



**American
Academy of
Home Care
Physicians**



August 26, 2013

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS -1450-P. Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses Policies

Dear Administrator Tavenner:

The American Academy of Home Care Physicians (Academy) appreciates the opportunity to provide our comments regarding the Centers for Medicare and Medicaid Services' (CMS) Home Health Prospective Payment System Rate Update for CY 2014.

The Academy represents those physicians and non-physician providers who are caring for some of Medicare's sickest, most costly and most vulnerable beneficiaries—those with multiple chronic conditions who are home-limited due to illness and disability.

While some estimates are that this population is around 4 million this number and demand will grow as the multimorbid population grows. Much of this beneficiary population is characterized by six or more chronic conditions as reflected in the CMS Chronic Conditions Among Medicare Beneficiaries ChartBook.

As a result of beneficiary/demographic demand and practice focus, our members have a large percentage of their patients who have had or will have a home health episode of care. Additionally, Academy members as you know render professional services that closely supports beneficiary and program goals related to the home health industry. These services include;

- Certification and Recertification of Home Care Services – Academy members certify and re-certify home health services. A number of Academy members serve as employed home health agency medical directors as well.
- Hospital Readmission Reduction Policies - Academy member services in transition care management and care coordination supports CMS policy to reduce hospital admissions and readmissions.

- CMMI Demonstrations – Academy members contribute to the CMMI Demonstrations through participation in ACOs and also as selected Independence at Home (IAH) Practice Sites. These Demonstrations emphasize the coordination of care and the location of care in the less costly settings of the community and residence.
- Transition Care Management - CMS is supporting improved care transitions and hospital avoidance/readmission care through its coverage and payment that began this year of transition care management (TCM) services and codes. The TCM codes include coordination of HHA service and Academy members render such important service.

The Academy view, based on our members first hand knowledge of beneficiary condition and involvement with HHA services, is that the proposal to eliminate diagnostic codes will produce counterproductive and unintended results. These results will be detrimental to beneficiaries, to caregivers, to the general provider community, and to the Medicare Program. The proposal to delete codes should be eliminated or revised for the following reasons that we discuss below.

- 1) Is CMS limiting the scope of physician/medical practice in the home?
- 2) Academy members report that they appropriately and safely see and treat beneficiaries in the home with the diagnosis codes on the list proposed for deletion.
- 3) The Proposed Rule does not provide evidence beyond the reference to ABT and 3 M contractors' determination to support deletion based on too acute to be treated at home.
- 4) The code deletion serves as revenue reduction on top of revenue reduction – The proposed rule includes provision for rebasing of HHA rates and along with rebasing a 14% phased in reduction of payment.
- 5) The deletion of codes will have detrimental impact, and will undermine the extent of success of demonstrations and other programs and research regarding the appropriate care of patients in the home. CMS should analyze the results of such demonstrations and research before determining that diagnosis are too acute to be treated in the home.
- 6) Deletion of the codes and inability of HHAs to be paid to render services in the home based on the diagnosis could lead to hospital admissions of patients against their documented preferences.
- 7) The deletion of codes could lead to increased hospital length of stay, access to care particularly in rural areas could be diminished, both leading to increased program cost and patient inconvenience.
- 8) The deletion of codes is contrary to technological advancement in communication, telemedicine and telehealth; and will have chilling effect on development.

- 9) The proposed deletion of codes could lead to inaccurate/misdiagnosis of patients.
 - 10) Will the deletion of codes as proposed be linked to Part B services? Will the deletion of codes lead to denials of accurately coded Part B claims?
 - 11) The deletion of codes could lead to increased risk management issues.
- 1) Is CMS limiting the scope of physician/medical practice in the home?

The deletion of codes as proposed is counter to prevailing public policy and medical practice finding that care in the home achieves the “triple aim” of better care, higher patient satisfaction, and lower cost.

The U.S. places excessive reliance on institutional care for the home limited elderly in comparison with the care delivery models in other developed countries. CMS is supporting the growth of alternatives such as Independence at Home and Hospital at Home which reflect the scope and reality of conditions that can be covered and managed in the home and the list of conditions safely managed and treated is growing and not shrinking as the proposed rule would mandate.

- 2) Academy members report that they appropriately and safely see and treat beneficiaries in the home with the diagnosis codes on the list proposed for deletion.

Academy members provide the following by way of example;

- “In my review of the diagnoses, I believe these could impact the home infusion anti-infective therapy patients, home TPN patients, and ostomy / surgical drain patients. I believe there is a reasonable literature and practical national experience with community anti-infective therapies as well as home TPN.

If you are serving as a medical director of a modern home health agency that works with these complex patients (often post-surgical, late stage oncology, etc) you may find that some of the diagnoses (albeit none in high volume) could end up benefiting from care at home at some point in their course of illness...this should be an individual decision by the patient and their physician/practitioner. Over time, I think we'll become more and more sophisticated on what we can do at home.”

Physician, President and CEO of a large VNA

- “We could have a high acuity patient who could need home health nursing for one of these diagnoses.”
Physician and Leader of Independence at Home (IAH) Practice Site
- “Imagine the total cost of incentivizing doctors to send people to the hospital even more!”
Physician, Central New Jersey

- “We certainly have had some of these issues – like acute intestinal obstruction, or acute GI hemorrhage of one kind or another that we have taken care of in a palliative way. Many patients are unable to be referred to hospice, so using nursing agencies to take care of these patients so they can die at home comfortably is very important.”
Physician, Academic Medical Center, New York City
 - “Wouldn't these same codes carry over from an acute hospital stay to a home care referral? For example - your average copd'er has chronic obstructive asthma, they catch an infection and go into status asthmaticus and go to the hospital for treatment. After a couple of days, they are sent home with a home care referral. Wouldn't the diagnosis be 493.21?”
 - “What about ulcers, paralytic ileus, and other bowel obstructions - don't we typically have home care nurses monitor the patients after an acute care stay to be sure that they are recovering?”
Nurse Practitioner, Southern New Jersey
 - “These are codes I think I might use in an Assisted Living Facility or in a home. I'd like to note that many times patients refuse to go to the hospital.”
Physician Assistant, West Coast of Florida
 - “I practice House Calls in a rural area of Ohio. These new rules would make it harder for me to get a Home Health agency to visit my patients.”
Physician, Rural Ohio
 - “We handle acute codes all the time-plenty of people want to avoid the hospital even for potentially lethal diagnoses--to deny services even further is a huge step backwards.”
 - “I find this entire idea of something to be too acute to manage at home interesting in the fact that is part of the Affordable Care Act. By mandating people go to the hospital to be treated for such things in spite of possibly being terminal all they're going to do is increase cost. Probably once or twice a month in my own small practice I am managing end-of-life care, which commonly would have some of these diagnoses. To bar us from doing so would merely increase costs, inconvenience the patient, in mandate the level of care which neither the patient nor treating provider would want.”
Physician Assistant, Western Massachusetts
- 3) The Proposed Rule does not provide evidence beyond the reference to ABT and 3 M contractors' determination to support deletion based on too acute to be treated at home.

For example;

- Has CMS convened expert panels to provide input such that diagnoses are too acute to be treated in the home? If so, it would be beneficial for the home health industry and for the Part B provider community who render services to beneficiaries in the home to see such clinical and scientifically based reports.

- Has treatment of beneficiaries with these diagnoses resulted in increase in number of episodes of home health services, have such beneficiaries been admitted/readmitted to the hospital at higher rates than beneficiaries receiving home health services with diagnoses that are not on the list for deletion? If so, it would be beneficial to see documentation of such results.
 - Have professional liability carriers reported to CMS that the incidence or payment of claims for beneficiaries seen in the home for these diagnostic codes exceeds that for beneficiaries with diagnostic codes that are not on the list for deletion? If so then it would be beneficial to see such results.
 - Have there been beneficiary or caregiver complaints for having been seen in the home with a diagnosis on the proposed list for deletion? Do these complaints or expression of decreased patient satisfaction exceed that for diagnostic codes that are not on the list for deletion? If so, then it would be beneficial to see such results.
- 4) The code deletion serves as revenue reduction on top of revenue reduction – The proposed rule includes provision for rebasing of HHA rates and along with rebasing a 14% phased in reduction of payment.

The codes recommended for deletion will not be included in future case mix weight calculation and thus will have the impact of reducing payment beyond the 14% phased in reduction. The proposed rule provides this impact as reducing average case mix from 1.3517 to 1.3417. In effect, 2 reductions are proposed. Our view is that this is an unwarranted addition to the large 14% reduction that HHAs will have to incorporate.

- 5) The deletion of codes will have detrimental impact and will undermine the extent of success of demonstrations and other programs and research regarding the appropriate care of patients in the home. CMS should analyze the results of such demonstrations and research before determining that diagnosis are too acute to be treated in the home

The deletion of codes will have the unintended effect of undermining the care patterns and momentum that the ACO and IAH Demonstrations are just now establishing. This is due to the fact that referral sources for home health services will be concerned that a beneficiary (with accurate diagnostic coding) will not be accepted by the HHA. This will undermine the care patterns being established to treat beneficiaries in the least costly setting and the encouragement the Demonstrations are producing for providers to consider non acute facility care whenever possible. This will undermine the extent of potential success of the Demonstrations.

Beyond the ACO and IAH Demonstrations there are also other programs/research projects such as Hospital at Home developed at the Johns Hopkins University School of Medicine that are evaluating the care of hospital level patients in the home. The proposed deletion of codes will have the effect of discouraging the enrollment of beneficiaries that while sick would be appropriately managed and treated in the home.

This will also have the effect of slowing the scientific progress of learning how to provide increasing levels of care in the home to those acutely ill in addition to those with chronic conditions. CMS, absent evidence of risk to the contrary as discussed above, should analyze the results of its Demonstrations and such other research before determining that diagnosis are too acute to be treated in the home.

- 6) Deletion of the codes and inability of HHAs to be paid to render services in the home based on the diagnosis could lead to hospital admissions of patients against their documented preferences.

A major policy initiative of CMS is for patient preferences to be formally established in the medical record, communicated and honored. This is seen in initiatives such as EHR incentive “meaningful use” measures and the measures in the CMMI Shared Savings Demonstrations such as ACOs and Independence at Home. This expressed policy initiative of CMS is also found in the 2014 Proposed Payment Rule for Complex Chronic Care Management Services and in current congressional proposals regarding Medicare payment.

As a result, providers are now obtaining and documenting patient preferences at increasing rates. Such preferences include the desire to not be transferred and receive services in a hospital setting. Thus, ironically, this proposal if it leads to a lack of HHA services in the home leading to beneficiary deterioration would in turn lead to admission against the beneficiaries communicated and documented preferences. Surely it is not CMS intent to lead to admissions against beneficiaries documented preferences.

Moreover, the home is also the most preferred setting according to beneficiary/patient satisfaction surveys. The home is also where the greatest amount of caregiver assistance is available.

- 7) The deletion of codes could lead to increased hospital length of stay, access to care particularly in rural areas could be diminished, both leading to increased program cost and patient inconvenience.

The code deletion could have the effect of extending hospital length of stay as HHAs become reluctant to accept beneficiaries with these accurately coded diagnoses. This will lead to increased hospital length of stay as hospitals work to arrange discharge and care in the home. This will increase program cost. Moreover, length of stay will increase the likelihood of hospital acquired infections that, in turn, will increase length of stay and increase cost.

And on the other side, we are concerned that beneficiaries in the community will have increased difficulty in obtaining home health services. As a result, we are concerned that HHAs will not be in communication with Part B providers such as Academy members whose services along with that of home health services could serve to safely treat and manage the beneficiary in the home (again as encouraged by CMS readmission policies and Demonstrations). Absent such access to HHA services and communication beneficiary condition could deteriorate such that admission is unavoidable. This will unnecessarily create beneficiary hardship due to inconvenience and trauma of travel to hospital and will increase Program cost.

- 8) The deletion of codes is contrary to technological advancement in communication, telemedicine and telehealth; and will have chilling effect on development.

The movement of care to the home has been supported by advancement in technology. In turn, the movement of care to the home supports continued advancement in technology and use cases for communication, telemonitoring and telehealth.

Technological advancements also support the appropriate care of increasing acuity in the home. CMS has policy to cover and pay for certain services rendered via telehealth. CMS in a current example, recognizes such appropriate care and technology support through its proposal in the 2014 Proposed Payment Rule to cover the Transition Care Management (TCM) services when components of such service are rendered by telehealth.

Thus, the proposed deletion of codes will have a chilling effect on the appropriate development and use of technology for support of medical care in the home. The deletion of codes will also be confusing to the Part B providers rendering care in the home, given the broad based policy of supporting care in the least costly setting down to the specific proposal to cover TCM via telehealth.

The home is also the most preferred setting according to beneficiary/patient satisfaction surveys. The home is also where the greatest amount of caregiver assistance is available.

- 9) The proposed deletion if occurs may lead to the inaccurate diagnostic coding/misdiagnosis of patients.

This could be the case as beneficiaries will want to be treated in the home rather than the hospital; home health agencies will desire to provide beneficial services and physicians will want to render efficacious services in the safe appropriate home setting.

As a result, and so as to not lose the opportunity to provide service that has been historically and safely rendered in the low cost setting, physicians and others involved with diagnostic coding will be under pressure to select diagnostic codes that are less accurate than those on the list to be deleted simply to preserve the ability for the beneficiary to receive service in the home where they most prefer. Again, this is surely not the intent of CMS to support other than the most accurate diagnostic coding.

- 10) Will the deletion of codes as proposed be linked to Part B services? Will the deletion of codes lead to denials of accurately coded Part B claims?

What impact on claim adjudication will occur if Academy members or any Part B providers submit a claim for a home or assisted living facility service with a diagnostic code that is on the list to be deleted (regardless of whether the beneficiary is receiving home health services)?

Will this lead to claim denial on the Part B provider side? That is what will occur if a provider sees a beneficiary and in good faith submits accurate diagnosis on their claims?

Will this be linked somehow to the Part A episode of care and lead to claim denial when the provider is merely accurately coding?

We hope the answer to these questions is no. Again, this could lead to the unintended consequence of inaccurate diagnostic codes being used on Part B claims.

11) The deletion of codes could lead to increased risk management issues.

Beneficiaries as discussed above with these diagnoses have been and are currently appropriately and safely being treated in the home (and more so with encouragement via CMMI Demonstrations). However, a concern is that CMS "too acute to be treated" designation will be mis-interpreted as a standard of care. Thus, absent an absolute CMS prohibition on Part B providers seeing such beneficiaries in the home or ALFs based on evidence of risk; the question then becomes will such regulatory de-facto designation of too acute to treat at home create a professional liability risk management issue?

This would be a very unfortunate outcome for both beneficiary and the provider. Further, this outcome would have a further chilling and discouraging effect on the development of the necessary housecall workforce. This will also be contrary to support of CMS policy and demonstration projects such as ACOs and Independence at Home that are designed to encourage care in the least expensive setting, the home, and to encourage more providers to provide service to this growing segment of high cost beneficiaries.

In closing, and for the reasons discussed above, it is our view that the proposed deletion of codes is counterproductive, will cause beneficiary hardship and inconvenience, will create unintended consequences and will have the effect of increasing rather than lowering total program cost.

We appreciate the opportunity to comment and would be happy to answer any questions.

Sincerely,



George Taler, MD
Chair, Public Policy Committee
American Academy of Home Care Physicians