August 24, 2016

U.S. Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1648-P  
Post Office Box 8016  
Baltimore, MD 21244-8016

Re: File Code CMS-1648-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2017

To Whom It May Concern:

The Home Care Association of New York State (HCA), Inc., on behalf of its 200 member agencies serving approximately 171,000 Medicare home health beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the 2017 Medicare Home Health Prospective Payment System (HHPPS).

This letter will provide HCA’s major comments on the 2017 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 Flaws in CMS’s Methodology

Of major concern, the rule, if adopted, will reduce Medicare payments to HHAs by $180 million nationally in 2017 which, when added to the three previous years of rebasing cuts, represents a staggering $700 million impact, based on a rationale which we have argued — and continue to maintain — is rooted in an 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 home care Medicare margins have remained negative for fourteen years in a row, with an un-weighted average margin of -16.36% in 2014 (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 analysis earlier this year (in a February 2016 report called Risk Factors) found that over 70% of NY home care providers were operating at a loss across all payors in 2014, 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).

It is imperative that CMS conduct a more thorough analysis examining the cumulative impact of rebasing from 2014 to 2016 – especially as sequestration cuts and other cost impacts continue to mount. By once again assessing only a one-year impact of rebasing, CMS is failing to account for the effect its rebasing initiative is having over the past three years 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. Unfortunately, these projections do not account for major new cost impacts affecting providers since 2011, including: the increasing cost of employee health and worker compensation benefits; regulatory requirements such as the administratively burdensome physician documentation requirements under the face-to-face (F2F) rule, New York State’s multi-billion-dollar minimum wage increase, and past cuts.

2. **We strongly object to CMS including an additional “case-mix creep” type adjustment in the final year of a four-year rebasing process.** CMS’s estimate of “real” case mix change is based upon 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’s proposal for additional case-mix-related cuts (“case-mix creep”), separate from the fourth recalibration of the Case Mix Weights, seems to be rebasing the 2017 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 percent 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 adjustment 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 2017 only assures that the average LUPA reimbursement to an HHA will be below average cost.

4. **CMS’s approach continues to ignore regional differences in home health operating margins.** As New York’s operating margins plummet, other regions of the country see positive margins that continue to fuel the CMS and MedPAC recommendations nationally. These other regions will continue to report positive margins in some cases, given that the rebasing formula is evenly applied regardless of regional variations in Medicare growth or spending patterns. New York State has among the nation’s highest labor costs, now alarmingly exacerbated by the state’s implementation of a phased-in $15 per-hour minimum wage hike, the balance of which is unfunded by Medicare. This mandate, when fully phased-in, will cost a stunning $2 billion for New York agencies across all payors (Medicaid, Medicare, managed care, commercial insurance and private-pay). New York also has a high concentration of dual-eligible beneficiaries and costlier chronic-care cases, as revealed in reimbursement data showing a comparatively weighty number of outlier episodes in New York State – those cases where CMS pays more for high-need beneficiaries, but only up to a capped threshold well below the need for coverage to New York State beneficiaries.

5. **CMS’s own analysis of 2015 home health claims data shows that the rebasing initiative is having an effect on access to care.** CMS’s preliminary analysis of CY 2015 home health claims data indicates that the number of home health episodes decreased by 3.8 percent from 2013 to 2014, and decreased by 1.7 person from 2014 to 2015. In addition, the number of home health users that received at least one episode of care decreased by 2.95 percent between 2013 and 2014, and decreased by 0.5 percent from 2014 to 2015. HCA believes this latest analysis shows that rebasing tragically undermines needed services for the elderly and disabled, affecting the 3.5 million homebound seniors and persons with permanent disabilities who use home health care annually.

6. **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 HHAAs having to implement unfunded regulatory requirements such as the F2F requirement, the Provider Enrollment Chain and Ownership System (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 the overtime requirements under the Fair Labor Standards Act and state-specific changes such as New York’s new minimum wage law as well as our state’s ongoing “worker wage parity” laws.
Rebasing Recommendations

CMS has admitted that preliminary analysis of 2015 claims data shows not only a decrease in the number of home health episodes between 2013 through 2015 but also a decrease in the number of Medicare beneficiaries receiving at least one episode of care. This admission—along with the home care community’s own data indicating a worse picture of provider sustainability under rebasing—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 last year’s 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 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.

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

As part of last year’s 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 $165 million and is in addition to CMS continuing its fourth year of an $80.95 rebasing reduction to the base episodic rate.

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 once again 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 of 3.41 percent between 2012 and 2014. 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.

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.”

**Recommendation on Case-Mix-Creep**

HCA believes CMS’s case-mix creep adjustment for CYs 2017 and 2018 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 Sensible Changes to Face-to-Face Requirement**

Another major area of concern is that for the second year in a row, the 2017 proposed rule made no reference or policy revisions to the current face-to-face (F2F) regulation.

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: practitioners find that it is easier to 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.

Now, in place of the physician narrative, CMS is requiring that physicians have sufficient documentation in their own files to support the certification of a patient’s homebound status and skilled care need. Yet CMS has not issued adequate guidance on how HHAs are to comply with this new requirement.

In fact, CMS’s own contractors find that 90 percent of home health billing errors are documentation-related. Fixing F2F is a prerogative. It would bring integrity to the billing system for Medicare contractors, reduce costs, and protect home care providers from unnecessary financial vulnerability, assuring access to care for Medicare beneficiaries.
Recommendations on F2F

HCA believes CMS made the home health F2F physician encounter requirement much more burdensome than 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 we urge CMS to do the following:

- Revise the requirements to eliminate or significantly modify the physician documentation requirements so that physicians must no longer 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.

- Have CMS modify this requirement so the F2F mandate can be met through the completion and collection of the separately signed and perhaps modified 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 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 implementation of its Home Health Value-Based Purchasing (VBP) pilot program in nine randomly selected states, which began on January 1, 2016.

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 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, and New York providers have enough work activities ahead of them to prepare for the New York-initiated VBP project without the added focus of a federal project.

But more generally we have some concerns about the design of VBP, particularly CMS’s approach to mandating participation by all HHAs in a state, which departs from CMS’s typical procedure of inviting interested agencies to apply. While we understand that CMS must have a representative sample of agencies on which to test the model, CMS’s current methodology of requiring participation from all agencies in a state threatens to leave behind agencies in other states that are eager to innovate while putting less resourced agencies at risk for closure by requiring their participation.

**Recommendations on VBP**

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. 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 in non-pilot states while putting less resourced agencies at risk for closure in the pilot states, and a voluntary approach would be the best avenue for testing payment innovations.

**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 time goes on and 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 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 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 2017 proposed rule:

- Removing 4 measures (care management, prior function, influenza vaccine data collection, and reason pneumococcal vaccine not received) that had not been fully developed;
- Adjusting the quality reporting periods from quarterly to annual;
- Increasing the timeframe for submitting new measure data;
- Developing a progress report on the VBP program by 2019; and
- Instituting a formal appeals process for HHAs in the program.

**Other Elements of CMS’s CY 2017 Proposed Rule**

HCA also offers the following comments and recommendations to other critical components of the 2017 HHPPS proposed rule.

**Outlier Policy**

CMS is proposing significant but budget-neutral changes to its outlier methodology for CY 2017, 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 proposed rule also continues to impose a per-provider outlier cap of no more than 10 percent of total Medicare revenues.

In its proposed rule, CMS states that CY 2015 home health claims data show significant variation in the visit length by discipline for outlier episodes. Those agencies with 10 percent of their total payments as outlier payments are providing shorter but more frequent skilled nursing visits than agencies with less than 10 percent of their total payments as outlier payments. Further analysis by CMS shows that the average number of skilled nursing visits per outlier episode (nationally) is significantly higher than the number of visits for the five other disciplines of care combined (34 skilled
nursing visits versus 17.2 for all other disciplines) and, therefore, outlier payments are predominately driven by the provision of skilled nursing services.

Based on this analysis of CY 2015 claims, CMS is concerned the current methodology for calculating outlier payments may create a financial disincentive for providers to treat medically complex beneficiaries who require longer visits.

Therefore, CMS is proposing to change the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. Along with this cost-per-unit change, CMS is proposing a cap on the amount of time per day that would be counted toward the estimation of an episode’s costs for outlier calculation purposes. Specifically, CMS proposes to limit the amount of time per day (summed across the six disciplines of care) to 8 hours or 32 units per day when estimating the cost of an episode for outlier calculation purposes. CMS notes that this proposal is consistent with the definition of “part-time” or “intermittent” which limits the amount of skilled nursing and home health aide minutes combined to less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).

CMS is also proposing to keep the same 80 percent outlier loss ratio but would increase the fixed dollar loss (FDL) ratio from 0.45 to 0.56. This would have the effect of reducing the number of episodes that would qualify for outlier payment. CMS indicates that such a change is needed to keep outlier spending within the 2.5% national spending limit. These overall changes will have a distributional impact with some HHAs receiving higher outlier payments due to the nature of their patient service time utilization, while other HHAs may receive lower outlier payment or no outlier payment at all.

CMS’s analysis of the impact of the change from a cost-per-visit to a cost-per-unit approach indicates that approximately two-thirds of outlier episodes under the cost-per-unit approach would have still received outlier payments as under the current cost-per-visit approach, while about one-third would not receive outlier payments.

Comments & Recommendations

HCA has significant concerns with CMS’s proposed changes to the outlier methodology.

While HCA can appreciate CMS’s concerns that the current methodology for calculating outlier payment may be creating a financial disincentive for HHAs to treat medically complex beneficiaries who require longer visits, we are very worried whether HHAs have sufficient and meaningful data to accurately capture all of the professional disciplines in 15-minute increments as well as whether HHAs and their software vendors will have adequate time to incorporate these proposed outlier changes to their Medicare billing systems and bill correctly.

HCA recommends that CMS delays this particular change to the outlier methodology in order for all HHAs to work with their software billing vendors to update their system. HCA strongly believes that the time period between CMS issuing the final rule (usually in early November) and
the effective date of the rule does not allow HHAs enough time to work with their vendors to make the necessary changes to bill outlier payments correctly in CY 2017.

HCA is also very concerned with CMS’s outlier proposals to increase the FDL ratio from 0.45 to 0.56 as well as CMS’s proposal to maintain the existing 10 percent outlier therapy cap on HHAs.

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

HCA also disagrees with CMS’s proposal 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 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 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.

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 in the near future on 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 the mandate for budget neutrality. 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 2017 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 expired at the end of CY 2015, CMS is proposing that the HHPPS wage index for CY 2017 continue to be fully based on the revised OMB delineations adopted in CY 2015.
CMS’s decision ten 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. 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 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 ten-year shift – from MSAs to CBSAs – has resulted in an estimated $70 million cut in Medicare home health reimbursement statewide and over $55 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 approximately 1 percent a year since 2004, 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.

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 exacerbates that instability.

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, the balance of 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 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.

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 to adopt for the CY 2018 payment determination four measures to meet the requirements of the IMPACT Act. Three of these measures are resource-based and calculated using Medicare claims. The fourth measure is assessment-based and is calculated using OASIS data. The proposed measures are as follows:

• All-condition risk-adjusted potentially preventable hospital readmission rates;
• Total estimated Medicare spending per beneficiary;
• Discharge to the community; and
• Medication reconciliation.
Comments

HCA requires additional time and details to comment and make recommendations on the new cross-setting measure constructs that CMS has chosen to potentially meet requirements of the IMPACT Act. HCA respectfully requests that CMS continue to employ a transparent process for measure development that allows for multiple avenues for stakeholder input and will be consulting with our members about the impact of these changes being considered for future payment determinations. HCA also recommends that CMS give due consideration to the burden involved for HHAs when developing new quality measures. CMS should balance the addition of new quality measures with eliminating older measures that are currently part of the HHQRP.

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, 2015 and before July 1, 2016.

However, because CMS believed the level of OASIS submission required under the current standards was minimal, CMS’s CY 2015 final rule increased the threshold of OASIS data submissions required 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 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.

Comments

HCA appreciates CMS clarifying in its CY 2016 final rule how the data submission process for OASIS converted from the former state-based OASIS submission system to a new national OASIS submission system known as the Assessment Submission and Processing (ASAP) System beginning in 2015.

We also appreciate CMS clarifying 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.

Lastly, we commend CMS on providing comprehensive education on the upcoming new standards 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 2017 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 2017 annual payment update includes HHCAHPS data submitted in the second quarter of 2015 through the first quarter of 2016 (the months of April 1, 2015 through March 31, 2016).

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 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.

Payment for Negative Pressure Wound Therapy Using a Disposable Device

CMS is proposing a separate payment mechanism (outside HHPPS) for HHA services in cases where the sole purpose of a visit is to furnish negative pressure wound therapy (NPWT) using a
disposable device. This separate service payment would be based on the Medicare Hospital Outpatient Prospective Payment System (OPPS) amount, which includes payment for both the device and furnishing the service.

Under this change, the HHA must bill these visits (or portions of these visits) separately under type of bill 34x (used for patients not under a home health plan of care, Part B medical and other health services, and osteoporosis injections). Visits performed solely for the purposes of furnishing NPWT using a disposable device are not to be reported on the HHPPS claim (type of bill 32x).

This change, as intended by the Consolidated Appropriations Act of 2016, is laudable, as the current reimbursement system involves payment to the HHA for the visit and payment to a DME supplier for the NPWT – but, in cases where the HHA uses a disposable NPWT, Medicare does not pay the HHA, who must absorb the cost of the device.

However, we are concerned about potential billing and claim alignment issues related to this policy change, especially in cases where a disposable NPWT device is used during the course of an otherwise covered HHA visit, requiring agencies to navigate two billing procedures, using type(s) of bill 32x and 34x. Under this scenario, part of the visit would be reported on the HHPPS claim (type of bill 32x), but only for the time spent furnishing the services unrelated to the provision of NPWT, while the portion spent providing NPWT, as we understand it, would be reported on type of bill 34x.

Recommendations

We recommend a simpler and cleaner approach for this billing scenario, by allowing for payment of the service entirely within type of bill 32x and payment of the device within type of bill 34x. Specifically, we ask that CMS make some accommodation in its proposal for cases where skilled and non-skilled services would be fragmented across the different claim types.

As it stands, the proposal would require skilled services (for the use of disposable NPWT) to be billed outside of HHPPS, using type of bill 34x, which raises questions as to whether other services reported under type of bill 32x during the same episode (i.e., non-skilled services) would be covered if those claims do not include the required skilled service that has been carved-out.

Advancing Health Information Technology/Exchange

In last year’s proposed rule, 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, the rule stated 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 disheartened to read the following from last year’s 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 2017 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 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,

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