September 4, 2015

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1625-P
Post Office Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-1625-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2016

To Whom It May Concern:

The Home Care Association of New York State (HCA), Inc., on behalf of its 200 member agencies serving approximately 180,000 Medicare home health beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the 2016 Medicare Home Health Prospective Payment System (HHPPS).

This letter will provide HCA’s major comments on the 2016 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, as well as those proposals which we believe to be positive steps for the system.

Rebasing Impact and Continued Methodology Flaws

Of major concern, the rule, if adopted, will reduce Medicare payments nationally to HHAs by $350 million in 2016 which, when added to the two previous years of rebasing cuts, represents a $930 million impact, based on CMS’s analysis of incomplete data that is more than four years old.

Moreover, CMS continues to assert that home health margins nationally are high compared to some unspecified standard. This is simply not the case in New York where approximately 70 percent of HHAs are experiencing negative Medicare margins. The National Association for Home Care and Hospice (NAHC) projects that this share of agencies operating in the red will increase to 76.2 percent in New York by 2017. This trend is unsustainable and will only continue under the crushing weight of further rebasing cuts.

It is imperative that CMS conduct a more thorough analysis examining the cumulative impact of rebasing for the remaining two years – 2016 to 2017 – especially as sequestration cuts and other cost
impacts continue to mount. By continuing to only assess a one-year impact of rebasing, CMS is failing to account for the effect its rebasing initiative is having in 2014 and 2015 on access to patient care, not to mention the lasting impact on the home care services infrastructure beyond these years.

The following are some specific concerns related to rebasing and the other prominent payment changes proposed in CMS’s rule.

1. **CMS’s rebasing estimates continue to use outdated, incomplete data.** By statute, CMS must use the “most reliable, available data” in its rebasing process. HCA asserts that CMS continues using unreliable, incomplete, and old data in maintaining its rebasing formulas. CMS’s estimate of a 13.09 percent national operating margin for HHAs in 2013 is based on an abbreviated version of 2011 cost report data. NAHC’s analysis of a broader sample of cost reports from 2011 shows a national home care margin of 11.25 percent, not 13.09 percent. In this year’s proposed rule, CMS states that, as part of its rebasing analysis, a full year of 2013 Medicare claims data was reviewed (prior to the 2014 rebasing adjustment), as well as the latest 2013 HHA cost report data. However, CMS fails to mention how many 2013 cost reports were actually reviewed and how many were disqualified. We ask CMS to include this information in its final rule for the sake of transparency.

2. **We strongly object to CMS including an additional “case-mix creep” type adjustment within the third year of a four year rebasing process.** CMS’s estimate of “real” case mix change is based on its earlier evaluation of old data from 2000 to 2010. CMS did not update its analysis with specific consideration of any data from 2012 to 2014. Secondly, CMS has recalibrated the case-mix-adjustment model several times along with rate rebasing, thereby eliminating the effect of any impact from or relevance of previous “nominal” changes in case mix weights. Third, CMS proposal for additional case-mix-related cuts (“case-mix creep”), separate from the third recalibration of the Case Mix Weights, seems to be rebasing the 2016 home health payment rates beyond the limits established by Congress. (See section on “Case-Mix Creep” later in these comments for further details.)

3. **CMS uses a “silied” approach in its 3.5 percent adjustment cap that brings reimbursement below cost.** In applying the 3.5 percent adjustment cap separately to the Low Utilization Payment Adjustment (LUPA) per-visit rates, CMS proposes per-visit rates that are as much as 28 points below cost of care. For home health, this leads to an estimated reduction of $80 million to $100 million nationally in 2014, 2015 and 2016 and $0.5 billion over the next 10 years. Overall, the formula employed by CMS assures that the average reimbursement to an HHA will be below average cost as the LUPA payments will fall below costs. The 3.5 percent LUPA adjustment – at the maximum allowed by Congress – is wholly inadequate in light of the fact that CMS’s own analysis shows that the per-visit by discipline costs are significantly higher. This proposed change for 2016 only assures that the average LUPA reimbursement to an HHA will be below average cost.

4. **CMS’s approach ignores regional differences in home health operating margins.** By attempting to eliminate the national average home health operating margin, CMS’s proposal severely jeopardizes providers in states like New York who are already operating at a net loss, leaving no resources for capital to keep pace with increasing regulatory requirements and
modernization through technology. In its 2014 HHPPS rulemaking, CMS estimated that 43 percent of all HHAs would face negative Medicare margins. However, a recent analysis by NAHC indicates that the percentage of all impacted HHAs nationally is now forecast at 53.71 percent experiencing negative margins by 2017 with the addition of the case-mix-weight adjustment proposed by CMS. NAHC’s analysis further indicates that some states are impacted to a much higher degree, such as New York where 76.2 percent of HHAs are forecasted to have negative margins by 2017.

5. **CMS’s proposal fails to seriously consider other reasonable alternative methodologies that would improve the likelihood of continued access to care.** While CMS explored limited alternative methods of calculating the rebased rates, it essentially confined alternatives to those that would reduce the rates further and appears to opt for a 3.5 percent rebasing reduction based simply on enacting cuts at the ACA statutory maximum. In so doing, CMS did not embrace commonly used rate-setting methods. For example, CMS could have evaluated rates based on the median rather than the mean. The median episode cost, using data from Abt, is $2567.69, or $113.98 higher than the CMS-estimated mean.

6. **CMS continues to only assess a one-year impact of its proposal and fails to adequately account for the effect on access to care.** CMS omits the cumulative impact of rebasing in the remaining two years – 2016 to 2017 – especially as sequestration cuts and other cost impacts continue to mount.

7. **CMS’s rebasing methodology fails to include all usual and necessary direct and indirect costs as well as new costs associated with regulatory obligations.** For a more complete financial analysis, CMS’s rebased payment rates should include: all allowable costs under Medicare cost reimbursement principles, such as the increasing cost of employee health benefits; costs considered as non-reimbursable under Medicare cost reimbursement principles but related to clinical services used in the care of patients such as telehealth, respiratory therapy and nutritionist and dietician services and others; a full allocation of Administrative and General (A&G) costs, including an allocation to those costs that are non-reimbursable under Medicare cost reimbursement principles; and an analysis of the costs associated with HHAs having to implement unfunded regulatory requirements such as the F2P requirement, the PECOS enrollment mandate, the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) patient surveys, ICD-10 changes, and wage and benefit changes. These wage and benefit changes, in particular, include impending minimum wage and overtime requirements under the Fair Labor Standards Act, along with state-specific changes such as “worker wage parity” laws enacted in New York.

**Recommendations**

CMS’s admission that data is lacking – and the home care community’s own proof that the data indicates a different story about provider sustainability under CMS’s rebasing program – lends even greater weight to the argument that rebasing should be suspended until all stakeholders have had an opportunity to conduct a full analysis.
One such stakeholder is Congress, which previously has introduced bi-partisan legislation challenging CMS’s approach to rebasing. The bill, known as the “Medicare Home Health Rebasing Relief and Reassessment Act,” would have suspended the rebasing rule for 12 months and require that CMS reassess the rule and submit a report to Congress on alternative rebasing methods, including methods offered by all stakeholders. More recently, a bipartisan Congressional letter sent to CMS’s Acting Administrator Andy Slavitt expresses major concern with the Medicare home health funding cuts set forth in the 2016 proposed rule.

Due to all of these stakeholder concerns, we strongly recommend that CMS consider alternative methodologies. We also recommend that CMS withdraw the proposed case-mix-weight adjustments proposed for 2016 and 2017. No adjustments should be considered until CMS conducts a thorough analysis of “real” versus “nominal” changes in case mix through evaluation of changes that occurred during the actual years of concern (2012 to 2014).

Finally, we recommend that CMS conduct a more complete impact assessment of the rebasing proposal over the entire four-year period, not just in 2014. A more rigorous look at the cumulative impact of these incremental reductions on beneficiaries and providers over four years would result in a better understanding of the rolling effect of 3.5 percent cuts in each of the four years through 2017.

“Case-Mix Creep” Cuts Stretch Reductions Beyond the Limit Set by Congress

On the issue of “Case-Mix Creep” reductions mentioned earlier in these comments, HCA is specifically concerned that CMS arrived at its $350 million proposed reduction for 2016 by not only continuing its third year of -3.5 percent rebasing adjustments, but by also applying a nominal case-mix growth reduction (aka “Case-Mix Creep” adjustment) to the CY 2016 episodic payment, based upon analysis of data from 2000 through CY 2010.

While Congress directed CMS to adjust the home health payment rate through rebasing, CMS states in the rule that the maximum rebasing rate authorized by Congress does not enable the agency to sufficiently reduce payment rates. Thus, it appears that CMS is proposing an additional case-mix-related cut under another name to rebase home health payment rates more than the limits (3.5 percent) established by Congress.

CMS’s latest analysis claims that HHAs nationally have experienced “nominal” case-mix growth (also known as case-mix creep) of 3.41 percent between 2012 and 2014. Based on this analysis, CMS proposes to reduce the 60-day episodic payment by 1.72 percent in 2016 and 2017, to account for this “nominal” case-mix coding intensity growth which CMS says is unrelated to changes in patient acuity. This two-year 1.72 percent reduction is in addition to CMS continuing its third year of $80.95 rebasing reductions required under ACA.

CMS estimates that 15.97 percent of the change in average case-mix relates to “real” changes in patients served while the remaining 84.03 percent is considered “nominal” case-mix growth that relates to up-coding. This breakdown, however, is still based upon CMS’s earlier evaluation of data from 2000 to 2010. CMS did not update its analysis with specific consideration of any of the data from 2012 to 2014.
The crucial need for updated data is supported by other analyses in home health, including a July 2011 report, titled “Analysis of 2000-2009 Home Health Care-Mix Change,” issued by CMS contractor Abt Associates, which sets out the factors that it concludes are “drivers” of “real” case-mix change in contrast to “nominal” changes. Abt evaluated as many as 921 variables in each model and concluded that only four variables predict a case-mix increase or decrease of more than 0.01. These “drivers,” summarized below, are followed by data points which substantiate the resultant increase in case-mix that CMS should account for in its analysis of “real” versus “nominal” case-mix increases:

1. **The proportion of voluntary, non-profit HHAs to freestanding for-profit HHAs.** Abt finds that “real” case mix increases with nonprofit HHAs, and according to the 2015 MedPAC Data Book, more propriety HHAs closed during this period, and a reduction in proprietary HHAs is associated with higher average case mix.

2. **The extent that patients had an inpatient hospitalization in the 14 days prior to the beginning of the home health episode.** According to federal data, the percentage of inpatient discharges to home health services grew from 15.2 percent in 2009 to 16.7 percent in 2012. This is an indication that the acuity level for patients admitted from hospital to home health has risen, a factor associated with a higher case-mix weight (Source: 2015 MedPAC Data book).

3. **Changes in the proportion of patients with Cerebrovascular Accident (CVA) and knee joint replacements.** Increases in such inpatients leads to high “real” case-mix change. Data shows that total hip and knee replacement surgeries are steadily increasing, with over 400,000 such procedures in 2013. A higher incidence of such patients in home health services has been found to increase “real” case mix (Source: CMS 2015 Fact Sheet).

4. **The number of hospital days preceding the episode.** Fewer hospital days are associated with higher “real” case-mix change. Data from CMS’s own research statistics shows, that the average hospital length of stay has decreased from 5.7 days in 2005, to 5.4 days in 2010 to 5.3 days in 2012, a sign of increasing “real” case-mix growth. MedPAC further found that the 2013 home health population includes more individuals that were dual Medicare-Medicaid eligibles, older, more likely afflicted with dementia, and experiencing longer lengths of service. These patients are generally associated with higher home health resource needs and higher case-mix weight. (Source: 2015 MedPac Data Book)

These arguments notwithstanding, Section 3131(a) of ACA explicitly **limited the amount that CMS may reduce the payment each year to no more than 14 percent (cumulatively) of the 2010 payment rate phased in equally over four years between 2014 and 2017 (or 3.5 percent each year).** However, CMS seeks to reduce home health payment rates by an amount greater than what is allowed by Congress and is doing so through a cut of another name. The nominal case-mix-growth cut measures one of the same factors already included in the capped rebasing adjustment approved by Congress: “intensity of services.”
Recommendations

HCA believes CMS’s proposed case-mix creep adjustment should be rescinded since CMS’s rebasing methodology already includes a recalibration of the case-mix weights. Furthermore, HCA maintains that the case-mix creep adjustment risks venturing into territory beyond the statutory limits set by ACA.

Absence of Substantive Changes to F2F

Another major area of concern is that, unlike the 2015 HHPPS rule, which included technical but no less burdensome changes to the Medicare home health face-to-face (F2F) requirement, the 2016 proposed rule made no reference or policy revisions to the current regulation.

CMS has recently posted a proposed electronic template that it developed for purposes of documenting and supporting the physician F2F encounter requirements. However, this template does not substitute for changes that are desperately needed in the underlying policy – changes that can be implemented to streamline the process and fulfill the statutory requirements established by Congress.

While HCA intends to submit separate comments to CMS on its proposed F2F electronic template, the template appears far too lengthy for most physicians to willingly complete. More importantly, it appears the template still requires the physician to compose the equivalent of a narrative for homebound and skilled care need, thus actually reconstituting the former requirements that CMS agreed to eliminate in the 2015 final rule.

Recommendations

HCA believes CMS made this home health F2F physician encounter requirement much more burdensome than the 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, and the best solution is a simple one: amend or include an addendum to the 485 or plan of care inserting a certification statement by the physician as to the need for home care services, eligibility and attestation that the F2F encounter has occurred. HCA has repeatedly made this recommendation and it is long past time for CMS to adopt it.

Value Based Purchasing

Another area of concern is CMS’s proposed Home Health Value-Based Purchasing (VBP) pilot program. 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 recently released a “Draft Medicare Alignment Paper” with proposals to integrate Medicare and Medicaid value-based payment 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 from the Medicare perspective 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. New York providers have enough work activities ahead of them to prepare for the New York-initiated Value Based Payment project without the added focus of a federal project.

Recommendations

While HCA is supportive of the concept of value-based purchasing, we encourage CMS to work with the home health industry to refine the proposed program in ways that will promote accountability and facilitate improvements in the quality and efficiency of care provided. Since New York is vigorously seeking CMS’s permission to administer Medicare fee-for-service payments for dual eligibles through the State’s VBP models, while continuing to pay for their Medicaid benefits through managed long term care plans, we are pleased that CMS did not include New York as one of the nine states to participate in its mandatory Medicare home health VBP pilot program.

But more generally, CMS’s approach to mandating participation by all HHAs in a state departs from CMS’s typical procedure of inviting interested agencies to apply, especially if the selection of states changes to include New York or other states not selected for the current iteration of the project. While we understand that CMS must have a representative sample of agencies on which to test the model, CMS’s current methodology for selecting participants threatens to leave behind agencies that are eager to innovate while putting less resourced agencies at risk for closure.

We recommend that CMS should develop a voluntary application process for interested HHAs to apply to participate in the VBP program. CMS could document the characteristics of these agencies and select a similar set of agencies for comparison. CMS would be able to document the characteristics that are unique to participating agencies to see if these characteristics contribute to success in the program.

CMS’s proposed home health VBP pilot program is also extremely long and puts the portion of the home health industry that is not participating at risk for being left behind. Other sectors, such as hospitals and physicians, continue to grow their expertise in VBP. It is critical that the home health sector not remain in a silo isolated from progress in other care providers. These silos exist given longstanding misalignment of payment models and performance metrics across providers. We believe a home health VBP program could be a significant step forward in aligning incentives across provider types. However, the timeframe and method for selecting participants will exclude the vast majority of HHAs from these incentives. These providers cannot wait seven years to catch up.

To that end, excluded HHAs (like here in New York) are likely to continue to pursue value-based payment arrangements with other payors (Medicaid and Managed Care). This may challenge CMS’s ability to evaluate the performance of the program as these agencies will not be suitable to serve as part
of the control group. It also means that agencies that are intently working on performance improvement will not be eligible for Medicare shared savings even in instances where they significantly improve their performance.

**HCA believes that CMS needs to expedite its VPB pilot program so that it is concluded in no more than 3 to 4 years**, rather than the current proposal of seven years. HCA believes CMS could do this by launching the voluntary program initially with six months of data, using January to June 2015 as the baseline data and January to June 2016 as the first performance period. Incentive payments based on the January to June data could begin in January 2017 and be subsequently updated quarterly. Once a complete year of data is available, the incentives/penalties would be based on annual data.

Finally, allowing agencies to voluntary choose to participate would enable those agencies with the highest level of readiness and motivation to come on board quickly. 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.

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 proposed incentive/penalty range: a minimum of five 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 a 5 to 8 percent level of risk to change HHA behavior, especially for HHAs that are experiencing negative operating margins. We believe CMS should modify its proposal to establish a more moderate risk corridor.

Lastly, while we understand CMS’s approach to selecting performance measurement – using a blend of process, outcome, and utilization measures and testing new measures in a pay-for-reporting capacity – we are very concerned with the number of measures proposed. Some of these measures are currently captured in Home Health Compare, but some of them are not and will be new from the perspective of agencies tracking their performance and prioritizing these measures as part of performance improvement initiatives. CMS could better direct agencies’ efforts by reducing the total number of measures used in the program.

**We urge CMS to modify its use of outcome measurement policy to take into account the fact that many home health patients may or will not experience improvement due to the acuity of their condition.** Indeed, HHAs are often called upon to maintain a patient’s condition and slow the decline of their health in order to prevent their re-institutionalization. As a result, CMS should consider inclusion of one or more measures that evaluate a patient’s stabilization, or modification of existing outcome measures, to account for HHAs’ performance in stabilizing and preventing the deterioration of patients.

**In Addition, HCA requests that CMS reduce the number of measures in its VBP pilot program.** The combined use of all of these measures, including the introduction of four new ones, and the necessity to train staff and update their reporting capabilities may be operationally challenging for many HHAs, especially in tandem with the home health quality reporting program and the Star
Rating program. As a result, we ask that CMS reexamine the proposed “starter measure set” and explore opportunities for aligning the VBP reporting process with those utilized for other home health-related quality programs.

**Other Elements of CMS’s CY 2016 Proposed Rule**

HCA also offers the following comments and recommendations to other critical components of the 2016 HHPPS proposed rule:

**Home Health Quality Reporting Program (HHQRP) Proposal**

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.

The IMPACT Act requires collection of data across eight domains. In keeping with the requirements of the IMPACT Act, CMS is proposing several changes to the Home Health Quality Reporting Program (HHQRP) initiative, including inclusion of one new measure and changes to the minimum reporting threshold for CY 2016 and CY 2017.

Measures for the other domains will be addressed through future rulemaking, although CMS is seeking feedback on the following four future, cross-setting measure constructs to potentially meet requirements of the IMPACT Act:

- All-condition risk-adjusted potentially preventable hospital readmission rates;
- Resource use, including total estimated Medicare spending per beneficiary;
- Discharge to the community; and
- Medication reconciliation.

While our colleagues at the national association level appear to support the proposed revisions to the HHQRP as well as the four future, cross-setting measures constructs CMS has chosen to potentially meet requirements of the IMPACT Act, HCA needs additional time to review more thoroughly and plans to provide further feedback in the future.

**Proposed Changes to OASIS Submission & Pay for Reporting**

CMS’s proposed rule will continue to reduce home health payment rates for HHAs that did not report OASIS quality data for episodes beginning on or after July 1, 2014 and before July 1, 2015. CMS includes OASIS and HHCAHPS data as part of the quality data submission mandate. If an
HHA fails to submit the required OASIS and HHCAHPS data, payment rates are currently reduced 2 percent for an entire year.

However, CMS believes the level of OASIS submission required under current standards is minimal, prompting CMS to propose an increase to the threshold of OASIS data submissions for providers to avoid the 2 percent rate penalty beginning in CY 2017 (OASIS submissions for the July 1, 2015 thru June 30, 2016 time period). In the first year (CY 2017), CMS is imposing 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.

**Recommendations**

**HCA recommends that CMS clarify what is meant by “OASIS submission,” explaining whether the standard requires submission or both submission and acceptance by the state agency. This would clarify whether OASIS acceptance must be within the measure timeframe.**

The proposed rule is also unclear whether the OASIS assessments considered in the HHQRP will include only the OASIS assessments for traditional Medicare, or whether it will also include OASIS assessments for Medicare Advantage and Medicaid home health care.

This should be clarified in the final rule, though HCA recommends that only the OASIS assessments for traditional Medicare be considered in the home health quality reporting program since OASIS submission requirements vary among Medicare Advantage plans and to some extent the various Medicaid programs.

CMS should also provide comprehensive education on the new standard at least six months before it is effective.

**Proposed Wage Index**

In 2015, CMS proposed and finalized significant changes to the home health wage index. Specifically, CMS decided to implement a one-year blend of the wage indexes of the previously used Core Based Statistical Areas (CBSAs) designations with the new CBSAs designated by the Office of Management and Budget (OMB) in 2013.

The one-year, transitional blend consisted of 50 percent of the old CBSA designation and 50 percent of the newer OMB designations for 2015. Because the one-year transition period expires at the end of CY 2015, CMS is proposing that the HHIPPS wage index for CY 2016 be fully based on the revised OMB delineations adopted in CY 2015.
CMS’s decision nine years ago to switch from Metropolitan Statistical Areas (MSAs) to the CBSAs for the wage index calculation has had serious financial ramifications for New York HHAs. HCA estimates that this nine-year shift – from MSAs to CBSAs – has resulted in an estimated $65 million cut in Medicare home health reimbursement statewide and over $48 million in cuts for HHAs in the New York City (NYC) metropolitan area. Just as damaging for HHAs in the NYC metropolitan area is that their home health wage index has decreased almost 1 percent a year since 2004.

Unlike past MSA designations – where all of the counties in the 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 last year’s final rule, CMS has added three more New Jersey counties (Middlesex, Monmouth and Ocean) to the NYC area wage index.

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.

In addition, HCA has consistently voiced its concern regarding the lack of parity between different health care sectors, each of which utilizes some form of a hospital wage index yet experiences distinct index values in its specific geographic area. CMS’s decision to continue to use the CBSA-based labor market definition serves to exacerbate that instability.

**Recommendations**

**HCA requests that CMS explore wholesale revision and reform of the home health wage index.** This reform should 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 that have negatively impacted New York HHAs throughout the years and jeopardize access to care;
- The inadequacy 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 the CMS Secretary 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 utilized within 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.

Outlier Policy

CMS’s proposed rule retains all of the outlier payment policy revisions associated with previous final rules, including the reduction of the total outlier fund from 5 percent to 2.5 percent of the total home health services estimated expenditures. CMS made this change because its analysis of 2010 data showed that providers were expending just 85 percent of the total amount permitted for outlier payments. This total allowance is 2.5 percent of all HHPPS revenues (nationally). CMS’s proposed rule also, unfortunately, continues to impose a per-agency outlier cap of no more than 10 percent of total Medicare revenues.

CMS made these major revisions to the outlier policy to address continued perceived abuses of outliers by a small segment of HHAs primarily located in South Florida. While CMS believes that few HHAs nationally have been affected by the 10 percent outlier cap, many HCA members have reported that the cap adversely affects them.

Reinforcing these concerns, HCA’s comments to CMS over the last four years have stressed that the restrictive outlier threshold does not recognize the needs of patients with extensive and clinically complex care requirements.

We also requested that CMS increase the 10 percent cap, so that all agencies serving high need and high cost beneficiaries could continue to do so, without losing critical outlier funding.

HCA based this request on data we regularly obtained from National Government Services (NGS), New York’s Medicare Administrative Contractor, which has indicated that the average number of HHPPS outlier claims for New York HHAs has been consistently over 10 percent (on average), despite some deviation from this trend in recent data. HCA would still need to examine this trend further, along with other data, to determine an appropriate outlier threshold that accounts for the clinical severity of services in New York’s home care system.

Recommendations
HCA has never believed that CMS’s outlier policy and 10 percent threshold cap are appropriate fraud fighting initiatives. While we recognize that CMS established the outlier policy to address abuse in South Florida, CMS should realize that the vast majority of HHAs who are receiving proper outlier payments are in reality losing significant money from their episodic payment due to serving high-need and high-cost beneficiaries. **HCA believes a more appropriate fraud fighting initiative would include a possible minimum provider specific cap on the 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, which, for most HHAs, means incurring significant financial losses.

**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 2016 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 submitting HHCAHPS data on time 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 2016 annual payment update includes HHCAHPS data submitted in the second quarter of 2014 through the first quarter of 2015 (the months of April 1, 2014 through March 31, 2015).

While HCA understands CMS’s intention for implementing a tool that measures the experiences of people receiving home health care from CHHAs, 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 also has concerns 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.

**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 new survey requirement as an addition to the home health COPs in Section 484.250(c).**
The HHCAHPS survey 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.

**Advancing Health Information Technology/Exchange**

In the proposed rule, CMS states 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, the rule states that HHS believes 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. Health IT that facilitates the secure, efficient and effective sharing and use of health-related information when and where it is needed is an important tool for settings across the continuum of care, including home health.

While these are laudable principles, we were dismayed to read the following from the proposed rule: “While home health providers are not eligible for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, effective adoption and use of health information exchange and HIT tools will be essential as these settings seek to improve quality and lower costs through initiatives such as VBP.”

**Recommendations**

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 asks that CMS and/or HHS incorporate funding in the 2016 final rule to invest in HIT and integrated clinical technology for home care.** Such technology investments 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 pconnole@hcanys.org or at (518) 810-0661.

Sincerely,
Patrick Conole, MHA
Vice President, Finance & Management
Home Care Association of New York State, Inc.