



September 4, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1358-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1358-P; Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies

Dear Acting Administrator Tavenner:

AARP is pleased to provide the following comments on the above proposed rule which was published in the *Federal Register* on July 13, 2012 (77 FR 41548). In this notice of proposed rulemaking, the Centers for Medicare & Medicaid Services (CMS) proposes an update to the Home Health Prospective Payment System (HH PPS) rates and addresses other Medicare home health proposed changes. CMS also proposes new requirements concerning the hospice quality reporting program. In addition, CMS proposes to establish requirements for unannounced, standard and extended surveys of home health agencies and provide a number of alternative (i.e., intermediate) sanctions if such agencies are out of compliance with federal requirements.

Home Health Face-to-Face Encounter

Under the ACA, health care providers must have a face-to-face meeting with patients as a Medicare payment requirement for home health and hospice care. CMS currently requires that, as a condition for home health payment, prior to certifying a patient's eligibility for the home health benefit, the physician must document that the physician himself or herself or a permitted non-physician practitioner has had a face-to-face encounter with the patient.

CMS proposes to modify the regulations to allow a nonphysician practitioner in an acute or post-acute facility to perform the face-to-face encounter in collaboration with or under the supervision of the physician who has privileges and cared for the patient in the acute or post-acute facility, and allow such physician to inform the certifying physician of the patient's homebound status and need for skilled services. The rationale for this proposed policy change is that it would result in more efficient care coordination between the acute or post-acute nonphysician practitioner and physician as well as the certifying physician

and that this more efficient care delivery will result in an improved transition of care for the patient from the acute or post-acute facility to the home health setting.

Lack of access to or delays in accessing home health care could mean that individuals receive more costly institutional care and that their ability to live in their home and community is compromised. With the proposed change, CMS will make it marginally easier to fulfill the face-to-face requirement, thus reducing the potential face-to-face encounter barrier. We believe, however, that the requirement should be further modified to permit nonphysician practitioners to certify/order home health, although we recognize that this would require a legislative change. This further modification could also prevent possible delays in accessing needed care.

Therapy Coverage and Reassessments

Current rules provide that in cases where patients are receiving more than one type of therapy and a required reassessment visit is missed for any one of the therapy disciplines for which therapy services are being provided, the therapy visits are not covered for any of the therapy disciplines until the qualified therapist who missed the reassessment visit complies with the reassessment visit requirements. As CMS notes, this requirement may impede beneficiaries' access to therapy services. If a home health agency anticipates that a visit will not be covered because one qualified therapist has not completed the required reassessment, it might be reluctant for any therapy visits to occur until that missed reassessment visit is completed.

In response to this concern, CMS proposes to modify the regulations so that in cases where multiple therapy disciplines are involved, if the required reassessment visit was missed for any one of the therapy disciplines for which therapy services were being provided, therapy coverage would cease only for that particular therapy discipline. Therefore, as long as the required therapy reassessments were completed timely for the remaining therapy disciplines, therapy services would continue to be covered for those therapy disciplines.

AARP strongly supports this proposed change in policy because we believe that it will remove a barrier to necessary, appropriate and timely home health services. We commend CMS for proposing this change.

Quality Reporting for Hospices

Under current law, hospices that fail to report required quality data will receive a reduction in their market basket update by 2 percentage points beginning with FY 2014. The Secretary is required to establish procedures for making quality data submitted by hospices available to the public. In addition, the Secretary is authorized to report quality measures that relate to services furnished by a hospice on the CMS Web site. We encourage CMS to make quality measures for hospice available on www.medicare.gov, as it does for other providers.

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In the proposed rule, CMS asserts that the development and implementation of a standardized data set for hospices must precede public reporting of hospice quality measures. CMS advises that it is still working on this and plans to announce the timeline for public reporting of data in future rulemaking. The data set may be implemented in 2014.

As part of these considerations, CMS is considering an expansion of the required measures to include some additional measures endorsed by the National Quality Forum (NQF) for annual payment determinations beyond FY2015. CMS identifies the measures of particular interest as NQF numbers 1634 (pain screening), 1637 (pain assessment), 1638 (dyspnea treatment), 1639 (dyspnea screening), and 0208 (family evaluation of hospice care).

It is essential to ensure that the goals of patients and families are met and person-and family-centered care is provided in hospice and palliative care settings. All individuals with life-limiting illness should have well coordinated care, symptom relief (from e.g., pain, shortness of breath, nausea, and depression), and opportunities for effective (linguistically and culturally appropriate) communication to ensure that their preferences are honored. The Measure Application Partnership's (MAP) June 2012 report on hospice and palliative care identified several high-leverage measurement opportunities as well as areas where there are not yet NQF-endorsed measures (e.g., access to the healthcare team on a 24-hour basis; comprehensive assessment (bundled measure); timeliness/responsiveness of care; and psychological and psychiatric aspects of care, particularly anxiety and agitation). AARP urges CMS to address the gap areas in order to have measures that will provide a more comprehensive picture of hospices' performance in areas of great importance to beneficiaries, their families, and clinicians.

To make public reports most meaningful to patients and their families, the MAP recommended that several measures be paired, including NQF # 1634 with #1637; #1638 and # 1639 (the NQF measures noted earlier in this section of our comments). We strongly urge CMS to report these measures as recommended so that users will have a more complete picture of care provided by the hospice.

We strongly support surveying families for feedback on hospice care experience because we believe they offer unique insights on the quality of care provided by hospices. AARP is pleased that CMS is considering implementation of the Family Evaluation of Hospice Care Survey (FEHC), as was recommended by the MAP, but the evaluation could be further enriched by assessing experience earlier in the care continuum and during transitions of care.

Home Health Survey and Enforcement Requirements

The Omnibus Budget Reconciliation Act of 1987 (OBRA'87) authorized HHS to change the manner in which they regulated and carried out enforcement actions with home health agencies. Because too many changes have occurred since the agency's 1991 initial and never finalized rule to codify these actions, CMS proposes to revise the original proposed rule and update it to include all current situations. The intent is to promote quality of care for patients by ensuring that home health agencies that are out of compliance with the Conditions of Participation are able to correct their performance and achieve prompt compliance through methods, such as civil money penalties, directed plans of correction, or directed in-service training (alternatives to the ultimate sanction of terminating a home health agency's participation in Medicare).

AARP commends CMS for taking steps to codify the OBRA'87 home health survey and enforcement requirements. Regulations are long overdue and we believe that having available a set of intermediate or alternative sanctions is critical to an effective enforcement program. Such alternatives give CMS a potentially more efficient and effective set of tools to encourage home health agencies to eliminate deficiencies. We do, however, want to indicate our specific support or concerns with certain of the following proposed measures:

Surveyor Qualifications. CMS proposes that surveys of home health agencies would have to be conducted by individuals who meet minimum qualifications prescribed by CMS. Included is a prohibition on individuals from surveying a home health agency if they have served on the staff or as a consultant to that agency. This prohibition would also apply if the surveyor has a financial or an ownership interest; has a family member who has a relationship with the agency; or has an immediate family member who is a patient of the agency to be surveyed.

AARP supports provisions to guard against potential conflicts of interest on the part of individuals who are responsible for surveying home health agencies to determine whether they are meeting the Conditions of Participation. These surveys are critical to ensuring the health and safety of Medicare beneficiaries served by home health agencies and should be conducted with a discerning and impartial eye, a perspective which may not be possible if the surveyor has a vested interest in the survey's outcome.

Termination of Provider Agreements: Notice and Disclosure Requirements. Under the proposed rule, if CMS or the state survey agency determined deficiencies existed which posed immediate jeopardy to patient health and safety, CMS would terminate the provider agreement (or the provider could voluntarily terminate its agreement). CMS and the survey agency would, if necessary, work with the home health agency to ensure the safe discharge and orderly transfer of all patients to another Medicare-approved home health agency. CMS proposes a set of procedures for terminating a provider agreement, including the opportunity for appeal and notice requirements. Specifically, CMS proposes to give notice to the agency at least two days before the effective date of the termination

and concurrent notice to the public when a termination based on deficiencies that posed immediate jeopardy to patient health and safety occurred.

AARP believes that there should be sufficient notice to the home health agency so that it has enough time to arrange for a smooth handoff and transfer of its patients to a new agency. The timing of public notice should also be as concurrent as possible with the notice provided to the home health agency in order to permit patients and their families to make alternative arrangements without jeopardizing continuity of care. Since many patients and families may not become immediately aware of a public notice, any such notice should be sent directly to all patients and the “responsible party”, if not the patient, of any agency being terminated. Any such public notice should also be posted on the Medicare Home Health Compare website.

Solicitation of Comments Related to Termination and Notices. CMS is considering that when a suspension of payments for new admissions and new payment episodes or a civil money penalty (CMP) is imposed, CMS could but would not have to issue a public notice. As CMS notes, the issuance of additional publicly-reported notices when certain sanctions are imposed would offer information to patients who were choosing a provider of home health services, as well as to current recipients of home health care. Such individuals do not necessarily know when a survey has been conducted at a home health agency and if deficiencies had been determined or sanctions imposed unless a surveyor visited the patient during a survey or the patient requested a copy of a Statement of Deficiencies from the survey agency or the home health agency.

AARP strongly supports a requirement that CMS provide for public disclosure in the case of a suspension of payments for new admissions and new payment episodes or the imposition of a CMP. As appropriate, such notice should be sent directly to patients and the “responsible party”, if not the patient, since many patients and families may not become immediately aware of a public notice. We believe that it is appropriate to provide notice not only to current home health patients but also to those who may become patients of the particular home health agency under sanction. Such information should also be made available to the public at large so that it is available to patient advocates and others who may advise beneficiaries of their options. Any such public notice should also be posted on the Medicare Home Health Compare website.

We also strongly support the proposal that CMS has included in §488.840 to prohibit the home health agency from billing the patient unless certain notices are given. We strongly support these notices, which are critical to ensuring that beneficiaries and their families have the information needed to understand their options and make informed decisions.

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We appreciate the opportunity to provide feedback on these important provisions related to Medicare home health and hospice services. We look forward to working with you as you implement these provisions. If you have any questions, please feel free to contact Rhonda Richards on our Government Affairs staff at (202) 434-3791.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David Certner
Legislative Counsel & Legislative Policy Director
Government Affairs