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

RE: CMS-1625-P, Medicare & Medicaid Programs; Calendar Year 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements; Proposed Rules.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including approximately 1,100 hospital-based home health (HH) 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) calendar year (CY) 2016 proposed rule for the home health prospective payment system (PPS). This letter addresses our substantial concerns pertaining to the proposed case-mix cut and value-based purchasing (VBP) model.

PROPOSED ADJUSTMENT FOR NOMINAL CASE-MIX GROWTH

Proposed Coding Cut Lacks Analytical Foundation. **We urge CMS to withdraw its proposed 3.41 percent coding cut, which is not based on an analysis of HH coding behavior during CYs 2012 through 2014, the years targeted by its proposal.** Rather, the agency bases its proposed cut on an analysis of nominal case-mix change in CYs 2000 through 2009, and simply extrapolates those findings to coding behavior in CYs 2012 through 2014. This analytical short-cut is unprecedented for the HH PPS and concerning. CMS's prior HH case-mix cuts have all been based on detailed analyses determining the specific portion of overall case-mix change that was nominal (not driven by increasing patient acuity). The agency bears the same responsibility for CY 2016 – to set forth a comprehensive analysis, and to then share its methodology, data and findings with stakeholders, allowing for adequate public comment prior to finalizing a change. We urge CMS to conduct the necessary analyses of CY 2012 through 2014 nominal case-mix change and share such analyses with stakeholders in the form of a new, evidence-based proposal.

The methodological shortcut CMS is proposing is wholly inappropriate since provider behavior in CYs 2000 through 2009 was not identical to that in CYs 2012 through 2014. For example, as with the broader continuum of care, including the post-acute care sector, in CYs 2012 through 2014, the HH field was adapting to the early stages of overall delivery system reform. In addition, the field changed certain procedures and processes in response to HH PPS changes, including the roll-out of the burdensome face-to-face encounter policy. As a result, these were not stagnant years with regard to marketplace evolution or policy changes. Furthermore, the scale of prior coding offsets amounts has fluctuated – making the use of extrapolation from one time period to another extremely inappropriate. For example, CMS applied an approximate 1.3 percent reduction per year for nominal case-mix increases in 2000 through 2005, and an approximate 1.76 percent annual cut for 2005 through 2009.

Overlap of Rebasing and Coding Cuts. The agency's proposal to apply both a coding cut and a rebasing cut in CY 2016 would be the first time these two types of cuts were implemented simultaneously. Specifically, in the first two years of the rebasing cut mandated by the Affordable Care Act (ACA), CYs 2014 and 2015, CMS refrained from also imposing a coding cut – the first time since CY 2008 that CMS did not apply such a cut. Instead, in those two years, CMS solely applied the first two of four installments of the rebasing cut, each statutorily capped at 3.5 percent of total 2010 payments, and the total rebasing cut capped at 14 percent. However, this final rule states CMS's preference for a larger rebasing cut in CY 2016, but notes that doing so was prohibited by the ACA's annual cap on the rebasing cut. This raises the question of whether the agency is implementing a coding cut simply to augment the statutorily capped rebasing cut.

The simultaneous implementation of coding and rebasing cuts raises policy questions about whether the two cuts are, in part, redundant. Specifically, there appears to be overlap in the purpose of the two cuts. While the rebasing cut has a wider policy mandate of reducing HH PPS payments to match provider costs, and the coding offset seeks to correct for nominal case-mix increases, both cuts reduce payments to offset prior payment rate increases that were not driven by increases in patients' medical acuity. As stated above, CMS should withdraw its proposed 3.41 percentage point coding cut and, instead, first conduct the necessary analyses of CYs 2012 through 2014 nominal case-mix change, including validation that no element of the proposed coding cut would duplicate reductions already accounted for in the rebasing cut.

Hospital-based HH Agencies Face Disproportionate Harm under the Proposed Rule. Since, on average, hospital-based HH agencies already have significant, negative Medicare margins. The rebasing cut would impose far greater financial pressure on them. Specifically, as reported in its March 2015 report, the Medicare Payment Advisory Commission (MedPAC) estimates that CY 2013 Medicare margins were far lower for hospital-based agencies than for freestanding agencies – *negative* 15.5 percent versus *positive* 12.7 percent. **The proposed coding offset would push the Medicare margin for hospital-based agencies even further into negative territory.** CMS estimates that in CY 2016, hospital-based HH agencies would experience a net impact of *negative* 2.0 percentage point.

Proposed Cut Would Reduce Ability to Help Transform Care Delivery. The scale of the proposed CY 2016 cuts overlooks the unique role of HH in health reform efforts. For example, 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 ways to improve care and reduce costs. These innovators are carefully retooling clinical pathways, which involves comparing all forms of post-surgery services, including services provided by HH agencies, to identify ways to improve transitions and reduce readmissions and cost. Some innovators are seeking improvements in clinical and financial outcomes through, in part, increased utilization of HH 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. While in the proposed rule CMS continues to assert that HH margins are high enough to absorb the proposed coding cut, we disagree. **Given that HH services are expected to continue to play a prominent role in alternative models of care and payment, we encourage CMS to avoid reducing margins for HH agencies to levels that threaten participation in these important initiatives.**

In addition, the proposed cuts would threaten the ability of HH agencies to invest in the infrastructure necessary to successfully participate in the proposed HH VBP program. For example, providers must acquire and update data systems and analytics, invest in connections to community partners, build business acumen through talent recruitment and training, and develop and deploy evidence-based clinical guidelines, among other infrastructure. The cost of these investments will vary by provider; many HH agencies would need to start from scratch, and very few, if any, would be prepared using their existing infrastructure alone. We note that the HH field did not benefit from financial incentives for information technology that Congress funded for other providers.

Proposal May Threaten Rural Beneficiaries Relying on Hospital-based HH Services. The proposed coding offset may endanger access for patients in rural counties who have access to few, and often a single, HH agency. HH access for these communities has become even more important as broader delivery system reforms appear to be increasing utilization in lieu of other, more costly, settings. In particular, MedPAC, in March 2013, reported that in some counties, hospital-based HH agencies are the sole source of HH services, and their already low *and decreasing* margins may cause access challenges. This finding is supported by Healthcare Market Resources' analysis of 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 HH 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 HH 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.

ICD-10 IMPLEMENTATION

We urge CMS to revise the HH prospective payment grouper to be consistent with the ICD-10-CM Official Guidelines for Coding and Reporting, which are part of the HIPAA code set standard. Specifically, we point to the application of the seventh character for ICD-10-CM for diagnosis codes under Chapter 19, Injury, poisoning, and certain other consequences of external causes (S00-T88). Codes with the seventh character of "A" for initial encounter should be recognized as these codes would recognize patients receiving active treatment in the HH setting, such as postoperative infections or infections related to devices. For example, if a patient is hospitalized for an infection of a total right hip joint prosthesis and is followed up at home for continuation of intravenous antibiotics to treat the infection, the correct ICD-10-CM code would be T84.51XA, Infection and inflammatory reaction due to internal right hip prosthesis, initial encounter, with the seventh character "A," initial encounter, for the infection being treated.

HH QUALITY REPORTING PROGRAM (QRP)

The Deficit Reduction Act of 2005 required CMS to establish a program under which HH agencies must report data on the quality of care delivered in order to receive the full annual update to the HH PPS payment rate. Since CY 2007, HH agencies failing to report the data have incurred a reduction in their annual payment update factor of 2.0 percentage points.

Outcome and Assessment Information Set (OASIS) Data Completeness Standard. **The AHA supports CMS's proposal to raise the OASIS data completeness standards for the CY 2018 and CY 2019 HH QRP.** CMS used the CY 2015 HH PPS final rule to establish a "minimum data submission threshold" – or data completeness threshold – to assess whether HH agencies have submitted sufficient data to calculate HH QRP measures. For the CY 2017 payment determination, HH agencies are required to submit complete OASIS quality assessments on a minimum of 70 percent of patients with episodes of care occurring during the applicable data reporting period. In this rule, CMS proposes to increase the minimum data threshold to 80 percent for CY 2018 payment determinations, and 90 percent for CY 2019 payment determinations and beyond. HH agencies that do not meet the data completeness standard will be subject to a 2.0 percentage point reduction to their annual payment updates.

New Pressure Ulcer Measure for CY 2018. CMS proposes to add a pressure ulcer measure to satisfy the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act is intended to foster greater alignment of measures across CMS's post-acute care quality reporting programs, including the HH QRP, by requiring the collection of measures on specific topics that are "standardized and interoperable" across post-acute care settings.

To address the IMPACT Act's "skin integrity" measure domain, CMS proposes a pressure ulcer measure that assesses the percentage of patients with Stage 2 to 4 pressure ulcers that are new or worsened since the beginning of an episode of HH care. CMS would calculate the pressure ulcer measure using items that HH agencies already complete and submit on the

OASIS assessment tool. The measure is endorsed by the National Quality Forum (NQF) and was supported for use in the HH QRP by the multi-stakeholder Measure Applications Partnership (MAP). **The AHA supports CMS's proposed pressure ulcer measure for the CY 2018 HH QRP, and appreciates that the agency has chosen a measure that uses data HH agencies already collect.**

However, we continue to urge CMS to develop and make publicly available a comprehensive plan describing how it will implement the provisions of the IMPACT Act in all of its post-acute care quality programs. The IMPACT Act is a multi-faceted law that will have significant operational impacts for HH agencies, long-term care hospitals (LTCHs), skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). The law's requirements will involve changes to quality measures and the patient assessment tools used for each care setting. A comprehensive plan would enable all stakeholders to understand whether CMS's approach works in a concerted fashion across its programs. It also would give all of the affected post-acute care providers an opportunity to plan for the potential impacts to their operations.

The AHA also urges CMS to adhere to several guiding principles in implementing the IMPACT Act that would ensure ample opportunities for stakeholder input, the use of reliable and accurate measures, and minimize unnecessary provider burden. For additional details on these principles, we refer the agency to our June 18, 2015 comment letter on the fiscal year (FY) 2016 IRF PPS proposed rule.

HH VALUE-BASED PURCHASING PROGRAM

Invoking its authority under the ACA to test payment models intended to improve quality and/or reduce cost, CMS proposes to implement a HH VBP program. Participation in the HH VBP would be mandatory for all CMS-certified HH agencies in nine states – Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington. HH agencies in these states would be subject to maximum upward and downward payment adjustments of 5 to 8 percent based on performance on 29 measures. The proposed scoring approach would recognize HH agencies for both their level of achievement versus benchmarks, as well as improvement over their own baseline performance. CMS proposes to begin the HH VBP program Jan. 1, 2016 and end the program Dec. 31, 2022. The program would adjust payments to the affected HH agencies in CYs 2018 through 2022.

The AHA supports the concept of a HH VBP program. We agree that a mix of public quality reporting and pay-for-performance measures can align the health care delivery system – including HH providers – toward continuous quality improvement, and reward providers for excellence. However, we strongly urge CMS to consider adopting a maximum payment adjustment of no more than 2.0 percent for its proposed HH VBP program. We also urge CMS to reduce the number of measures in the program to promote focus on high-priority issues for improvement.

Proposed Payment Adjustment. **The AHA believes placing 5 to 8 percent of HH agency payment at risk for performance is too high, too fast, especially in light of the significant Medicare payment reductions HH agencies have endured in recent years. The AHA is especially troubled by the potential impact of the large payment adjustments on hospital-based HH agencies, whose average Medicare margins were *negative* 15.5 percent in 2013.** Hospital-based HH agencies are integral to their parent organization's efforts to reduce readmissions, coordinate care, promote efficiency and participate in innovative care delivery models such as accountable care organizations (ACOs). As highlighted earlier in this letter, the re-basing cuts impinge upon the ability of HH agencies to invest in the infrastructure for improvement that is required to be successful in a VBP model. HH agencies also face additional reductions in CY 2018 under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which will limit the market-basket update in CY 2018 to only 1.0 percent.

If CMS is intent on implementing a mandatory program, we strongly urge the agency to limit the HH VBP upward or downward adjustment to only 2.0 percent. A maximum payment adjustment of 2.0 percent is consistent with the VBP program for hospitals, and the upcoming SNF VBP program that will begin in FY 2019. Tying a smaller amount of payment to performance as part of this initial test also would allow CMS to closely assess whether other aspects of the program – i.e., the measures, the scoring methodology – work without negative unintended consequences. We understand that the agency is interested in determining whether tying large amounts of payment to quality performance leads to greater improvement than existing programs. However, we do not believe the most appropriate way to test this hypothesis is to apply large adjustments to providers that have never participated in mandatory pay-for-performance programs.

Interactions with Comprehensive Care for Joint Replacement (CCJR) Initiative. **The AHA is concerned by the potential interaction of the HH VBP program with the recently proposed CCJR initiative.** If CMS adopts the recently proposed CCJR model testing a retrospective bundled-payment model for joint replacements, hospital-based HH agencies also will be called upon to help optimize the costs and quality of the beneficiaries included in the CCJR. Indeed, five of the nine states where CMS would test the HH VBP model also include Metropolitan Statistical Areas (MSAs) where the CCJR model would be tested. Thus, a requirement to participate in a HH VBP model with such a large payment adjustment would likely cause hospital-based HH agencies to divert significant resources from the CCJR and other critical activities to meet the needs of the HH VBP program. Balancing HH VBP requirements with participation in other organizational initiatives calls into question the financial viability of hospital-based HH agencies under the proposed HH VBP model.

Proposed VBP Measures. **The AHA urges CMS to reduce the number of measures in the HH VBP program and ensure the program measure set is focused on the highest priority areas for improvement.** We are disappointed that CMS's stated measure selection criteria for the HH VBP program focus on achieving a balance of particular measure types – process, outcome, costs, appropriate use and so forth. Instead, CMS should select measures because they address the most important aspects of performance that will lead to better outcomes and health for patients. Given that CMS proposes to weight each measure equally in determining

VBP performance, it is especially critical that the program's measure set be small and focused on critical issues. Thus, rather than using 29 measures, the AHA believes the agency should limit the HH VBP program to no more than 10 measures focused on the issues it believes are the highest priority for improving care and outcomes for HH agency patients. We believe selecting from the outcome measures on the proposed list may help the agency hone in on the most salient topics.

Thank you again for the opportunity to comment. For any questions regarding the payment provisions in this letter, please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For quality-related questions, please contact Akin Demehin, senior associate director of policy, at ademehin@aha.org.

Sincerely,

/s/

Tom Nickels
Executive Vice President