Greetings:

I am writing on behalf of the Home Care Alliance of Massachusetts to comment on the Proposed Rule: Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies. The Home Care Alliance of Massachusetts is the trade association that represents approximately 100 Medicare certified home health care agencies in Massachusetts, including VNAs, hospital-based agencies, and for-profit agencies.

Thank you for your consideration of our comments, submitted on behalf of these agencies, on the above referenced proposed rule. Our comments on the provisions of the proposed rule are organized in the order in which they are presented in the Federal Register notice.

**Affordable Care Act Rebasing Adjustments**

We take strong exception to CMS’ proposal to continue the maximum allowable rebasing cut of $80.95 (roughly 2.8%) over each of the next three years, for a total cut of 14% between CY 2014 and CY 2017. We strongly believe that payment reductions of this magnitude are unjustified and fail to take into account significant new cost burdens on agencies since 2012 – including the cost to agencies of full implementation of the Face-to-Face requirement and the new Therapy reassessment requirement – and the significant anticipated costs in the next year to implement ICD-10-CM and the OASIS-C1.

The ACA language authorizing the rebasing states that the rates “shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the
number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies.”

The ACA language gave CMS wide discretion in considering a broad spectrum of factors in the rebasing project, yet CMS seems to have focused exclusively on allowable cost per episode in the rebasing process.

*We urge CMS to update its analysis either to include data from 2013 cost reports or to capture costs associated with the implementation of the Face to Face and therapy reassessment requirements from 2012/2013 in projecting profit margins.*

**Proposed Changes to the Face-to-Face Encounter Documentation Requirements**

We welcome CMS’ recognition of the problems with implementing the ACA Face to Face (F2F) encounter provision as a condition of payment. We are in support of the elimination of the F2F narrative requirement for home health as all indications have been that the current process is a barrier to smooth transitions for Medicare beneficiaries referred to home health care.

We are, however, concerned that the burden of creating a “narrative” sufficient to qualifying a patient for home health services shifts to the physician and hospital in this proposed rule. In the proposed rule, CMS indicates that patient eligibility for home health status should be evidenced in the “patient’s medical record.” This is a position we agree would be the ideal. However, as the HHS Office of the National Coordinator would attest, work to create a central patient record with all related documentation and clinical findings is far from complete and may be years away. (Inclusion of home health in the record is further hampered because home health agencies are not eligible for meaningful use funding under the HITECH Act.)

Instead of looking at the totality of the record, CMS is suggesting that a determination of skilled need and homebound status will be tied to a review “ONLY of the medical record for the patient from the certifying physician or the acute/post-acute provider.” If those records are “not sufficient to demonstrate that the patient was eligible to receive services,” then both the home health claim and the physicians claim for certification/re-certification will be denied. HCA is opposed on a number of grounds to shifting the burden for this “sufficiently” documented narrative onto the physician/hospital medical record.

First, we have no reason to expect - given the history of the past two years with face to face - that the “sufficient documentation” standard in these reviews will be any clearer than it has been in relation to the current narrative requirement. All indications have been that education of the past two years has done little to bridge the gap between how physicians view and
document diagnosis and symptoms leading to a referral for home health and what reviewers have deemed sufficient.

Given these facts, we believe this proposed process will place an undue and potentially unsustainable medical review burden on physician practices by establishing - without appropriate dialogue with the medical community - a new standard of medical record documentation, especially in relation to documenting a patient’s homebound status. The specific definition of homebound as outlined in Home Health Benefit Policy Manual Chapter 7, Section 30.1.1-Patient Confined to Home, is expected in home health documentation. However, physicians do not document by these criteria. CMS would need to provide training throughout the physician and hospital community before there would be an expected change in the documentation of homebound. The collaborative nature of home care with other providers dictates that CMS look for proof of eligibility in the “medical record” as a whole; such documentation resides in the physician and hospital’s patient records as well as throughout the HH medical record.

Second, we are strongly opposed to home health claims being made payable based on another provider’s documentation. The liability this poses is tremendous. HHAs have no control or oversight of other providers’ documentation. It is not reasonable that after providing care to the Medicare beneficiary, that HH claims would not be paid based on another provider’s documentation.

Finally, it is unclear how these physician/hospital records will be requested and obtained in any home health medical review or audit process. Will it be the home health agency’s responsibility to obtain these documents? Will medical reviewers be requesting these directly from hospitals or physician’s office with every home health medical review? Neither approach is practical. HCA believes that CMS is correct in expecting that physicians be more attentive to their role and responsibilities in ordering home health services. The Congressionally mandated face to face encounter is already having that effect. We also share CMS’ position that when we do have a fully consolidated “patient medical record,” it should, in fact, be able to support eligibility for home health services. But in the interim, the work-around proposed here is not supportable.

Given these concerns, HCA recommends that CMS:

- **Eliminate the need for the physician to include a brief narrative on the F2F documentation in ALL cases, including when ordering skilled nursing visits for management and evaluation of the patient’s care plan. Requiring the narrative in only some instances adds an unnecessary level of complexity and will surely be confusing both to physicians and home health agencies;**

- **Eliminate the requirement that the F2F encounter be documented separately from the plan of care. Instead, we recommend that the physician documentation of the face to face encounter shall consist solely of a simple and concise statement that such**
encounter occurred provided by notation of the date of the encounter on the form CMS-485, Home Health Certification and Plan of Care, the same plan of care document the physician signs to order the home health services required by the patient;

- If CMS does continue to require separate F2F documentation, we recommend that CMS develop and include a checklist on a standardized form to document homebound status;

- Continue with the long standing medical review process of seeking proof of medical necessity and home bound status from the documentation found in home health agencies’ medical records.

If CMS intends to proceed with this proposal as written, CMS must first convene a task force of physicians, home health and medical record experts to establish standards and provide guidance on documentation sufficiency for both consolidated electronic health records and individual physician office records. This guidance must respect and reflect how MDs practice and document, as well as include consistent tools for applying the homebound and medical necessity criteria.

Finally, in recognition of the vagaries of the “sufficient documentation” standard that has plagued the current narrative requirement, we recommend that CMS halt all current audits of the face to rule and reopen for further review any claims that have been denied because of insufficient narratives on the F2F encounter documentation.

Proposed Recalibration of the HH PPS Case-Mix Weights

We are pleased that CMS has used updated claims and cost data to recalibrate all of the case-mix weights. However, we are somewhat confused by the significant increase in weighting for high-therapy episodes (and the resulting financial incentives to increase therapy visits), even though CMS has stated its intention that therapy visit volume should have less impact on the weights.

Additionally, we question why CMS has not expanded the analysis to include additional variables that impact the cost of home health services to Medicare beneficiaries. Specifically, the 2014 Proposed Rule issued in July, 2013, noted that CMS was in the final stages of completing a review of costs associated with providing ongoing access to home health care for low-income beneficiaries, those in medically underserved areas, and those with varying levels of severity of illness, as required by Section 3131(d) of the Affordable Care Act. The final report of that study was due in March, 2014, yet we see no reference to that study in the 2015 case mix analysis.
To ensure vulnerable Medicare patients maintain access to needed home health care and equitable reimbursement to agencies that serve these patients, we urge CMS to incorporate findings from that access study into the case mix system for Calendar Year 2015.

**OASIS Data Submission**

The Home Care Alliance supports the continued use and submission of the OASIS assessment tool for purposes of quality measurement and payment. However, the proposed rule does not clarify what is meant by “submission.” The HCA recommends CMS explain whether the standard requires both submission and acceptance by the state agency and clarify whether OASIS acceptance must be within the measured timeframes.

The proposed rule is also unclear regarding the impact of long term care patients (lengths of stay greater than 1 year) on the “Quality Assessment Only” (QAO) formula. Many long term chronically ill patients are covered under Medicaid and generate “non-quality” assessments. High numbers of “non-quality” assessments would impact the denominator of the “Quality Assessment Only” metric effecting home health agencies percent of compliance.

**HCA recommends that CMS:**

- *Share with each home health provider their current compliance percentage. This will enable home health providers to assess and understand their compliance to date and will create a benchmark against which providers can seek to improve over time;*

- *Consider that home health agencies whose caseload is primarily Medicaid with long term patient may not meet the threshold for 90 percent on the QAO metric;*

- *Provide comprehensive education on the new standard at least six months before it is effective.*

**Home Health Wage Index**

Over the years, we have repeatedly expressed concerns to CMS about inequities in how the wage index is calculated and implemented for home health agencies as compared to hospitals within the same Core-Based Statistical Area (CBSA). The wage index for home health agencies is based on pre-floor, pre-reclassified hospital wage data, but hospitals in the same geographic regions have the ability to apply for re-classification to another CBSA and may be eligible for the rural floor wage index. This inequity has for many years created a competitive advantage for hospitals in recruiting and retaining increasingly scarce nurses and therapists.

Since 2012, the case mix inequity in Massachusetts has been magnified, as virtually every hospital in the state became eligible for a new rural floor based on wage data from a tiny
hospital on Nantucket. Because Nantucket is a resort island with very high living costs, wages on the island are extremely high. As a result, the wage index – and Medicare reimbursement rates – for all hospitals in the state increased dramatically in 2012. In many CBSAs in the state, hospitals enjoy a wage index that is over 25% higher than the wage index for home health agencies in the same CBSA!

Faced with these wage index inequities, home health agencies across Massachusetts – already at a serious competitive disadvantage – struggle to compete with their local hospitals for increasingly scarce nurses and therapists. The result could very well be reduced or delayed access to home health services for Medicare beneficiaries in Massachusetts. The irony, of course, is that the wage index is supposed to be a method to REDUCE wage inequities.

We recommend that CMS adopt the same definition of a “rural” area that is used by the Federal Office of Rural Health (ORH). ORH explicitly recognize that “the New England states require special consideration as “their geographic divisions are different than typical counties.” There are many towns within Massachusetts that are very rural, yet they lie within large counties that are designated a CBSA based on the fact that there is a small city within that county. We recommend that CMS modify the CBSA approach to recognize rural census tracts within large counties.

We understand that CMS is reviewing the entire wage index system and considering a move to a Commuting-Based Wage Index that would set hospital-specific wage indices. We urge CMS to expedite that review and implement a system that not only recognizes variations between localities, but also treats all provider types within a local market equitably. Until such a system is in place, we urge CMS to adjust the 2015 home health agency wage index to reflect a policy to limit the wage index disparity between provider types within a given CBSA to no more than 10%.

**Proposed National Per-Visit Rates**

We are dismayed that CMS’s failure to properly adjust per-visit rates in the years prior to rebasing to keep up with rapid increases in per-visit costs will continue to penalize agencies under rebasing. Applying the 3.5% adjustment cap to the increase in per-visit rates will still result in payment rates significantly below costs even when fully implemented in 2017. We urge CMS to increase the per-visit rates by more than the proposed 5.54%.

**Payments for High-Cost Outliers Under the HH PPS**

We are somewhat dismayed that the proposed rule does not include any adjustments to outlier payments, especially given the analysis that shows that outlier payments have consistently fallen well below the 2.5% target for the last several years, and are again projected to be well below that target for 2015. CMS’ history of overly conservative outlier projections has deprived
HHAs that take on the high cost cases of a level of payment that should have been made. With the expected oversight on insulin injection-based outlier episodes, it can fairly be assumed that the CMS forecast overstates outlier expenditures. We urge CMS to reduce the Fixed Dollar Loss Ratio and/or increase the Loss-Sharing Ratio and recalculate outlier payment levels to get closer to the 2.5% target.

**Medicare Coverage of Insulin Injections Under the HH PPS**

We support CMS’ effort to reduce overuse of the home health benefit through the development of guidelines for determining when a patient is capable of self-injecting insulin. However, we strongly encourage CMS to engage the home health industry in a deliberate, reasoned analysis of the problem, and that the guidelines be based on empirical clinical experience and be developed using the National Coverage Determination processes.

We concur with the comments submitted by the American Hospital Association and their extensive list of additional ICD-9-CM diagnosis codes that should be added to the list of diagnosis codes that indicate a potential inability to self-inject insulin in Table 28 of the proposed rule. In addition to the diagnosis codes listed by AHA, we suggest these codes be added to Table 28:

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td></td>
</tr>
<tr>
<td>950.0-950.9</td>
<td>Injury to Optic Nerve</td>
</tr>
<tr>
<td>Cognitive/Behavioral</td>
<td></td>
</tr>
<tr>
<td>295-299</td>
<td>Other Psychoses (includes Schizophrenic, Bipolar)*</td>
</tr>
<tr>
<td>After Effects from Stroke/Other Disorders of CNS/Intellectual Disabilities</td>
<td></td>
</tr>
<tr>
<td>438.0</td>
<td>Late effects CVA with cognitive deficits</td>
</tr>
<tr>
<td>438.7</td>
<td>Late Effects CVA with disturbances in vision</td>
</tr>
<tr>
<td>340</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>335.20</td>
<td>ALS</td>
</tr>
<tr>
<td>358.00 – 358.01</td>
<td>Myasthenia gravis</td>
</tr>
<tr>
<td>334.0</td>
<td>Friedreich’s ataxia</td>
</tr>
<tr>
<td>344.2</td>
<td>Diplegia of both upper limbs</td>
</tr>
<tr>
<td>317</td>
<td>Mild Intellectual Disabilities **</td>
</tr>
<tr>
<td>319</td>
<td>Unspecified Intellectual Disabilities (NOS Code)</td>
</tr>
</tbody>
</table>

*Note: Many Behavioral health codes not included in proposed list. Difficult to assess as level of ability.  
**Note: Only the codes for moderate & severe intellectual disabilities were include in the proposed list. Codes are based on IQ level – which usually is not provided to HHA.
However, we also recommend *that a determination of coverage eligibility for insulin injections must be based on the complete medical record, and that Table 28 be considered a guide to determine coverage eligibility, not a rule.*

**Implementation of ICD-10-CM**

*We strongly encourage CMS to expedite the development and posting of ICD-10-CM information to give software vendors and agencies as much lead time as possible to make the system changes necessary to submit acceptable claims as of the October 1, 2015, effective date.*

**Proposed Change to the Therapy Reassessments Timeframes**

We support the elimination of the 13th and 19th visit reassessment requirement as the current therapy regulations have added burden, caused scheduling problems and increased cost to home health agencies including: clinical and clerical time, software changes, added auditing requirements, scheduling problems and numerous non-covered visits. Since the current Administration has identified the reduction of regulatory burden as one of its main objectives, the HCA hopes that CMS will consider the following recommendations in place of the proposed rule for therapy reassessments every 14th day.

*HCA recommends that CMS amend the therapy reassessment requirements in the 2015 Home Health PPS final rule to require a therapy reassessment every 30 days, and provide a window of 5 days before or after the 30th day.*

Requiring the reassessment every 30 days conforms to longstanding professional practice in the outpatient and nursing home settings. We believe that patients may not show appreciable improvement or change between reassessments if they are required every 14 days. Lengthening the period from 14 days to 30 days will provide flexibility to achieve cost efficiencies and consider other factors that may preclude a visit on the 30th day such as: an order to provide therapy services at this required time frame may not be present, the patients schedule will not conform with the time frame, or environmental factors prevent a visit.

**HHA Value-Based Purchasing Model**

We applaud CMS for continuing to explore ways to improve quality through Value-Based Purchasing (VBP) initiatives. We support demonstrations and pilot programs that incentivize agency performance through alternative payments and we are confident that less restriction in payment methodologies will lead to better outcomes.
However, the evaluation report on the last VBP demonstration acknowledges flaws and limitations, such as the fact that proprietary agencies were underrepresented. To eliminate potential selection bias with voluntary demonstration participation, the current proposed rule suggests that a future VBP demonstration may be mandatory for agencies that are selected. The **Alliance would strongly encourage CMS to reconsider requiring participation from all agencies in selected states.** Recent regulatory and reimbursement hurdles – several of which are mentioned in these comments – have placed significant burdens on many agencies. Therefore, we hope that a sampling approach, with the agency’s approval, will help participants be representative of home health agencies nationwide while also ensuring that the selected agencies are invested in the program.

We also consider the use of a mandatory and essentially undefined VBP program in 5-8 states with a 5-8% rate adjustment range to be premature. The suggested amount of payment withheld places affected HHAs at risk of eliminating resources necessary to achieve high performance and potentially puts them at risk of closure. Cost report data from 2012 shows that 48.1% of all HHAs had Medicare margins of 10% or less with 30.3% experiencing margins below zero. Overall margins for freestanding HHAs in 2012 are 2.9%. Early indications show margin declines in 2013 and 2014. We believe that many agencies may not be able to sustain the initial payment reduction required to participate in the VBP demonstration.

Our state Medicaid program (MassHealth) conducted a similar pay-for-performance demonstration with skilled nursing facilities and spent the first year on data accumulation before moving on to holding providers accountable. If all home health agencies are to be participants, it should only be for a data collection phase of the program. Another valuable piece of our state demonstration with nursing facilities is that they focused on three quality indicators rather than an across the board approach. This might prove valuable for home health agencies to be able to focus on improving certain areas of care. The third valuable lesson from MassHealth’s pay-for-performance project was that improvement was weighted just as heavily as excellence. Agencies should certainly be rewarded for excellent care, but should also be rewarded for improvements in quality that put them on levels with other higher performing agencies.

The evaluation report on the previous VBP demonstration also mentioned limitations such as a budget-neutrality requirement, which led to “substantial uncertainty during each year of the demonstration as to whether there would be any funds to distribute as incentive payments, and it was not known until well after the end of each demonstration year what the size of the incentive pool was in each region” (Hittle, Nuccio & Richard, 2012). Moreover, the evaluators noted that, with lag times between performance measurement and payment, “it is not surprising that the impact of the demonstration on home health agency performance was very small.” With this in mind, the Alliance encourages CMS to avoid having these limitations impact the efficacy of the future demonstration program.

Another piece of the previous VBP demonstration that could be viewed as a limitation was that agencies could apply different strategies such as home telemonitoring or a falls prevention
program. The Alliance encourages CMS to work with stakeholders to assemble a menu of strategies that agencies may choose from so that each strategy can be evaluated for effectiveness. The same should certainly apply to the quality standards chosen for the VBP demonstration, which should be done with home health care stakeholder input and an array of outcomes, process and patient experience measures taken into account.

The Alliance is pleased that CMS will solicit additional comments on a more detailed proposal to be included in future rulemaking, although we encourage dialogue with NAHC, Visiting Nurse Associations of America, state associations like the Alliance, the Home Health Quality Initiative (HHQI) and potentially any agencies involved in the previous demonstration. We further encourage this dialogue to begin before the more detailed proposal is released.

**General Comments**

We are dismayed that CMS continues to enact broadly punitive payment and regulatory policies that impact the entire home health industry because of the questionable clinical and billing practices of a small minority of agencies who are abusing the Medicare home health benefit.

*The Home Care Alliance of MA strongly urges CMS to:*

- Utilize the existing fraud and abuse prevention processes to identify and target specific agencies that have excessive profit margins rather than impose these blanket rate reductions for all agencies;

- Use your enforcement authority to conduct targeted claims reviews and deny payment for claims where the case mix weight is not supported by the plan of care rather than cut the national standardized episode rate for all agencies;

- Conduct a thorough review of the deemed-status process that bypasses state oversight in allowing new agencies to enter the Medicare market;

- Expand the recent targeted moratorium on new agencies from selected areas in Texas, Florida, and Illinois to be nationwide until the deemed status review is completed.

Thank you for your consideration of our comments and recommendations.

Sincerely,

Patricia M. Kelleher
Executive Director