the HHCAHPS home health survey as part of the 2018 annual payment update, with no proposed changes.

All Medicare-certified HHAs must continue to provide their survey vendors with information about their survey-eligible patients every month in accordance with existing guidelines, and HHCAHPS survey data must be submitted and analyzed quarterly. CMS encourages HHAs to monitor their respective HHCAHPS vendors to assure they are timely in submitting HHCAHPS data using the HHCAHPS Data Submission Reports.

The proposed rule also maintains the current guideline that all approved HHCAHPS survey vendors fully comply with all HHCAHPS oversight activities, and CMS plans to include this survey requirement in the Conditions of Participation (CoPs).

The period of data collection for the CY 2018 annual payment update includes HHCAHPS data submitted in the second quarter of 2016 through the first quarter of 2017 (the months of April 1, 2016 through March 31, 2017).

While HCA understands the rationale for this tool measuring the experiences of home health beneficiaries, we continue to be most concerned that the HHCAHPS survey places another unfunded administrative burden on HHAs – a mandate that requires significant time and resources.

HCA is also concerned with CMS's decision in 2013 to codify the HHCAHPS guideline so that HHAs have to ensure that their survey vendors fully comply with all HHCAHPS requirements.

HCA Recommendations

While HHAs can certainly monitor survey vendors' activities through reviews of their survey data submissions, HCA believes CMS's decision to codify the guidelines in the 2013 final rule is problematic since this requirement to verify full compliance of HHCAHPS vendors is not within the total control of the HHA. **HCA requests that CMS eliminate this survey requirement in the home health CoPs, in Section 484.250(c).**

The HHCAHPS survey also places yet another unfunded mandate on HHAs and we request that CMS consider including an administrative reimbursement mechanism in its final rule to help cover these costs.

Request for Information on CMS Flexibilities and Efficiencies

HCA appreciates the opportunity to work with CMS on ways to construct rules that are "less complex" and "reduce burdens", as stated in the Request for Information ("RFI") contained in the proposed rule. As we already mentioned in our comments on the burdensome F2F requirement, we believe it is critical to "simplify rules and policies for beneficiaries, providers and clinicians in ways that "increases quality of care and decreases costs".

In order for Medicare beneficiaries to receive the home health benefit, documentation is required to verify patients' eligibility. This documentation includes proof of their homebound status and medical need for skilled homecare, their homecare plan, evidence of a F2F encounter with a physician or approved practitioner and that physician or approved practitioner's validation of the patient's homebound status. The lack of uniformity within the home health eligibility documentation has created a subjective and overly complicated system, which ultimately hurts patient access and increases improper payments to providers.

HCA Recommendations

HCA strongly encourages CMS to consider standardizing and streamlining the entire Medicare home health eligibility requirements so that benefit's documentation requirements are as minimally subjective as possible.

Advancing Health Information Technology/Exchange

In previous rules, CMS stated that the Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of health information technology (HIT) and promote nationwide health information exchange to improve health care.

Furthermore, HHS and CMS have stated that all individuals, their families, their health care and social service providers, and payors should have consistent and timely access to health information in a

standardized format that can be securely exchanged between the patient, providers, and others involved in the individual's care. The secure, efficient and effective sharing and use of health-related IT information, when and where it is needed, is an important tool for settings across the continuum of care, including home health.

HCA absolutely agrees that these are laudable principles; however, we are disappointed that HHAs remain ineligible for monies through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

HCA Recommendation

HIT and clinical technology are at the core of every aspect of health facility/agency operation; they are integral to service delivery, quality evaluations and outcomes, cost-effectiveness and administration. However, to date, federal, state and private payors have long overlooked home care in the health IT development area, even though virtually every new state and federal care model or demonstration project – including VBP – requires this kind of technology infrastructure and interoperability to succeed.

HCA urges CMS and/or HHS to incorporate funding in the 2018 final rule to invest in HIT and integrated clinical technology for home care. Such technology investments are essential in an evolving integrated health system and should be targeted to promote health care quality, cost-effectiveness, care management and integration of home care within provider systems and between sectors.

Conclusion

HCA appreciates this opportunity to submit comments and respectfully requests CMS's consideration of our concerns and recommendations. I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or (518) 810-0661.

Sincerely,



Patrick Conole, MHA
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