Andrea L. Devoti, MSN, MBA, RN
Chairman of the Board

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD
President

September 2, 2014

Marilyn Tavenner

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attn: CMS-1510-P, Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 21244-1850

Electronic Submission: http://www.regulations.gov

Dear Administrator Tavenner:

The National Association for Home Care & Hospice (NAHC) is the largest trade association in the country representing home health agencies. NAHC members represent the entire spectrum of home health agencies, including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding, proprietary home health agencies. NAHC members serve nearly 3 million Medicare home health beneficiaries each year.

We are writing to request your consideration of our comments, submitted on behalf of these agencies, on "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" (CMS-1611-P). (Hereinafter "NPRM") Each year, the HHPPS rate rule is the most

significant regulatory action with respect to Medicare home health services undertaken by CMS as it is the linchpin in continuing access to high quality services. As such, CMS must be ever vigilant in its proposals to modify the reimbursement model and the corresponding rates to ensure that care access is not compromised. With this year's NPRM, significant proposals are advanced that are unrelated to payment rates. These proposals as well necessitate careful attention by all stakeholders along with CMS.

I. 2015 HHPPS PAYMENT RATES

The 2015 proposed rule includes the second year phase-in of the most significant change in payment rates since the inception of the Home Health Prospective Payment System in October 2000. The rate rebasing would decrease payment rates by nearly 14 points over 2014-2017 with the 4-year phase-in of rebasing. Our analysis demonstrates that over 57% of existing home health agencies (HHAs) will be paid less than the cost of care with this NPRM by 2017. Rebasing as instituted in the 2014 rule and further implemented by this NPRM will have the natural and foreseeable effect of eliminating access to care in much of the country. The rebasing is inconsistent with the rate rebasing authority delegated by Congress to CMS, counter to the publicly available data set out in Medicare cost reports, and a vast regulatory overreach if the goal is to reset payment rates while maintaining access to essential services.

Given that the NPRM simply continues the 4 year phase-in of rate rebasing consistent with the 2014 rule, we refer you to our full comments as submitted on August 26, 2013 (Attachment A). However, as a summary of our concerns with the methodology employed by CMS in 2013, we offer the following:

A. Overall Evaluation of the Rebasing Methodology

As is set out in greater detail below, NAHC considers the rebasing methodology employed by CMS to be one that adversely impacts on access to care and presents the one of the most harmful options of all the alternatives available to rebase payment rates. The 2015 rebasing action continues the same methodological concerns we expressed last year. Overall, we recommend that CMS utilize a fairer and more accurate approach to rate rebasing as the methodology employed for the rate rebasing presents serious care access consequences for the following reasons:

1. It limits rebasing consideration to an "average cost" end product with no consideration of what it takes to maintain access to care. A "zero margin" approach to HHA rate setting will result in a significant loss of access to care.

2. It splits a bundled payment model into four distinct components where the sum of the parts is less than the whole.

RECOMMENDATION: CMS should rebase payment rates with consideration of the overall result on payment rather than to segment and isolate parts of the payment structure. The application of the rebasing cap should be applied in the aggregate.

3. It relies on proxies for payment and cost determinations while such are readily available from cost report data.

RECOMMENDATION: CMS should determine the cost of home health services using direct data from the most recently available and reliable cost reports rather than the proxies employed in the NPRM. Trimming out of cost reports should be kept at a minimum.

4. It does not properly forecast the impact of rate cuts that succeed the base data year used.

RECOMMENDATION: CMS should re-visit the cost report data using the most recent 2012 and 2013 cost reports to evaluate the trends in costs and revenue. Data we reviewed in 2011 and 2012 indicated a declining Medicare margin that is not incorporated into CMS assumptions.

5. It fails to account for and address the wide range in revenue/cost per episode experience by disparately located HHAs serving a very diverse patient population. A single payment rate adjusted with available adjusters leads to significant payment inaccuracies requiring a rate "cushion" to maintain access to care.

6. It does not recognize all current costs, in particular new regulatory compliance costs and the use of clinical technologies and services permitted to be used in a home health episode of care.

RECOMMENDATION: CMS should include all existing normal home health services costs in its calculation of the cost of care. These include normal business costs, clinical costs, and regulatory compliance costs. To the extent that data is not currently available to determine such costs, reasonable estimates should be employed.

7. It neglects to factor in the essential need for operating capital.

RECOMMENDATION: CMS should engage in an in-depth analysis and study of the health care economics at play in the home health care marketplace in determining the level of profit/margin that is reasonable to offer in rebased rates of payment. The home health agency marketplace is not the equivalent of the hospital, physician, or nursing facility marketplace. For example, hospitals have significant opportunity to balance the financial outcomes of both extensive commercial payments and public program payments. Home health agencies have little commercial insurance revenue and most of it comes from low paying, low utilizing Medicare Advantage plans and Medicaid managed care plans. In addition, home health care services are predominately financed through government programs including Medicare, Medicaid, the VA, and TRICARE. Overall, these programs provide little or no margin opportunity outside Medicare. While Medicare may not be responsible for payment rate shortfalls in other public program, NAHC believes that Medicare must recognize the need for a margin opportunity in its rates and the dynamics of the home health care marketplace overall. If the level of Medicare margin falls below what is needed to create and sustain a home health agency overall, the entire organization is at risk and access to care for Medicare patients and non-Medicare patients both suffer.

B. Impact of the Proposed 2015 HHPPS Rates

CMS estimates that the overall impact of the proposed rate rebasing and other rate changes is a reduction in Medicare spending in 2015. The impact analysis provided by CMS in the proposed rule shows a somewhat disparate impact, in the aggregate, on HHAs depending upon type and geographic location.

These data do not tell the real impact of the proposed rates for several reasons.

First, the CMS analysis does not look at all at the impact on access to care. It looks merely at Medicare payment amount changes. Second, the analysis is a one year impact assessment rather that the full four years of the rebasing action. The proposed rule sets out the second year impact of a four year rule on rate rebasing that leads to declining reimbursement particularly when combined with sequestration and the productivity adjustment. Third, the focus on payment amounts disregards the impact on HHA financial stability as it ignores that costs will increase in 2015 and later years. Finally, the impact analysis is in the gross aggregate rather than local where care is provided. As is detailed below, HHAs currently experience a wide range of financial outcomes with Medicare that is not reflected in the use of "averages."

RECOMMENDATION: CMS should conduct a full impact analysis involving the four year implementation of the rate rebasing. The impact analysis should look at the overall impact on the financial viability of HHAs in contrast to the reduction in revenue that is the basis for the NPRM impact analysis. Further, the impact analysis should evaluate the impact on Medicare beneficiaries as well as providers of care. Finally, the impact analysis should consider the overall impact on Medicare spending in all relevant sectors, particularly inpatient hospitalization and skilled nursing facility care.

OVERALL RECOMMENDATION: All methodological and calculation options should be explored and evaluated by CMS. The option that results in the greatest degree of financial stability in the delivery system should be implemented. With an additional year of cost/revenue data from 2013 now available, CMS can determine whether the current rebasing methodology achieves the essential outcome of providing sufficient payment to assure access to high quality care nationwide.

C. Case Mix Adjuster Weights Recalibration

The case mix adjuster weight recalibrations cannot be sufficiently evaluated as CMS has not provided full and adequate technical information and data on the nature and basis for the changes in case mix adjuster weights. Unlike previous recalibrations, CMS has not provided a technical report so that stakeholders

such as NAHC have the opportunity to fully review the proposed action. This is most notable in the explanation that the R-squared value of the model has increased to 0.4691 from 0.3769 for the 2012 model while dropping 62 variables, adding 19 new variables with a resulting use of 121 point-giving variables in contrast to the 164 in the 2012 model. Intuitively, less inputs should weaken the R-squared value. A full technical report would be a great assistance in understanding the reliability and validity of the recalibration.

It is especially concerning that CMS explains its proposed increases and reductions in the weight given to certain therapy utilization variables, but does not provide the evidentiary basis for these modifications. The NPRM references that "(t)hese adjustments were made to discourage inappropriate use of therapy while addressing concerns that non-therapy services are undervalued." As such, it is confusing how the case mix weights for therapy related episodes disproportionately increase over those with limited or no therapy visits. Attachment B.

For example, Payment Group 40111, All Episodes, 20+ Therapy Visits, C1F1S1 has a base episode payment rate of $5,324.52 in contrast to the 2014 rate of $4,804.71, a difference of $519.81. With the rate cut related to rebasing and the case mx weight reduction of 5 percent in the weights associated with 20+ therapy visits, it is wholly confusing how the other variables in the recalibration could lead to a payment rate increase of nearly 10 percent.

In contrast, while the NPRM indicates that the weights associated with 0 to 5 therapy visits were increased by 3.75 percent, Payment Group 10121, 1st and 2nd Episodes, 0 to 5 Therapy Visits, C1F2S1 experiences a rate reduction from $2,189.67 to $2133.22.

Attachment B is a comparison of the base episode rate impact of the recalibration on each case mix category. This comparison shows the unexpected impact on case mix categories with various levels of therapy utilization.

These inconsistencies in rate impact exist throughout the recalibration. It is a result that is counterintuitive, but also in direct conflict with the NPRM references to modification in therapy-oriented episode weights. While we are aware that all the variables in the weight calculation have been recalibrated, the results presented in the NPRM are surprising.

As such, we believe it is essential that CMS fully validate the recalibration before implementation. It would be very valuable for CMS to make public the complete technical report on the recalibration methodology and regression analysis to allow stakeholders to conduct their own comprehensive evaluations as well. With the criticisms levied on the home health industry over the years related to therapy utilization, we are concerned that the increased payment rates will be viewed again as incenting the overutilization of therapy visits. We have long supported a reform of the HHPPS case mix adjuster model to eliminate the Service Utilization domain. We hope that CMS efforts in that regard are progressing smoothly.

RECOMMENDATIONS:

1. CMS should make all technical reports and analyses regarding the recalibration of the case mix weights publicly available immediately in order to permit stakeholders review of the significant changes outlined in the NPRM.

2. CMS should conduct a thorough validation review of the proposed case mix weight recalibration and evaluate the potential impact on utilization, spending, access to care, and other relevant matters.

D. Outlier Payment Proposal

The proposed Outlier episode policy remains the same as in 2013 and 2014. Under the Medicare law, outlier payments should not exceed 2.5% of total home health spending. Section 1895(b)(3)(C) of the Social Security Act. To meet that standard, CMS engages in a series of spending estimates and establishes a "loss-sharing ratio" and a "fixed dollar loss (FDL) ratio." With the loss sharing ratio at .80, Medicare pays the additional estimated costs of an episode of care at the ratio's percentage for those costs above a threshold amount, the FDL.

In the past, CMS used the FDL to address changes in outlier spending. The FDL in 2013 and 2014 is 0.45. That was a change from 2012 (0.67) and allowed for a greater number of episodes to qualify for outlier payment. However, no change in the loss-sharing ratio has been made since the beginning of HHPPS in 2001.

In estimating spending in 2014, CMS noted that outlier payments in 2014 may only reach 1.82% of total home health payments. Normally, that would warrant a further reduction in the FDL to qualify more episodes for outlier payments. However, CMS did not adjust the FDL or the loss-sharing ratio in 2014 despite this projection.

With this NPRM, CMS now estimates that the outlier spending will equate to 2.01 percent of total payments. If this new estimate is accurate, the result will be that home health agencies have been deprived of nearly $100 million in reimbursement that the law requires be made available. That deprivation would be on top of the spending shortfalls in 2011, 2012, and 2013 that were triggered by CMS's failure to adjust the outlier payment standards in spite of its own spending estimates.

CMS now projects that outlier spending will once again fall short of the 2.5 percent of total spending that is intended under the law as the NPRM indicates a projection of 2.26 percent spending.

What is most notable about CMS's continued restrictions on outlier payment standard modifications is that the cost of outlier episodes for providers of services is, on average, nearly 160 percent of the amount of reimbursement. For example, 2012 cost report data shows that of 9333 valid cost reports from all home

care agency sectors, $634,901,589 in payments were made for episodes costing $1,004,135,253 creating a loss of $369,233,674.

These data demonstrate that the current CMS formula for outlier payments is not working. The payment levels are less than reasonable. Given that estimated outlier spending is short of the full 2.5 percent budget and that CMS adjusted the FDL in 2013, it would be reasonable and prudent to adjust the loss-sharing ratio to address the estimated shortfall in spending. Also, this approach would not increase the number of episodes subject to outlier payments. Instead, it would more fairly reimburse them.

RECOMMENDATION: NAHC recommends that CMS modify the loss sharing ratio to reflect the estimate that outlier spending will fall short of the 2.5% budgeted for 2015 under the current payment formula. The loss-sharing ratio is the preferred approach to achieve full expenditure of the outlier budget because of the continued under-reimbursement of costs in outlier episodes.

E. Wage Index Changes

CMS proposes to transition to new wage index geographic area designations using revised OMB standards in 2015. That transition will mirror the approach used in 2006 by blending the wage index values of the 2014 CBSAs and the new CBSA devised by OMB at a 50/50 ratio. NAHC supports this transitional blending as a way to avoid significant, overnight shifts in the wage index values for certain CBSAs.

It appears that in 2006, the rural add-on was initially applied in both MSA and CBSA designations rural areas when CMS blended the wage index areas together for the 2006 rate year. Transmittal 211. In other words, if the area was rural under the 2005 designations or the 2006 designations, the add-on applied. However, CMS issued a correction of its policy position (Transmittal 887) and ultimately limited the rural add-on to those areas that were non-CBSAs, i.e. rural, only under the new CBSA designation and excluding those under the previous MSA-based designations.

The policy language in the correcting transmittal states, “For purposes of implementing the DRA rural add-on payment, Medicare recognizes as rural all services furnished in any area that would be identified by a rural CBSA code if the 2006 blended wage index were not in effect.”

The rural add-on temporarily ended on 4/1/05. It was restored under section 5201 of the Deficit Reduction Act (DRA) for episodes beginning on or after 1/1/06 and before 1/1/07. CMS did not issue any formal regulatory guidance on the rural add-on. Instead, CMS implemented the DRA provision through Transmittal 211 (Feb. 10, 2006) and the corrective Transmittal 887 (March 10, 2006).

"Medicare recognizes as rural all services furnished in any area that would be identified by a rural CBSA code if the 2006 blended wage index were not in effect."

In implementing its corrected policy, CMS limited the add-on to areas with CBSAs beginning with a "999" code along with certain other specific areas beginning with a "50" code. The policy statement listed those specific "50" counties. In reviewing the outcome of the CMS policy, those counties that were rural under the 2005 MSA designations and non-rural under the 2006 CBSA designations did not gain the rural add-on.

CMS explained in discussions with NAHC that it intends to be consistent with its 2006 action. However, given that CMS implemented the DRA rural add-on outside the public rulemaking process, NAHC and all other stakeholders did not have the opportunity to convey its analysis of the impact of the action and any recommendation for an alternative approach. As such, CMS should not rely on its 2006 policy position as a reasonable and appropriate approach. While it may be consistent with the 2006 action to deny the rural add-on to providers serving the more than 100 counties that lose rural status under the new CBSAs, consistency with that action does not automatically translate to good policy.

A true consistency would be to recognize that the principle behind blending 50/50 wage index values using the 2014 and 2015 area designations is to achieve a less disruptive transition for those providers that may otherwise see a significant change in payment levels. Just as the wage index is relevant to that transition, so is the rural add-on. This year over 100 counties lose rural add-on status in the 2016 geographic area designation. The resultant loss of the 3% add-on at a time when rates are being reduced through rebasing, the first year of the productivity adjustment, and a continuation of the 2% sequestration is more disruptive that most of the changes in the wage index. Attachment C. As such, NAHC recommends that CMS apply the rural add-on to both 2014 and 2015 non-CBSA areas in 2015.

NAHC remains concerned that the wage indexes used for payment adjustments in the various health care sectors fail to provide a means for equitable payment distributions that reflect real area-specific wage differences. In using the pre-floor, pre-reclassified hospital wage index for Medicare home health services while using wholly different indexes for hospitals, SNFs, and hospices, CMS creates an uneven playing field between providers that often employ the same type of health care personnel. Most concerning is that the home health agencies are subject to a wage index database that they have no control over. As such, the HHAs are at the mercy of hospital data submission and have no means to correct erroneous data or avoid the impact of any unusual compensation changes in a hospital.

NAHC continues to support the modernization of the wage indexes used in Medicare.

RECOMMENDATIONS:

1. CMS should apply a 50/50 blend of 2014 and 2015 CBSA wage index values in CY 2015.

2. CMS should provide the 3% rural add-on to all claims for services to residents of any county considered rural under either the 2014 or 2015 CBSA geographic designations.

3. CMS should replace the wage indexes employed in Medicare with one that provide a more accurate display of wage differences in health care generally and recognizes that various health care providers employ comparable staff.

II. FACE-TO-FACE PHYSICIAN ENCOUNTER RULE

A. Physician Narratives

NAHC wholeheartedly supports the proposal to eliminate the narrative requirement in the face-to-face physician encounter rule for all of the reasons referenced in the NPRM. NAHC extends its sincere thanks to CMS for maintaining an open dialogue on the rule since its April 2011 implementation. Further, NAHC is very grateful that CMS, through the NPRM, is willing to work with the industry to address valid concerns on program operations and program integrity.

While finalization of the proposal will go a long way to bringing about a remedy to the barriers to care, high administrative costs, physician paperwork burdens, and claim denials, CMS must consider further actions to deal with the difficulties faced by home health agencies in past months as they attempted in good faith to comply with the full requirements of the face-to-face rules.

Specifically, many agencies throughout the country experienced retroactive claim denials based on an allegation of "insufficient" physician narratives. NAHC estimates that over 20,000 such claim denials were issued by the various Medicare contractors. A high volume of these denials are presently pending in the administrative appeals process at one level or another.

The standard of a "sufficient" narrative from a physician who the agency has not control over is nearly impossible to meet, particularly when subjectivity enters into the elusive definition. Also, the appeals process is a costly, cumbersome and over-burdened manner of addressing a system-wide issue in claims administration and review for both home health agencies and Medicare. In addition, the current waiting time for a hearing before an Administrative Law Judge is approaching three years.

There are reasonable steps that CMS can take to remedy the concerns related to the past claim denials that were issued solely on the basis of an insufficient physician narrative. CMS can order the reopening and payment of all such claims provided that there is some narrative from the physician. Alternatively, CMS can issue clarifying guidance to be applied at whatever step in the process the claim denial may be, providing an explanation as to what constitutes a compliant narrative. This guidance can also include a finding by CMS that a provider of services is "without fault" under 42 USC 13955gg, Section 1870 of the Social Security Act, in receiving payment on a claim where the physician has provided some narrative in addition to meeting all other face-to-face rule requirements. The "without fault" finding would permit the

waiver of recovery of any alleged overpayment. This approach would not mean that CMS found the specific narrative compliant. Instead, it would mean that CMS is simply acknowledging that the nature of earlier guidance could lead to a provider acting in good faith submitting a claim that might not meet the documentation standards.

RECOMMENDATIONS:

1. **CMS should reopen any claim denials that were based on the sufficiency of the narrative and return any monies recouped from HHAs subject to such denials**

   Alternatively, CMS should provide clarifying guidance on what constitutes a "sufficient" narrative and instruct Medicare contractors to find that any HHA claim that includes a narrative of any form or content should not be subject to recovery based on a finding that any such provider is without fault in receiving payment.

2. **CMS should suspend any auditing of the face-to-face physician narratives on the basis that the NPRM makes clear that such audits are fraught with subjectivity and victims of unclear standards of narrative sufficiency.**

. B**. New Proposed Requirement on Physician Documentation**

CMS proposes to institute a new documentation requirement relative to the physician face-to-face encounter requirements. The new standard would require that a certifying physician maintain sufficient documentation in his/her own files to support the certification. NAHC objects to the proposal that the certifying physician have sufficient documentation within his/her files to support the homebound and skilled care need certification.

It is the home health agency that provides Medicare beneficiaries with care, incurs the costs of care, and submits claims to Medicare. It is reasonable ad sensible to hold the HHA responsible for its own documentation, but HHAs have no control over or knowledge of what a physician has in his/her files. Creating responsibility and liability over something outside the control of an entity is actually a step more problematic than the narrative requirement that is proposed for elimination because of the burdens and problems it created. While we firmly support the proposed elimination of the narrative requirement, substituting the proposal that requires HHAs to ensure that the documentation in a physician's file is sufficient will only make matters worse. Neither requirement should be used.

Once a physician has certified that the patient is homebound and in need of skilled care, the proof of coverage eligibility is in the record as a whole, not just the physician's records. No claim determinations should be based on the sufficiency of part of the documentation. Instead, all determinations should be based on whether the full patient record, regardless of who holds it, establishes that the patient is

homebound and in need of skilled care. Otherwise, we end up with the same problems that were triggered by an undefinable "sufficient" narrative requirement where truly homebound patients with an absolute medical need for skilled care have claims denied because an individual reviewer is looking for different language or grammar to describe the patient's condition.

The proposal suffers from the same problems that afflicted the narrative requirement: "Sufficiency" is too subjective and un-definable in an objective manner and an HHA has no control over the documentation, but all of the risk of liability triggered by a claim denial.

Assuming that "sufficiency" can be understood, the burden imposed on physicians and HHAs caused by this proposed requirement does not justify its promulgation. To assure itself that the physician has sufficient documentation, the HHA would need to conduct frequent on-site audits of the physician record prior to the submission of any claims. That would take both the HHA staff and the physician staff away from their primary objectives----providing patient care.

RECOMMENDATIONS:

1. **CMS should withdraw its proposal to require that HHA be responsible for the documentation contained in certifying physician's patient files. A determination as to the validity of a certification and the patient's entitlement to Medicare coverage should be based upon the overall patient record.**
2. **If CMS intends to maintain this proposal, a comprehensive definition of "sufficiency" must be developed through a joint effort of CMS, the home care community, and practicing physicians and included in the final rule. While this may necessitate CMS returning to an original rulemaking proceeding, a proper outcome will more likely be reached.**
3. **HHAs should be permitted and, in fact, encouraged to submit any and all patient assessments and clinical records that it has to the certifying physician and these records will be part of what would be considered in applying the rule.**
4. **CMS should engage in physician and HHA training on any new requirement and test the outcome of that training before initiating any enforcement of it. Any enforcement should be prospective only.**

C. Payment for Physician Certification

NAHC appreciates CMS's efforts to find ways to ensure that physicians are actively engaged in the planning and oversight of the home health services provided to their patients. The vast majority of such physicians are intensely involved and manage their patients' care in a manner equivalent to inpatient, nursing home, and outpatient care. However, it must be recognized that the small payments for certification/recertification and care plan oversight have not driven physician behaviors. In fact, most physicians do not even claim such payments. At the same time, physicians spend significant time in managing home health care patients and completing the required paperwork. That time is spent regardless of whether the Medicare claim is ultimately paid or denied.

If physicians continue to be significantly involved in Medicare paperwork on home health claims, it would be unfair to deny them the small reimbursements that are available for certifications of homebound

status and medical necessity of skilled care in the event of a retroactive claim denial. Such a threat would not drive "better behavior." Instead, it is more likely to discourage physicians from referring any patients to home health care.

RECOMMENDATION: The proposal to reject claims for payment to physicians for home health certifications in the event that the home health services claim is denied should be withdrawn. Physicians should not be liable in any capacity for the outcome of a home health claim. A certification by the physician should be judged on good faith standards, not the payment determination on the home health claim. In addition, the payment of a certification claim is intended to encompass more than just the act of certification. All the care planning activity will have occurred even if Medicare later finds the home health claim is not covered.

D. Start of Care Certifications

CMS proposes to clarify that a new Start of Care OASIS and new face-to-face encounter documentation is required when a patient is admitted to a home health agency within the 60-day period of a home health episode after having been previously discharged with goals met. In the Impact Statement, CMS projects that there are 837,000 such episodes.

First, it should be verified that nearly one-seventh of all episodes fit into a category of admissions shortly following discharges with goals met. The number seems high.

Second, while NAHC can understand the technical focus of CMS that such episodes are best categorized as a new Start of Care (and that this already is CMS policy), there are concerns that the clarification as it relates to the physician face-to-face encounter rule will unnecessarily increase paperwork and administrative costs without any benefit in return. There are likely to be many situations where the certifying physician has been continually involved in the patient's care throughout the preceding episode. Also, the admission may relate directly to the reason for care in the preceding episode even when there was a discharge with goals met.

Third, a targeted policy approach with the face-to-face rule may be more appropriate and reasonable. It would be prudent to apply the face-to-face requirements if there is a new physician attending/certifying the patient. It may also be reasonable to apply the face-to-face requirements if the reason for the admission is completely unrelated to the patient's condition and care in the preceding episode. Finally, if the patient is changing to a new home health agency, the application of the rule may make sense.

RECOMMENDATION: CMS should revise its proposal and require a new face-to-face encounter documentation only when the second admission to home health services is for a wholly different reason than presented in the original admission, a new physician is certifying the care plan, or a new home health agency is providing the care.

III. PROPOSED CHANGE TO THE THERAPY REASSESSMENT TIMEFRAMES

CMS proposes to eliminate the requirement for each therapy discipline to functionally reassess the patient on the 13/19th therapy visit, and at least every 30 days.

Currently, in single discipline cases, the therapist must functionally reassess the patient on the 13th /19th therapy visit and at least every 30 days. In multidiscipline cases, each discipline must functionally reassess the patient after the 10th therapy visit but no later than the 13th therapy visit and after the 16th therapy visit but no later than the 19th therapy visit, and at least every 30 days.

CMS proposed to simplify the therapy reassessment requirement by requiring that each therapy discipline conduct a functional reassessment of the patient at least every 14 days.

NAHC applauds and supports CMS' proposal to simplify the therapy reassessment requirements. However, we are concerned that requiring a reassessment every 14 days is too narrow a time interval and may cause similar scheduling difficulties as the current therapy reassessment requirements. In addition, 14 days seems to be an arbitrary time interval not necessarily associated with a home health patient's progress or care needs.

Under Part B outpatient therapy, Medicare requires that the therapist assess and document the patient's functional status and progress toward goals, at a minimum, every 10th treatment visit. CMS requires a reassessment by at least the 10th treatment visit to coincide with the recent functional limitation reporting (FLR) rule. Prior to the FLR requirement, outpatient therapy had a progress reporting requirement of every 10th treatment visit or every 30 calendar days which ever was less. In SNFs, the patient must be reassessed at least every 30 days.

Therapy services for a home health patient are typically provided on an intermittent basis. Therefore, the 10th visit for any of the therapy disciplines would occur at about or later than the 30th calendar day. For example, physical therapy (PT) is usually ordered 2-3xw, occupational therapy (OT) 2-3xw and speech-language pathology therapy (SLP) 1-2xw. A range of 8-12 visits for any of the therapy disciplines would be provided by the 30th day. Requiring a reassessment at least every 30 days in the Medicare home health benefit would provide the same quality assurance for reasonable and necessary therapy as every 10th visit in outpatient therapy settings and have the same standard for reassessments as in SNFs. In addition, requiring a functional reassessment at least every 30 days would be more manageable to schedule than a per visit or every 14 day reassessment requirement. Agencies would not be at risk for having to write off visits where necessary therapy had been provided or have to expend resources that could be better dedicated toward other patient care initiatives.

RECOMMENDATION:

NAHC recommends that CMS maintain its proposal to shift to a day-based interval for therapy assessments, but modify it to require that each discipline functionally reassess the patient no less than every 30 days. This will better align therapy reassessment requirements for therapy provided under the Medicare home health benefit with reassessments for outpatient therapy services provided under Medicare Part B and skilled nursing facilities (SNFs).

IV. MEDICARE COVERAGE OF INSULIN INJECTIONS UNDER HHPPS

CMS proposes to require an additional diagnosis on claims that supports why a diabetic patient who requires skilled nursing visits to inject insulin is not able to self inject. CMS has identified a list of conditions, Table 28 in the proposed rule, of ICD-9 –CM diagnosis codes that it believes supports a patient's inability to self inject insulin. CMS is seeking comments on whether the list of conditions that would prevent a patient from self injecting insulin is a comprehensive list. Also in the proposed rule, CMS argues that a patient who has been prescribed an insulin pen is able to self inject. CMS maintains that a physician would only prescribe an insulin pen to a patient who is capable of self injecting insulin. Therefore, patients who have insulin pens would not be in need of skilled nursing for insulin injections.

NAHC agrees with CMS' proposed policy to require inclusion on claims of a diagnosis that supports why a diabetic patient requires skilled nursing visits to inject insulin. We also agree that the conditions on the list in the proposed rule would support a patient's inability to self inject insulin. However, we do have concerns as to whether the list is a comprehensive list. For example, a patient with psychiatric condition could exhibit an inability to self inject insulin. There are no psychiatric conditions listed. NAHC also has concerns as to whether a comprehensive list can be developed, and what criteria CMS will use that ensures any list of conditions is a comprehensive one.

Without certainty regarding the completeness of a list, patients who need skilled nursing to inject insulin will be at risk for having categorical claim denials due to the absence of a permissible condition listed on the claim.

NAHC disagrees with CMS' premise that any patient who has been prescribed an insulin pen would not need skilled nursing to inject insulin. CMS argues that because of the added expense of insulin pens, a physician would likely only prescribe an insulin pen to a patient who has exhibited the ability to self inject. NAHC believes that a physician might also prescribe an insulin pen when the patient is exhibiting difficulty managing their insulin administration, suggesting a decline in condition. A patient could have an exacerbation or a worsening of a mental or physician condition that would prevent them from self injecting even with an insulin pen. Again, it is the presumptive nature of CMS' position that raises concerns regarding patients who are in possession of an insulin pen.

Recommendation: In cases where a patient possesses an insulin pen and /or a second diagnosis is either absent or is not a condition that CMS has included on a their list of acceptable conditions, require that the Medicare claims review contractors review the entire medical record to determine whether skilled nursing visits are required to inject insulin. Determining whether skilled nursing visits for insulin injections are reasonable and necessary Medicare services can only be accomplished through a complete review of the medical record.

A list of conditions that support a patient's inability to self inject and/or the presence of an insulin pen should provide guidance to claims review contractors about reasonable and necessary skilled nursing visits, but should not be used to presumptively deny claims for conditions not so listed. Denials for necessary skilled nursing visits based solely on the absence of a permissible condition or because the patient possesses an insulin pen could have catastrophic consequences for an insulin dependent diabetic patient.

The coverage standards should be developed and implemented through the CMS National Coverage Determination process.

V. "PAY FOR PERFORMANCE" REPORTING REQUIREMENT FOR SUBMISSION OF OASIS DATA

CMS proposes to define a more explicit performance requirement for the submission of OASIS quality data in order for home health agencies to receive the full market basket update for the payment year. Agencies that do not submit the required quality data receive a 2% reduction in payments. CMS has never set a minimum threshold for the number of quality assessments an agency must submit in order to receive the full payment update.

CMS proposes to ultimately require a 90 % compliance rate for OASIS quality assessment submissions, which is to be phase-in over three years. In the first year agencies will be required to submit 70 % of their OASIS quality assessments, 80 % the following year, and 90 % in the third year and beyond.

In the proposed rule CMS defines a quality assessment in several different ways and states that follow-up assessments will be considered "Neutral" and not count toward or against the pay for reporting performance requirement. However, it is unclear what impact follow-up assessments will have if a reporting period has only follow-up assessments or there is missed follow-up assessment during the reporting period.

NAHC appreciates CMS' willingness to phase-in the required performance percentage over three years and believes agencies will be able to comply with a 70 % submission rate for the first reporting year. However without further analysis, it is unknown whether a 90%, or even an 80%, compliance rate is a realistic goal.

RECOMMENDATIONS:

1. CMS should clarify whether the standard requires both submission and acceptance and whether OASIS acceptance must be within the performance period. CMS consistently uses the term "submission", when in fact; we suspect CMS intends that the OASIS must be accepted into the state database during the performance period to count toward the submission threshold.

2. With respect to follow-up assessments:

a. CMS should clarify that a patient who has only recertification assessments recorded during a performance period will not be included in the quality assessment rate calculation. This will accommodate long term patients where a SOC/ ROC assessment would have been conducted prior to the performance period.

b. CMS should clarify how quality assessments will be counted when there is one or more missed recertification assessments during the performance period.

3. CMS should provide compliance training at least six month in advance of the implementation date of the quality assessment submission requirement.

4. CMS should carefully monitor compliance rates over the next two years to determine if a 90 % compliance rate is a realistic goal.

VI. VALUE-BASED PURCHASING

CMS sets out, in the NPRM, a base-level concept of a value-based purchasing (VBP) model and invites comments on it and a possible implementation in the near future. The presentation is not a formal proposal or rule change. Instead, it is an early invitation to comment on the development of a VBP in Medicare home health services.

The base model outlined does not include any detailed suggestions on performance measures or the essential risk adjustment that must be part of any VBP. No proposals are set out on how incentive payments would be distributed. Instead, the outline is limited to a potential start date, CY2016, a range of the portion of payments that would be withheld to finance the VBP, 5-8%, and that it would be mandatory in 5-8 yet-to-be-determined states.

NAHC has long supported the development and implementation of a reasonable VBP as providers should be encouraged and rewarded for positive patient outcomes. In particular, NAHC supported the two-year demonstration program that started in 2008 and worked constructively with CMS and others to design the program. NAHC has also voiced support for the efforts by the Medicare Payment Advisory Commission (MedPAC) to advance the study and development of VBP in home health services. Overall, while NAHC might not agree with ever idea or concept surfacing in the VBP dialogue, we have long considered that some form of VBP is in the best interest of Medicare patients and the Medicare program.

Throughout, NAHC has maintained that a set of principles must be adhered to in the development of a reasonable VBP program. These principles include:

1. Access to care should be maintained throughout the country. VBP should not trigger a loss of care access.
2. A VBP program must be developed in a transparent manner and with the active engagement and involvement of all stakeholders.
3. Any program must be thoroughly tested as a pilot program prior to full-fledged implementation.
4. VBP should include both process and outcome measures to ensure fairness in its assessment of quality of care.
5. VBP must include a robust and reliable risk adjuster that reflects the wide variation in patients served in home health services.
6. To the extent possible, VBP should utilize existing data and documentation sources such as OASIS. Additional data collection efforts should be minimized and employed only after reliability and relevancy testing.
7. HHAs should be rewarded and penalized only for matters that are within their control.
8. Rewards should be given for both high performance and material improvements in quality of care. Measures should evaluate performance within the home health context along with the dynamic value to the entire Medicare program, i.e. cost avoidance through quality outcomes.
9. VBP should not pose cash flow difficulties for HHAs. The amount of withheld payment must be manageable when the overall business of home care is considered.
10. The timetable for full-scale VBP should provide the home health agency community with sufficient lead time to implement all the programmatic adjustments necessary.

The CMS outline of VBP in the NPRM falls short of the detail necessary to offer in-depth constructive comments on the VBP model itself. We view such as a good thing, indicating that CMS has not chosen to issue a prescribed VBP without meaningful stakeholder involvement. As such, it appears that VBP subject areas including the process for VBP development, performance measures, risk adjustment, data sources, the reward/penalty criteria, and more are open for discussion and consideration with the entire stakeholder community.

However, the VBP outline does include two elements that are essential parts of any VBP roll-out: the pilot test framework and the amount (range) of payment that would be withheld to finance the incentive pool. As set out, NAHC has serious concerns regarding CMS's potential VBP.

CMS suggests that VBP be tested in 5 to 8 states and that participation be mandatory. Such an approach is problematic as the design of the VBP is sketchy at best. How can CMS consider making VBP mandatory on an undesigned, untested program? While NAHC can understand why it may be necessary to have a

mandatory VBP in order to get a true measure of provider performance, it seems premature to suggest a mandatory program throughout 5-8 states when CMS has yet to offer even a rudimentary design of the VBP measures, risk adjuster, or incentive payment model.

The outline also sets out a suggestion that the amount of payment withheld range from 5 to 8 percent. That level of withheld payment is unsustainable by the vast majority of home health agencies. While some, potentially many, may ultimately qualify for incentive payments, those payments cannot be expected for 18 or more months if the 2008 demonstration program is any indication.

The time delay problems pale in comparison to the cash flow difficulties created by the depth of a 5 to 8 percent withhold. Medicare cost report data indicates that in 2012, freestanding HHAs experienced an overall margin of 2.96 percent when all payers are considered. While the margin on Medicare fee for service (FFS) payment is higher than the overall level, the other payers are primarily Medicare Advantage and Medicaid. That means that it is not possible to continue to serve patients who have government-based payment sources if 5-8 percent of Medicare FFS payments are withheld, even temporarily.

The 2012 cost reports also offer a focused understanding of the impact of a 5-8 percent withhold when just Medicare FFS payments are considered. Cost reports with a year-end date in 2012 show that nationwide nearly 50percent of all HHAs had Medicare FFS margins of 8 percent or lower. The data also shows that 48.8 percent had margins at 5percent or lower. These margins are calculated using the method employed annually by MedPAC.

On a state level, the picture is even bleaker. New York has over 65 percent of HHAs with margins lower than 8 percent and 59 percent with margins lower than 5 percent. California shows nearly 73 percent at 8 percent or lower margins and 61.8 percent at 5 percent or lower. Oregon has nearly 84 percent of all HHAs with margins under 85 percent and 77.2 percent with margins under 5 percent. These states are not even the worst of the country.

The scary part is that the margins have been on an annual decline and the onset of rate rebasing in 2014 assures that the margins will be even lower in 2016 when VBP may arrive under the CMS outline.

If CMS moves forward with a VBP withhold anywhere near the 5-8 percent referenced in the NPRM, access to care will be lost throughout the country as HHAs will be unable to withstand the cash flow impact. In addition, for those few that may have sufficient margins, the withhold will surely compromise their ability to deliver high quality care as the restriction in resources will create barriers to the innovative activities, such as telehealth supports, that have brought about valuable patient outcomes that include reductions in hospital readmissions.

The proposed 5-8 percent withhold amount is in stark contrast to the amounts in play with the inpatient hospital and Skilled Nursing Facility VBP programs. As CMS is well aware, these sectors face less than 2 percent withhold with the hospital VBP phasing in that level over several years. CMS may also be aware that these sectors both have higher overall margins than home health agencies. SNF Medicare margins are also well in excess of the HHA Medicare margins.

The bottom-line is that the home health industry cannot survive with a 5-8 percent payment withhold in Medicare FFS. To the extent that some survive, quality of care will be negatively impacted. The VBP will end up giving incentive payments for performance levels that are below average today.

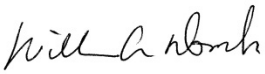
RECOMMENDATION:

1. **CMS should initiate a design of a VBP employing the ten principles set out above.**
2. **CMS should not consider a VBP that is mandatory in 5-8 states with a payment withhold of 5-8 percent.**
3. **CMS should create a Technical Experts Panel to develop a more comprehensive design of a VBP that can be pilot tested expeditiously.**

VII. CONCLUSION

Thank you for the opportunity to submit these comments. If you need further information, please do not hesitate to contact the undersigned.

Very truly yours,



William A. Dombi

Vice President for Law

Mary C. Carr

Vice President for Regulatory Affairs

.