UnityPoint at Home

Administration
11333 Aurora Avenue
Urbandale, Iowa 50322
unitypoint.org

September 25, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1672–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: **CMS–1672–P** – Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements; published at Federal Register, Vol. 82, No. 144, July 28, 2017.

Submitted electronically via www.regulations.gov

Dear Ms. Verma,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Home Health rules for calendar year 2018. UnityPoint at Home is the Home Health Agency affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment (DME), pharmacy, palliative care, hospice care, and (in certain locales) public health. Among our achievements, we are early HIT adopters (telehealth, video, remote wound care, I-phones) and have been recognized for our progressive programming – our palliative care program started in 2005 and earned the American Hospital Association's Circle of Life Award in 2013. Our Home Health Agencies have achieved high Star Ratings – in Iowa, we have two Five-Star ratings with the remainder earning 4.5-Star ratings; in Illinois, we have 4.5-Star ratings; and in Wisconsin, our rating is 3.5 Stars. In 2016, UnityPoint at Home provided more than 610,000 visits to consumers in Iowa and Illinois. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMMI Next Generation ACO Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa, and is a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. We respectfully offer the following comments to the proposed Home Health regulatory framework.

I. PROPOSED PROVISIONS OF THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Rural Health Add-On: In its current iteration, the home health rural add-on is a statutory provision that provides an increase of 3 percent of the payment amount otherwise made under section 1895 of the Act for home health services provided in a rural area (as defined in section 1886(d)(2)(D) of the Act), for episodes and visits ending before January 1, 2018. This add-on terminates for new CY 2018 episodes and/or visits.

Comment: In Iowa and central Illinois, we have a significant rural population. We are extremely concerned about the impact this policy will have on our ability to continue to provide services to rural beneficiaries. The termination of this reimbursement add-on will negatively impact access to care in rural-only areas, where beneficiaries are older, have more chronic conditions, and face provider shortages. For one of our Home Health Agencies (HHAs) serving an average of 235 patients per day, the loss of this rural add-on equates to roughly -$75,000 annually (i.e. the equivalent to one RN FTE). Without the rural add-on, HHAs serving rural areas will be forced to re-evaluate their service areas, and many will likely discontinue coverage. The exodus of rural HHAs already exists today in some of the nation's most rural areas and will only increase with the removal of the rural add-on. To compound matters, areas that receive rural add-on payments typically have much lower wage indices, and therefore are already faced with providing the same level of care as other HHAs but with less Medicare reimbursement.

Proposed CY 2018 HH PPS Payment Adjustment: Medicare payments to HHAs in CY 2018 will be reduced by 0.4% or $80 million.

Comment: We are concerned that the continued reduction in payments based upon average net margins across all types of HHAs reduces access to Medicare beneficiaries that live in areas of the country where most HHAs are already experiencing very small operating margins. For HHAs that continue to focus on high quality care and providing only reasonable and necessary home health services, these reductions further erode any profit margins resulting in the inability to reinvest in the infrastructure needed to continue to improve quality and patient satisfaction. Ultimately, these reductions will result in fewer HHAs and lessen consumer choice in seeking quality home health options. We request that prior to proposing further reductions that CMS study the impact upon beneficiary access to home health services by examining the effect on HHAs serving rural areas as well as for-profit HHAs versus nonprofit HHAs.

Proposed Implementation of the Home Health Groupings Model (HHGM) for CY 2019: CMS is proposing a new model that relies more heavily on clinical characteristics and other patient information and eliminates therapy use thresholds. It relies on six clinical groups based on principle diagnosis: Musculoskeletal Rehabilitation; Neuro/Stroke Rehabilitation; Wounds—Post-Op Wound Aftercare and Skin/Non-Surgical; Wound Care; Complex Nursing Interventions; Behavioral Health Care; Medication

Management, Teaching and Assessment (MMTA). In addition, this model establishes 30-day periods of care, instead of 60-day periods of care, beginning on or after January 1, 2019.

Comment: We are extremely concerned with the short implementation timeframe associated with this complete re-visioning of the HH PPS. Given the limited timeframe of this comment period, we cannot provide support for this proposal but simply appeal to CMS to allow time for stakeholders to thoroughly analyze, react, and prepare. In this vein, we urge CMS to reconsider national implementation in favor of a small pilot, like the process used by CMS to test the Home Health Value-Based Purchasing Model. Specifically, we would recommend that 5 or 6 states be selected for this pilot; that selected states exclude those currently participating in the Home Health Value-Based Purchasing Model; that implementation begin in CY 2020 to allow for corresponding EHR infrastructure to be put in place as well as technical assistance and staff training to occur for those participating states; and that the remainder of states begin implementation in CY 2023 to allow for more seamless implementation given the benefit of a pilot evaluation and subsequent improvement efforts. If CMS elects to move forward with this demonstration project on a national scale, we request that implementation be delayed at least until CY 2020 to enable infrastructure builds and appropriate training, as well as the gift of time to further review and provide comment to CMS on this proposal. In support of this delay, we offer the following questions/insights/concerns.

In general, our immediate reaction to this proposal is not favorable. While a Request for Information was recently released to solicit a "New Direction" for the CMS' Innovation Center in response to its release of mandatory demonstrations, in our opinion this Proposed Rule sets a more egregious precedence. The mandatory national implementation by CMS of an entirely untested payment model is inappropriate and unprecedented. There is no real-world implementation method or stringent evaluation of the model available for review or other analysis to fully understand its impact on beneficiary access and our industry. The group modeling tool proposed by CMS was only released with this Proposed Rule, making it extremely difficult to fully interpret during the brief comment period.

Substantively, the proposed HHGM methodology and payment model represents a radical shift in how home health services are reimbursed, using an entirely new and significantly different case-mix model focused on patient characteristics. It also shifts Medicare home health from a 60-day episode of care payment model to a 30-day episode of care payment model effective January 1, 2019. Most alarming, this radical change has been modeled only on paper and has never been tested by any HHA in any area of the country.

Operationally, the adoption of the HHGM in 13 months from the publication of the Final Rule will not give HHAs enough time to prepare. This is especially true for electronic health records that will need to incorporate numerous changes. Additionally, HHGM will entail multiple OASIS updates which all impact electronic health record vendors as well as HHAs that need to educate clinicians and other staff on the details and item intent for any OASIS change. As presented, the HHGM clinical grouping model does not include sufficient detail to accurately reflect the many different complexities of beneficiaries served by HHAs. In our opinion, today's clinical score (based on all 6 diagnoses with individual case-mix contributions) more accurately captures the risk adjustment and case-mix scoring needed to demonstrate the clear clinical picture of home health beneficiaries.

We question the context for the elimination of therapy service use thresholds in the HHGM. We believe that therapy service thresholds should only be replaced after taking all disciplines into account. Today, the most complex and costly beneficiaries for a HHA are those that require intensive nursing care, while those that require intensive therapy produce a significant margin with less cost. While eliminating therapy service use thresholds will undeniably reduce costs, it does not address appropriate costs. We encourage CMS to revise HHGM to take into account all visits to better reflect HHA costs to providing holistic and appropriate care to beneficiaries.

As for introducing a 30-day period of care, we are generally supportive of the concept and agree that the elimination of the split percentage would align with a 30-day payment. We do have concerns related to process. Specifically, we caution against introducing a notice of admission similar to the hospice notice of election process, which will only create unnecessary administrative burden on both the HHAs and the MACs. CMS is aware of the multiple changes and revisions to the hospice notice of election process since its implementation and should avoid a recurrence.

From a financial perspective, it is unclear whether the HHGM is intended as a cost-cutting measure as opposed to an improved payment system that supports clinical objectives and beneficiary access. CMS estimates that moving to this model will remove $950 million in Medicare home health reimbursement. That is an unsustainable cut for an industry of such critical importance to the success of patient-centered, community-based care delivery models. The home-based care industry has endured years of rebasing and payment cuts. Despite these cuts, the industry has maintained significant investments in technology and quality improvement programs. Like CMS, we are committed to high-quality, patient-preferred care option delivered at a lower cost to Medicare (over institutional based care)—but we cannot sustain additional cuts. Cuts of this magnitude will impact our ability to serve patients, forcing patients into high-cost institutional settings.

The HHGM proposal dramatically cuts home health payments and restructures home health care delivery. This puts our patients, their caregivers, our employees, and our community at risk for an unprecedented interruption in home health services. As an early adopter of health care innovation and a Participant in the Next Generation ACO Model, we look forward to working with CMS and other stakeholders to develop a payment model that promotes access, bolsters quality, controls costs and engages our beneficiaries. At this time, we are not convinced that HHGM forwards these constructs.

II. PROPOSED PROVISIONS OF THE HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

Iowa is one of the nine states participating in the Home Health Value-Based Purchasing Model pilot, a five-year demonstration project. UnityPoint at Home has 13 locations within Iowa.

Quality Measures: CMS is proposing to:

(1) Increase the number of minimum number of completed Home Health Care Consumer Assessment of Healthcare Providers and System (HHCAHPS) surveys from 20 to 40. This minimum number triggers scores to be generated for the HHCAHPS quality measures that are included in the calculation of the Total Performance Score; and

(2) Remove the Outcome and Assessment Information Set (OASIS)-based measure, Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care, from the set of

applicable measures for performance year 3. CMS data indicates that this measure has achieved full performance.

Comment: UnityPoint at Home supports both proposed changes. The change to the minimum number of HHCAHPS surveys better aligns the requirements of HHVBP reporting to that of Home Health Compare. In terms of the eliminating the OASIS measure, we support this removal and encourage CMS to further streamline quality reporting.

III. PROPOSED UPDATES TO THE HOME HEALTH CARE QUALITY REPORTING PROGRAM (HHQRP)

Quality Measures Proposed Beginning with CY 2020: CMS is proposing to replace the current pressure ulcer measure entitled Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) with a modified version of the measure and to adopt one measure on patient falls and one measure on assessment of patient functional status. The proposed measures are (1) Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury; (2) Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674); and (3) Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).

Comment: While we support the proposed measure additions, we want to encourage CMS to streamline reporting and reduce duplicative efforts. As CMS adds NQF measures that are similar to OASIS-based measures, CMS should review the total number of data points, including the OASIS measure set, to eliminate HHA documentation and administrative burden.

IV. REQUEST FOR INFORMATION ON CMS FLEXIBILITIES AND EFFICIENCIES

CMS is requesting input related to improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. Ideas solicited may include payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences.

Comment: For your consideration, we offer the following suggestions to remove barriers that hamper our efficient and effective delivery of home health services to our beneficiaries.

- **Eliminate the Medicare Prior Authorization of Home Health Services Demonstration (CMS–10599).** While CMS has "paused" this demonstration, we request that it be eliminated altogether or, in the alternative, more narrowly targeted to HHAs with a record of compliance issues. Casting the demonstration to entire states was overly broad, and this loose approach was overly burdensome without demonstration of added value to the overall care of beneficiaries.

- **Streamline the duplicative and administratively burdensome audit process**. Presently multiple audit processes exist at both government and provider levels – RAC, Pre Claim Review, Probe &

Educate, and routine MAC ADR probes. We encourage CMS to establish controls, limits, and timeframes over audit volume and clearly define audit scope (i.e. who and what can be audited). We suggest that audit frequency should be determined using current data along with PEPPER reports to identify underperforming and/or noncompliant agencies. In addition, audits should be limited to topics within statutory and regulatory parameters.

- **Recognize efficient beneficiary home health transitions between traditional Medicare and Medicare Advantage**. Presently, when a home health beneficiary switches between Fee-for-Service Medicare and Medicare Advantage, the HHA must re-establish the beneficiary's home health eligibility to continue home health services. To avoid gaps in service and reduce HHA administrative and clinical documentation burden, we recommend that CMS simply enable home health eligibility to continue regardless of Medicare payment source.

- **Remove the regulation for home bound status for home health beneficiaries in a risk-bearing Medicare ACO**. With the shift to value-based payment, CMS should permit providers that are in risk-bearing relationships the ability to determine whether a patient needs a home care episode even if the beneficiary is able to ambulate and does not require a taxing effort to leave the home. Effectively, this permits providers and beneficiaries, and not a regulator/payer, to determine the preferred course and setting for service delivery.

- **Remove Requirement for Home Health Face-to-Face Encounter for Certification/Recertification for Post-Acute or Skilled Discharges**. SE 1436 ("Certifying Patients for the Medicare Home Health Benefit") sets for requirements for physicians to certify / recertify home health services. It allows no flexibility to recognize referral sources / settings. In situations in which a home health referral is made as part of a post-acute or skilled nursing facility discharge, a mandatory face-to-face encounter for purposes of certification is not necessary and a waste of physician time and associated costs. We would recommend that CMS permit these certifications to be claims based and to rely upon the medical record of the patient.

- **Authorize Nurse Practitioners and Physician Assistants to sign home care orders**. Presently this authorization is limited to physicians and delays services in areas with provider shortages. We encourage CMS to actively support legislative efforts to expand this authority, including the Home Health Care Planning Improvement Act of 2017 (S. 445 / H.R. 1825).

- **Reinstate Part B Payment for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device**. Prior to CY 2017, NPWT using a disposable device under a home health plan of care was paid separately using OPPS rates (i.e. Part B billing). In CY 2017, HHAs are required to bill these visits separately. We encourage CMS to revisit this policy and revert billing to Part B.

  First, this payment rule creates uncertainty as to how HHAs should divide time and effort between HH PPS and OPPS. Disposable NPWT devices are about $500.00/dressing/device change and are not billable Durable Medical Equipment or the visit charge. The NPWT is generally

considered a procedural visit and the nursing visit length averages 1.5-2 hours depending on the complexity of the wound(s). The use of a disposable device is a non-covered NRS and consequently HHAs have assumed the cost of the device. The proposed rule requires HHAs to bill separately for one specific device care visit which creates administrative burden and confusion.

In addition, this rule does not prioritize patient-centered care as it fails to recognize that a patient's condition may warrant the use of a disposable NPWT device independent of whether an outpatient approved NPWT device can be used. Presently, HHAs are a predominant provider for this service. Current practice patterns reflect funding limitations (i.e. hospitals and outpatient offices do not get reimbursed for the management or application of disposable NPWT devices) and the limited time capacity of physician offices and wound centers to perform this type of wound care. Effectively, this rule embeds procedural complexity that will drive service and the use of a particular device over the judgment of a provider relating to patient care.

- **Authorize Occupational Therapy to be a qualifying skilled service to independently meet eligibility requirements for admitting patients into the Medicare program.** This change would promote operational flexibility and efficiency by allowing HHAs to deliver the right care for the beneficiary without having to send a nurse or physical therapist to "start" the visit. It is a common practice of occupational therapists to perform the initial assessment for admission for commercial payers.

- **Add flexibility to Durable Medical Equipment benefit** to remove administrative requirements that delay care without offering value and put providers at financial risk. These administrative burdens create operational inefficiencies and increase costs**:**
    - **Eliminate face-to-face requirement** to promote timely access;
    - **Remove health system DME operations from the competitive bidding process**;
    - **Re-evaluate circumstances requiring a "Written Order prior to Delivery"**;
    - **Reduce administrative requirements**, such as date stamps and administrative elements unrelated to medical/clinical necessity.

We appreciate the opportunity to provide comments to the proposed Home Health rules for calendar year 2017 and their impact on our home health agency. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Margaret VanOosten, RN, BSN
VP/Chief Clinical Officer
UnityPoint at Home

Sabra Rosener, JD
VP/Government and External Affairs
UnityPoint Health