August 26, 2013

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1450-P
Post Office Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-1450-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2014

To Whom It May Concern:

The Home Care Association of New York State (HCA), Inc., on behalf of its 225 member agencies that serve approximately 175,661 Medicare home health beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the Medicare Home Health Prospective Payment System (HHPPS) for Calendar Year (CY) 2014. HCA members serve the majority of Medicare beneficiaries throughout the state, and HCA actively participated in the development of home health PPS – a background and experience which we bring to our comments on the 2014 proposal.

Overview

HCA appreciates the attention that CMS has given to our questions, concerns and comments in the development and refinement of HHPPS these past thirteen years. However, the 2014 proposal contains some of the most dramatic reimbursement changes to Medicare home health in this time, and we share the very serious industry-wide concerns regarding CMS’s approach to these changes, specifically the proposed rebasing methodology for 2014 and other elements of the rule.

While we recognize that CMS is required by the Affordable Care Act (ACA) to rebase the HHPPS rates, it is evident that the formulas used by CMS to achieve this change in the home care statistical base do not include reliable or complete data, as detailed later in our comments.

CMS’s rebasing proposal calls for a 3.5 percent home health reduction in each of the next four years, reducing payments to home health agencies (HHAs) nationally by $290 million annually. The intended purpose of these cuts is to address CMS’s projection of a 13.63 percent national provider Medicare operating margin in 2013. HCA objects to the principle of this approach – that the intention of rebasing is to eliminate all positive provider operating margins, leaving no resources for
capital). We also object to the methods and data sets used to arrive at a cost and operating-margin profile for home care providers.

Putting aside, for the moment, any specific arguments about the rebasing methodology or its calculations, just the sheer size of these rebasing cuts will dramatically worsen a decade-long trend of deep and escalating Medicare losses for New York State HHAs, threatening access to care for homebound elderly and disabled Medicare beneficiaries.

We strongly oppose these reductions at a time when many providers, especially HCA’s members in New York, continue to struggle financially with negative overall Medicare and total operating margins, contrary to CMS’s national data analysis about the cost and revenue profiles of home care. In fact, New York’s home care Medicare margins have remained negative for eleven years in a row, with an unweighted average margin of -19.27 percent in 2011 (the most recent year of cost report data available). According to an analysis by Avalere Health and Dobson DaVanzo & Associates, New York is among 13 states whose Medicare margins will plunge deeper into the red as a result of CMS’s proposed 2014 PPS rebasing.

Meanwhile, as New York’s operating margins plummet, other regions of the country where operating margins have been positive will continue to have positive margins in some cases, given that the rebasing formula is applied regardless of regional variations in Medicare growth or spending patterns.

A more thorough examination of data reveals that these rebasing cuts will be disastrous for New York and many other states. These cuts far exceed the levels expected from any purposeful approach to rebasing that should be the benchmark for adjusting reimbursement rates. As detailed later in these comments, HCA offers specific recommendations for the recalculation of CMS’s rebasing formula and the need for a more complete impact assessment, as required under ACA.

In addition to rebasing, HCA also asserts that CMS’s rule should, but does not, include any refinements to the administratively burdensome Medicare HHA face-to-face (F2F) encounter requirement. As with rebasing, we acknowledge that the F2F requirement is mandated by ACA. However, our concerns are chiefly about CMS’s implementation of the rule. Despite repeated recommendations from the home care industry, CMS’s F2F rule maintains what Members of Congress have characterized as “complicated and overlapping documentation requirements that exceed the intent of the law passed by Congress,” according to a recent letter initiated by New York Congressional Reps. Tom Reed and Paul Tonko and signed by dozens of their colleagues in the House.

This letter, which will soon be sent to CMS Administrator Marilyn Tavenner, echoes the industry’s call for a sensible approach to physician certification of home care services. It urges CMS to streamline the documentation process by allowing physicians to certify the F2F requirement via the existing 485 form in place of a separate and duplicative documentation process. In response to Congress and the concerns repeatedly expressed by the home care industry, we hope CMS will consider this reasonable adjustment to its F2F policy before issuing the CY 2014 PPS final rule in October.

Finally, CMS’s notice of proposed rulemaking (NPRM) maintains many provisions that have been detrimental to New York’s home care system, such as: the outlier payment policy; the existing wage
index methodology; the home health quality reporting update; requirements for unannounced, standard and extended surveys of HHAs; and the alternative (or intermediate) sanctions which could be imposed for HHAs that are not compliant with federal requirements.

Upon conducting a detailed analysis of CMS’s CY 2014 proposed rule, HCA offers the following comments for consideration as CMS evaluates rebasing and other changes to the HHPPS.

**Rebasing**

ACA requires that CMS reset or rebase the home health services episodic payment rate beginning in 2014 and phased-in proportionately over a four-year period. The ACA legislative mandate provides some direction to CMS on the various factors which should be considered in these calculations. However, in a broad sense, it appears that the methodologies used by CMS rest largely on a narrow set of cost elements – to the exclusion of other important factors that should be accounted for – by using a limited subset of cost report data. ACA specifically states:

Subject to sub-clause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) 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 free-standing agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

This provision requires that CMS consider costs but not to use costs exclusively as a factor in rebasing. Even the Medicare Payment Advisory Commission (MedPAC), which has historically been aggressive on payment cuts to home care, clearly states in its 2010 recommendations that MedPAC does not support rebasing rates based solely on costs (see [http://www.medpac.gov/transcripts/0108-0109MedPAC.final.pdf](http://www.medpac.gov/transcripts/0108-0109MedPAC.final.pdf), pages 203-207).

Not only is the rebasing methodology limited to a subset of cost factors, but CMS has also used a limited number of cost reports in its data analysis, further narrowing the horizon of information that forms the basis of its analysis. According to the rebasing report prepared by CMS contractor Abt Associates: “The calculation of average costs was done through the use of Federal Year End (FYE) 2011 cost reports. After extensive ‘trimming’ of unusable or aberrant cost reports, Abt Associates used only 6,252 cost reports out of the 10,327 available.” As detailed later in our comments, an analysis using a broader sample of cost reports found significantly worse operating margins for 2011.

Finally, the proposed rule indicates that CMS performed FYE 2011 cost report audits on 98 HHAs. Those audits determined that approximately 8 percent of claimed costs should be disallowed for unspecified reasons. CMS provides no indication that the audited HHAs were afforded appeals rights on these findings which have a substantial impact on the overall financial and cost profiles for home health that are at the root of CMS’s rebasing calculations. Since the initiation of HHPPS in October 2000, there have been no other known cost report audits for HHPPS years.
Beyond these larger issues, the following is a brief summary of the most critical elements of CMS’s rebasing of the CY 2014 HHPPS as well as HCA’s concerns and recommendations.

**Rebasing the National Base Episodic Rate**

In determining the proposed 2014 episodic payment base rate, CMS developed two separate calculations: the estimated average payment per episode and the estimated average cost per episode. The estimated average payment per episode was then compared to the estimated average cost per episode using Medicare cost reports from 2011.

Based on this analysis, CMS asserts that a 3.6 percent reduction in each of the next four years is needed in order to achieve rebasing and eliminate a projected 13.63 percent home health operating margin for 2013. However, since the ACA statute limits the rate of rebasing to a maximum of 3.5 percent annually, CMS has chosen a 3.5 percent (not 3.6 percent) annual reduction for CYs 2014 to 2017. Irrespective of the 3.5 percent maximum under ACA, it is unclear how CMS arrived at its assumption of a 3.6 percent reduction needed to achieve rebasing since the figure 3.6 multiplied by four (for a cumulative 14.4 percent reduction) results in a higher impact than the 13.63 percent aggregate Medicare operating margin assumed by CMS’s projections.

Furthermore, the projection of a 13.63 percent margin is significantly at odds with 2011 cost report data examined by the National Association for Home Care and Hospice (NAHC). NAHC’s analysis shows a national home health margin of 11.25 percent in 2011 based on an analysis of over 8,200 Medicare cost reports – a much fuller grouping than CMS’s ‘trimmed’ subset of 6,252 cost reports. It bears further noting that this 11.25 percent margin is a snapshot of 2011 cost reports, while CMS’s projection of a 13.63 percent margin represents a forecast for 2013. However, since 2011, home care providers have faced ACA-mandated reimbursement cuts, sequestration reductions, a raft of new unfunded mandates, and other costs that call into question CMS’s projection for 2013, considering the extreme financial duress that would have only applied downward pressure on the 11.25 percent aggregate margins estimated by NAHC in 2011.

**Rebasing of the Case-Mix Weights**

CMS’s proposed rule states that when HHPPS was created, CMS expected that the average case-mix weight (CMW) would be approximately 1.00 but that CMS’s analysis has shown that this CMW has consistently been above 1.00 since the start of HHPPS.

Based on this assertion, CMS proposes in the 2014 HHPPS to use the 2012 revised CMWs for each of the 153 home health resource groups (HHRGs) but lower them so that the average CMW in CY 2014 is 1.00. To implement these changes in case-mix weight, CMS plans to apply the same reduction factor to each weight or HHRG, thereby maintaining the relative values in the weight set. A preliminary CY 2012 claims data analysis by CMS shows that the average CMW for non-Low Utilization Payment Adjustment (LUPA) episodes in 2012 was 1.3517, which CMS proposes to reduce to 1.0000 for CY 2014.

CMS arrived at its CY 2014 proposed CMW weights by dividing the CY 2013 CMWs (which are the same weights as those finalized in the CY 2012 rulemaking) by 1.3517. To offset the effect of re-
setting the CMWs such that the average is 1.00, CMS increased the proposed CY 2014 national, standardized 60-day episodic payment rate by the same factor used to decrease the weights (1.3517).

HCA is concerned that even with this proposed increase in the national standardized 60-day rate, providers will nevertheless experience an estimated net Medicare payment decline of $650 million nationally due to the offsetting impact of draconian across-the-board reductions to each CMW aimed at achieving a recalibrated average of 1.0.

Furthermore, HCA believes CMS’s proposal to reduce each of the 153 HHRGs – so that the overall effect is an average case-mix of 1.0 – is arbitrary in its attempt to achieve an aggregate case-mix benchmark without regard for the impact of this rebasing exercise on specific clinical scenarios. Such an approach does not account for genuine increases in case-mix due to real increases in the severity of need since the inception of PPS that are caused by: earlier and sicker hospital discharges; technology improvements which enable more complex cases to be cared for at home; improvements in the accuracy of OASIS coding that more precisely measure patient severity; and increased patient therapy needs which also indicate a higher level of patient acuity.

**Rebasing the LUPA Rates**

In calculating the CY 2014 national per-visit (aka LUPA) rates, CMS first had to determine the rebasing adjustment which entails a comparison of the current per-visit discipline payment rates to the estimated 2013 cost per-visit by discipline. In so doing, CMS observed that costs per visit would be **19.5 to 33.1 percent higher than the current 2013 per-visit payment rates**.

However, despite this variance, ACA mandates that CMS can only adjust the per-visit payment rates by 3.5 percent each year. Therefore, CMS proposes to increase the per-visit payment rates by just 3.5 percent every year from 2014 to 2017. After this annual adjustment is applied, CMS applies the outlier adjustment of 0.975, a wage index budget neutrality adjustment of 1.000003 and the expected home health market basket update of 1.024.

The 3.5 percent LUPA adjustment is wholly inadequate in light of the fact that CMS’s own analysis shows that the per-visit by discipline costs are significantly higher. This proposed change only assures that the average reimbursement to an HHA will be below average cost.

**Rebasing: ICD-9-CM Code Changes**

In the 2014 proposed rule, CMS’s clinical staff and the coding staff from Abt Associates completed a thorough review of the ICD-9-CM codes included in CMS’s HHPPS Grouper and identified 170 ICD-9-CM diagnosis codes that CMS is proposing to remove from the HHPPS Grouper, effective January 1, 2014. These codes fall into two categories: (1) Diagnosis codes that are “too acute” to be cared for in a home health setting; or (2) Conditions that would not require home health intervention, would not impact the plan of care, and would not result in additional resource use when providing home health services to the patient.

CMS states that Category 1 codes likely reflect conditions the patient had prior to the home health admission (for example, while being treated in a hospital setting). Conditions coded under this
category are anticipated to have progressed to a less acute state, or are completely resolved for the patient to be cared for in the home setting, thus meaning that another diagnosis code would likely have been a more accurate reflection of the patient’s condition in the home. CMS proposes to remove Category 2 codes from the HHPPS Grouper.

HCA objects to CMS’s decision to remove 170 ICD-9-CM codes from the HHPPS Grouper which we believe HHAs should be able to utilize. These changes only serve to reduce overall payments by 0.5 percent in 2014 and will reduce the average CMW from 1.3517 to 1.3417. This reduction in CMW will reduce overall payments to HHAs by $100 million in 2014 alone.

Furthermore, we question why CMS continues to use a CMW of 1.3517 in all of its calculations for the 2014 PPS rates in the event that CMS plans to eliminate 170 ICD-9-CM codes – an action which lowers the average CMW.

Rebasing Conclusions and Recommendations

The following are HCA’s conclusions about the 2014 HHPPS rebasing proposal and our recommendations for consideration.

1. **The rebasing estimates use outdated, incomplete data.** By statute, CMS must use the “most reliable, available data” in its rebasing process. HCA asserts that CMS used neither reliable, nor complete, nor recent data in developing its rebasing formulas. CMS’s estimate of a 13.63 percent national operating margin in 2013 is based on an abbreviated version of 2011 cost report data. HCA and the home care community nationally question CMS’s sampling methods. NAHC’s analysis of a broader sample of cost reports from 2011 shows a national home care margin of 11.25 percent, not 13.63 percent.

2. **CMS uses a “siloed” approach in its 3.5 percent adjustment cap that brings reimbursement below cost.** In applying the 3.5 percent adjustment cap separately to the LUPA per visit rates, CMS proposes per visit rates that are as much as 28 points below cost of care. This leads to an estimated reduction of $40 million to $50 million nationally in 2014 home health spending alone and $0.5 billion over the next 10 years. Overall, the formula employed by CMS assures that the average reimbursement to an HHA will be below average cost as the LUPA payments will fall below costs.

3. **The reimbursement methodology fails to include all usual and necessary direct and indirect costs.** For a more complete financial analysis, CMS’s rebased payment rates must include the following:

   - All allowable costs under Medicare cost reimbursement principles, such as increased fuel prices and the increasing cost of employee health benefits;
   
   - Costs considered as non-reimbursable under Medicare cost reimbursement principles but related to clinical services used in the care of Medicare home health patients, including, but not limited to, telehealth services and equipment, respiratory therapy and nutritionist and dietician services and others; and
4. CMS does not include the costs of new HHA regulatory obligations. The following are just a sample of some of the known new cost areas related to recent changes in legislative and regulatory requirements which are not clearly factored into CMS’s calculations:

- The Medicare physician F2F requirement: HHAs report significant increases in training, systems development, and other administrative costs to achieve compliance with F2F;
- Physician Medicare enrollment requirements (specifically the Provider, Enrollment, Chain and Ownership System, or PECOS, mandate) are requiring HHAs to hire additional full time equivalents (FTEs) to check for compliance thus increasing their overall administrative costs;
- Therapy assessment and documentation include new costs associated with the increased assessment by professional therapists and the restriction on use of therapy assistants for those visits where the assessments occur as well as increased care documentation costs;
- Costs of implementation, administration and training related to OASIS-C;
- Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) patients satisfaction surveys have required HHAs to hire vendors thus increasing their administrative costs; and
- Wage and benefit changes, including impending minimum wage and overtime requirements under the Fair Labor Standards Act, along with state-specific changes such as “worker wage parity” laws enacted in New York.

These are just a sample of the new costs and are not meant to be an exhaustive list of recent cost increases triggered by legislative or regulatory requirements. The rate rebasing must include all such relevant costs that are not otherwise reported in the FY cost report used by CMS in the rebasing analysis. Where current data is not available, CMS should use reasonable estimates.

5. CMS’s approach ignores regional differences in home health operating margins. By attempting to zero-out the national average home health operating margin – in complete disregard for the need and merit of capital holdings – CMS’s proposal severely jeopardizes providers in states like New York who are already operating at a net loss, leaving no resources for capital to keep pace with increasing regulatory requirements and modernization through technology. Even assuming CMS’s flawed calculation of a 13.63 percent national operating
margin in 2013, rebasing would lower New York’s unweighted operating margin to -33 percent.

6. CMS’s proposal fails to seriously consider other reasonable alternative methodologies that would improve the likelihood of continued access to care. While CMS explored limited alternative methods of calculating the rebased rates, it essentially confined the alternatives to those that would reduce the rates further and appears to opt for a 3.5 percent rebasing reduction based simply on enacting cuts at the ACA statutory maximum. In doing so, CMS did not embrace commonly used rate-setting methods. For example, CMS could have evaluated rates based on the median rather than the mean. The median episode cost, using the Abt data, is $2567.69 or $113.98 higher than the CMS-estimated mean.

7. CMS only assesses the one-year impact of its proposal and fails to account for the effect on access to care. In assessing only the 2014 impact of its proposal, CMS omits the cumulative impact of rebasing in the remaining three years – 2015 to 2017 – especially as sequestration cuts and other cost impacts continue to mount.

While HCA acknowledges that the rebasing methodology is a complex task, CMS must in turn acknowledge that this proposal has serious consequences to the Medicare program: the providers of care and the patient they serve. As such, it must be performed carefully and correctly. The CMS proposal fails on numerous counts, but most notably in the absence of any consideration of its impact on access to care and the ripple effects of this proposal on other areas of the health care continuum.

**Recommendations:** HCA believes the proposal should be abandoned and replaced with one that puts care access first, considers all methods of calculating rates, recognizes all of the current costs of care, and includes an appropriate margin to secure operating capital and a fair return on investment to allow for continued modernization of home health care for today’s health care delivery innovations.

HCA also respectfully asks for greater transparency in CMS’s calculations and an explanation in the final rule regarding the mathematical calculations used to arrive at four annual reductions of 3.5 percent when the division of 13.63 percent four times equals 3.4075. Such calculations warrant clarification, even assuming CMS’s forecast of provider operating margins and its view that rebasing is principally intended to eliminate any capital reserve by flattening the aggregate home care operating margin. HCA believes these calculations must account for true provider cost increases that have occurred in the two-year period between the 2011 cost reports and the 2013 base year used to estimate provider margins.

Finally, we recommend that CMS conduct a more complete impact assessment of the rebasing proposal over the entire four-year period, not just in 2014. A more rigorous look at the cumulative impact of these incremental reductions on beneficiaries and providers over four years would result in a better understanding of the rolling effect of 3.5 percent cuts in each of the four years through 2017.
Other PPS Payment/Reimbursement Issues

While rebasing is a major new concern in the 2014 proposed rule, HCA urges CMS to modify other payment, reimbursement and regulatory issues in the 2014 HHPPS proposal as outlined below.

Continuation of Existing Outlier Policy

CMS’s 2014 proposed rule continues all of the structural and content changes made to the outlier payment policy between the 2010 and 2013 final rules, including a reduction in the outlier fund from 5 percent to 2.5 percent of the total home health services estimated expenditures. CMS will also continue to cap provider outlier revenues at 10 percent. CMS has implemented this change by requiring Medicare Administrative Contractor (MAC) claims processing systems to keep a running tally on individual agency outlier payments to ensure that the 10 percent ceiling is not exceeded. CMS continues to believe that only a few HHAs would be negatively impacted with the proposal, as the majority of providers have outlier episodes that account for far lower than 10 percent of their revenues.

CMS has stated that the purpose of this change was to address continued perceived abuses of outliers by a small segment of HHAs primarily located in South Florida. However, since the implementation of this new outlier payment policy in January 1, 2010, HCA has heard from many member agencies that have been negatively impacted by this change and we shared these concerns with CMS in our comments to the 2011-2013 proposed rules.

Agencies that have expressed concerns about the continuation of CMS’s 10 percent outlier cap include large facility-based agencies serving the New York City Metropolitan area, free-standing Certified Home Health Agencies (CHHAs) serving suburban areas in upstate New York as well as most of the state’s special need or designated CHHAs that provide services to predominantly high need beneficiaries with chronic conditions like HIV/AIDS or with mental health needs and developmental disabilities. All of these member agencies that provide services to a high-need population have reported being negatively impacted by CMS’s implementation of this ongoing 10 percent outlier cap.

HCA continues to obtain data from New York’s principal MAC, National Government Services (NGS), which indicates that, in the period between July and December 2012, a startling average of 14.19 percent of HHPPS final claims for HHAs in New York resulted in an outlier payment (that percentage was 10.06 percent for the same period in 2011). Furthermore, NGS reported during a recent home health advisory meeting that approximately 132 agencies in New York had been subject to the 10 percent outlier threshold cap, which represents over 70 percent of the 184 Medicare certified agencies in the state.

We strongly believe this 14.19 percent of claims resulting in an outlier payment, as well as the 70 percent of HHAs impacted by the 10 percent threshold cap, reflects not only the high number of special-needs and/or otherwise medically complex patients (often dually eligible) being served by HHAs in New York but also exemplifies the inadequacy of the current 10 percent outlier cap.

Recommendations: HCA does not believe that CMS’s outlier policy and 10 percent threshold cap is an appropriate fraud fighting initiative. While we recognize that CMS established the outlier policy to
address abuse in South Florida, CMS should realize that the vast majority of HHAs who are receiving proper outlier payments are in reality losing significant money from their episodic payment due to serving high need and high cost beneficiaries.

HCA requests that CMS exempt from the 10 percent outlier cap CHHAs that serve high-cost patients with multiple clinical issues. HCA also believes it is critical that CMS revise the 10 percent outlier cap to a 15 percent threshold, so all agencies serving high need and high cost beneficiaries can continue to do so, without losing critical outlier funding.

**OASIS-C Update – Potential Pay for Reporting**

CMS’s proposed rule continues to reduce home health payment rates by 2 percent for HHAs that did not report OASIS quality data for the period July 1, 2012 through July 1, 2013. While HCA is supportive of CMS continuing the pay-for-reporting requirements mandated by the Deficit Reduction Act (DRA) in the 2010 proposed rule, we continue to have significant concerns as CMS considers transitioning to a pay-for-performance (P4P) environment.

New York’s home care system includes a pioneering 1915(c) waiver program called the Long Term Home Health Care Program (LTHHCP) which provides an intensive array of Medicaid home and community-based services to nursing-home-eligible patients. The majority of patients in the LTHHCP are dually eligible (Medicare/Medicaid). The state requires LTHHCP providers to meet the Medicare Conditions of Participation, but Medicaid is the appropriate payer of services approximately 90 percent of the time. Patients must also meet the requirements of a mandatory state assessment every 180 days, which is separate from the federal OASIS requirement.

Even as New York has commenced a policy of shifting LTHHCP services into managed care, the current statistical base does not differentiate between New York State’s LTHHCP and our traditional Medicare CHHA providers. CMS simply recognizes both as Medicare certified providers submitting OASIS data. However, the majority of patients being served by LTHHCPs have long term, chronic needs, the progress of which are not reflected – and, indeed, are mischaracterized – in the discharge data as the LTHHCP patients do not improve in the same manner as CHHA patients with more short-term acute needs and expectations for recovery as measured by CHHA discharges. In fact, many LTHHCP patients receive ongoing chronic care to address needs that do not change over several years, where the goal is maintenance and stability. Given that LTHHCPs have different outcomes based on the specific purposes of their program model, these agencies will be adversely affected in a pay-for-performance environment.

Finally, New York also has 13 CHHAs that are designated to serve “special needs” patients with either HIV/AIDS or with mental health or developmental disability needs. These patients also have long term chronic needs that could negatively impact those CHHAs under a P4P system.

**Recommendation:** CMS has previously cited Medicare rules stating that the submission of OASIS assessments is required by the home health Conditions of Participation (COPs) and as a Condition of Payment, with exceptions only for: (1) prepartum and postpartum patients; (2) patients under the age of 18; (3) patients not receiving skilled health care services; and (4) non-Medicare/non-Medicaid patients. Since New York’s LTHHCPs and Special Needs CHHAs do
not fall within these exclusions, CMS has indicated it will not waive the reporting requirements for these provider types.

HCA requests and urges CMS to reconsider this position based on our comments above and remove New York’s LTHHCPs and any Special Needs CHHAs from this pay-for-reporting initiative. This would ensure that these unique New York State programs will not be adversely and unfairly affected/penalized in the future when CMS actually begins basing payment on OASIS performance measures.

**Maintaining Current Wage Index Methodology**

HCA has consistently raised concerns with CMS’s decision to maintain the current policy of using the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next. CMS’s decision seven years ago to switch from Metropolitan Statistical Areas (MSAs) to the Core-Based Statistical Areas (CBSAs) for the wage index calculation has had serious financial ramifications for HHAs in New York. HCA estimates that this six-year wage index shift from using MSAs to CBSAs has resulted in an estimated $52 million cut in Medicare home health reimbursement statewide and over $38 million in cuts for HHAs in the New York City (NYC) metropolitan area. Just as damaging for HHAs in the NYC metropolitan area is the fact that their home health wage index has decreased almost 1 percent a year since 2004 (1.4414 in 2004 to a proposed CY 2014 wage index of 1.3117).

Unlike the MSA designation, the CBSA wage index designation adds Bergen, Hudson and Passaic counties from New Jersey into New York’s wage area for NYC. As the provision of home health care is a local endeavor, CMS’s decision to view the current CBSA area designation in the “aggregate” for a large geographic region like NYC fails to represent the actual impact of the change. CMS’s shift to the CBSA wage index designation has resulted in below trend reimbursement for NYC agencies since 2007.

In addition, HCA has consistently voiced its concern regarding the lack of parity between different health care sectors, each of which utilizes some form of a hospital wage index yet experiences distinct index values in its specific geographic area. CMS’s decision to continue to use the CBSA-based labor market definition serves to exacerbate that instability.

**Recommendations:** HCA requests that CMS explore wholesale revision and reform of the home health wage index. This reform should consider the following:

- The impact on care access and financial stability of HHAs at the local level;

- The unpredictable year-to-year swings in wage index values that are often based on inaccurate or incomplete hospital cost reports that have negatively impacted New York HHAs throughout the years and jeopardize access to care;

- The inadequacy of the pre-floor, pre-reclassified hospital wage index for adjusting home health costs; and
• The labor market distortions created by reclassification of hospitals in areas in which home health labor costs are not reclassified.

Existing law permits CMS a nearly unlimited degree of flexibility to utilize a wage index that recognizes the geographic differences in labor costs in the provision of home health services across the country. Section 1895(b)(4)(C) of the Social Security Act (SSA) mandates the establishment of area wage index adjustment factors, provides the CMS Secretary discretion to determine which factors to consider, and permits the Secretary to utilize the same wage index adjustment factors that are utilized in composing the hospital wage index. However, despite CMS’s ongoing recognition that HHAs compete in the labor marketplace for the same health care staff utilized within inpatient hospitals, the wage index employed is comparable in name only.

HCA recommends that CMS reform the home health wage index by instituting a proxy that allows HHAs to receive the same reclassification as hospitals if they provide services in the same service area. Furthermore, we believe that New Jersey’s Bergen, Hudson and Passaic Counties should be removed from the NYC wage index. Making these policy changes will result in the important goal of parity in the labor marketplace between hospitals and home health agencies.

**Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey**

HCA remains concerned that CMS’s proposed rule maintains its existing policy (as promulgated in the 2011, 2012, and 2013 HHPPS final rules) to expand the home health quality measures to include the CAHPS home health survey. Under this provision, HHAs are required to contract with an approved CAHPS survey vendor in order to collect and submit home health CAHPS data in accordance with the protocols located on the CAHPS website. HHAs that do not meet these requirements will be subject to a 2 percent reduction in the home health market basket increase as part of CMS’s CY 2014 annual payment update.

The period of data collection for the CY 2014 annual payment update includes CAHPS data submitted in the second quarter of 2012 through the first quarter of 2013 (the months of April 1, 2012 through March 31, 2013).

While HCA understands CMS wanting to implement a tool that measures the experiences of people receiving home health care from CHHAs, we continue to be most concerned that the CAHPS survey places another unfunded administrative burden on HHAs – a mandate that requires significant time to work with CMS’s approved vendor selected by the provider.

HCA also has concerns with CMS’s decision last year to codify the HHCAHPS guideline so that HHAs have to ensure that their survey vendors fully comply with all HHCAHPS requirements. CMS believes that HHAs should monitor their respective HHCAHPS survey vendors to ensure that vendors submit their HHCAHPS data on time, by accessing their HHCAHPS Data Submission Reports.

**Recommendations:** While HHAs can certainly monitor survey vendors’ activities through reviews of their survey data submissions, HCA believes CMS’s decision to codify the guidelines last year is problematic since this requirement to verify full compliance of CAHPS vendors is not within the total
control of the HHA. HCA requests that CMS consider not including this new survey requirement as an addition to the home health Conditions of Participation (COPs) in Section 484.250(c).

The CAHPS survey places yet another unfunded mandate on HHAs and we request that CMS consider including an administrative reimbursement mechanism in its final rule to help cover the costs of implementing this ongoing administrative mandate.

**Home Health Physician Face-to-Face (F2F) Encounter for Medicare**

CMS's HHPPS proposed rule does not address and essentially maintains the existing physician face-to-face (F2F) encounter requirement which is mandated under Section 6407(a) of ACA. This section amended Sections 1814 and 1835 of the Social Security Act (SSA) to require that – prior to certifying a home health plan of care for a Medicare beneficiary – the physician or a specified non-physician practitioner (NPP) must document that he or she has had a face-to-face encounter (including through the use of telehealth) with the patient no more than 90 days prior to the home health start of care (SOC) date or 30 days after the SOC. The requirements apply only to the initial certification period and do not apply to re-certifications.

Home health episodes without this F2F physician encounter do not qualify for payment under the Medicare program.

Last year’s final rule revised the requirement to allow patients admitted to a HHA from an acute or post-acute facility to have the F2F requirement met by an allowed NPP in collaboration with or under the supervision of the physician who has privileges and cared for the patient in the facility. The supervising physician must inform the certifying physician in the community of the patient’s homebound status and need for skilled services. Documentation must still be signed by the certifying physician.

While HCA appreciates that CMS has implemented some changes that offer flexibility to the F2F encounter requirement – such as allowing the F2F requirement to be met by NPPs in collaboration or under the supervision of the physician who cared for the patient in the facility – HCA and our colleagues throughout the home care industry (NAHC, the Visiting Nurse Associations of America and others) still believe that extensive relief from the F2F reporting requirements is needed.

HCA understands the requirement for the physician F2F home health encounter is statutory; however, we believe CMS is within its jurisdiction to simplify the requirement since it has proven to be an ineffective and burdensome condition placed on physicians, HHAs and patients with little positive impact on program integrity.

The following are just some of the concerns the F2F requirement has caused since its implementation:

- Many physicians who interact with our members have expressed confusion or have complained to New York HHAs about this relatively new Medicare home health requirement, and some physicians have said that they will refuse to provide the required documentation;
Medicare beneficiaries who are homebound or, even worse, bedbound have faced additional access-to-care burdens. Many have not been able to travel to their doctor’s offices to satisfy the face-to-face requirement. Furthermore Medicare home health patients in remote rural areas continue to face additional access-to-care burdens due to long travel distances to their doctor’s offices and lack of transportation options; and

The requirement imposes additional operational and financial burdens on home health agencies and physicians.

As mentioned earlier in our comments, two members of New York’s Congressional Delegation – Reps. Tom Reed (R-Corning) and Paul Tonko (D-Amsterdam) – are leading a bipartisan Congressional letter to CMS Administrator Marilyn Tavenner urging an expeditious solution to ease the regulatory burden of the Medicare physician F2F requirement.

The letter, which is expected to be signed by Congressional Representatives from all 50 states, asks CMS to rectify the administrative burden of F2F by allowing providers to satisfy the requirement through an addition made to the existing 485 form.

**Recommendations:** While HCA understands that CMS is mandated by ACA to implement the home health F2F physician encounter requirement, we know this requirement is causing significant burdens on homebound patients and their agencies and physicians, possibly even adding a disincentive for physicians to recommend home health services.

Within all relevant rules and regulations, we ask that CMS consider modifying this requirement to allow that the F2F regulation be met through the completion and documentation on the separately signed and, if necessary, modified 485 POC form as reflected in the recommendations endorsed by a growing number of Congressional representatives.

We also ask CMS to give full consideration to a letter forthcoming in the near future signed by Congressional Representatives across the country urging CMS to significantly revise this requirement in this proposed fashion so that it minimizes the burden on everyone.

**Coverage of Therapy Services**

CMS’s proposed rule does not address all of the changes to the therapy assessment requirements for HHAs and essentially maintains the revisions that were incorporated into last year’s final rule.

**Recommendations:** HCA recommends that CMS retain the “close-to” criterion for visit compliance rather than try to regulate exact timing for patients where multiple therapies are provided, or where patients live in rural communities, or where there are exceptional circumstances. The therapy assessment schedule already creates unnecessary regulatory burden and is particularly cumbersome in the case of multiple therapy patients, in an environment in which many HHAs are already short of therapists. In fact, many HCA agencies currently struggle regularly with recruiting and retaining enough fully qualified therapists and these regulatory changes have only exacerbated existing shortages. The final rule should afford greater flexibility in this area so that valuable therapist time is spent in treatment, not administrative duties/tasks.
Finally, we recommend that CMS convene a technical expert panel (TEP) to begin the work of examining how therapy is paid for and delivered under the Medicare home health benefit.

**Survey & Enforcement Requirements & Proposed Cost Allocation of Survey Expenses**

CMS’s proposed rule does not address and thus maintains all of the survey requirements and alternative sanctions for HHAs that were outlined in last year’s final rule, including civil monetary penalties (CMPs), suspension of payment for new admissions, imposition of temporary management, directed plan of corrections (POC), directed in-service training, and suspension of payment for new admissions.

**Recommendations:** In last year’s final rule, CMS communicated its intent for a very open dialogue with the home care industry in the development of the alternative sanctions interpretive guidelines, which we are not aware has happened yet. HCA requests that CMS give an implementation update of the upcoming home health survey and enforcement requirements that includes when the discussions with the home industry will begin and whether state association representatives can be included in those discussions. We would also appreciate an update as to when CMS plans to issue further guidance on the alternative sanctions implementation process via interpretative guidelines.

**Conclusion**

HCA thanks CMS for this opportunity to submit comments and respectfully requests CMS’s consideration of our concerns and recommendations.

I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or at (518) 810-0661.

Sincerely,

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