August 25, 2016

RE: CMS-1648-P; CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
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Dear Mr. Slavitt:

I write on behalf of the Pennsylvania Homecare Association’s 700 homecare and hospice agencies to offer our comments on the CY 2017 Home Health Prospective Payment System (HHPPS) Proposed Rule. We appreciate the opportunity to share our feedback on the proposed changes that affect our member agencies and the patients and families they serve. Below we reiterate our concerns regarding the continued rebasing of home health payment rates and urge CMS to reconsider its formula which targets all home health providers rather than a select few that are engaging in fraudulent behavior. As value-based healthcare continues to grow, it is important for the home health industry to maintain its reputation and integrity as a trusted and valuable post-acute care partner. CMS is stifling that growth and tarnishing the home health reputation by continually penalizing the industry as a whole with payment cuts instead of targeting the bad actors.

The rebasing formula is flawed and unfairly targets compliant providers in Pennsylvania.

This proposed rule brings the fourth consecutive year of deep cuts as a result of CMS’ rebasing of the national episode rate. CMS estimates another $180 million reduction in 2017, for a staggering total of $700 million in Medicare cuts from 2014 to 2017. While the decreases have been predictable, they have never been sustainable. Other types of businesses such as retail, construction, or airlines could not remain in business if revenues dropped each year. Unfortunately, home health agencies are facing that challenge.

PHA understands the need to reexamine the prospective payment system periodically to maintain the integrity of the payment calculation process, however the rebasing formula that has been employed by CMS has been flawed since the beginning. The calculations are indifferent to regional differences. In other words, by zeroing-out the national average operating margin, the formula jeopardizes providers in states like Pennsylvania, where many providers are already operating at a net...
loss. This only leads high-profit agencies to profit less, while those with already negative margins fall deeper into the red.

The formula also inappropriately uses outdated claims data from 2011 to determine the national operating margin. This does not account for several critical post-2011 changes like the Affordable Care Act (ACA) employer insurance mandate and new regulatory burdens like the face-to-face encounter.

In addition, hospital-based home health agencies are not considered when calculating the national profit margin. MedPAC reported in March 2013 that 2011 profit margins for hospital-based agencies are far lower than freestanding agencies (-10.9% v. +14.8%), yet the formula excludes this very large population of providers.

Rather than imposing a blanket reduction for all home health providers, PHA urges CMS to target rebasing cuts to providers in areas that have a higher risk or history of fraud. In 2012, MedPAC reported that excessive home health revenue growth occurred in just 25 counties (“MedPAC 25”) in the United States located in Texas, Florida, Oklahoma, Louisiana, Mississippi and Tennessee. The five highest-spending areas accounted for 20% of all home health spending in the nation.

Pennsylvania providers should not be considered for the same cuts as the MedPAC 25. Data shows the number of home health agencies in the MedPAC 25 from 2005 to 2009 grew more than 15 times faster than the number of agencies in Pennsylvania. During the same time, Medicare revenue growth in the MedPAC 25 was almost 30 times more than the increase in Pennsylvania.

CMS has access to a vast and growing library of claims data that can be used to target cuts to agencies that are abusing the prospective payment system. In an era where value-based payments are the new normal, there is no reason why Medicare should be treating all home health agencies the same. Instead, it should reward providers like those in Pennsylvania who are in compliance and striving every day to stretch Medicare dollars to care for the patients who need them.

**PHA supports the proposed outlier payment changes, but seeks greater clarity.**

The proposed change to the calculation of outlier payments from a per-visit basis to a per-unit basis will better capture the time home health professionals are spending in patients’ homes. As CMS notes in the rule, a skilled nursing visit is not always just a “visit” to the patient to check vital signs. Some patients require hours of nursing care each day.

Prior to implementation of this change, providers will need more clarity from CMS on how the 15-minute units should be calculated and tracked by the agency. For instance, agencies will need to know how to report the visit length on the claim form and how to accurately and uniformly round the total number of units reported. In the skilled nursing facility setting, providers report 15-minute units using an 8-minute rounding window so that services provided from 3:00 to 3:09 count as one unit, but services from 3:00 to 3:08 do not reach one unit. PHA asks for more details on how CMS will expect agencies to report this information.

In addition, we oppose the proposed 8-hour cap which may negatively impact certain patient groups. The cap may create a disincentive for some agencies to admit patients with high acuity needs
who need home health care the most. We urge CMS to remove this cap given that outlier payments are already controlled for budget neutrality.

**Providers are concerned about changes for negative pressure wound therapy (NPWT) payment.**

While PHA understands this change is mandated by the Consolidated Appropriations Act of 2016, we are disappointed to see CMS segregating payment for a specific service from the overall home health episode. The industry’s episodic payment model is viewed by other healthcare providers as a best practice for interdisciplinary care that caters to the unique needs of the patient. We fear the separation of NPWT payment is a small step in the direction to eliminate this valuable payment system.

Apart from this fundamental concern, PHA members have serious questions about how this change can be practically implemented. As discussed above, the interdisciplinary nature of home health care means a nurse who visits a patient’s home for wound therapy is not going to ignore the patient’s other needs; he or she is constantly assessing the patient with each visit. The nurse might check vital signs or talk to the patient about their pain in the midst of providing NPWT. It is unfair to the nurse and the patient to wear blinders in the home. That means there might not be many cases where a visit is solely for the purpose of NPWT. Agencies need guidance from CMS on how to reliably track that specific time and bill separately.

We would also like clarification on whether these episodes would now be considered therapy-only episodes if the patient’s only skilled need is for NPWT.

**PHA reiterates comments on Potentially Preventable Readmissions (PPR) and Medicare Spending Per Beneficiary (MSPB) measures.**

In November, RTI International and Abt Associates received comments from our association regarding the development of the PPR measure for post-acute care (PAC) providers. We reiterate those comments briefly here, given the proposal to include the PPR measure in the home health quality reporting program.

- We support exclusions that narrow the focus to only home health patients admitted directly from an acute care stay. Our members have reported that patients admitted from the community rather than an acute setting are more likely to have unmanaged chronic conditions and healthcare needs that are complicated by other economic or social factors that are not easily controlled by the agency.
- We oppose many conditions on the list of potentially preventable diagnoses (influenza, dehydration, urinary tract infection) that place unreasonable expectations on the agency’s ability to control the patient's actions and choices after discharge. For example, an individual can catch the flu by chance, having nothing to do with proper discharge planning or care instructions. While the agency can teach the patient how to avoid these illnesses and disease complications, there is no control over his or her actions post-discharge when it comes to communicable diseases or dietary choices.
- Another concern from the list of potentially preventable hospital readmissions is the inclusion of adverse drug events. PHA urges this be modified to include only adverse
events tied to medications that the patient was using at the time of discharge from the post-acute provider.

With respect to the MSPB measure, PHA submitted comments to Acumen in January when the draft measure specifications were made available for review. We summarize those comments below:

- We appreciate that the measure is structured to allow episodes between consecutive PAC providers to overlap, which will promote coordination between hospitals and each successive PAC provider and incentivize cost efficient care throughout the continuum.
- PHA opposes the 30-day associated services period during which HHAs will be accountable for beneficiary spending without the ability to exercise any control over the beneficiary’s actions. One can easily imagine a scenario in which the HHA discharges a patient, the patient sees his community physician two weeks later for a follow up and is prescribed a new medication. Without proper medication instructions from the community physician, the individual could end up in the hospital within the 30-day window through no fault of the HHA. With the 30-day associated services period in place, the HHA would be accountable for all of that spending that was completely unpredictable and outside their control.
- PHA recommends collapsing consecutive home health episodes into one MSPB-PAC episode to account for the treatment of patients with long-term chronic healthcare needs. By not collapsing consecutive episodes, agencies who serve chronically ill patients for more than one 60-day episode will consistently see high Medicare spending in the associated services period.
- PHA recommends the use of a state or region-specific median as the denominator used to calculate an agency’s MSPB-PAC score. This will account for healthcare access factors as well as cost variances across the country. In Pennsylvania, with some large, urban areas with multiple hospitals and health systems and other very rural areas that struggle to access needed healthcare, Medicare costs and cultural diversity of Medicare beneficiaries can vary tremendously.

Guidance is needed on new medication reconciliation quality measure.

CMS is also proposing to add a new quality measure under the IMPACT Act that examines an agency’s response when a medication reconciliation indicates a potential clinically significant issue. The measure would report whether the agency had a “timely follow-up” with a physician each time a potential issue is identified following drug regimen review. In the past with other OASIS-based items, timeliness has been measured not by how quickly the agency notifies the physician but by how quickly the physician responds.

Feedback from the technical expert panel that reviewed this measure shows that PAC providers are concerned about being measured on how quickly the physician responds when alerted by the PAC provider of a potential issue. A majority of the panel agreed that 24 hours is sufficient to collect and report medication issues to the physician, however most also agreed that it is not feasible for the physician to respond to the provider within 24 hours. PHA requests more guidance from CMS as to whether home health agencies will be held accountable for the physician’s own timely response.
PHA recommends using the Center for Medicare & Medicaid Innovation (CMMI) website for public reporting of value-based purchasing (VBP) performance.

PHA supports the proposed changes to the VBP pilot program that are discussed at length in the rule. As part of those changes, CMS requested preliminary feedback on how it might report agencies’ performance in the pilot through a public forum such as Home Health Compare or the CMMI website. We recommend using the CMMI website as the vehicle for this reporting rather than Home Health Compare, as the VBP program is still an innovation initiative and the reporting of both VBP and general quality measures on Home Health Compare might cause confusion among consumers when comparing agencies.

PHA thanks CMS for continually engaging home health providers and for consideration of the comments outlined above. We look forward to working together to improve the Medicare home health benefit and keep more patients and families together at home.

Sincerely,

Vicki Hoak
CEO