GRANITE STATE
Home Health Association
An Affiliate of the Home Care Association of New Hampshire

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Marilyn Tavenner
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Via electronic submission at www.regulations.gov

RE: CMS-1611-P

Dear Administrator Tavenner:

I am writing on behalf of the members of the Granite State Home Health Association (GSHHA) to comment on the proposed rule CMS-1611-P: *Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies.*

Affordable Care Act Rebasing Adjustments

New Hampshire's Medicare-certified home health agencies believe that CMS's proposal to continue to maximize the allowable rebasing cut of $80.95 annually for the next three years will financially destabilize agencies throughout our state and negatively impact access to care for Medicare and Medicaid beneficiaries. (We understand that this proposed rule relates only to Medicare, but we urge CMS to consider the consequences for Medicaid beneficiaries as well.) CMS's rebasing analysis fails to consider many expenses not currently reflected in cost reports. These include costs associated with critical capital expenditures such as telemedicine equipment and electronic medical record systems; new regulatory requirements related to HIPAA, ICD-10, and OASIS-C1; and the overwhelming administrative burden resulting from an *unwarranted deluge* of face-to-face (F2F) documentation reviews and denials.

We are concerned that the continued rebasing cut will erode Medicare margins among New Hampshire agencies, causing as many as two-thirds to have negative Medicare margins. With losses on both Medicare and Medicaid, many agencies may have no alternative but to limit services or cease operations altogether. There could be many parts of the State where seniors and Medicaid enrollees will have little or no access to home health care. This will result in increased Medicare and Medicaid expenditures in higher cost institutional settings. This is contrary to CMS's goals of providing all

beneficiaries with coordinated care in appropriate post-acute settings and reducing unnecessary hospitalizations.

We urge CMS to **analyze the current rebasing proposal to determine the full financial impact on home health agencies *in each state through 2017***. It should also **assess the resulting impact on access to home health care for Medicare and Medicaid beneficiaries.** This assessment should include a **report to Congress and States regarding estimates for additional expenditures in higher cost institutional settings.**

Changes to the Face-to-Face Encounter Requirements

We support CMS's recommendation to eliminate the requirement for a "brief narrative" from physicians conducting the F2F encounter for home health. We applaud CMS for listening to concerns expressed by members of Congress, all types of providers in New Hampshire, and national advocacy groups about the administrative burden caused by redundant F2F clinical documentation. We agree with CMS that this should simplify the F2F encounter requirements and mitigate the burden on physicians and home health agencies.

We suggest that CMS also eliminate any requirement that the F2F encounter be documented separately. The Affordable Care Act simply requires that the physician, or NPP working with the physician, document that they had a F2F encounter with the patient. We believe that a simple attestation regarding the date of the encounter – which could be included in the physician's certification of the patient's need for home health, or in the plan of care – should satisfy Congress's intent.

In light of the proposal to eliminate the F2F narrative, **we urge CMS to order Medicare Administrative Contractors to suspend all pending documentation requests related F2F narratives, and to reopen for further review any claims that have been denied because of insufficient F2F narratives**. New Hampshire's home health agencies have been overwhelmed by F2F ADRs and denials, especially in the last eight months. The appeals process for denials is burdensome and time-consuming – agencies may go *years* without receiving reimbursement.

While we are pleased that CMS has recommended elimination of the narrative, **we are dismayed that CMS has recommended that a patient's eligibility for home health would be based *only* on a review of the medical records from the physician or the discharging facility. The patient's home bound status and need for skilled care should be based on a review of the *complete* medical record, including records from the MD, any discharging facility, and the home health agency.** We are concerned that reimbursement for home health services would be based solely on "sufficiency" of documentation from another provider. Home health agencies have no knowledge or control over what is in a physician's file or how the MD documents the patients' clinical condition. What's more, "sufficiency" is subjective. Our experience is that MAC medical reviewers vary widely in their interpretation of clinical requirements for home care. The confusion created by this requirement would equal or exceed the confusion that exists due to the F2F narrative requirement. **We urge CMS to delete this section from the proposed rule.**

Home Health Wage Index

New Hampshire's home health agencies remain concerned that the home health wage index is based on the hospital wage index. While hospitals can classify to the neighboring CBSA or take advantage of the "rural floor", home health agencies do not have this ability. This results in inadequate home health cost

adjustments that negatively impact agencies' abilities to recruit and retain nurses and therapists in a highly competitive labor market. This problem is especially difficult in southern New Hampshire, where home health agencies must compete with Boston-area medical centers for staff.

We urge CMS to work with home health providers to develop regulatory and legislative remedies to the continuing problem of wage index disparity. In the meantime, **we urge CMS to implement an immediate policy to limit the wage index variations among provider types within CBSA's and adjacent markets.**

Changes to the Therapy Reassessments Timeframes

We support the elimination of the 13th and 19th visit therapy reassessment requirement. The current requirement creates scheduling problems and increased clinical, administrative, and IT costs. **We recommend that CMS amend its proposed rule by requiring a therapy assessment every 30 days, with a 5-day window before or after the 30th day -- rather than every 14 days.** This would be consistent with clinical practice in outpatient and nursing home settings.

General Comments

New Hampshire's Medicare-certified home health agencies are dedicated to providing high quality skilled nursing and therapy services to Medicare beneficiaries who are home-bound and who require our care. We are concerned that regulatory burdens are detracting from the resources that should be focused on patients. As essential partners in efforts to achieve national health policy goals, we look forward to a Final Rule that provides reasonable reimbursement and regulatory oversight that positively impacts our ability to care for New Hampshire's elderly citizens.

Thank you for your consideration of our comments and recommendations.

Sincerely,

Gina Balkus
Chief Executive Officer