



UnityPoint at Home

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August 26, 2016

Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
ATTN: CMS-1648-P  
PO Box 8016  
Baltimore, MD 21244-8016

**RE: CMS-1648-P** – Medicare and Medicaid Programs; CY 2017 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](http://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 2017. 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 2015, UnityPoint at Home provided more than 450,000 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. 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

**A. Case-Mix Weights:** CMS proposes to continue the recalibration methodology to reflect current home health resource use and changes in utilization patterns.

*Comment:* UPH is concerned that case-mix payment adjustments continue to jeopardize home health agencies (HHAs) already experiencing small profit margins. These adjustments continue to incentivize higher therapy utilization. Each year, the proposed rule cites case mix creep as a rationale for case mix adjustments; however, case mix creep does not occur in every HHA, but rather in HHAs with other practice behaviors identified in the HHA PEPPER reports. HHAs that continue to focus on high quality care and providing only reasonable and necessary home health services continue to see decreases in profit margins resulting in the inability to reinvest in the infrastructure needed to continue to improve quality and patient satisfaction. Ultimately, we believe that these adjustments will result in fewer HHAs and lessen consumer choice in seeking quality home health options.

**B. Home Health Rate Update:** CMS is proposing a market basket update of 2.3%, resulting in a 60-day episode payment amount of \$2936.68. Per-visit payment amounts by service were similarly updated as well as low-utilization payment adjustment add-ons, non-routine medical supply (NRS) payments, and rural payment add-ons.

*Comment:* Although the episodic rate decreased by approximately 1% for homecare, this was exacerbated in most of our HHAs from the negative impact of the proposed wage index. As a result, most of our HHAs will experience a net negative impact of over 2%. Based on 2016 figures, HHAs located in Moline, Illinois and Dubuque, Iowa would have an approximate 3% decrease, with only one of our HHAs with a sufficient positive wage index increase to offset the decrease in episodic rates. It appears that the proposed change to the wage index disproportionately impacts Midwest HHAs outside of major metropolitan areas and we question if other regional variations or trends are evident. We encourage CMS to revisit the determination of the wage index to ensure that it is not eroding HHAs efforts to remain financially viable in conjunction with the Home Health Rate update.

**C. Payments for High-Cost Outliers:** Outlier payments are predominantly driven by the provision of skilled nursing services. CMS is proposing to calculate outlier payments using a cost-per-unit approach, rather than the current cost-per-visit approach. CMS has proposed a 15-minute unit rate duration based on national per-visit payment rates. When estimating the cost of an episode for outlier purposes, CMS is proposing the amount of time per day to be limited to 8 hours or 32 units. The total outlier amount will maintain the cap of 2.5% of total payments. CMS is proposing to raise the fixed dollar loss ratio from 0.45 to 0.58.

*Comment:* While UnityPoint at Home supports the use of outlier cost payments, the change in methodology may result in additional costs from our EHR vendor to capture cost-per-unit instead of cost-per-visit as well as from staff training to document time in and time out when in the home. The extra expense and time resources do not appear to have been considered by CMS in its economic impact analysis of this proposed change.

**D. Payment for Negative Pressure Wound Therapy Using a Disposable Device:** Current law requires NPWT using a disposable device under a home health plan of care to be paid separately using OFFS rates. CMS is proposing that HHA bill these visits separately. If the HHA visit relates solely to this purpose, the visit should not be reported on the HH PPS claim. If the service occurs during an otherwise covered HHA visit, time spent on this service should be excluded from the HH PPS claim.

*Comment:* We oppose this proposed change. Disposable NPWT devices are about \$500.00/dressing/device change and are not billable Durable Medical Equipment or the visit charge. Today we code NPWT as 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 we 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. It is unclear how HHAs should divide time and effort between HH PPS and OFFS. We urge CMS to not require separate billing for a service encompassing a NRS. Instead, CMS should consider permitting this device to be covered in the skilled nursing visit portion of the HH PPS bill (with appropriate reimbursement) and avoid a policy which differentiates NPWTs by device – either disposable or non-disposable.

In addition, this rule does not prioritize patient-centered care by failing to recognize that a patient's condition may warrant the use of a disposable NPWT device until 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 particular devices over the judgment of a provider relating to patient care. It is likely that this rule will result in service delays due to transportation barriers and/or use of devices that may not be the best suited to a patient's condition.

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

Iowa has been selected as one of the nine states to test the Home Health Value-Based Purchasing Model, a five-year demonstration project. UnityPoint at Home has 13 locations within Iowa.

**A. Smaller- and Larger-Volume Cohorts:** CMS is proposing to calculate the benchmarks and achievement thresholds at the state level rather than at the smaller-volume cohort or larger-volume cohort levels for all model years. In terms of payment adjustment methodology, CMS is proposing that smaller-volume cohorts contain a minimum of eight HHAs and that, if a state has less than eight HHAs, the smaller-volume HHAs would be included in the larger-volume cohort for calculating the LEF and payment adjustment percentages.

*Comment:* This proposed rule would be a challenge for HHAs that have branch offices in rural locations and it is unclear if this will impact rural reimbursement. We recommend CMS consider the impacts of HHA that have both an urban and rural component as well as its potential impacts to the cohort prior to implementing this change.

**B. Quality Measures:** CMS is proposing to remove the following four measures: (1) Care Management: Types and Sources of Assistance; (2) Prior Functioning ADL/IADL; (3) Influenza Vaccine Data Collection Period; and (4) Reason Pneumococcal Vaccine Not Received. The proposed remaining measure set contains twenty metrics, including three new measures with suggested reporting frequency: (a) Influenza Vaccination Coverage for Home Health Care Personnel (annual reporting); (b) Herpes zoster (Shingles) vaccination (quarterly reporting); and (c) Advance Care Plan (quarterly reporting). CMS is also proposing to increase the reporting timeframe to 15 calendar days from 6 calendar days.

*Comment:* UnityPoint at Home generally supports the need to be transparent and accountable through the collection and reporting of quality measures. We applaud the removal of the four measures as an effort to minimize HHA administrative and cost burdens. As we have stated in past regulatory comments, UnityPoint at Home supports the adoption of no more than 10 process and outcome metrics 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. We also recommend to the greatest extent feasible that CMS utilize the STAR measure set which is already in play and has been vetted for Triple Aim objectives.

In terms of the proposed measure set (Table 31), we support the proposed changes to reporting frequency. We agree that annual reporting for the Influenza Vaccination Coverage measure will decrease administrative time and support the increased timeframe for data submission to promote reporting accuracy.

**C. Appeals Process:** CMS is proposing reduced timeframes for the two-stage appeal process. Specifically, for a recalculation appeal, this first appeal must be submitted within 15 calendar days of the posting of the Interim Performance Report or the Annual TPS and Payment Adjustment Report. For the reconsideration, this second appeal must be submitted within 15 calendar days of CMS' notice of the outcome of the recalculation request for Annual TPS and Payment Adjustment Report. The final TPS and payment adjustment percentage will be provided in a final report no later than 30 calendar days in advance of the payment adjustment taking effect.

*Comment:* We oppose the reduced timeframes for appeals. Fifteen calendar days, instead of 30 days, does not provide ample opportunity for HHAs, particularly large agencies, to collect detailed data in support of the appeal request. We urge CMS to maintain the 30-day timeframes for both the recalculation and reconsideration appeals.

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

**A. Quality Measures Proposed for Removal from CY 2018 Payment Determination:** Among changes for payment determination, CMS is proposing the removal of 6 topped out measures: (1) Pain Assessment Conducted; (2) Pain Interventions Implemented During All Episodes of Care; (3) Pressure Ulcer Risk Assessment Conducted; (4) Pressure Ulcer Prevention in Plan of Care; (5) Pressure Ulcer Prevention Implemented During All Episodes of Care; and (6) Heart Failure Symptoms Addressed During All Episodes of Care.

*Comment:* We have “topped out” on the six measures proposed for removal. While we are supportive of their removal, we do have some concerns regarding perfunctory removal of topped out measures from payment determinations. First, we are concerned regarding public perception. If several or all topped out measures are removed, there is a risk that public perception will erode as HHAs scores may experience fluctuation when several topped out scores are replaced in favor of new metrics. Second, many of the topped out measures are best practices from national quality boards related to monitoring, assessing and treating certain condition. We are concerned the removal of all topped out measures will divert HHAs from implementing best practices as recommended. For example, the National Pressure Ulcer Advisory Council recommends pressure ulcer risk assessment (i.e. Braden) interventions to be incorporated in the plan of care and implemented. We would recommend that CMS monitor removed topped out measures to assure that quality does not decrease.

**B. Modifications to OASIS Assessment Data Reporting:** CMS is proposing that (1) full thickness (Step 3 or 4) pressure ulcers should not be reported as unhealed pressure ulcers once complete re-epithelialization has occurred; and (2) once a graft is applied in a pressure ulcer, the wound will be reported as a surgical wound and not as a pressure ulcer.

*Comment:* In terms of the first proposal, UPH agrees that the OASIS data set report full thickness (Step 3 or 4) pressure ulcers should not be reported as unhealed. Instead, UPH recommends that such pressure ulcers be reported as closed once complete re-epithelization has occurred. Evidence-based medicine supports that such pressure ulcers usually are closed as they have underlying structural damage that regenerates with scar tissue.

For the second proposal, UPH opposes this change. The application of a graft is akin to putting a layer over the pressure ulcer (like a Band-Aid), and every graft should not be associated with changing the structure of a pressure ulcer. The proposed rule conflicts with the interpretation of the National Pressure Ulcer Advisory Panel. This national expert panel limits the circumstance that change wound classification from pressure wound to surgical wound – pressure ulcer structure is only altered when muscle flaps are performed surgically. Should CMS choose to treat grafts other than as a pressure ulcer, we suggest that CMS clearly specify which grafts change the staging of the ulcer to a surgical wound.

Aside from the currently proposed modifications, UPH urges CMS to consider the following additions to the OASIS Assessment:

- Urinary diversions (a.k.a. urostomy). Similar to bowel diversions for colostomy, we recommend adding case mix points and modification to OASIS questions to include urinary diversions. HHAs are not adequately reimbursed for the non-routine medical supplies (NRS), which have consistently increased in cost.
- Arterial ulcers exempt from the stasis ulcer category. We recommend adding case mix points and modification to OASIS questions to include patients with arterial ulcers which are exempt from stasis ulcer category. These patients are medically complex and involve healing an arterial wound. HHAs are not adequately reimbursed for NRS related to arterial ulcers and cost for management of arterial wounds.

**C. QRP Quality, Resource Use, and Other Measures for CY 2018 Payment Determination and Subsequent Years:** CMS is proposing to include four additional measures to meet IMPACT requirements – MSPB-PAC HH QRP; Discharge to Community — Post Acute Care Home Health Quality Reporting Program; Potentially Preventable 30-Day Post-Discharge Readmission Measure for Post-Acute Care Home Health Quality Reporting Program; and Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post-Acute Care Home Health Quality Reporting Program.

*Comment:* In general, we have concerns with each new measure as proposed, the learning curve and resources required to appropriately capture them, and the limited timeframe in which to perfect data collection and reporting. We request that CMS consider first-year implementation of these metrics as exploratory reporting only (similar to Medicare Advantage display measure status). UnityPoint at Home reserves our support of these metrics after an exploratory period and once clear definitions and benchmarks have been established. We will address our concerns with each measure separately below.

For IMPACT Act Domain of Resource Use and Other Measures: MSPB–PAC HH QRP, the measure is calculated as the ratio of the MSPB–PAC Amount for each HHA divided by the episode-weighted median MSPB–PAC Amount across all HHAs. The calculation for this measure is overly complicated and as such it will be extremely difficult to use this measure to drive performance.

For IMPACT Act Domain of Resource Use and Other Measures: Discharge to Community— Post Acute Care Home Health Quality Reporting Program, this metric will require staff resources and training to ensure that HHA discharge processes and billing processes accurately reflect discharge codes when returning patients to the community. Given the various underlying calculations related to this measure, we request that CMS exclude any negative effect resulting from the transfer of a patient directly from a home health episode to hospice. Frequently, home health providers are identifying hospice-appropriate patients and, with current advanced care planning expectations through HHVBP, more of this type of care coordination should be occurring. HHAs should not be penalized in under this measures for getting patients to the appropriate level of care.

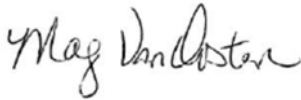
We seek further clarification for the measure, IMPACT Act of 2014 Domain of Resource Use and Other Measures: Potentially Preventable 30-Day Post-Discharge Readmission Measure for Post-Acute Care Home Health Quality Reporting Program. While we are generally supportive of avoidable readmissions measures, we are unclear concerning how this measure is defined – what diagnoses will be included as “unplanned and potentially avoidable”? In addition, we would request that behavioral health diagnoses be excluded from this measure until further study.

For IMPACT Act Domain of Medication Reconciliation: Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post-Acute Care Home Health Quality Reporting Program, UnityPoint at Home questions whether HHAs are solely responsible for this measure. This measure raises a fundamental problem of determining the source of truth for the medication list - is it the hospital, the clinic, the patient, or home care? For instance, the proposed rule would potentially penalize HHAs for something out of their control. If a HHA admits a patient on a Saturday afternoon and notifies a physician’s office, the HHA often hears from an on-call provider that is not willing to make medication changes on behalf of a colleague causing reconciliation delay. Also, this metric will require additional OASIS documentation for the clinician. Practically, this measures creates a significant burden on HHAs to complete a ‘look back’ to determine if

any significant medication issues were identified as the clinician workflow will not accommodate this time burden review. Should CMS decide to implement this measure as is, we urge clarification surrounding the definitions of a “potential clinically significant medication issue” and “follow up.”

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](mailto:sabra.rosener@unitypoint.org) or 515-205-1206.

Sincerely,



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