American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS–1353–P; Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2012.

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations – including approximately 1,350 hospital-based home health agencies – and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2012 proposed rule for the home health prospective payment system (PPS). Our comments address two issues in the proposed rule: 1) the proposed across-the-board cut to adjust for coding procedures and documentation; and 2) implementation of the physician face-to-face encounter requirement for beneficiaries referred for home health services.

PROPOSED 5.06 PERCENT CODING OFFSET

CMS proposes a coding offset of 5.06 percent to adjust for changes in coding procedures and documentation from 2000 to 2009. To support this proposed reduction, the fifth in a series of annual coding offsets, the proposed rule notes that CMS has conducted additional examination of coding and documentation practices by home health agencies for this time period. This effort included research led by Harvard University on real case-mix growth for home health patients. Based on the Harvard research, CMS has refined its methodology for analyzing case-mix change by adding hierarchical condition categories (HCC) data, beneficiary-level data used by CMS to risk-adjust payments to managed care organizations in the Medicare program.

The AHA remains concerned that the 5.06 percent coding offset is too high and does not reflect real changes in the complexity of patients treated in hospital-based home health agencies. Hospital-based home health providers continue to report substantial, steady increases in the medical acuity of their patients. This ongoing pattern is attributed to well-known population trends that are producing larger numbers of sicker beneficiaries; the ongoing pressure on general acute hospitals to discharge patients to post-acute care, including home care, as soon as clinically appropriate; and the stricter admission standards being applied by other post-acute settings, which are resulting in patients being treated in home care today who were typically treated in higher-intensity post-acute settings in the past. Given these clinical trends, we remain concerned that the proposed 5.06 percent coding offset is too large and places unwarranted, additional pressure on hospital-based home health agencies.

We are especially concerned about the impact of the coding offset on hospital-based agencies since the substantial Medicare margins reported for free-standing providers do not exist for hospital-based agencies. The proposed rule inaccurately cites the Medicare Payment Advisory Commission's (MedPAC) March 2011 report to Congress, stating that MedPAC reported that home health agency margins average 17.7 percent. In fact, MedPAC's 17.7 percent margin estimate for 2009 is only for freestanding agencies. While not reported in the March 2011 report, MedPAC in prior years noted that hospital-based home health agencies have far lower, negative Medicare margins. Hospital-based agencies, on average, treat sicker patients who are medically able to leave the hospital, but may be difficult to place in the community due to their need for more involved, and often more costly, home care. These patients typically use higher levels of non-therapy services, which, as MedPAC reported in 2011, appear to be undervalued under the current case-mix system. In fact, a recent analysis by the Urban Institute for MedPAC suggests that, under a more accurate home health payment model, Medicare would pay higher rates for currently underpaid services and settings – and specifies that non-therapy services and hospital-based home care agencies are currently underpaid.

We also are concerned that the proposed across-the-board coding cut fails to target the dominant influence on case-mix change reported in the proposed rule. The proposed rule notes a continued trend of increased occurrence of episodes with "14 or more" and "20 or more" therapy visits per episode. The regulation also discusses MedPAC's finding that the current high Medicare margins are associated with agencies providing more therapy episodes. Given these patterns, we remain convinced that an across-the-board payment reduction does nothing to address the practice of those providers who shift per-patient therapy utilization to fit the new therapy thresholds and optimize Medicare payments.

We urge CMS to continue to evaluate and refine its case-mix methodology to target the drivers of case-mix change and more effectively capture the influence of real case-mix change. This effort should be coordinated with other efforts under way as part of the *Patient Protection and Affordable Care Act* (ACA), including the current study and demonstration project addressing patients and services that are not fully compensated by

the home health PPS, which will address MedPAC's concerns that across-the-board cuts may exacerbate the access problems faced by medically complex patients.

The AHA again urges CMS to focus on the particular geographic areas and practices that have exploited some of the weaknesses in the payment system. An across-the-board cut that penalizes all providers does not address these problems. CMS already has several more effective remedies on the table, which we support. In particular, we believe the following will meaningfully reduce the incidence of improper home health service use:

- The proposed re-weighting of the home health payment units to redistribute funds from high therapy payment units to low- and no-therapy episodes;
- The future rebasing of the home health PPS, per the ACA;
- Recent clarifications on therapy documentation requirements;
- The new home health consumer satisfaction survey; and
- Recent, more stringent provider enrollment requirements on capitalization.

These will complement the changes approved by Congress to increase the operational integrity of the home health field, especially the pending rebasing of the home health PPS.

FACE-TO-FACE PHYSICIAN ENCOUNTER

The AHA supports CMS's efforts to ensure that home health services are provided to beneficiaries only when reasonable and necessary. While we recognize and appreciate that CMS has taken steps to align the new face-to-face encounter requirements with both the ACA mandate and the practical realities of the delivery system, we believe that the face-to-face encounter process still requires close scrutiny, and perhaps further intervention to facilitate the transition of clinically appropriate patients from hospitals to home care.

The ACA requires home health patients to have a face-to-face encounter with a physician (or nurse practitioner, physician assistant or clinical nurse specialist in combination with a physician) to attest that the patient is eligible for Medicare home health services. CMS guidelines on the face-to-face encounter took effect in January 2011 and require that the encounter must occur within 90 days prior to the start of home care services, or 30 days following the initiation of care. The certification must attest that the physician saw the patient and affirm that the patient's clinical condition supports a homebound status and need for skilled home health services. If a physician orders home health care for the treatment of a new condition that was not evident during a recent visit, the certifying physician must see the patient within 30 days after home health services begin.

Under this proposed rule, CMS clarifies that the face-to-face encounter requirement may be met when the physician certifying the need for home health care is informed of the patient's need for home care by a separate physician who treated the patient in the hospital or other prior post-acute stay. **We appreciate the additional flexibility provided through this clarification, which appropriately recognizes the focused role of hospital-based physicians.**

While the additional flexibility granted under the proposed rule is helpful, we still anticipate problems with some patients transitioning from the hospital to home care as they try to meet both the face-to-face encounter requirement and the establishment of eligibility for home care. Criteria posted online by CMS allow hospital staff to extract pertinent information from the hospital medical chart to document that the face-to-face encounter occurred and that the patient is homebound and the need for skilled home care exists. Unfortunately, the level of detail on a hospital patient's post-acute needs that is typically available in standard hospital medical record notes is not adequate to satisfy CMS's requirements for the face-to-face encounter. Hospital-based physicians typically lack information on the criteria related to Medicare's definition of homebound status, are not trained to make judgments on homebound status following discharge, and do not address this issue in their documentation in the hospital medical record. In addition, while hospital-based physicians are generally willing to communicate with a hospital patient's private physician and provide an initial order for post-acute care, they often are uncomfortable signing off on a home health plan of care for which they are not trained and will not be involved as the overseeing physician.

We urge CMS to closely monitor the impact of the face-to-face encounter processes on hospital-to-home health transitions and, if needed, to develop further regulations if patients' access to appropriate home health services is negatively affected. Hospital discharge planners and home health staff are collaborating to manage the challenges discussed above in order to facilitate a timely transfer for patients whose medical status warrants home care. However, the noted challenges reduce the likelihood of a timely transfer from hospital to home care, as most home health agencies want to ensure the physician encounter and home health certification are completed prior to providing services. We encourage CMS to continue to study transitions from hospitals to home care to evaluate the following access and quality of care questions, which provide CMS and stakeholders with patient-centered criteria for determining whether the current face-to-face encounter criteria are meeting Congress' goals for the policy:

1) Whether face-to-face encounters improve care coordination for patients transitioning to home care from hospitals and other settings.
2) Whether face-to-face encounters discourage home health utilization by patients who do not qualify for Medicare-covered home health services.
3) Whether the face-to-face encounter policy contributes to preventing or delaying access to medically necessary home care.

An assessment of these three areas will determine whether the face-to-face encounter is working, and whether CMS needs to intervene with additional rulemaking to refine this policy.

Additionally, we are concerned that CMS's use of online postings of "Frequently Asked Questions" (FAQ) is not a reliable mechanism to ensure consistent application of Medicare's home health rules. While we appreciate the added clarity provided by the FAQ's, we are concerned that CMS is developing policy through *ad hoc* FAQs instead of formal notice and comment rulemaking. It is very difficult for providers to track sporadic, online updates to the face-to-face guidelines – which frequently have been modified with no notice to providers. Instead, CMS should use the traditional means of rulemaking to ensure that providers remain informed of the agency's standards and policy changes are established through rulemaking that is subject to public comment.

Thank you for your consideration of our comments. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President