



**American Hospital
Association**

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August 26, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1450-P, Medicare & Medicaid Programs; Home Health Prospective Payment System Rate Update for Calendar Year 2014; Home Health Quality Reporting Requirements; and Cost Allocation of Home Health Survey Expenses (Vol. 78, No.1281), July 3, 2013

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including almost 1,200 hospital-based home health agencies – and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the calendar year (CY) 2014 home health prospective payment system (PPS). Our concerns, outlined below, focus primarily on the proposed rebasing of the home health PPS and the proposed changes to the home health quality reporting program (QRP). Our recommended changes align with the interests of our full membership, which requires reliable and timely access for patients who, following treatment in a general acute care hospital, have medical necessity of home health or other post-acute services.

The *Patient Protection and Affordable Care Act* (ACA) provided CMS with substantial flexibility in determining how to rebase the home health PPS. In exercising this autonomy, CMS elected a zero margin as its goal for the rebasing process. As discussed below, **we urge CMS to recalculate the rebasing cut to account for the current costs of providing home health services to Medicare beneficiaries and to offer home health agencies (HHAs) a fair opportunity to generate a margin needed to make the ongoing investments that are necessary to maintain and improve patient care. These rebasing changes are especially important for hospital-based providers already facing a negative margin. In addition, the AHA recommends that CMS not proceed with the adoption of new measures that have not been endorsed by the National Quality Forum (NQF) and are too similar to existing measures.**



REBASING OF THE HOME HEALTH PPS

The ACA requires CMS to rebase the home health PPS beginning in 2014. Per the ACA, the rebasing cut must be implemented through four annual adjustments of up to 3.5 percent, which collectively may not exceed 14.0 percent. The ACA specifically mandates that rebasing account for changes since the home health PPS was implemented in 2000 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 relevant factors. This rule initiates the home health PPS rebasing process by proposing a reduction to the national standardized 60-day episode rate, an increase to the low-utilization payment amounts (LUPA) applied per visit, and a reduction to the non-routine medical supply (NRS) rates. CMS estimates that the proposed rebasing of these three payment rates would collectively reduce CY 2014 payments by 3.4 percent (-\$650 million).

CMS's Goal of Zero Medicare Margins for HHAs is Inappropriate and Disproportionately Affects Hospital-based Agencies. While not required by the ACA, CMS has stated that its goal for the rebasing process is to realign *average* Medicare payments with *average* costs for home health services, thereby resetting average Medicare margins under the home health PPS to zero. **The agency neither explains the rationale for pursuing a zero margin through home health rebasing, nor addresses the related, indirect assertion that agencies require no margin to sustain, much less improve, quality services for patients and maintain operations.** In failing to recognize that all health care providers require a margin to be able to adopt critical improvements and meet new regulatory requirements, the agency departs from the conventional policymaking approach, including that used by the Medicare Payment Advisory Commission (MedPAC), to assess whether Medicare payments are "adequate." For example, for HHAs, MedPAC's March 2013 report to Congress recommended that rebasing should realign payments and costs to be "closer," to an approach that would retain a positive Medicare margin, rather than margin elimination.

CMS estimates that hospital-based agencies would face a slightly smaller net decrease from the 2014 installment of the rebasing cut – a 3.2 percent cut compared to a 3.4 percent rebasing cut for freestanding agencies. However, since hospital-based agencies already struggle with negative Medicare margins, the rebasing cut imposes far greater financial pressure on them. Specifically, as reported in its March 2013 report, MedPAC estimates 2011 Medicare margins are far lower for hospital-based agencies than for freestanding agencies – *negative* 10.9 percent versus *positive* 14.8 percent. Given the already significant negative margins for hospital-based agencies, the AHA is concerned that CMS's proposal to reset the overall home health Medicare margin to zero by 2017 would push hospital-based agency margins even lower than negative 10.9 percent.

Such cuts overlook the unique role of hospital-based HHAs. MedPAC's March 2013 report notes that, in some counties, hospital-based agencies are the sole source of home health services, and their already low *and decreasing* margins may cause access challenges. This finding is supported by Healthcare Market Resources' analysis of the Medicare hospital-based versus freestanding providers (2006 Medicare claims), which found that, as a percentage of Medicare payments, hospital-based agencies are the dominant type of home health provider in Alaska,

Arkansas, North Dakota, Oregon and South Dakota. In fact, in North Dakota, hospital-based agencies accounted for more than 85 percent of Medicare home health payments. In locations such as these, where beneficiaries completely or largely depend on hospital-based agencies, the impact of a total rebasing cut of 14 percent over four years, coupled with already negative margins, would impose a major barrier to access.

The AHA is concerned that CMS's rebasing goal of a zero margin, by definition, sets a course for even more negative margins for hospital-based agencies. Therefore, the AHA urges CMS to instead rebase home health payments in a manner that provides agencies with an opportunity to continue to improve patient care and participate in the delivery system reforms that are under way. However, if the agency persists in pursuing zero margins for HHAs by 2017, the agency must provide a detailed justification for this unprecedented policy goal.

Hospital-based HHA Need A Positive Margin To Transform Care Delivery. Selected general acute care hospitals, post-acute and other providers collaborating with physicians and payers are currently testing new shared savings and bundling arrangements to identify different ways to improve care and reduce costs for an episode of care. These innovators are carefully comparing all forms of post-surgery service utilization, including services provided by HHAs, other post-acute providers, and readmissions to general acute care hospitals. We anticipate that some innovators will seek ways to improve clinical and financial outcomes by growing the use of home health services, as this setting fits with beneficiaries' preference to remain in the home when clinically suitable and is the least costly post-acute care alternative. **Given that home health services are expected to be prominent in these shared savings and bundling demonstrations, we encourage CMS to scale the rebasing cuts in a manner that maintains the margin HHAs need to be able to engage in these important initiatives. Resetting home health margins to zero does not align with the concurrent CMS efforts to develop and test improved models of care, as a zero margin would reduce the opportunity for the field to help design and test systemic reforms that improve transitions of care, reduce avoidable readmissions and bring new efficiencies.**

Cost Reports in Rebasing Analysis Do Not Reflect Current Regulatory Burden. In conducting the analysis of home health PPS costs and payments, CMS relied on contractor Abt & Associates' analysis of fiscal year (FY) 2000 through 2011 cost reports. The Abt analysis did not fully account for recent HHA costs resulting from regulations that were implemented in 2011 and more recently. These additional regulatory requirements include the ACA-mandated face-to-face encounter requirement implemented in January 2011. This new policy requires a physician to certify a beneficiary's eligibility for the home health benefit through an in-person examination. Obtaining documentation of these mandatory encounters from physicians has proven difficult. It was particularly challenging during the first year of the policy, but still remains problematic. **The substantial costs associated with this new documentation validation process have not, and must be, fully accounted for in CMS's rebasing calculations.**

Another example of significant new regulatory change is the requirement, as of April 2011, for therapy reassessments by a qualified therapist at the 13th and 19th therapy visits during every

home health episode. In these assessments, the HHA therapist for each type of therapy being provided reviews the patient's progress and determines whether the patient will benefit from additional therapy visits. Medicare required these new assessments to ensure medical necessity for further treatment, given that payments increase substantially for episodes that provide a 14th therapy visit, and further for a 20th therapy visit. Implementing the new requirements has been a complicated process for both CMS and providers and, as such, has been the subject of ongoing policy adjustment and clarification by CMS. **The costs associated with this substantial new patient assessment requirement have not, but must be, fully accounted for in CMS's rebasing calculations.**

While not recognized by CMS's rebasing methodology, Medicare margins have been decreasing since 2011 due, in part, to costly regulatory interventions such as those discussed above. Per MedPAC estimates, Medicare margins for freestanding HHAs (the only margin analyses provided for 2011 through 2013) dropped from 14.8 percent in 2011, to 13.7 percent in 2012, and further to 11.8 percent in 2013. CMS's rebasing calculations to realign Medicare payments with home health costs, and produce a zero margin, fail to account for these material increases in Medicare costs that have occurred since 2011.

By failing to fully account for new costs, CMS's rebasing calculations overestimate the rebasing cut needed to achieve CMS's goal of bringing Medicare margins to zero, which, as noted above, is an unwarranted goal. Therefore, we urge CMS to recalculate the rebasing cut to take into account the major regulatory expansions that have occurred in recent years. This new, more accurate rebasing calculation would provide HHAs with the opportunity to continue to fill their important clinical role and to actively engage in CMS's current delivery systems reform initiatives.

HOME HEALTH QUALITY REPORTING PROGRAM (HHQRP)

The *Deficit Reduction Act of 2005* required CMS to establish a program under which HHAs must report data on the quality of care delivered in order to receive the full annual update to the home health PPS payment rate. HHAs failing to report the data will incur a reduction in their annual payment update factor of 2.0 percentage points.

New Measure Proposals for CY 2014. CMS proposes to add two new measures to the HHQRP, measuring readmissions and emergency department (ED) visits within 30 days of the start of home health services. The readmissions measure assesses HHAs on the rate of unplanned, all-cause readmissions to acute care hospitals for patients within the first 30 days of home health care. The ED use measure calculates the rate of unplanned, all-cause ED visits without an inpatient admission within the first 30 days of home health care. The patient population of both measures (i.e., the measure denominator) includes only those patients who had an acute inpatient hospitalization in the five days before the start of their home health care. Both measures also are risk-adjusted for patient characteristics, such as age, sex and health status.

The AHA believes that identifying and reducing avoidable readmissions – including those related to home health care – has the potential to improve patient safety, improve coordination of care across settings, and reduce health care spending. We also agree that avoiding *unnecessary* visits to the ED is a desirable outcome for patients receiving home health care. **However, the proposed measures have yet to receive endorsement by the NQF. Moreover, the HHQRP already includes measures that assess readmissions and ED use over a different timeframe (i.e., 60 days). The addition of these two measures may create confusion in interpreting measure results. For these reasons, the AHA urges CMS not to adopt them for the HHQRP at this time.**

Lack of NQF Endorsement. The AHA has long urged CMS to use NQF-endorsed measures in its quality reporting programs, and believes that NQF endorsement should be viewed as a minimum standard for measures being used in a public program like the HHQRP. The NQF measure endorsement process constitutes an in-depth, multi-stakeholder review of a measure’s technical specifications and testing data. NQF endorsement provides all stakeholders with assurance that measures are important, scientifically sound, useable and feasible to collect. Unfortunately, because the proposed measures have yet to undergo NQF endorsement review, we do not yet have an assessment of whether they give the public an accurate view of HHA performance and generate data that HHAs can use to benchmark and improve their performance. For example, NQF endorsement review would allow stakeholders to examine testing data for the measures’ risk adjustment model, and verify that a given HHA does not perform poorly on the measure simply because its patient population is sicker and requires more ED visits or re-hospitalizations.

The AHA is not the only stakeholder concerned that neither proposed measure has received NQF endorsement. In January 2013, the measures were reviewed by the Measure Applications Partnership (MAP). Convened by the NQF, the MAP is a multi-stakeholder board charged with making annual recommendations to the Secretary regarding which measures should be included in national quality reporting programs. Neither measure received the MAP’s full recommendation. Instead, they received a vote of “support direction” because MAP members were concerned that the measures were not yet NQF-endorsed and needed additional development.

Thus, CMS should obtain NQF endorsement of the readmission and ED use measures before proposing their addition to the HHQRP. Once the measures are endorsed, we urge CMS to ask the MAP to re-review the measures before they are proposed for the HHQRP. Following these steps will ensure that these measures have adequate rigor for a public reporting program, and that all stakeholders agree they are important to improving the quality of care provided by HHAs.

Overlap with Existing HHQRP Measures. **In addition, the AHA is concerned that the two proposed measures are too similar to the readmission and ED use measures already reported in the HHQRP.** Indeed, CMS reports ED use and hospital readmissions for HHA patients within 60 days of the start of home health care. Publicly reporting measures that assess the same care outcomes but use different timeframes is unnecessary and redundant, and may create confusion in interpreting measure results. We believe it is possible for an HHA to score well on the 30-day measures, but poorly on the 60-day measures, and *vice versa*. For a public

reporting program, we believe it is best to have a single standard for each measure so that all HHAs can drive toward a common target. One potential approach for setting a single standard for ED use and readmissions would be for CMS to retire the 60-day measure from the HHQRP if the 30-day measure receives NQF endorsement and MAP review. However, this is not the AHA's preferred approach.

Instead, we recommend that CMS engage a variety of stakeholders – HHAs, hospitals, consumer groups, physicians and others – to assess which, if any, of these measures best fit with broader national improvement priorities. This exercise would be especially important for the readmission measure. The experience of the field to date suggests that readmission reduction requires participation from, and collaboration among, all providers—acute care hospitals, post-acute care providers and physicians—as well as the patients and communities they serve. However, the field is still learning exactly what combinations of interventions among these players are most likely to result in reduced readmissions. It also is not yet clear what configuration of performance measures for each care setting are the most likely to spur the entire health care field to reduce readmissions.

A multi-stakeholder, strategic assessment of readmissions measurement would give the field assurance that any readmission measures selected for a given reporting program contribute to the health care system's overall goal of reducing readmissions. This assessment would need to consider a variety of issues, ranging from risk adjustment approaches to measurement timeframe. It also is crucial that the measures selected for each setting of care are specified, tested, and NQF-endorsed for use in that setting. This will ensure the measures accurately reflect each provider's performance.

Data Submission. The AHA supports CMS's proposal to consider Outcome and Assessment Information Set (OASIS) assessments submitted by HHAs as fulfilling one portion of the HHQRP requirements for each payment year. For CY 2014, CMS proposes to use OASIS-reported care episodes beginning on or after July 1, 2012 through June 30, 2013. CMS proposes to use this same submission timeframe, July 1 through June 30, of the calendar year two years prior to the calendar year of the annual update for all subsequent years of the HHQRP.

The AHA also supports CMS's proposal to continue its existing data submission requirements for the Home Health Consumer Assessment of Healthcare Providers and Systems survey. The data collection periods and submission deadlines for CY 2014 and CY 2015 were outlined in previous rulemaking. For CY 2016, HHAs would be required to report data for each quarter between April 1, 2014 and March 31, 2015, with data due approximately four months after the close of each quarter.

HHA Feedback Report. HHAs receive confidential reports on HHQRP measures through CMS's Certification and Survey Provider Enhanced Reports (CASPER) reporting application. CMS currently reports separate rates for short-term (i.e., 60 days or less), long-term (i.e., greater than 60 days) and all episodes of home health care for nine clinical process measures, including depression interventions, treatment of pressure ulcers and falls prevention. For CASPER reports beginning with CY 2014 HHQRP, CMS proposes to report only an all episode-of-care rate for the nine process measures above. The agency claims that this change would provide needed

quality information to HHAs in a less burdensome fashion. CMS also proposes to report the all episode of care rate for the measures on *Home Health Compare*.

In general, the AHA supports these proposed changes. However, we also urge CMS to ensure that HHAs have access to data files allowing them to calculate their own short and long-term rates, and to benchmark their performance on those rates against other HHAs. This file should be made available simultaneously with the release of *Home Health Compare* data. We agree that reporting single measure rates makes for a cleaner data display, and may facilitate easier data interpretation by the public. However, to improve performance, organizations often need access to more detailed data that allow them to understand exactly how their performance differs from other organizations. We believe our proposed approach would allow CMS to simplify the CASPER and *Home Health Compare* data displays while providing HHAs with additional detail if they need it.

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

Sincerely,

/s/

Rick Pollack
Executive Vice President