

Centers for Medicare & Medicaid Services Special Open Door Forum:
Designing A Home Health Value-Based Purchasing Program
Thursday, February 24, 2011 1:30-3:00 pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on designing a value-based purchasing program for home health agencies (HHAs). The purpose of this Special Open Door Forum is to solicit input from all parties interested in the development of the plan for implementing a VBP program in HHAs.

Section 3006 of the Affordable Care Act requires the Secretary of Health and Human Services to develop a plan to implement a value-based purchasing program for payments to home health agencies under the Medicare program. The Secretary must submit a report containing this plan to Congress not later than October 1, 2011. Currently, we are in the process of identifying and analyzing key components of an effective VBP program for home health care.

After a brief presentation by CMS on the statutory requirements and the goals and objectives for today's call, we will open the phones to comments. CMS is seeking stakeholder input on a number of topics defined in the statute including:

1. The ongoing development, selection, and modification process for measures of quality and efficiency;
2. The reporting, collection, and validation of quality data;
3. The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality, the size of such payments, and the sources of funding for the value-based bonus payments;
4. Methods for the public disclosure of information on the performance of home health agencies; and
5. Any other issues.

The following list provides additional questions and findings from a literature review of existing VBP programs that we are interested in getting feedback.

1. **Quality Measures.** Which types of measures do you think should be used to measure agency performance under a VBP program?
2. **Measuring Performance.** What are the advantages and disadvantages of using individual measure scores or composite scores?
3. **Ranking Performance.** Should performance incentives be based on attainment, improvement, improvement with an attainment floor or a combination?
4. **Payment Mechanisms.** What factors should be considered in deciding how to reward incentive payments (e.g., payment frequency could be yearly, quarterly, or more frequent) and to collect penalties (e.g., withholding a percentage of all payments and distributing accumulated funds to high performers would eliminate the need to collect

payments from poor-performing agencies)? What do you think is an appropriate payment level to promote high-quality care, without introducing excessive uncertainty about revenue?

5. **Data Infrastructure.** What do you think are the most pressing concerns in the current data collection system for home health care? What can be done to reduce the burden of data collection, and ensure timely and accurate data submission?
6. **Public Reporting.** How can public reporting complement a VBP program?

You are also encouraged to submit additional thoughts or feedback following the session to an email address established for this purpose: HHVBP@cms.hhs.gov

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial 1-800-837-1935 Conference ID 37941789

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and a Relay Communications Assistant will help.

An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around March 24, 2011.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.gov/opendoorforums/>.

Thank you for your interest in CMS Open Door Forums.

Transcript & Audio File -

<http://media.cms.hhs.gov/audio/ValueBasedPurchasingEffortHH022411.mp3>

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar
February 24, 2011
1:30 p.m. ET

Operator: Good afternoon. My name is (Sarah) and I'll be the conference operator today. At this time, I'd like to welcome everyone to the Home Health Value-Based Purchasing and Special Order Open-Door Forum Conference Call. All

Lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a comment session. If you wish to state a comment during this time, simply press star then the number one on your telephone keypad. If you'd like to withdraw your comment, press the pound key. Thank you, Ms. Cebuhar, you may begin your conference.

Barbara Cebuhar: Thank you (Sarah) and welcome to our special open-door forum where we hope to receive public input on crucial components of the implementation plan for the Home Health Value-Based Purchasing Report to Congress. Today, CMS will be in a listening-only mode.

Our hope is to capitalize on your accumulated experience and insights to help guide the design of a value-based purchasing program for home health agencies as required under Section 3006 of the Affordable Care Act.

My name is Barbara Cebuhar and I work in the office of External Affairs and Beneficiary Services. While I'm not an expert on value-based purchasing, there are colleagues on the line who look forward to hearing your insights and comments. Again, CMS will be in a listening-only mode.

In addition to hearing your comments on the call today, please send any additional feedback that you think would be valuable to consider in this report to Congress to hhvbp@cms.hhs.gov. Let me repeat that. That's hhvbp@cms.hhs.gov. That's hhvbp@cms.hhs.gov. We will be accepting written comments in the mailbox until close of business on March 4th, 2011. I'd like to introduce John Pillote, Acting Director, Performance-Based Payment Policy Staff with the Center for Medicare, who will provide background on this effort. And then, I will take you through the questions that are posted on the special open-door forum Web site and were sent out as part of the invitation to this session.

John, go ahead please.

John Pillote: Thank you, Barb and thank you all for taking the time out of your busy day to join us for this open-door forum. We very much appreciate your time and effort on this and look forward to getting your comments in the areas that

Barb will be walking you through later. As Barb mentioned, the goal of today's call is to receive public input on the crucial components of the Home Health Value-Based Purchasing Report to Congress. The Affordable Care Act requires the Secretary of Health and Human Services to develop a plan to implement a value-based purchasing program for payments to home health agencies under Medicare and the plan is due to Congress no later than October 1, 2011.

So it's timely and your feedback will be valued and help shape what this report ultimately looks like and recommends. We're especially interested in your feedback today in several areas. First is what types of measures including the ongoing development, selection and modification process of measures to the extent feasible and practicable of all dimensions of quality and efficiency should be included in the home health value-based purchasing report?

How should the reporting, collection and validation of quality data be structured in order to minimize administrative burden on agencies, as well as ensure the timely collection of data for quality reporting purposes? What should the structure of the value-based payment adjustments including the determination of (thresholds) or improvement in quality look like for purposes of adjusting or providing additional incentive payments to home health agencies?

And again, here, I would like to emphasize a lot of CMS value-based purchasing initiatives and areas focused on not only the attainment of high quality but also rewarding organizations to improve over time. We're interested in your thoughts and input on this area as well. And finally, what method of public disclosure of information on performance results should be included and publicly be made available by CMS, in order to promote more informed decision making on behalf of our Medicare beneficiaries to utilize home health services and their caregivers, as well as to promote greater transparency in this value-based purchasing initiative, as well as a larger value-based purchasing programs across the agency?

Again, I'd like to thank you for taking the timeout to participate today. We very much look forward to your comments. I encourage you all to comment on this. We have a significant amount of time devoted to this and I hope we take advantage of your collective knowledge as Barb mentioned to gain industry insight into these areas that will again help shape our report to Congress on this. So with that, I'll turn it back to Barb. Thank you very much.

Barbara Cebuhar: Thank you, John. Measure and quality is the first step in linking payment to the quality of care provided by home health agencies. Ideally, the set of measure used for payment will capture different elements of care. Currently, several types of measures are used to measure a home health agency performance and these measures can be grouped into five categories, process, utilization, patient satisfaction, potentially avoidable events and functional or clinical outcomes. Individual measures can have specific properties that may affect how useful they are for value-based purchasing.

Measures may have a very narrow distribution, meaning that almost all agency score within a small percentage range or a measure could be topped out, meaning that almost all agency score between 95 percent and 100 percent, or a measure could also only apply to few patients so the scores could be volatile from year-to-year. These variations among measures are important to keep in mind when selecting the most important measures of agency performance. Our question today is which type of measures do you think should be used to measure agency performance under a value-based purchasing program? Which types of measures do you think should be used to measure agency performance under a value-based purchasing program? (Sarah), could we open the phone lines now?

Operator: At this time, I would like to remind you, in order to make a comment, please press star then the number 1 on your telephone keypad. We'll pause for a brief moment to compile the roster. Your first comment comes from (Donna Craft), your line is now open.

(Donna Craft): Hi, thank you for hosting this today. The first one that comes to my mind is that the acute care hospitalization rate that if home cares keep patients at home

providing the quality healthcare and keep them in the home and out of the hospital, that definitely should be part of value-based payment.

Barbara Cebuhar: Thank you (Donna). Our next comment please.

Operator: Your next comment comes from (Donna Margen). Your line is now open. (Ms. Margen), your line maybe on mute. Please unmute your line.

(Donna Margen): Thank you. One of the things that is most important is looking at clinical outcome, are you keeping the patient out of the hospital, are you keeping them out of the nursing home and how are you utilizing Medicare dollars wisely (inaudible) thousand dollar hospital stay per day certainly would not be beneficial to patients who you can keep on home health and perhaps spend \$2,000.00 for 60-day episode. So when you're looking at clinical outcomes, you also have to look at the frailness of the patients that are involved because all patients cannot be scored equally. Some patients are not going to improve but they're going to be able to remain in their home longer. Thank you.

Barbara Cebuhar: Thank you. Our next comment.

Operator: Next comment comes from (Mary St. Pierre). Your line is now open.

(Mary St. Pierre): Hi, Barbara. Thanks for this opportunity to comment. We will certainly be submitting our written comments and responses. NAHC and a large representative of the provider community did participate in the development of some recommendations for value-based purchasing review for (inaudible) performance, back at that time, it's been some time since we met but we did establish a series of recommendations that we currently have in our National Association for Home Care and Hospice Regulatory blueprint.

Some of the basic premises for identifying the measures are one of the things that we really strongly feel that any measure that is selected should be one that is in the control of the home health agency and susceptible to the influence of the home health agency. This is particularly important being that the services are provided in the home where the patient is under their own care or the care of the family members for the majority of the time. So we feel it's really

important that whatever measures selected are those that the agency can control.

Also, we do have some concern the fact that we now have new process measures and we feel that measure sure be selected based on uniform data that the agencies have collected and reported for a sufficient period of time to ensure that there's consistency and reliability. Yes we think process measures should be collected. We've actually lobbied (further) to be process measures in home health but there needs to be enough time for these new process measures to kind of shake out and make sure that they truly are reflective and accurate in reflecting the quality of care provided by the agencies.

And then of course with our outcome measures, they are now based on Oasis (inaudible) and there's a new risk adjustment that's being established isn't even out there yet and won't be until the spring. And so again, I think that before we identify specific outcome measures, we really need time to see how this risk adjustment methodology works as new risk adjustment methodology.

Barbara Cebuhar: Thank you, (Mary). (Sarah), do you mind announcing the organization name of the people please.

Operator: Yes, that's no problem.

Barbara Cebuhar: Thank you. Are there any comments?

Operator: The next comment comes from (Charlotte Pickett), from Sunrise Home. Your line is now open.

(Charlotte): Yes ma'am. We were looking at maybe the (HCHAP) survey could play a crucial part in that since we're all having to do (HCHAP) surveys now as part of the value based.

Barbara Cebuhar: Thank you, (Charlotte).

(Charlotte): Thank you.

Operator: The next comment comes from (Beth Hendricks) of Home Health. Your line is now open.

(Beth Hendricks): Yes, hi. We were also discussing clinical outcome so our recommendation has already come up.

Barbara Cebuhar: Thank you very much.

Operator: The next comment comes from Val Edison of IA Health Home Care. Your line is now open.

Valerie Edison: My comment very much shadow what (Mary St. Pierre) said that in a measure that's very important is reducing that acute care hospitalization but certainly include the risk adjusted level with that. Many of us do take patients that are more difficult to keep out of the hospital. I do think that some of the timely initiation of care process measure and the heart failure in a short term episode of care are very, very important in reducing their hospitalization. So I would certainly recommend that along with an outcome measure of improvement in oral medication.

Barbara Cebuhar: Thank you, (Val). Our next comment.

Operator: Your next comment comes from Bob Wardwell of VNAA. Your line is now open.

Bob Wardwell: Hi Barbara.

Barbara Cebuhar: Hi, how are you?

Bob Wardwell: Thank you. I think one point I'd like to pick up on, (Mary St. Pierre) kind of alluded to at the end of her remarks is how critical it is that whatever measures come into this are very well risk adjusted. The current risk adjusted system is (inaudible) as good enough. I'm not sure if good enough for what. Right now, it's mostly influencing reported outcome measures and although it had some influence on behavior. I don't think it has had a great influence on behavior. When this begins to take an impact on payment, people will take this even more seriously.

And the real risk here is that a measure is not really very well risk adjusted (while) exacerbated problem that already exist with the patients and the

current payment system in terms of risk adjustment. There is real temptation to select patients based on their potential revenue and their potential outcome. So if we don't have a really sound risk adjustment system on any measure or measures we pick, we all real risk of exacerbating a problem that already has too many patients and too many areas being left behind waiting for safety net providers like VNAA to pick them up because they don't have a good prognosis and are going to be costly to care for.

So I think number 1 is, in our view, speaking on behalf VNAA, is to make sure that measures that are selected have risk adjustment that is better than good enough and really excellent so everybody in the community can stand behind the fact that this actually is measuring differences in performance, not differences in what patients come to our door and are accepted for admission.

Barbara Cebuhar: Thank you, Bob. Our next comment.

Operator: Your next comment comes from Jeanne Ryan of VNA & Hospice. Your line is now open.

Jeanne Ryan: Hi, this is Jeanne. I think I can't say more about what needs to happen as in what (Mary St. Pierre) said. I think you're asking us for our feedback and I think what you're hearing is that there are number of pieces in the system right now that are problematic for us and so it's difficult to answer this question but I would say this, I would say two things. Absolutely, if we're talking about value-based purchasing because it's really a value to the patient and the payer, I would really be clear that it's within the home care agency's ability to do and I think acute care hospitalization as we know from all of our transitions in care work is a really difficult multifaceted experience that's also true for oral medication when we look at medical medicine reconciliation.

So I think any of these that touch various places are problematic. I'm not saying that's not where our work is but I think it's difficult to rate an agency strictly on those. And the other thing I's day is if we're going to go anywhere, I would stick with our Oasis outcomes. A number of us have already been involved in a pay for performance demonstration project. It's been the source document since 2000 and I would suggest, if we can fix some of the risk

adjustment that we look at value-based purchasing based on an agency's outcomes of care.

Barbara Cebuhar: Thank you, Jeanne. Do we have any more comments?

Operator: You do. Your next comment comes from the line of (Beth Hafney) of Southern Hospice. Your line is now open.

(Beth Hafney): This is (Inaudible) and I'd just like to offer (inaudible) with all the remarks that have been said but I suggest that we might also think about some measures that like (Mary St. Pierre) said that the home health provider does have some control over but also have long-term impact as far as the true value of a staying in and working with a patient and that is the work that we do to help an individual change their behavior.

So instead of just a patient satisfaction measure, look at things like a patient engagement measure or a patient self-efficacy or self-confidence in continuing to perform pertaining to once we are no longer in there and I think (inaudible) nicely with many of the initiatives in healthcare reform for new models of care such as the patients (under) medical home. It's all about how we work with an individual to help them in self-management support and our practice could be measured on that, so that's from our suggestion. Thank you.

Barbara Cebuhar: Thank you, (Beth). (Sarah), we have time for one more question.

Operator: The next comment comes from Dianne Hansen of Partners in Hospice. Your line is now open.

Dianne: I would like to emphasize the perspective of rural agencies and choosing measures that don't have impact based on the volume of patients in our current reporting that is later to come out this year. One of the measure is increase in pressure (ulcers) for a small agency, one single event can potentially cause to be higher than the national average and I think those considerations need to be taken into consideration when choosing measures where the size of the agency would implicate a decrease in the payment because of one single event.

Barbara Cebuhar: Thank you very much Dianne. (Sarah), we're going to go to the next question, if that's OK, please. One of the ways that providers can be rewarded for high-quality work is through payment adjustments that service bonuses. Policy makers can provide separate payments or bonuses based on the score for each individual quality measure or they can use a single composite score as the source for a single payment adjustment or bonus. Also, we can use payment adjustments to reflect the relative importance of each quality measure by using a weighting mechanism. With individual measure scores, weights can be determined how an agency's performance on individual measures affects that agency's overall payment adjustments.

With composite measure score, the different measures that contribute to the overall score could be weighted differently in order to come up with one bonus that rewards the overall quality of care provided. Our question is what are some advantages and disadvantages of using individual measure scores or composite scores? (Sarah), if we could instruct the folks how to get into the queue again, I'd appreciate it.

Operator: Again, a reminder. If you'd like to queue for a comment, please press star 1 on your telephone keypad. The first comment comes from (Joanne Kelly) of (Monson) Home House, your line is now open.

(Joanne Kelly): Thank you. One of the things that I think that we need to consider in the provider community but certainly with value-based program are the agencies that have possibly a higher percentage of chronically ill patients. I don't think any of us would disagree that avoidable hospitalizations are important but I think it's particularly important if you have a population of chronically ill patients with COPD or CHF that are in and out of your ED, and if you as a home care provider are able to keep those patients in their home, out of the hospital, I think that there should be some kind of a weighted measure given to allow for agencies that have a higher population more of a value-based score.

Barbara Cebuhar: Thank you, (Joanne). Our next comment, please.

Operator: Your next comment comes from Bob Wardwell of VNAA. Your line is now open.

Bob Wardwell: Yeah. I think one of the things that would be helpful in forming this when we see a complete final report from the demonstration that's currently underway, maybe (inaudible) I haven't seen it yet but it strikes me that while the individual measures have an inherent attractiveness it will be possible to develop a composite score that weighted multiple factors that might wind up being a fairer system and one way to offset one of the inherent statistical problems with the composite score of multiple elements is to use, rather than an absolute score, use a confidence interval around each score so that we get a sort of a fair representation of people that have various population numbers.

Entities will have relatively small numbers of patients when some will have larger and the confidence (inaudible) absolute score would help make the system fair in the long run but I think in the long (inaudible) may need that to reserve judgment on composite scores versus individual scores that we see the results of the demonstration and can also analyze what the statistical impact and accuracy and risk adjustment possibilities are in both types of systems.

Barbara Cebuhar: Thank you, Bob. Our next comment.

Operator: Your next comment comes from (Susan Halik) of (inaudible) Health System. Your line is now open.

(Susan Halik): Hello. A few comments based on some of the opportunities to weigh a score and/or receive payment. I would like to suggest so if there are outcomes that could improve scores and data that supports decrease admission into acute care hospital and/or disease burden then there are a lot of home care agencies that I know work with acute care hospitals and partner with them to deliver care and come up with ideas, innovative ideas across to continue to do that that there be weighted opportunities and/or payment opportunities for those home care organizations that can achieve those kinds of results through innovation and collaboration so they can see the benefit of that through the value based project.

Barbara Cebuhar: Thank you, (Susan). Our next comment please.

Operator: Your next comment comes from Judy Flynn of Partners HealthCare. Your line is now open.

Judy Flynn: Hi. I'm wondering if we can look a little outside of homecare and this kind links to the very first comment and is that there are CMS demos that I think entering now the fourth year looking at high cost beneficiaries and there are few others that are looking at high risk beneficiaries. Most of them are based in the hospitals or in the physician's practice environment and those are the patients, I think that what we're all trying to say is I'm not sure you can look completely at the home health agency and the Oasis data to get the level of risk or the level of high cost to the system.

And so, I think to really be able to profile the patient and then be able to evaluate what the agency is able to do with that patient, such as keeping them out of the hospital or increasing their independence in taking care of their own chronic disease. I think there are ways that you already have that data available to you. I think that there are ways that we can look at it that way also.

Barbara Cebuhar: Thank you, Judy. Our next comment, please.

Operator: Your next comment comes from (Allison Smith) of (All Country Home Care), your line is now open.

(Allison Smith): I think when we're talking about acute care hospitalization rate I think it needs to be taken into consideration. The patient who are members in the Medicare Advantage Plan or the Medicare so called buyout plan. I think with the delegation of care, it sometimes makes it challenging to provide the adequate level of care when they are only approving x amount of visits and that is something that we run across and I think if there's a way to take that under consideration when we're looking at these acute care hospitalizations and different things like that.

Barbara Cebuhar: Thank you, (Allison). Our next comment please.

Operator: Your next comment comes from Mary St. Pierre of NAHC. Your line is now open.

(Mary St. Pierre): I just pretty much what I had intended to say has already been said but just to throw in a couple of those considerations that would be the agencies that have a significantly older population or happen to be serving populations that have a large number of comorbidities or even the duly eligible population that have larger numbers of patients who are duly eligible. In terms of the acute care hospitalization, also, one of the things that's not considered at this point in the calculation of the acute care hospitalization rate is the length of time a patient is in a home health episode and that's really an important thing to consider and to take into consideration when calculating ACH rate for home health agencies.

Barbara Cebuhar: Thank you, Mary. Our next comment, please.

Operator: Your next comment comes from (Christy Cocker) of Interim HealthCare. Your line is now open.

(Christy Cocker): I think it's also important that we consider the acuity of the patients we are receiving from the hospital. We see a lot more highly acute patients coming out and it's difficult to base our care on some of those patients when they come out and they are readmitted rather quickly. Thank you.

Barbara Cebuhar: Thank you. Our next comment, please.

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: OK, great. I will move to our third question which is in the area of ranking performance. In most value-based purchasing programs, single or multiple thresholds are used to identify providers that offer excellent rather than poor quality care. Typically, these thresholds determine which providers are eligible for bonuses and which owe penalties. Two key standards have been widely used to identify providers eligible for bonuses and penalties under value-based purchasing, attainment and improvement over time. Our question is should performance incentives be based on attainment, improvement,

improvement with attainment floor or a combination. (Sarah), if you could instruct people how to queue up again, I'd appreciate it.

Operator: Again, if you would like to queue up for a comment, please press star 1 on your telephone keypad. A reminder, you must press star 1 each time there is a comment session to queue up. The first comment comes from (Donis Morgan) of Community Home Health. Your line is now open.

(Donis Morgan): Hi, thank you. Attainment versus improvement, if you're taking care a lot of chronically ill patient and patients with a lot of comorbidities, you're not going to be able to attain improvement over time. The idea would be to keep them stable, to keep them out of the hospital but I don't think you got to be able to show improvement in a lot of these patients. Thank you.

Barbara Cebuhar: Thank you for your comment. Our next one.

Operator: The next comment comes from Gayle Bentley from Robinson Hospice. Your line is now open. (Ms. Bentley), your line may be on mute. Please unmute your line.

Gayle Bentley: I was just addressing the same comment that was just made. We have a lot of patients that we see that we're doing medication and trying to reconcile and we reconcile them but they're going to be at a level 1 when we answer that question and when we discharge under a level 1, there is no really improvement, it's stabilization that's the issue. They're not declining so that's where I think there has to be some consideration that we're actually getting penalized because the patient will not probably never improve in that kind of situation but they're stabilized at least. So, I think there has to be consideration in that mode as well. Thank you.

Barbara Cebuhar: Thank you, Gayle. Our next comment please.

Operator: Your next comment comes from Marty Minitti of SNI. Your line is now open.

Marty Minitti: Yes, hi. I actually tried to comment last time but I think I can combine these. My comment was in terms of what should be measured, I think it is the

hospitalization rate and it is a rehospitalization rate but I think you have to look at the past three to five years data by region and if there is improvement in the region and if there is improvement in the particular agency, then that should go towards rewards. The other side of this, however, though is in order to manage the patients at home and there is going to be a huge shift to more patients at home particularly with medical home, the increase in certified medical homes, I think we're going to see cost rising to manage those patients 24/7 to manage a different level of acuity, not that we haven't been taking care of very acute patients but I think we're going to see the addition of more telehealth and more home monitoring and more requirements to actually keep those patients out of hospital which is a good thing for everyone but the current cost structure would not, or reimbursement structure would not recognize all that.

So I think we need to look at the population norms as they shift and pay attention to the savings that are going to be taking from one component but the costs that are going to be occurred in another component.

Barbara Cebuhar: Thank you, Marty. Our next comment.

Operator: Your next comment comes from Bob Wardwell of VNAA. Your line is now open.

Bob Wardwell: Hi, I think that all you can say is that it amends the notion that there are certainly a lot of patients who are in homecare and belong in homecare where you can't see a major improvement over time. Stabilization is a goal but often when we talk about this and the context of value-based purchase and we're talking about individual agency scores that improve versus individual agency scores that attain a certain level and I was on the impression there is almost a consensus to be fair, both of those have to play some role. It is perhaps waiting how much of reward goes for improvement of an agency versus how much goes to attaining a certain high level of performance in achieving a balance and that is a delicate issue.

And certainly you don't want to necessarily reward people who have improved if they have improved over a really dismal level of performance

where they aren't even in the ballpark with other agencies, that you don't want to encourage low-balling in scores like this. I think it ultimately will be a blend of both but it will take some experience to learn what kind of blend will work best and achieve the best outcome of rewarding actual improvement and attainment.

Barbara Cebuhar: Thank you, (Bob). Our next comment please.

Operator: Your next comment comes from Barbara Colin of Bayada Nurses. Your line is now open.

Barbara Colin: Yes, good afternoon. I really am in agreement with much of what has been said, but I think this is an area where I see client satisfaction coming to play and that I believe and I know an earlier person said this but the client's feeling of confidence and confidence about how they might be managing their disease process, especially chronic illness, I think can be taken into consideration along with the balance of attainment, containment measure.

Barbara Cebuhar: Thank you Barbara. I hope we can get our next comment, please.

Operator: Your next comment comes from (Donna Craft) of CNS Home Health, your line is now open.

(Donna Craft): Hi Barbara. It's (Donna). My comment comes that I do think there should be a combination and also some of the issue that is occurring and the comments that are made is the Oasis tool does not reflect acuity. You can have a patient that has a very high acuity that comes out with a quite low case (inaudible) and we have a palliative program along with an intermittent program that all falls into intermittent so our scores, after we start our palliative program because of achievement of stabilization being a really big goal for palliative in some of the patients go to hospice, it had a direct impact on our state report when they were still doing the state report. They have not restarted those but that does impact us so I think a couple of people have related to that and also we have one other comment.

(Marsha Nusgrove): This is (Marsha), and my comment is in regards to, it seems as if Medicare initially started the home health program as more of a short stay, get them

better, get them back to be functional, et cetera. But now, it feels a little schizophrenic to me because now it's about decreasing readmissions for chronic illness and in order to do that, it doesn't become one of those short stays, get some therapy and get them better, becomes chronic management. So in order to even talk about performance incentive, then achievement of outcome measures it feels like it would be helpful to have CMS clarify what their expecting from the home health delivery of care.

Barbara Cebuhar: (Marsha), your last name please.

(Marsha Nusgrove): (Nusgrove).

Barbara Cebuhar: Thank you.

(Donna Craft): Can I have one last comment regarding the HCAP? I think the best fantastic idea, I think what's important to know is that it just recently started so there's a lot of bugaboos in that in order to collect enough good data that we need to take that into consideration.

Barbara Cebuhar: Thank you, (Donna). I think we've got time for two more comments, please.

Operator: The next comment comes from (Anne Brasette) of (Bronx and Home Health). Your line is now open.

(Anne Brasette): Hi and thank you for taking my comment. I agree. I think that stabilization needs to have some importance in the equation, stabilization and improvement. I do have some concerns, though, over re-hospitalization because many times, we're trying to prevent re-hospitalization but you receive patients that maybe were discharged early or not well and if we look at what home care can impact, there are sometimes we cannot impact those patients that has to go back into the hospital that that decision to have the patient go back in is the appropriate decision. Thank you.

Barbara Cebuhar: Thank you very much (Anne). We do have time for two more questions, I'm sorry.

Operator: The next comment comes from (Jone Dezano) of (dobsondezano.com), your line is now open.

(Al Dobson): Yes, (Al Dobson, Dobson Dezano). A broader question, is there any way we can length readmission rates at the agency level to the broader readmission rates in the community? If we have a few agencies knocking off a few hospitalizations with the broader communities increasing more hospitalizations, we're not really getting a system wider population based effect.

Barbara Cebuhar: Thank you for your comment (Al), we appreciate it. Our next comment please.

Operator: Your next comment comes from (Richard May) of (Mercer Health). Your line is now open.

(Richard May): Thank you for taking the call. I do think it's important to clarify those terms that are being used between attainment and improvement. Attainment does not necessarily mean pure sustainment. It could mean attaining goals that could lead to improvement. So I think, crystal clear or clarity on defining those terms and I do, by the way favor on improvement model with an attainment floor.

Barbara Cebuhar: Thank you, (Richard). We are going to go on to our next question, if that's all right (Sarah)? The home health value-based purchasing program can feature a number of different structures and methods to pay agencies. The first option is to pay bonuses and collect penalties at the end of the year. This would ensure budget neutrality. Another option is to alter future agency payments based on past performance. In this case, the agency's base rate would be modified depending on its score on a prior year's quality metrics.

A third option is to withhold the percentage of all payments and then distribute the accumulated funds to high performers. This would eliminate the need to collect payments from poor performing agencies, lowering the administrative burden for CMS, and ensuring budget neutrality. All three of these payment options could be implemented yearly, quarterly or more frequently. Our question is what factors should be considered in deciding

how to reward incentive payments and to collect penalties? (Sarah), if you could instruct folks how to queue up again, I would appreciate it.

Operator: To queue up for a comment, please press star 1 on your telephone keypad. Again, a reminder, you need to press star 1 every time there is a comment session throughout the conference. The first comment comes from (Karen of Lake Center Home Care. Your line is now open.

(Karen): Just two points for a consideration relative to this question. So that smaller companies are able to balance internally with payments received, I would like to suggest that money paid are not recouped at a later date that some form of year end or quarterly distribution be set aside for payments to occur from. And then the second comment is with regards to the ultimate measurement means with regards to penalties, I don't know if it's being considered to have a fixed and known level at which a bonus would occur or a penalty would occur or if it's going to be a measurement between one-home health agency's performance than another home health agency's performance.

Personally, I do not feel that comparative measures relative to payment penalties that rely on the outcomes between one agency compared to another would be as appropriate as utilizing a known bonus point or a penalty point that is constant for all.

Barbara Cebuhar: Thank you for your comment. Our next one, please.

Operator: Your next comment comes from (Erin Dunhor) of Center Health at Home. Your line is now open.

(Erin Dunhor): Yes, I am very, very concerned about sole proprietors, sole agencies that are in rural America. When you're talking about for the most part, these are agencies that are working at a deficit and are subsidized by either county, public health entities or others that the population really has to be evaluated that they're serving and also, the risk that penalties could actually put them out of business and access would be impacted. Thank you.

Barbara Cebuhar: Thank you, (Erin). Our next comment.

Operator: Your next comment comes from Marty Minitti: of SNI. Your line is now open.

Marty Minitti: Thank you. I think a good reward mechanism is to look at a percent of the savings from hospitalizations to be dispersed to home care. And on the penalty side, I think that putting a penalty in place is a mistake similar to what's going on with the (ACOs). There's got to be a period of adjustment where there's more incentives and less fear about penalty to get people working in the right direction and to be able to afford the infrastructure to keep the patients out in the first place.

Barbara Cebuhar: Thank you, Marty. Our next comment.

Operator: Your next comment comes from (Joe Dezano) of (dobsondezano.com), your line is now open.

(Joe Dezano): Yes, on a small numbers problem, one way is you certainly want to go cordially with rural agencies that have a small number of people. He may even hatch the big agencies by (inaudible) small agency to solve the small number problem, probably going to have to be paid in bonus less often so they can smooth over their small numbers.

Barbara Cebuhar: Thank you. Our next comment please.

Operator: Your next comment comes from Bob Wardwell of VNAA. Your line is now open.

Bob Wardwell: Perhaps it goes without saying but I'd hope the people are thinking about this. It has to be at least 60 years of very good behavioral research in terms of what happens in terms of rewards and punishments in human behavior. Certainly, rewards have been proven to motivate, change in the direction where the reward is given. Punishment have a very unpredictable and sometimes perverse effect which suggests to me that any take backs of money have to be done in extremely carefully, certainly, not retroactively and if a pool has to be created to keep this thing budget neutral through some sort of a take back that if taken back in a broad way as isolated as possible from the reward mechanism.

I also mentioned, although I appreciate the logistic issue of small numbers that motivational research also says that the closer the reward happens to the behavior, that being rewarded is a better chance that you're going to motivate additional behaviors, positive behaviors. Just some basic principles of behavioral change that should be paid attention to.

Barbara Cebuhar: Thank you, Bob. Our next comment, please.

Operator: Your next comment comes from (Christine Wagner) of Interim HealthCare. Your line is now open. Ms. Wagner, your line may be on mute. Please unmute your line.

(Christine Wagner): Sorry about that, thank you. I just wanted to comment on the other agency personnel who had mentioned that they had, she thought it might be a good idea to get a pool from the money we're saving Medicare by decreasing the (ACH) rate. It seems that home care agencies traditionally have the least amount of fat in their budget. It's pretty lean to begin with. We're also shown, either research shows that really, we have some of the most, I would say beneficial impact in trying to keep the patient out of a hospital but we have to do that at this point in an imperfect system with a lot of barriers to care which can become very costly for us.

So if we're going the extra mile in ways that we really aren't reimbursed for at this point, in the end, it saves us a tremendous amount of money to keep the patients out of the hospital and that's where you could draw the payments, the value-based payments from. Similar to like with an ACO, we just have an imperfect system at this point and I would be concerned about decreasing access to care by putting home care agencies out of business by decreasing their bottom line.

Barbara Cebuhar: Thank you, (Christine). Our next comment, please.

Operator: Your next comment comes from Rob Wisner of Health South. Your line is now open.

Rob Wisner: Yeah, I think the value of perspective payment has been certainty in payments over time and I think that maybe some consideration should be made to base the current year payment on past year performance but bill that in to either a per claim basis or a pass through type of payment that CMS has done in other avenues to pay for Medicare bad debt or other things and some other settings but that would keep the cash flow coming consistently based on the expenditures that are being incurred at each agency.

Barbara Cebuhar: Thank you, (Rob). Our next comment, please.

Operator: Your next comment comes from (Mary St. Pierre) of NAHC. Your line is now open.

(Mary St. Pierre): Thank you. Just a couple of comments in this regard. We firmly believe that agency should be rewarded on several levels of relative achievement rather than only rewarding the highest performance. I wanted to say that and we also believe that there should be incentive pools that are funded by the overall cost savings attributable (inaudible) home health that comes from throughout the Medicare program. Our basis for this is our concern that penalizing agencies and funding the rewards to the high performers by collecting money from those that have poor performance may in fact have a negative impact on patient access to care.

And of course, there has been a lot of discussion during this call about the rural agencies or those smaller agencies that may not have the opportunity to demonstrate their quality of care through the current outcome measures and process measures that are out there. But also, I just like to mention here, and even I don't have another opportunity, there should be some sort of financial incentives provided for the adoption of technology by home health agencies.

Barbara Cebuhar: Thank you, Mary. We have time for two more comments.

Operator: Your next comment comes from (Christine Andrews) of (Adamax Associates). Your line is now open.

(Christine Wagner): Hi. I agree with Mary and Bob. I have just a short comment. If they could consider regards to any penalties if enacted, would there be a method

for agencies to challenge any of these penalties in some type of comp review process, especially for the smaller agencies of limited populations in certain acuties? Thank you.

Barbara Cebuhar: Thank you, (Christine). Our next comment, please.

Operator: There are no other comment queued up at this time.

Barbara Cebuhar: Great, thank you very much. Our next question is about payment mechanisms. Payment incentive should be designed to ensure that providers' incentives align with program goals. The size of the payment should be large enough to incentivize providers to improve the quality of care. There are a few payment characteristics that could be considered in determining payment levels. First, the size and composition of the payment should be large enough to incentivize providers to improve quality of care. Currently, existing bonus payments for value-based purchasing programs and other care settings ranged from 0.5 percent to 25 percent of provider reimbursement.

Second, the payment spread determines which share of agency is eligible for bonuses and penalties. One could give a 25 percent bonus payment to all agencies in the top percentile of quality care or that same amount could be distributed as a smaller bonus payment to all agencies in the top quartile of quality care. Our question is what do you think is an appropriate payment level to promote high quality care without introducing excessive uncertainty about revenue? (Sarah), if you could instruct people how to queue up, I'd appreciate it.

Operator: To queue up for a comment again, please press star 1 on your telephone keypad. Your first comment comes from (Maryellen Pilate) of (Catholic and Home Care). Your line is now open. (Maryellen), your line may be on mute. Please unmute your line.

Barbara Cebuhar: Our next comment.

Operator: The next comment comes from Bob Wardwell of VNAA. Your line is now open.

Bob Wardwell: You know, I think a good principle in regulatory policy as it is in medicine is above all, do no harm. With that in mind, in approach that starts quite low with a good feedback (inaudible) to see how behavior is changing would seem to recommend itself in this kind of a situation. There is just too much possibility in a system like this to have a perverse effect take place if there was a significant amount of money on the table at day one. Particularly, especially in a situation where that money is coming from the providers themselves which I fear is the most likely approach, even though I think everybody, (Mary St. Pierre), I think we'd all like a system with that reward money comes from some place other than the agencies themselves in this period of cutback in payments overall.

So moving slowly with a good feedback to see what effects are happening focusing mostly on the reward end or exclusively if possible and carefully monitoring what's happening in terms of access to patients through this process so that you don't have this, I fear possible effect of people with poor prognoses or people with high cost of care because the severity of their illness are most at need patients somehow getting pushed out and as an unintended effect of trying to motivate positive change.

Barbara Cebuhar: Thank you, Bob. Our next comment, please.

Operator: The next comment comes from (Gary Becker) of (inaudible). Your line is now open.

(Gary Becker): Thank you. One of my concerns in this area (inaudible) large concern in these areas, there are several others that do not believe pay improves performance and there's a lot of this to do a great deal of work everyday to try to improve performance without having any incentive payments. My concern is you have about 20 percent out there, the 80/20 rule that probably aren't doing what they need to be doing and 80 percent of us that are really working hard, conduct work and figure out best ways to provide care for our patients.

So for me, I would prefer that we keep the dollar figures low, small because my inherent belief is that it might improve the 20 percent but I'd rather figure

out other mechanisms to get to the 20 percent and not the 80 percent of us that are doing a great job.

Barbara Cebuhar: Thank you (Gary). Our next comment.

Operator: Your next comment comes from (Joe Dezano) of (dobsondezano.com). Your line is now open.

(Joe Dezano): Yes. On the side of small, what seems like a small number, say 1 percent, if you happen to have a low margin just to pick a number or percent, 1 percent of your business would be 25 percent of your margin. So on the edge, a small number can make quite a difference particularly on the penalty side. So I'm kind of in favor being really careful as well because when you think about what this can do to margins, a small number can really be a lot of the margin for a (inaudible) company, so to speak.

Barbara Cebuhar: Thank you. Our next comment, please.

Operator: Your next comment comes from (Curtsie Neland) of (Province Home Care). Your line is now open.

(Curtsie Neland): Thank you. One of the things that we've been thinking about listening to all the comments with all the questions is that we want to make sure that with whatever incentives or whatever outcomes are used from reimbursement that like other people have said to make sure that agencies don't so call cherry-pick patients and don't deny access of care to patients that won't show improvement or won't be able to meet any targets for incentive payment. We've already experienced some of that already with agencies not taking patients that won't have high therapy need and those kinds of things. So that's our concern.

Barbara Cebuhar: Thank you. Our next comment, please.

Operator: Your next comment comes from (Michelle Funk) of (Inaudible Healthcare). Your line is now open.

(Michelle): Hi, thank you for taking my comment. I agree with the last commenter completely and I feel also that we could tie payments to an acuity level, meaning that the higher percentages of the funds be distributed to those agencies who have the higher acuity and the improvements with the higher acuity, some sort of a scale to go by. I think that would be helpful.

Barbara Cebuhar: Thank you, (Michelle). Our next comment.

Operator: Your next comment comes from (Michael Robinson) of (HM Home Care), your line is now open.

(Michael Robinson): Thank you for taking the comment. I agree with the cherry-picking comment, however, I also think that there needs to be some consideration given to appropriate alignment models with positions. If we all support competition, then competition is going to potentially drive some inappropriate position alignment relationships that don't help us. They will only, in the long run, hurt us. And so I just encourage us to take in to account how we are monitoring position relationships on the backside.

Barbara Cebuhar: Thank you, (Michael). Our next comment.

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: OK, great. Our next question is related to pressing concerns about data. Home health data are currently available from Medicare claims, Oasis assessments and HHCAHP's surveys, however, lack of data and late submissions of quality information can reduce precision which could influence performance measure calculations. Lack of data and late submissions could also introduce potential for gaming a value-based purchasing program. Our question is what do you think are the most pressing concerns in the current data collection system for home healthcare? Sarah, if you could tell people how to queue up again, I appreciate it.

Operator: To queue up to leave a comment, please press star 1 on your telephone keypad. The first comment comes from (Donna Craft) of (CNS Home Health). Your line is now open.

(Donna Craft): Hi Barbara. In regards to debit collection, I spoke a little bit earlier to the Oasis tool, there is, we're all working across the entire country and (inaudible) reliability in regard to how the answers are scored and again, the model of that particular Oasis is a functional recovery for most of the outcome and so I think that the Oasis tool itself is just difficult to use as an incentive based program because you could have the agencies that are doing the right thing per se, be penalized.

Barbara Cebuhar: Thank you for your comment. Our next one please.

Operator: We're not showing any other comments queued up at this time.

Barbara Cebuhar: OK, and if people would like to comment about data collection later, that would be helpful. Home health agencies currently collect and report a wealth of data. This data can be enhanced to improve the measurement of quality of care and support incentive payments in a value-based purchasing program. Substantial improvements in the quality of data available for home health value-based purchasing can be achieved by increasing the attention to data quality. Our question is what can be done to reduce the burden of data collection and ensure timely and accurate data submission? (Sarah), if you could instruct people how to queue up, please.

Operator: If you'd like to queue up for a comment, please press star 1 on your telephone keypad. We'll pause for a moment to compile the comment roster. The first comment comes from (Michael Robinson) of HM Home Care. Your line is now open.

(Michael Robinson): Thank you. I think regarding both questions, I think it becomes important to truly evaluate all of the current data that we currently submit and collect. So if we add more data, is there something that we could do away with and make sure that they're not burdening all of us with additional data requirements.

Barbara Cebuhar: Thank you, (Michael). Our next comment.

Operator: We're not showing any other comments queued up at this time.

Barbara Cebuhar: Our next issue is about public reporting. In the home health setting, the rationale for publicly reporting provider quality measures is to inform beneficiaries and discharge planners of agency quality, motivate agencies to improve their performance and introduce new performance measures before they are used for payment. Our question is how can public reporting complement a value-based purchasing program? (Sarah), if you could instruct people how to queue up, please.

Operator: To queue up for a comment, press star 1 on your telephone keypad. Again, that's star then 1 on your telephone keypad. The first comment comes from (Donna Craft) of CNS Home Health. Your line is now open.

(Marsha Mascarov): Hi this is (Marsha Mascarov) again and one of the thing you have mentioned was the burden of the data collection and what isn't really clear to us that maybe the information is out there but I think it would be nice if CMS put out the projected amount of time that the Oasis data collection takes for the start of care, the resumption of care, the discharge, the transfer Oasis, because then administration could totally see the burden of the data collection and they could pay the clinicians appropriately.

Barbara Cebuhar: Thank you, (Marsha). Our next comment, please.

Operator: Your next comment comes from (Mary St. Pierre) of NAHC. Your line is now open.

(Mary St. Pierre): And I guess my comment is really in the form of a question. I'm not really sure how this publicly reporting would be any different than what's currently out there now on home health compare where a large number of outcome and process measures are reported and also where the home health caps the patient perception and care satisfaction results are reported.

Barbara Cebuhar: Thank you, (Mary). Our next comment, please.

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: I thought that we might use the remaining time that we have to offer an opportunity for any other thoughts or comments or issues that you would like

to bring up or that you think as we prepare this Report to Congress that might be helpful. If we could queue up, instruct people how to queue up, I'd appreciate it.

Operator: To queue up, please press star 1 on your telephone keypad. The first line queued up is (Christy Neiland) of (Province Home Care). Your line is open.

(Christy Neiland): Yes, we would just like to comment on what an incredible burden it has been to try to deal with the new regulation of having to do these face-to-face and how difficult it has been to really determine how we're supposed to document it and we really feel that it is going to be an access issue that it may prevent access to care.

And also the MDs, the doctors are really pushing back against it and we also feel like they were not properly educated about this regulation and that has been an extra burden on home health agencies to have to provide education to the physicians and again, this is something that we're not really getting reimbursed for.

Barbara Cebuhar: Thank you, (Chris). I appreciate your comment. Our next comment, please.

Operator: Your next comment comes from (Cary Becker) of (Inaudible). Your line is now open.

(Cary Becker): Thank you. My question or concern would be at what point would you consider the outcomes to be excellent? In other words, I'm looking at our home health CAPs as an example (inaudible) CAPs and I see maybe everybody is performing at a 90 percent plus in a particular category where he may have 90 percent of the folks functioning at 90 percent plus. At what point where we say we've achieved excellence in that area and there wouldn't be a penalty because 50 percent of the group is at 91 and 50 percent is at 90 when 90 is an excellent score. Does that make sense?

Barbara Cebuhar: That's helpful (Cary), thank you. Our next comment.

Operator: Your next comment comes from (Carol Slushman) of CHI Nebraska Health. Your line is now open

(Carol Slushman): Hi I have a fairly specific question and my comment, actually is that since one of the outcomes that has been publicly reported all along and we can expect that to continue on the status of the surgical wound, there are two points I would like to make about that. One is that after the Q and As came out in April and August, there was some instruction about that and it's very hard to answer that question to show improvement if you don't have a fairly long length of stay with your patients and if you're like our agency that has a lot of patients with total joint replacements who are being prepared to be able to attend outpatient therapy for completing a rehabilitation, we have a fairly short length of stay so our surgical wounds will never show improvement according to the scale that has been given in that question.

And if I may give my analysis, I think the problem is that that publicly reported question is trying to combine the reporting on both primary intention and secondary intention wounds into one question and that makes it very confusing and it also makes it very difficult because if a wound is healing normally but yet you haven't gotten to the final stage of healing, you can't show improvement even though the wound has been progressing as it should be normal. So my first point is that the Oasis question as a publicly reported question should be divided into two parts, one for primary intention wound and another for secondary and my second part of that is that the part of the risk adjustment for reporting the improvement in surgical wound should include some material about the length of stay that the patient was in the home care services because those of us who have a fairly short stay such as un in Iowa and Nebraska are somewhat handicapped in trying to show the kind of improvement that they show in the rest of the country where they tend to have longer length of stay.

Barbara Cebuhar: Thank you, (Carol). Our next comment, please.

Operator: Your next comment comes from (Sharon Wood) of (Inaudible) Care). Your line is now open.

(Sharon Wood): Hello. Thank you for taking my call. Something that I noticed a lot of comments went back to was talking about risk adjustment, looking at patients

that don't improve or patients that are expected to greatly improve. And I think that I would like to urge CMS to evaluate the data that they already have at hand. Hospitals are using DRG system. I know that we have our (inaudible) system but we know from previous data that patients with certain disease processes do not improve and perhaps that would be something to look at so your agencies that do get a lot of joint replacements, they're expected to improve have a different risk adjustment model than your patients that have diabetes or COPD or CHF as a primary diagnosis and are expected to improve so greatly. Thank you very much.

Barbara Cebuhar: Thank you for your comment. Our next comment, please.

Operator: Your next comment comes from (Barbara McCan) of Interim HealthCare. Your line is now open.

(Barbara McCan): Thank you, I appreciate that. I would like to comment again on some of the overall measures. Functional status is one of the most important things that we do in home care making people able to stay in their home safely and I think that should be given generous consideration in value-based purchasing. I'd also like to ask if we look at reinstating discharge to the community, that probably is one of best indicators of how well home care works. We provide service to them and they return back to the community not just a more negative utilization rate of ER and hospitalization.

With regard to hospitalization, I'd like to request consideration of some harmonization with what's going on with value-based purchasing as proposed for hospitals. They look at 30 days post discharge. If we could have a couple of breakdowns in our measurements that would certainly help us in working with hospitals to improve processes of care for a successful transition. Also like value-based purchasing in hospitals, I would encourage CMS to stay in the (lane) of looking at measures for which there's little distinction of little variation among the providers such as many of the process measures and consider how valuable those are in value-based purchasing.

Finally, I'd also like to say to consider like hospitals that no measures are used that have not been posted for at least one year on the public Web site,

especially in consideration of the short timeframe in which those working on risk adjustment have had to create a risk adjustment based on data, which I would say for all of us was a little shaky the first three to six months. I really appreciate the opportunity to comment. Thanks.

Barbara Cebuhar: Thank you, (Barbara). Our next comment, please.

Operator: Your next comment comes from (Shelly Williams) of (Absolute Skilled Health). Your line is now open.

(Shelly Williams): Thank you. I think one of the advantages of home health is that we are the cost savings versus facilities but I'm afraid that our focus is turning into instead of patient services just people work and documentation and between the face-to-face and the Oasis (inaudible) and the new therapy requirements, we have so many clinicians doing documentation instead of doing the patient services and whereas the cost savings then go from there and I also feel that somebody else had stated before about the 80/20 rule, 80 percent of us is doing what we're supposed to be doing and with this system or not, that 20 percent is still going to learn how to manipulate the system and the 80 percent of us are still burdened with their actions and I don't see how, this is going to be the focus instead of the patient care, trying to keep our doors open and how do we get the revenue in and taking away from patient care.

Barbara Cebuhar: Thank you, (Shelly). Our next comment, please.

Operator: Your next comment comes from (Veronica Simons) of Medicare Home (Inaudible). Your line is now open.

(Veronica Simmons): Yes, hi. My name is (Veronica Simons). Thank you so much for taking me the call. One of my comment is if you can let them know that when we get patients and in the middle of the care, they get the Medicare Advantage and somebody's Medicare Advantage. They don't pay for other network (inaudible) get the authorizations on time, so that is a loss for us. Thank you.

Barbara Cebuhar: Thank you, (Veronica). Our next comment, please.

Operator: Your next comment comes from (Cathy Newhouse) of (Holiday Retirement).
Your line is now open.

(Cathy Newhouse): Can you hear me?

Barbara Cebuhar: Yes.

(Cathy Newhouse): Oh good. I thought I muted myself too. I had just a couple things. One is on acuity and again I think that goes to risk adjustment as well and there has been a lot of conversation about that during today's call but certainly the source of a referral depending on whether it's based from a hospital or community based referral can make such a difference and I'm now no longer in the homecare provision but I represent about 40,000 older adults that are community based that need to get care and services and one of the things I have always stated is that there is multiple stages of care that go on under the Medicare benefit and I think we need to really define those more clearly.

Curative care and restorative which is what the benefit was originally designed for and now are continuing to provide care under disease state management and palliation to get the services that older adults need. Most of the people that live with me across the country in our community are at the tail end of that. They are not getting the elective surgery. They're not driving, they're chronically homebound. They occasionally need curative and restorative care under Medicare but what they really need is disease management and palliation. And to say that those people have less acuity in terms of risk adjustment, I think we've got to define those levels of care under the Medicare benefit and we've got to figure out how to assign acuity within that scope, curative, restorative, disease management, and palliative.

The other thing I need to say is that I think there is still tremendous disparity across the state. When I have to work with 45 of them, the level of care, I started to try to measure for 83 year olds at the average that people live with us, their falls, their emergent care, the percentage on home health in some states and communities, it's very difficult to get access to home health because people don't know how to provide disease management and palliation to community based seniors. So there really is a clinical food chain that

makes an impact on the kind of patients and the acuity that we have and we really are not necessarily getting all the treatment out to people that we could and then just on the outcome measures too. There has never been anything in my experience that does more to promote care than quality clinical outcomes and some of the best care I've seen when I can sit back and analyze it from multiple providers is really when it gets down to measuring by individual care provider within an agency. So I'd recommend if there is a way that we can begin to trend and track that, we will raise the bar and we'll teach people what to look for and how to look for that.

Barbara Cebuhar: Thank you, (Cathy). Do we have any other comments?

Operator: You do. Your next comment comes from (Roberta Dezino) of (Daycare HomeCare). Your line is now open.

(Roberta Dezino): Yes, can you hear me?

Barbara Cebuhar: Yes, now we can.

(Roberta Dezino): OK, thank you. I just wanted to add that no matter what quality measures are chosen, in looking at measuring whether a patient improves or stabilizes, I think that there definitely needs to be clarification in regards to what data time point, particularly from an Oasis perspective that they're using to measure, whether a patient improves or stabilizes because currently, right now, when we reported on home health compare, improvement stabilization or decline is measured just using our start of care or resumption of care through discharge. I believe our recertification of follow-up assessment is not factored in there. And then also, clarifying if they're going to be using short term episodes of care or long term episodes of care because that can definitely impact patient outcomes as I think several callers eluded to that, how long the patient is in a home care episode of care. Thank you.

Barbara Cebuhar: Thank you, (Roberta). Our next comment, please.

Operator: Your next comment comes from (Maryellen Pillate) of (Catholic Home Care), your line is now open.

(Maryellen Pillate): Can you hear me?

Barbara Cebuhar: Now we can.

(Maryellen Pillate): Ok thank you. I just wanted to agree with a previous caller. First of all, good afternoon. Thank you for taking my call. I'd like to agree with the previous caller discussing the face-to-face requirements which has become very burdensome and is a really bit in turn to all of us that I think again philosophically, we're certainly not opposed to the idea of having our patients seen by a physician and to have that care given by a physician 90 days prior 30 days after that were in agreement with it's the way that needs to be documented that it's very difficult for the physician community and (inaudible). In terms of value-based purchasing, I hope that its used by CMS as an opportunity to encourage innovation and care and not just a way to look at the current indicators and reward or punish because I think again that they call it (inaudible) of that system as (inaudible) of the other parts of perspective payment that have been implemented.

And finally, that integrity as the discussion point for us, for the agencies in New York State, where we had a long-term home care Oasis program, right now, our indicator still include the data from that program which appears that it makes it really not a levelled playing field. (Inaudible) hope that they will take a look at. (Inaudible) the data from our long-term home healthcare program in New York State. Thank you.

Barbara Cebuhar: Thank you, (Maryellen). Do we have any other comments?

Operator: Your next comment comes from (Richard York) of (Nurse Finder). Your line is now open.

(Richard York): Thanks for taking my comment. Actually I am going to add to what some of the previous callers have said with regards to the face-to-face burden that is putting on us as homecare agencies and detracting from what our true business is which is taking care of the patients is significant. That combined with (inaudible) and the requirement of the physicians to go electronic, the feedbacks I am getting in our community is the physicians basically are deadest against it and they're going to wait until the last minute before they

make any of their changes and I think that's some education or more campaigns for the physician to understand that this not individual home health agencies that are making these requirements but it is CMS. So that was my comment.

Barbara Cebuhar: Thank you very much, (Richard). Our next comment?

Operator: Your next comment comes from (Bob Wardwell) of VNAA. Your line is now open.

Bob Wardwell: I just thought I would suggest to the folks that are responsible for this value-based purchasing report to take a look at the technical expert panel minutes from the section 31D technical expert panel because I think those notes reflect a lot of variables that are not currently being considered in the perspective payment system and some of those things variables could be added to the next get a better risk adjustments in the value-based purchasing.

It has been touched on a little bit today as the variation between states and regions and current outcome measures and when you see variations like that you realize that we're measuring things other than the performance of individual agencies, we're measuring physician behaviour, we're measuring hospital behaviour, we're measuring the ability of the patients to get into the hospital, we're measuring a lot of things other than the actual performance of the agency and sort of returning to something (Mary St. Pierre) said. I think all of the homecare associations had gotten on board with it. Whatever we do in value-based purchasing, it has to be something where the agency performance is the driving variable if we're not measuring other things in the system.

Barbara Cebuhar: Thank you, Bob. Our next comment.

Operator: Your next comment comes from (Joe Dezano) of (dobsondezano.com). Your line is now open.

(Al Dobson): Yes, (Al Dobson). I would like to reiterate a comment a bit ago that where patients come from probably makes a lot of difference at how this plays out. Sixty percent of the patient (inaudible) come from the community and forty

percent are post acute care from the hospital. I would guess that the treatment goals are different. The patients are different and the measures are to be different and CMS are to pay a lot of attention to that distinction between the referral source of the patient as they come in to home healthcare.

Barbara Cebuhar: Thank you, (Mr. Dobson). Our next comment, please.

Operator: Your next comment comes from (Marcy Yansen) of (Mason District Hospice). Your line is now open.

(Marcy Hansen): Yes, can you hear me.

Barbara Cebuhar: Yes.

(Marcy Hansen): I'd just like to say thank you for having this conference and that I am in physical therapy and I know there has been a lot of change at the New Year as well as coming in April for evidence-based medicine functional outcomes, and I just recently came back from New Orleans from the American Physical Therapy Association conference they held. The name I'm going to toss out there for CMS to really get in touch with is our American Physical Therapy Association home health president, Cindy Kraft. She is in the state of Illinois, and she's quite a resource for all of us as physical therapists to do our jobs better and to push quality measures, to push evidence-based medicine and all the functional outcome measures that we're looking at implementing in April and I think she does a great job for our association and for all of us, whether we're therapists, nurses, the home health aide.

A big part of the communication to do the best job for our patients and I know paper work is always going to be there and is a part of our lives but I think quality definitely has to be implemented. We all want to get paid for the services that we provide but also putting the patient at the center, in the focus but again, just thank you and utilize Cindy. I hope she won't shoot me for saying that but she's quite a valued resource for us in the State of Illinois. Thank you.

Barbara Cebuhar: Thank you, (Marcy). Our next comment, please.

Operator: Your next comment comes from (Cynthia Chrisman) of (Inaudible Memorial Home). Your line is now open.

(Cynthia Chrisman): Yes, my comment is the increase to home health just to maintain and to improve patient outcome needs to be considered when it comes to the reimbursement. Not just cut across the board. Some of these increased costs such as those of us who have gotten into (inaudible) in monitoring solely to improve outcomes and to lower our re-admission rate is not even considered for any type of reimbursement right now. And I know many of us would like to even improve upon the technology we currently have and move further ahead in the technology world, but it's so cost prohibited and I would just like to see some consideration when it comes to introducing technology and home to remotely monitor our patients.

Barbara Cebuhar: Thank you, (Cynthia). Our next comment.

Operator: There are no further comments queued up at this time.

Barbara Cebuhar: OK. We are very, very grateful for all of your inputs. We encourage you to make use of the encore feature which can be accessed for two business days until February 28 at midnight. So there is a recording that will be available by dialing 1-800-642-1687, and you can include the pass code which is 37941789. Once again, if you have comments or insights, please send them to hhvbt@cms.hhs.gov by close of business, March 4, 2011. We are very grateful for your participation and help with this effort. Your insights have been invaluable to the folks working on the report to Congress and this does conclude our call. We do appreciate your help.

Operator: This concludes today's conference call. You may now disconnect.

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