September 9, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244-1850

Via Electronic Submission

RE: CMS-1510-P

Dear Sir/Madam:

The Home Care Alliance of Massachusetts is the trade association that represents nearly 100 Medicare certified home health care agencies in Massachusetts, including VNAs, hospital-based agencies, and for-profit agencies. Many of our member agencies have been serving their communities for a hundred years or more. Our comments reflect the input of senior executives and managers in those agencies who are directly involved with the management and provision of care to Medicare beneficiaries.

In general, our members are united in their concern with the scope/breath of the changes proposed in this payment rule. A number of these changes clearly go beyond the Congressional direction expressed in the Patient Protection Act of 2010. Other changes we believe will have far reaching impact on agency operations – the extent and cost of which CMS has underestimated. Once again, the Medicare program is asking for agencies to do far more – in terms of paperwork, supportive documentation – while asking that they absorb a payment cut.

Our experience in Massachusetts, as reflected in these comments, is that such widespread change -- implemented with insufficient lead time, and in many cases insufficient justification – will substantially destabilize an industry that is already in far too much flux. This destabilization is coming at a time when many new PPACA provisions will be depending on committed community-based care providers.

We are writing to request your consideration of our comments, submitted on behalf of these agencies, on "Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2011" (CMS-1510-P).

Case-Mix Adjustment

Between the outlier adjustment provision of the Afford able Care Act that imposes a 5% reduction to the national standardized episode rate, the ACA provision that requires a 1% reduction to the market basket

increase, and the 3.79% case mix adjustment, the proposed rule includes a cumulative cut to home health reimbursement rates of 9.79%. We believe that such a large cut will have a serious destabilizing effect on home health agencies in Massachusetts and could jeopardize patient access to services.

We further believe that the 3.79% case mix adjustment that CMS proposes is at least partially duplicated by the proposed removal of ICD-9-CM code 401.9 Unspecified Essential Hypertension, and ICD-9-CM code 401.1, Benign Essential Hypertension, from the PPS model's hypertension group. According to the analysis in the proposed rule, removing these hypertension diagnoses will result in lower case mix scores for over half of all Medicare home health episodes. Although your analysis does not quantify how much this change will affect case mix scores, an analysis by the National Association for Home Care & Hospice indicates that this change will reduce overall average episode payments by 1.87%. We believe that CMS is "double dipping" by reducing case mix weights by changing the hypertension scoring while at the same time making the case mix adjustment to the national standard episode rate.

Furthermore, we believe that the 5% cut mandated by the ACA should be counted as the 3.79 case mix cut, not be in addition to it. We do not believe it was Congress' intent to impose a cumulative 8.79% cut to the national standard episode rate.

We also question whether CMS has done any analysis to examine regional variations in "nominal" case-mix increase. For 2009, the average case-mix weight in Massachusetts was 1.264, fully ten percent lower than the national average of 1.406. Case-mix weights have historically increased at a much slower rate in Massachusetts than the national averages you cite in the proposed rule. This would indicate to us that agencies in Massachusetts are not "gaming" the system by inflating case mix scores – yet Massachusetts and the Northeast will experience the largest reduction in rates, according to the analysis included in the proposed rule. The across-the-board reductions that CMS has imposed over the last few years have a disproportionate impact on Massachusetts agencies that have NOT inflated their scores. Once again, this rule penalizes the majority of agencies that play by the rules while only minimally reducing the inflated billings of the few agencies that are causing the problem.

The Home Care Alliance of MA strongly urges CMS to:

- **Rescind the proposed payment rate cut related to the increase in average case mix weights.**
- **Use your enforcement authority to conduct targeted claims review 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.**
- **Alternatively, recalculate the case mix weight change to take into account the 1.87% impact of the change in hypertension coding.**
- **Remove the adjustment to medical supplies unless CMS can establish that there is a change in case mix weights specifically regarding medical supplies that is not due to real changes in patient characteristics.**

<u>Face-to-Face Physician Encounter Requirement</u>

This proposed section of the regulation implements section 6407 (a) of the Patient Protection and Affordable Care Act of 2010, implements language in the PPACA intended to strengthen physician oversight of home health services. But the regulation as drafted takes a well intentioned vision of the ideal healthcare experience and implements it in a way that will greatly complicate the transition process of patients moving from other care settings into home health.

Currently in Massachusetts – and even prior to passage of PPACA -- there are multiple statewide efforts in which home health agencies are already actively engaged in efforts to make standard practice what is the intent of this rule change: coordinated hand-offs of care with alignment of goals and shared information. These include: the Institute for Health Care Improvement (IHI) STAAR project, the work of the Massachusetts Care Transitions Forum, and Health Information Exchange activities established through ARRA, and the CMS home health quality improvement activities via the LANE NETWORK.

What these efforts have made clear is that building accountability and coordination of information into the delivery system cannot be achieved through a restrictive mandate such as is being proposed; and that in fact these goals might be thwarted by this rule as drafted. Efforts already in place in Massachusetts tell us that most patients initially come into home healthcare from a hospital or post acute care facility. These patients who are referred from a hospital or rehabilitation facility enter home healthcare with multiple co-morbidities, making it highly likely that the condition for which they are hospitalized – and are assessed and referred to home health – could be unrelated to the last visit to their primary care clinician. They may well have been seen, and have some follow-up care scheduled with a specialist. They are, of course, also deemed to be "homebound" to the point where it could be difficult and contraindicated to get out of the house for a face-to-face encounter with their PCP within just 14 days of the home health start of care. Physician availability and transportation to and from an appointment are also complicating factors. The goal is – and should be - to get them the correct level of services that they need and are qualified for and to assure that information flow establishes both accountability and continuity.

The Home Care Alliance acknowledges that CMS has Congressional direction to implement a face to face encounter provision. This proposal rule, however, ignores the reality of the current situation and the work that is ongoing to address the issue and goes beyond statutory intent by: 1) requiring that the face to face encounter be directly for the primary reason for the prescribed home health services, 2) by limiting the timeframe for the encounter to 14 days post admission to care, and 3) by conditioning home health payment on ***physician documentation in the patient's medical record*** on the face to face encounter.

In order to comply with PPACA provisions and to allow other important federal efforts aimed at improving accountability for care to proceed, the Home Care Alliance recommends that:

- **The time periods for the encounter be made more flexible (Congress suggested six months rather than the 30 days proposed by CMS). The 14-day window after the home health start of care should be expanded to 60 days.**
- **The hospitalist be able to conduct the face to face encounter –with communication of such to the primary care physician. The primary care physician would retain responsibility (as presently) to certify the home health plan or care.**
- **The burden placed on physicians be mitigated with a simple, standardized format that would guide them and reduce the chance of inadvertent omissions or error and that implementation be delayed until such time as this is available**
- **HHAs be explicitly held harmless regarding the veracity and validity of physician certification of face-to-face encounters.**
- **Telehealth or telephonic "visits" be allowed in situations where leaving home would be considerably taxing if CMS retains the 14-day window post start of care.**

36 Month Rule/Capitalization Requirements

While Massachusetts has seen limited examples of entities entering the home health marketplace for the sole purpose of inflating the value of their business and generating a quick sale, we are greatly concerned about the ease of entry into the certified home health marketplace. As a state with no Certificate of Need, we are seeing an escalation in the numbers of newly opening agencies, including in areas of the state that have capacity that is sufficient and even approaching excessive. Far from slowing down the process, the CMS decision to allow certification of new providers almost exclusively through deemed status has had an opposite effect. Our relatively small state has added 27 certified home health agencies in the past 4 years – an increase of almost 18%.

In the course of awarding deemed status, it seems clear that these accrediting bodies have limited ability to truly examine a new organization's fiscal or clinical viability. State surveyors - absent a serious complaint – fail to even visit a new provider until three years post accreditation. As an association committed to industry support, we take frequent calls from new agencies that demonstrate to us a glaring lack of understanding of federal and state rules. We try to be of assistance; but we are now at a point in our state in which several agencies granted deemed status are in the process of being decertified for failure to comply with Medicare rules. While we are not alleging or have seen no evidence of deliberate fraud; it seems clear that some organizations being granted deemed status are not up to the job, and that such entries into and exits from the industry are adding to federal overhead costs and are not in the interest of optimal patient care.

Because of these concerns and CMS' and MEDPAC's assertions that nationally there is adequate access to home health services, the Home Care Alliance supports these proposed changes to the capitalization requirements so as to provide an opportunity for more stringent examination of a prospective agencies capacity to provide home health care in a manner expected under the Medicare program. We believe that these rules do not go far enough. Given local and national concerns about degree of industry growth and impact on quality of care, the Home Care Alliance believes that CMS should:

Use the final rule to suspend all deemed status certifications and impose a national "cooling off period" for new entries to the marketplace. We suggest that this occur for a minimum of eighteen months following publication of this final rule. The authority for the Secretary to take this action was explicitly granted in the Patient Protection and Affordable Care Act of 2010.

We urge CMS to exercise that authority until such time as both the changes in this proposed rule and a full PPS rebasing can be implemented.

Given that in past legislative proposals, savings have been attributed to such a home health moratorium, we urge that the savings be used to partially back down the proposed case mix creep cuts as supported in previous comments.

Collecting Additional Claims Data for Future HHPPS

The HHPPS notice establishes a plan for collection of several new Healthcare Common Procedure Coding System (HCPCS) "G" codes and the reporting of these new codes on home health claims beginning in 2011. We are concerned, though, that adding new G codes requires significant lead preparation and education time for agencies and vendors. HCA recommends:

- **That CMS delay the implementation of these changes until 2012.**
- **That CMS develop and disseminate educational materials for providers on how to determine which code(s) to report, particularly when multiple services are provided during a visit, which is often the case.**
- **That CMS establish two separate codes for Management & Evaluation and Observation & Assessment. These are inherently different service based on different patient needs.**

Future Plans to Group HHPPS Claims Centrally During Claims Processing

CMS has solicited public comments on an idea for future changes to claims submission and processing procedures whereby HIPPS codes would no longer be assigned by home health agencies as they now are, but would be assigned by CMS during claim processing. This change would create a requirement to report all OASIS items necessary to group an episode on the HHPPS bill. We are concerned that this change will simply replace one burden on agencies (calculating the grouper) with a new burden (reporting additional data on the OASIS). The change would require significant programming changes for vendors with no clear benefit to the Medicare program.

We recommend that CMS not move forward with this change at this time.

HHCAHPS

While we have no concerns regarding the timeline for implementation of the new HHCAHPS requirement, we do have concerns that CMS is imposing a new administrative cost on agencies at the same time that reimbursement rates are being reduced. HHCAHPS is a significant operational change for home health agencies, which brings with it specific costs to contract with one of the CMS-approved vendors in addition to administrative costs to implement and maintain the system. An analysis by the National Association for Home Care has found that agencies report significant costs – ranging from $3500 for small agencies to as much as $85,000 by the largest agencies – just for the vendor contract. These numbers do not reflect the agencies' administrative costs.

We recommend that CMS recognize the added cost of this new requirement and increase the national episodic base rate to reflect this new cost to agencies.

Therapy Coverage Requirements

The Alliance generally supports CMS' changes to clarify coverage guidelines for therapy services so as to reduce over-utilization. We do, however, have a number of concerns and recommendations. First, we recommend that CMS allow some flexibility regarding the visit timing of the reassessments. CMS has proposed that the reassessments occur on the 13th and 19th therapy visits. Given the severe shortage of qualified therapists (at least in Massachusetts) and concerns about tracking and scheduling these reassessments, **we recommend that the reassessments be on the 12th or 13th visit and the 18th or 19th visit.** This flexibility could help to reduce unnecessary interruptions in the provision of skilled care. We also would like guidance regarding who does the pre-threshold reassessments in a multi-rehab discipline case. Will each discipline be required to document full reassessments at visits 13 & 19? We are concerned that patients may miss their needed therapy visits from one discipline if a scheduled reassessment visit is cancelled or postponed by the patient.

We also believe that more detail is needed regarding the accepted tests and measures CMS will accept at the reassessments for each of the rehab disciplines. In addition, CMS will need to establish clear guidelines to determine which patients fall into the category of having a "transient & reversible" condition.

CMS proposes that only a qualified therapist may establish and teach a maintenance program at the end of a home care rehabilitation period. We believe that the therapy assistant, who may have been treating and educating the patient/caregiver throughout the episode and has established a greater rapport with the patient/caregiver, may, in fact, be the most effective teacher towards the end of the episode of care. Furthermore, teaching is within the scope of their practice by law (at least in MA.) **We recommend that CMS allow therapy assistant to establish and teach the maintenance program if it is within their scope of practice according to state law.**

There is a severe shortage of qualified therapists not only at the local level but nationally as well. We are concerned that, in the age of doctorates for PT's, CMS is imposing unrealistic burdens that unnecessarily limit agencies' flexibility to utilize all levels of the discipline who are educationally prepared and regulated by their state.

In summary, the scope of these changes and the immediacy of their implementation threaten an industry that is already attempting to deal with Medicare cuts through the health care reform law and a series of unfunded mandates, including OASIS-C and CAHPS Surveys. We believe Medicare and patients reliant on it would be better served by CMS targeting fraud and abuse rather than disrupting an entire industry with sweeping changes that negatively impact those agencies that follow the regulations, do not scam the system and provide excellent, cost-effective care to their patients.

Thank you very much for this opportunity to comment.

Sincerely,

Patricia M. Kelleher
Executive Director
Home Care Alliance of Massachusetts