



UnityPoint at Home

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September 4, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1625-P – Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Submitted electronically via www.regulations.gov

Dear Mr. Slavitt:

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 2016. 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. In 2014, UnityPoint at Home provided more than 400,000 home health 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. In our central northwest Iowa region, UnityPoint at Home is an ACO Participant in the Trinity Pioneer ACO, one of two predominantly rural ACOs participating in the CMMI Pioneer ACO Model Program and we are included in UnityPoint Health Partner's application for the CMMI Next Generation ACO Model.

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.

Proposed Provisions of the Home Health Prospective Payment System:
Proposed Reduction to the National, Standardized 60-Day Episode Payment Rate to Account for Nominal Case-Mix Growth

The nominal case-mix growth is an adjustment calculation offered to the home health prospective payment system (PPS) by CMS to account for coding increases unrelated to patient severity. In the proposed rule, CMS has recommended a 3.41% episode payment reduction to reflect this nominal case-mix growth. This payment reduction was calculated by applying an historic 84% nominal rate to the rate of payment growth in 2013 and 2014.

Comment: UnityPoint at Home believes that even if 84% was the valid rate before 2010, it no longer reflects the nominal portion of the case-mix growth and this outdated percentage is not appropriate for use in recalculating 2016 payment rates. Specifically, we question the validity of utilizing pre-2010 claims data to calculate an adjustment to the nominal case-mix growth for 2016. We believe that 16% underestimates the percentage of payment growth that represents patient acuity. Since 2010, the patient severity of Medicare PPS home health beneficiaries has significantly increased due to:

- *Increase in Medicare beneficiaries with Medicare Advantage plans* – Medicare Advantage patients are usually younger and “healthier” consumers, and are increasingly opting for Medicare Advantage plans. One analysis found that between 2010 and 2013, 70% of new Medicare beneficiaries enrolled in a Medicare Advantage plan. This leaves the older and sicker Medicare patients disproportionately represented in traditional Medicare fee-for-service, which negatively impacts the average case mix (i.e. increases average patient severity level). In Feb. 2015, a consulting firm indicated that Medicare Advantage patients grew steadily from 10.2 million in 2008 to 16.4 million in September 2014, with a growing penetration rate from 22.7% of the Medicare-eligible to 30.7%. In 2014 one prominent research firm projected 19 million Medicare Advantage enrollees in 2020, citing data from the Kaiser Family Foundation and from Milliman.
- *Higher levels of referrals from hospitals for Medicare beneficiaries* – Home Health patients with Hospital referrals have a higher level of acuity, which negatively impacts the average nominal case mix.

Without examining the case-mix growth ratio to assure accurate patient severity, Home Health agencies are being inequitably penalized for providing services to a population with increased acuity and high-risk needs. UnityPoint at Home respectfully requests CMS to reconsider the proposed percentage reduction to accurately reflect the heightened acuity of patients being served.

Proposed Home Health Value-Based Purchasing (HHVBP) Model

CMS has proposed a value-based purchasing program for Home Health Agencies based on similar programs and demonstrations, such as the Hospital Value-Based Purchasing Program and the Home Health Pay-for-Performance and Nursing Home Value-Based Purchasing Demonstrations. The five-year

demonstration is proposed to start January 1, 2016. The proposed model applies a payment reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, for all home health agencies delivering services within nine randomly-selected states. Payment adjustments are applied on an annual basis, beginning at 5% and increasing to 8% in later years of the model. The proposed model requires CMS to inform HHA quarterly of their performance on each of the individual quality measures used to calculate the Total Performance Score (TPS). CMS proposes that HHAs will have 10 days after the quarterly reports are provided to request a recalculation of the measure scores if the HHA believes there is evidence of discrepancy.

Comment: Iowa has been selected as one of the nine states to test the Home Health Value-Based Purchasing Model. UnityPoint at Home has 13 locations within Iowa. Generally, we would like to echo the following comments made by MedPAC in its comment letter dated August 18, 2015 on this regulation: (1) Measures should focus on a limited set of outcome measures that are important to beneficiaries; (2) Measuring performance primarily on the basis of achievement of specified quality scores (with a declining emphasis over time on improvement versus achievement), and (3) Benchmarks for performance should be established prospectively in advance of the performance year. We also agree with the concern expressed by the National Association for Home Care and Hospice and a number of members of Congress regarding the aggressive payment adjustment ramp-up beginning at 5% and increasing to 8% being “too much too fast.” UnityPoint at Home recommends the HHVBP model provide HHAs 30 days, instead of 10 days, after the quarterly and annual reports are provided to request a recalculation of the measure scores if the HHA believes there is evidence of discrepancy.

Proposed HHVBP Quality Measures:

CMS proposes a starter set of 29 quality measures combining both process and outcomes for HHVBP participants. Four of these measures are new. Data sources for these measures include OASIS, Medicare claims, HHCAHPS surveys, and data reported directly from Home Health Agencies to CMS. CMS expresses a preference to utilize NQF-endorsed measures, when available. In addition, CMS reserves the ability to modify this list of quality measures in future rulemaking and specifically places Home Health Agencies on notice of its future intent to coordinate these measures with the IMPACT Act of 2014, which mandates the collection and use of standardized post-acute care assessment data.

Comment: UnityPoint at Home generally supports the need to be transparent and accountable through the collection and reporting of quality measures. Our 2013 Circle of Life Award from the American Hospital Association was earned in recognition of our innovative quality reporting system, which we internally developed and implemented in support of our palliative care program. UnityPoint at Home understands the importance of accurately and timely collecting, tracking and trending of data to promote continual improvement efforts and increase consumer satisfaction. Despite this, we are extremely concerned about the administrative and cost burdens imposed by the sheer number (29) of proposed HHVBP quality metrics. If all proposed 29 quality and patient satisfaction measures are retained, the impact on our current Performance Improvement / Process Improvement process would generate the need for

additional resources coupled with across-the-board reductions in reimbursement. In particular, UnityPoint at Home recommends no more than 10 process and outcome metrics be required for this program based upon an analysis of which improved metrics realize the greatest cost reduction and improved quality of care for the patient overall. As an alternative to the proposed starter set, we recommend that CMS utilize the STAR measure set which is already in play and has been vetted for the Triple Aim objectives.

If CMS elects to proceed with the proposed starter set as is, we are also concerned that several proposed measures have no national benchmarks. Without benchmarks, we question their inclusion within the initial starter measure set. Specifically:

- *Proposed metric for discharge to community (M2420)* is not captured in Home Health Compare, and thus there are no national benchmarks. We suggest removing this metric from the starter set. If CMS is interested in utilizing this in a future measure set, we would suggest using this metric now for exploratory reporting only (similar to Medicare Advantage display measure status). UnityPoint at Home reserves our support of this metric after an exploratory period and once clear definitions and benchmarks have been established.
- *Proposed metric for ADL/IADL (M1900)* is not captured in Home Health Compare, and thus there are no national benchmarks. Of greater concern, the proposed metric is only captured at start and resumption of care and is not documented against discharge assessment, which does not permit the outcome measure to be captured. We suggest removing this metric from the starter set altogether.
- *Proposed metric for Care Management Types and Sources of Assistance (M2102)* is not captured in Home Health Compare, and thus there are no national benchmarks. We suggest removing this metric from the starter set. If CMS is interested in utilizing this in a future measure set, we would suggest using this metric now for exploratory reporting only (similar to Medicare Advantage display measure status). UnityPoint at Home reserves our support of this metric after an exploratory period and once clear definitions and benchmarks have been established.

Lastly, for efficiency and to reduce administrative burden, we are supportive of CMS' intent to coordinate HHVBP measures with the IMPACT proposed metrics for CY2018 performance measurement. UnityPoint at Home respectfully requests that CMS reconsider the starter set to reduce the number of measures to 10 measures or less with preference being given to existing STAR measures.

New HHVBP Quality Measures:

CMS proposes to require four new measures, not currently reported by Medicare-certified Health Home Agencies. These new measures are proposed to "fill gaps in the NQS Domains not completely covered by existing measures" within the home health care environment. CMS proposes that these measures will be reported by Home Health Agencies via a dedicated web-based platform. If a Home Health Agency has a sufficient number of episodes of care, the scores for these new measures will be included within the final

Total Performance Score for year 1; however, the scores will be based on pay-for-reporting, not performance.

Comment: UnityPoint at Home has concerns with each newly proposed measure. It should be generally noted that we prefer to have measures reported through existing collection and reporting streams, instead of the new proposed web-based platform to include only these new measures. Administrative burdens associated with a new reporting stream for this limited measure set would appear to outweigh its benefit. Any additional measures should be incorporated within current mechanisms.

Advance Care Planning – The proposed metric poses collection issues and added expense. Currently this metric is not in a discrete format for data collection within our Electronic Medical Record, nor is it a field in the OASIS tool. Additionally, this multi-part question creates abstraction issues – there are too many variables within the numerator for clean abstraction of the metric. The resources and time commitment required to be able to reliably report on this metric would create undue hardship for January 1, 2016 implementation. UnityPoint at Home respectfully recommends that this metric implementation be delayed until CY2017 and that it be included within OASIS for data collection due to complexity of the question and its multiple parts.

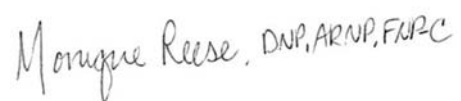
Adverse Event for Improper Medication Administration and/or Side Effects – This metric is already collected via OASIS, and its collection and reporting through the proposed web-based platform appears to be duplicative. This metric is yet another proposed measure that is not captured in Home Health Compare. UnityPoint at Home respectfully recommends collection of this metric through OASIS in CY2017 (after collection of a national benchmark in 2016), with pay for performance occurring no sooner than CY2018.

Influenza Vaccination Coverage for Home Health Care Personnel – As currently proposed, this metric does not include consideration of the overall supply availability of staff vaccine at the local/state level regardless of known national declared shortages. Regional availability limits should be reflected within the measure so as not to unduly penalize Home Health Agencies. The resources and time commitment required to be able to reliably report on this metric would create undue hardship for January 1, 2016 implementation. UnityPoint at Home respectfully recommends that this metric implementation be delayed until CY2017 and that it be included within OASIS for data collection in CY2017, with pay for performance occurring no sooner than CY2018.

Herpes Zoster Vaccine (Shingles Vaccine) for Patients – The proposed metric poses collection issues and added expense. Currently this metric is not in a discrete format for data collection within our Electronic Medical Record, nor is it a field in the OASIS tool. The resources and time commitment required to be able to reliably report on this metric would create undue hardship for January 1, 2016 implementation. UnityPoint at Home respectfully recommends that this metric implementation be delayed until CY2017 and that it be included within OASIS for data collection in CY2017, with pay for performance occurring no sooner than CY2018.

We appreciate the opportunity to provide comments to the proposed Home Health rules for calendar year 2016 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, Public Policy and Government Payors at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,



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