



September 2, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445—G
Hubert H. Humphrey Building, 200
Independence Avenue SW
Washington, DC 20201

RE: Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies (CMS-1611-P)

Dear Administrator Tavenner:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the “Alliance”) in response to the Centers for Medicare and Medicaid Services’ (CMS’) request for Public Comment on the proposed rule, **Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies (“Proposed Rule”).**¹ Thank you for the opportunity to provide comments on the Proposed Rule.

About the Alliance for Home Health Quality and Innovation

The Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation’s healthcare system. For more information about our organization, please visit: <http://ahhqi.org/>.

We appreciate the opportunity to provide comments on the Proposed Rule, and offer recommendations and considerations to CMS on the following topics: (1) home health care’s

¹ Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies, 79 Fed. Reg. 38,366 – 420 (July 7, 2014) (herein after “Proposed Rule”), <http://www.gpo.gov/fdsys/pkg/FR-2014-07-07/pdf/2014-15736.pdf>

value proposition; (2) the impact of Medicare home health payment rate changes; (3) the face-to-face requirement; (4) therapy reassessments; (5) home health value-based purchasing; (6) the home health quality reporting program; and (7) health information technology.

I. Home Healthcare's Value Proposition

Home health care presents a strong value proposition for individual patients and to the healthcare system at large: it offers quality care that is both cost-effective and patient preferred.

Home health is the least costly option for patients and the health care system at large when looking at post-acute care. For example, Medicare expenditures for a patient receiving home health care following a hospital stay are nearly \$8,000 less than average amongst all settings (\$20,345 versus \$28,294). For patients receiving care following a major joint replacement, this difference is about \$5,000 per patient (\$18,068 vs. \$23,479).

Moreover, Medicare patients who receive home health care are more likely to improve self care. Furthermore, more often than not, patient outcomes improved after receiving home health care. According to data from Home Health Compare, 89% of wounds improved or healed after an operation for patients following a home health episode. This is coupled with additional data that shows that 67% of patients had less pain when moving around, 66% get better at bathing, and 64% had improved breathing after receiving home health care. Perhaps most importantly, patients generally prefer to receive care at home, rather than in a facility.²

However, despite the value home health offers to patients and the U.S. health care system, challenges exist which may cripple the ability of home health to continue providing high quality, cost-effective care to patients in the home. The payment cuts set forth in the Proposed Rule threaten patient access to quality home health care. Without adequate home health services, utilization of institutional care (including hospital and skilled nursing facility services) will be more likely for patients than it should be, increasing overall Medicare costs and decreasing quality of care. In short, inadequate funding of home health care services may lead to the unintended consequences of increasing overall health system cost and poorer quality of care.

The Alliance urges CMS to bear in mind the role and value of home health care in the overall health care system as it makes changes to the home health prospective payment system.

² According to the AARP, persons 50 and older with disabilities, particularly those age 50 to 64, strongly prefer independent living in their own homes to other alternatives. Preferences for services at home rather than in nursing homes are widespread among persons with disabilities. Even in the event they needed 24-hour care, 73 percent of persons with disabilities prefer services at home. Among the general population of persons 50 and older, 58 percent prefer services at home. http://assets.aarp.org/rgcenter/il/beyond_50_il.pdf

II. The Alliance continues to be concerned with the changes to Medicare home health payment rates and the impact they may have on access to quality and efficient care for beneficiaries.

As a non-profit foundation, the Alliance's mission focuses predominantly on the pursuit of research and education on the value of home health care services for patients and the entire U.S. health care system. With respect to the payment changes articulated in the Proposed Rule, the Alliance offers comments from the perspective of how payment rate changes will affect patients and their ability to access home health care. For issues related to specific payment rate-setting, the Alliance recommends that CMS to consider the comments submitted by the National Association for Home Care and Hospice (NAHC), the Visiting Nurse Associations of America (VNAA), and the Partnership for Quality Home Healthcare.

a. Reductions in home health payment rates threaten access to a patient population that is poorer, sicker, and older than the general Medicare population, and threaten the efficiency of the health care system.

Any policy changes in home health care should take into consideration the demographics of the patients who will be affected by those changes. In this section, we have provided some of the most relevant data drawn from the 2013 Home Health Chartbook, a compilation of descriptive statistics from government data sources that includes the Medicare Current Beneficiary Survey, 2011 Bureau of Labor Statistics, the U.S. Department of Commerce, Medicare Cost Reports, Home Health Compare, Medicare fee-for-service claims, and other data from the Centers for Medicare and Medicaid Services.³ The Alliance urges CMS to consider the proceeding demographic and clinical profiles of home health patients when making decisions that will affect a vulnerable patient population.

In general, Medicare home health patients are older, sicker, and poorer than the general Medicare population. Among Medicare home health beneficiaries, nearly one in every four is over 85 years of age, and more than one in every three lives alone. By comparison, only 12.5% of all Medicare beneficiaries are aged 85 or older.⁴ Additionally, 62.5% of home health users have income under \$25,000 per year; by comparison, only 57.5% of skilled nursing facility users and 49.5% of general Medicare beneficiaries have income under \$25,000 per year.⁵ In addition, as reflected in the chart below, home health users tend to suffer from more chronic conditions, are more likely to report fair, poor, or worsening health, and have more limitations on their activities of daily living ("ADLs") than their peers.⁶

³ Avalere Health LLC, *Home Health Chartbook, 2013*, Alliance for Home Health Quality and Innovation (Aug. 2013), http://ahhqi.org/images/uploads/AHHQI-AVALERE_Home_Health_Chartbook_FINAL_081513.pdf.

⁴ *See id.* at 14.

⁵ *Id.* at 13.

⁶ *Id.* at 14.

Demographics of Home Health Users

Table 2.6: Selected Characteristics of Medicare Home Health Users and All Medicare Beneficiaries, 2011

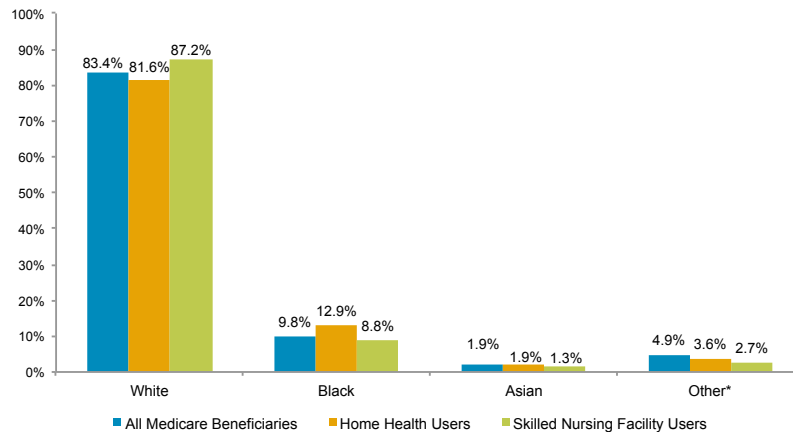
	All Medicare Home Health Users	All Medicare Beneficiaries
Over age 85	24.2%	12.5%
Live alone	35.6%	29.4%
Have 3 or more chronic conditions	83.2%	60.5%
Have 2 or more ADL limitations*	28.7%	10.6%
Report fair or poor health	45.8%	26.6%
Are in somewhat or much worse health than last year	41.3%	23.0%
Have incomes under 200% of the Federal Poverty Level (FPL)**	64.5%	48.9%
Have incomes under 100% of the Federal Poverty Level (FPL)**	34.8%	22.0%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.
 *ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
 **In 2011, FPL for a household of 1 was \$10,890, a household of 2 was \$14,710, a household of 3 was \$18,530, and household of 4 was \$22,350.

Furthermore, as reflected in Chart 2.4, home health agencies tend to serve a greater percentage of racial minorities than SNFs, and the home health population tends to be more racially diverse than the general Medicare population.⁷

Demographics of Home Health Users

Chart 2.4: Race of Home Health Users, Skilled Nursing Facility Users, and All Medicare Beneficiaries, 2011



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011
 *Other includes American Indian, Alaska Native, Native Hawaiian, Pacific Islander, Other race, and More than one race

⁷ *Id.* at 12.

It is also important to note that Black and Hispanic home health users are poorer than the general home health population, and poorer still compared to the general Medicare population. Higher percentages of Black and Hispanic patients also tend to have 2 or more ADL limitations and report fair or poor health.⁸ Thus, if these patients have difficulty accessing home health care, they may face still higher barriers and burdens as a result of their socio-economic status and health status.

Demographics of Home Health Users by Race and Ethnicity

Table 2.9: Selected Characteristics of All Medicare Home Health Users and Medicare Home Health Users by Race and Ethnicity, 2011

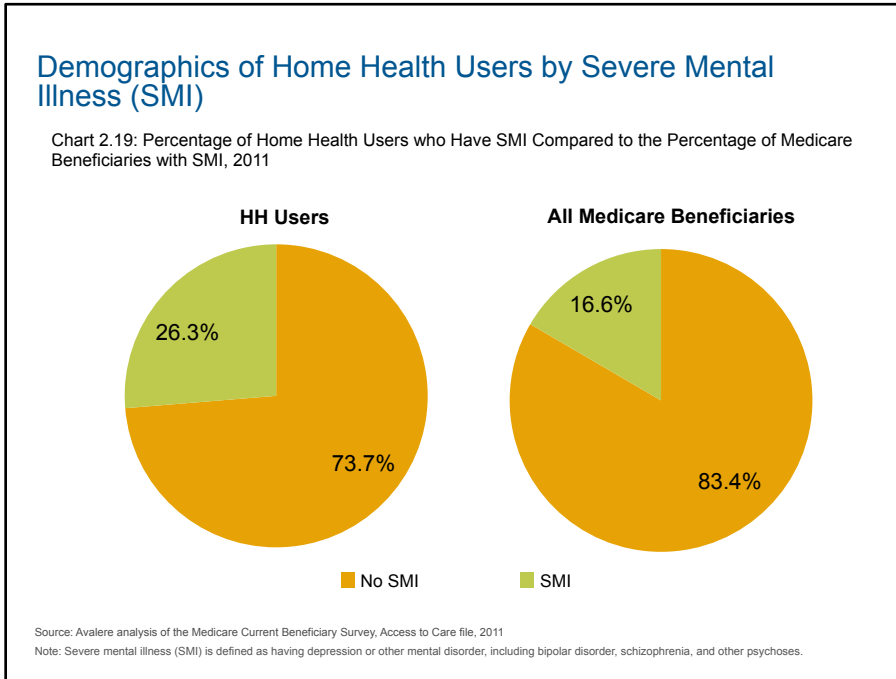
	Black Medicare HH Users	Hispanic Medicare HH Users	All Medicare Beneficiaries
Over age 85	18.7%	19.9%	12.5%
Live alone	34.5%	31.8%	29.4%
Have 3 or more chronic conditions	81.6%	76.1%	60.5%
Have 2 or more ADL limitations*	36.3%	30.9%	10.6%
Report fair or poor health	55.1%	55.2%	26.6%
Are in somewhat or much worse health than last year	33.0%	48.3%	23.0%
Have incomes under 200% of the Federal Poverty Level (FPL)**	85.1%	82.2%	48.9%
Have incomes under 100% of the Federal Poverty Level (FPL)**	66.6%	53.4%	22.0%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
**In 2011, FPL for a household of 1 was \$10,890, a household of 2 was \$14,710, a household of 3 was \$18,530, and household of 4 was \$22,350.

In addition, payment cuts to Medicare home health disproportionately threaten access to care for mentally ill patients. More than a quarter of all home health beneficiaries are managing severe mental illnesses, as compared to 16.6% of all Medicare beneficiaries.⁹

⁸ *Id.* at 17.

⁹ *See id.* at 27, with “Severe Mental Illness” defined as depression or another mental disorder such as bipolar disorder, schizophrenia, and other psychoses.



Home health beneficiaries who have severe mental illness also tend to be more vulnerable than the Medicare population at large, as described below:¹⁰

Demographics of Home Health Users by Severe Mental Illness (SMI)*

Table 2.18: Selected Characteristics of All Medicare Home Health Users and Medicare Home Health users with SMI, 2011

	Medicare Home Health Users with SMI	All Medicare Beneficiaries
Over age 85	12.9%	12.5%
Live alone	38.3%	29.4%
Have 3 or more chronic conditions	90.3%	60.5%
Have 2 or more ADL limitations**	37.5%	10.6%
Report fair or poor health	69.7%	26.6%
Are in somewhat or much worse health than last year	50.0%	23.0%
Have incomes under 200% of the Federal Poverty Level (FPL)***	71.5%	48.9%
Have incomes under 100% of the Federal Poverty Level (FPL)***	40.6%	22.0%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.
*Severe mental illness (SMI) is defined as having depression or another mental disorder, including bipolar disorder, schizophrenia, and other psychoses.
**ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
***In 2011, FPL for a household of 1 was \$10,890, a household of 2 was \$14,710, a household of 3 was \$18,530, and household of 4 was \$22,350.

¹⁰ *Id.* at 26.

Reducing home health payments jeopardizes access to quality care for patients who are in greatest need of protection. Home health is often the lowest cost option for quality care, where appropriate, and is a preferred setting for aging in place.¹¹

For instance, the average home health first setting episode Medicare payment is \$18,068 for patients discharged after a major joint replacement under Diagnosis Related Group, compared to \$23,479 for the average episode payment.¹² Consistent with this data, researchers in a recent paper published in the *Cleveland Clinic Journal of Medicine* found that patients could receive clinically appropriate rehabilitation services in the home following knee replacements, and that such patients need not receive post-acute care in facility-based settings.¹³

Home health agencies already incurred very significant payment rate reductions for CY 2014, and further payment cuts in CY 2015 will threaten the ability to provide high-quality, lower cost care to the populations described above who need it most. In order to deliver quality care to patients, home health care providers must incur costs for appropriate skilled nursing and therapy services, workforce training, and infrastructure (including health information technology). The Alliance is concerned that lower home health payment rates threaten the ability of home health providers to make such costly but necessary investments to provide better care for patients and the entire health care system.

Recommendation: Given the risks that further payment cuts pose to the most vulnerable patient populations, the Alliance urges CMS to exercise its discretion and mitigate these risks by limiting the rebasing cuts.

- b. The Alliance recommends that CMS take a fast-tracked, robust approach to assessment and evaluation of the impact of rebasing payment cuts on access to quality home health care.**

CMS asserts that it plans to “monitor potential impacts of rebasing” but states that it does not have enough CY 2014 home health claims to analyze the impact of rebasing adjustments as yet. The Alliance acknowledges the limitations inherent in the relatively small number of claims available for CY 2014 to date, but urges CMS to find ways to obtain and use CY 2014 claims data more quickly. It is often the case that there is a lag in the public’s ability to access administrative data (both claims and cost reports). In this case, however, the consequence of a lag in accessing administrative data is a slower timeline for detection of patient access issues stemming from the rebasing adjustments. If access issues are occurring today, but not detected until next year, then because of the regulatory cycle, changes to home health payment rates cannot occur until 2016. Patients will have suffered access issues for two full years before even

¹¹ AARP, *Beyond 50.03: A Report to the Nation on Independent Living and Disability*. p. 177-178 (2003), http://assets.aarp.org/rgcenter/il/beyond_50_il.pdf

¹² A. Dobson et al., “Clinically Appropriate and Cost-Effective Placement (CACEP) Project Working Paper Series, Working Paper #2: Baseline Statistics of Medicare Payments by Episode Type for Select MS-DRGs and Chronic Conditions,” at p. 30, <http://ahhqj.org/images/pdf/cacep-wp2-baselines.pdf>, October 2012.

¹³ See Mark I. Froimson et al., In-home care following total knee replacement, 80 (e-suppl1) *Cleveland Clinic J. Med.* E-S15 (Jan. 2013), http://www.cejm.org/content/80/e-Suppl_1.toc (stating that patients recovering from knee replacements can receive in-home care comparable to institutional care).

the possibility of relief. The Alliance urges CMS to fast-track its analysis of the administrative data to assess impact on patient access this year, and to make adjustments to the rates if rebasing appears to have negatively impacted access.

In addition, access to home health care is multidimensional, and assessing its adequacy will be difficult through administrative data alone. The Institute of Medicine defines access to care as “the timely use of personal health services to achieve the best possible outcome.” (IOM 1993) Clearly, CMS should look beyond the type of cost report data cited in the Proposed Rule. Though cost report data does provide insight into the number and type of home health providers serving Medicare beneficiaries, cost report data alone will not provide insight into a beneficiary’s ability to find and use a home health agency. Moreover, the use of claims data is key to understanding trends in usage, but may not provide a full picture of whether the patient was able to access appropriate care that led to the best possible outcome. Beyond claims and cost report data, CMS should consider collecting data directly from beneficiaries and providers through surveys, interviews and focus groups. Such qualitative data may be limited and present challenges given variations that may be local in nature, but using such methods will enable a more well-rounded understanding of the timeliness and appropriateness of care delivered and received.¹⁴

As stated above, Medicare home health beneficiaries are often some of the healthcare system’s most vulnerable patients, as they are older, sicker, and poorer than the general Medicare population. As a result, access to quality, affordable, and patient-preferred care may be limited for those patients who need it the most. Furthermore, payment cuts further threaten access to care for patients in areas with health professional shortages. As represented in the figure below, 40% of all home health agencies operate in areas where the whole county faces health professional shortages.¹⁵

¹⁴ MedPAC, Report to Congress: Medicare Payment Policy (March 2003), p. 154.
http://www.medpac.gov/documents/mar03_entire_report.pdf

¹⁵ Avalere Health LLC, Home Health Chartbook, 2013, Alliance for Home Health Quality and Innovation (Aug. 2013), p. 41. http://ahhqi.org/images/uploads/AHHQI-AVALERE_Home_Health_Chartbook_FINAL_081513.pdf

Organizational Trends in Home Health

Chart 5.4: Percentage of Agencies Operating in Total Health Professional Shortage Area (HPSA) Counties by Agency Size, 2011

HHA Size (Medicare Revenue in 2012)	Number of Agencies in Area Where Whole County is HPSA	Total Number of Agencies	Percent of Agencies Where Whole County is HPSA
<\$500,000	1,219	2,823	43%
\$500,000 - \$1,000,000	956	2,226	43%
\$1,000,001 - \$1,500,000	569	1,329	43%
\$1,500,001 - \$2,000,000	311	854	36%
\$2,000,001 - \$3,000,000	377	940	40%
\$3,000,001 - \$4,000,000	192	487	39%
Over \$4,000,000	267	1,005	27%
Total	3,891	9,664	40%

Source: Dobson | DaVanzo analysis of home health agency cost reports (freestanding and hospital-based). HPSA designation provided from the 2012-13 Area Health Resource File. Includes only agencies with completed cost reports for 2011, prior to trimming.

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Additionally, 42% of home health agencies operate in “Majority-Minority” counties.¹⁶ Given the prevalence of home health use by Black and Hispanic Medicare beneficiaries, payment cuts, which threaten access for older Americans, will harm these populations more significantly.

Recommendation: The Alliance urges CMS to use timely and robust approaches to evaluate whether the rebasing adjustments to home health payment rates are leading to access issues for patients in need of home health care.

c. Transparency in Making Changes in the Case Mix Weights

CMS proposes home health payment rates with changes to the case mix weights that appear to decrease payments for third (or later) episodes of care, while increasing payments for second episodes of care that have higher numbers of therapy visits. Many home health providers serve patients with multiple chronic conditions. These patients often have significant medical conditions, such as heart failure, and home health care is a means of paying for critical home visits that can make a significant difference in care management. Patients receiving optimal care management at home are less likely to be hospitalized; investing in cost-effective home care can be an alternative to high cost hospitalization.¹⁷¹⁸¹⁹²⁰²¹ Reducing payments for such

¹⁶ *Id.* at 42.

¹⁷ Dobson et al., “Clinically Appropriate and Cost-Effective Placement (CACEP) Project Working Paper Series Working Paper #4: Baseline Statistics of Acute Care Hospital Readmissions by Episode Type for Select MS-DRGs and Chronic Conditions”, (July 2012). <http://ahhqi.org/images/pdf/cacep-wp4-baselines.pdf>

¹⁸ Shaughnessy et al., “Improving Patient outcomes of Home Health Care: Findings from Two Demonstration Trials of Outcome-Based Quality Improvement”, *Journal of the American Geriatrics Society*, 50:1354-1364 (2002)

¹⁹ Beales JL & Edes T., “Veteran’s affairs home based primary care”, *Clin. Geriatr. Med.* 25: 149-154 (2009).

episodes of care is likely to have an impact on how home health providers will treat patients with chronic conditions.

The methodology and rationale underlying these changes are not clear. Clarity regarding what practice or utilization changes CMS is trying to achieve would be useful in understanding why these changes are being pursued. For example, it would be helpful to understand if there are particular types of patients that CMS believes should not be receiving third episodes of home health care, and/or if there are certain patients who should receive a different approach to care that would be less costly than the care delivered at present.

Recommendation: The Alliance urges CMS to provide greater transparency regarding both its method of calculating these case mix weight changes, as well as the rationale for making these changes.

III. The Alliance supports the elimination of the narrative requirement for the face-to-face patient encounter for home health certification and urges CMS to provide further clarifying guidance to support home health provider compliance efforts.

The narrative requirement of the face-to-face encounter for certification of beneficiary eligibility has placed a reporting burden on providers and physicians that has been vague and therefore extremely challenging from a compliance perspective. Therefore, the Alliance appreciates and supports CMS's proposal to eliminate the narrative requirement, which appears in regulation at section 424.22(a)(1)(v). However, there are remaining issues that still need to be addressed with regard to the face-to-face encounter requirement moving forward.

- a. The Alliance fully supports the elimination of the narrative requirement, however, further clarification is needed on what documentation is required, and who will provide the documentation moving forward.**

While the Proposed Rule outlines the elimination of the narrative requirement for the required face-to-face encounter, further clarifying guidance is needed to enable home health providers to comply. Specifically, the Proposed Rule states that CMS would review only the medical record from the certifying physician or the acute/post-acute facility from which the patient was referred to support certification of patient eligibility. CMS states that if the patient's

²⁰ Kaye S. et al., "Do noninstitutionalized long-term care services reduce Medicaid spending?", *Health Affairs* 28(1): 262-272 (2009); Cyer L. et al., "Costs for 'Hospital at Home' patients were 19 percent lower, with equal or better outcomes compared to similar inpatients", *Health Affairs* 31(6): 1237-1243 (2012); Frick KD et al., "Substitutive hospital at home for older persons: effects on costs", *American Journal of Managed Care* 15(1): 49-56 (2009).

²¹ Source: Dobson | DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2008, wage index adjusted by setting and geographic region. All analyses are conducted at the MS-DRG level.

medical records are insufficient to document eligibility to receive home health care, then payment will not be rendered to the home health agency.

The issue with this approach is that current health information systems do not enable home health agencies to have access to physician and acute/post-acute care facility medical records. Although some hospitals and facilities may provide a discharge summary that may serve as appropriate documentation, physician offices do not share similar documentation that would enable the home health agency to determine if the physician adequately determined and documented the patient's eligibility for home health care. Thus, while the onus is on the physician to complete the certification, the penalty for not having documentation is imposed on the home health agency—despite not having control over the documentation. Home health agencies need to be able to assess their own compliance with the face-to-face encounter requirement. Home health providers are concerned about the risk of non-compliance that exists if the documentation of eligibility can only be verified by another provider or professional, in records that the home health agency does not possess and cannot access. In the absence of clear and concise direction on what home health providers can do and document, home health providers will have numerous compliance questions.

The Alliance commends the spirit of the face-to-face requirement, which was intended to document the relationship between the medical care provided by the physician, and the skilled care provided by the home health agency. However, the implementation of this law to date has heightened administrative burden and anxiety for those home health providers that want nothing more than to comply with the law.

To address the intent and spirit of the face-to-face requirement, the Alliance supports the furtherance of models of care that align incentives between physicians and home health providers. Accountable care organizations and bundled payment programs are examples of such models that seek to align incentives to achieve better outcomes at lower cost through improved coordination of care. Aligning incentives in this way makes achievement of improved coordination between physicians and home health agencies a more reasonable and achievable proposition.

Notwithstanding, the Alliance urges CMS to seek any and all means of implementing the face-to-face legal requirements in a manner that will be least burdensome for home health providers and physicians, and that will address concerns that this may be interfering with patient access to the home health benefit.

One way that CMS could streamline the documentation that is needed to comply with beneficiary eligibility requirements for home health care would be to consider whether it is possible to use the Form CMS-485 to provide sufficient documentation for eligibility purposes. Regardless of the specific method used, clear compliance guidance that is least burdensome for providers needs to be provided by CMS.

Recommendation: Further clarification from CMS is required on the roles of home health agencies and physicians with regard to what each party has to do and document in order to be compliant with the face-to-face encounter requirement.

b. Furthermore, the elimination of the narrative requirement for face-to-face encounters needs to apply to claims retroactively.

Although the elimination of the narrative requirement attempts to simplify the face-to-face encounter requirement for home health eligibility, existing claims do not currently have protection under the Proposed Rule. The elimination of the requirement should apply retrospectively to all previous claims and pending cases that may be scrutinized for compliance with the narrative requirement. The Alliance also asks for further clarification on whether new physician face-to-face documentation will be needed for home health beneficiaries who return to a home health agency post-discharge but still during the 60-day episode.

IV. CMS should consider alignment of the therapy reassessment requirement with Medicare outpatient therapy reassessment requirements.

The Alliance is supportive of efforts to improve therapy for home health patients, but is concerned about the therapy reassessment changes proposed by CMS. The Alliance recommends a therapy reassessment period that would be at least every 30 days, which better aligns with current therapy professional standards of care. The 30-day timeframe is also more consistent with many private payer and state policies. Thus, the Alliance recommends a period of at least 30 days, which is a more reasonable timeframe for therapy reassessment.

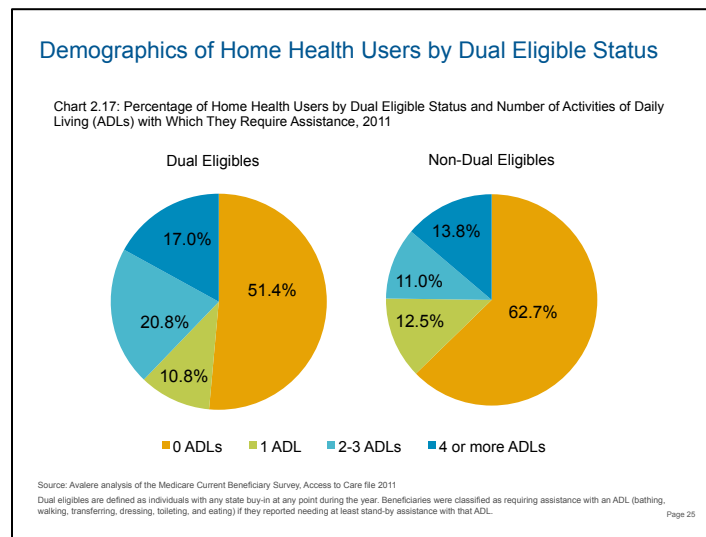
V. The Alliance supports CMS's use of value-based purchasing ("VBP") as a means to move from a system that is based on paying for volume to one that is paying for value.

New and emerging models of payment and health care delivery are critical to the success of the health care system in the future, and the effort to use value-based purchasing as a means to move health care to a system that promotes value over volume is commendable. The Alliance thus supports the idea of VBP as a means of working toward a system that promotes quality patient care, and agrees that the hospital model for VBP provides a good starting construct for a similar model for home health care. Specifically, two characteristics of the hospital program should be implemented for the home health community in any proposed model. First, CMS should involve and engage home health community stakeholders in matters related to VBP, including the selection and weighting of measures for bonus payments. Similar to the approach with hospitals, measures in home health VBP should include an array of outcomes, process, and patient experience measures. A significant emphasis should be placed on involving the home health community in the selection of measures that are meaningful and achievable. Baseline measures should also be put in place to account for the already fragile health of many home health patients. Among some Medicare beneficiaries, it may be legitimate goals to moderately improve or maintain health, where full recovery is not a reasonable option. The Alliance offers to assist CMS in any way in bringing together home health community stakeholders to engage with CMS related to quality matters. The Alliance has a Quality and Innovation Work Group, comprised of clinical and quality leaders from the Alliance's membership, and stands ready to assist and support CMS in its efforts.

Recommendation: Home health care community stakeholders should be included in the discussion of multiple aspects of a VBP model for home health.

- a. Risk adjustment for socioeconomic and socio-demographic factors, and harmonization across settings should be factored into the quality measures for VBP.

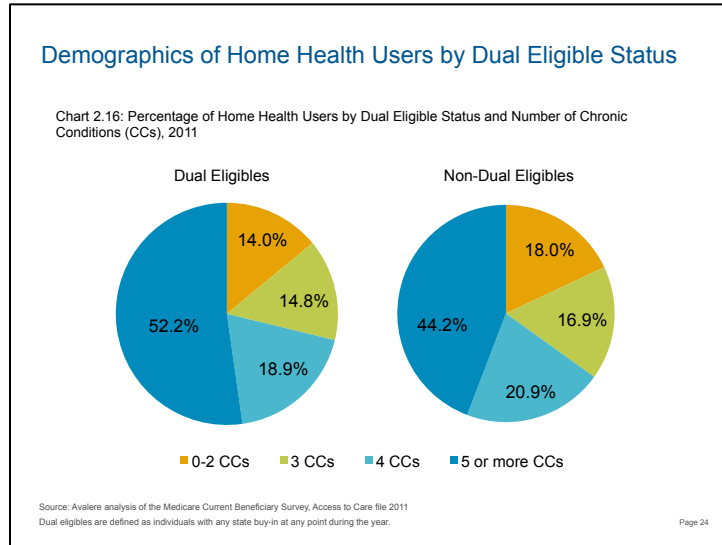
As referenced in (I)(a), home health beneficiaries are poorer, sicker, and older than the general Medicare population. Over 37% of dual eligible home health users require assistance with two or more ADLs, compared to less than 25% of non-dual eligibles.²²



Over 50% (52.2%) of duals suffer from five or greater chronic conditions, and over 70% suffer from at least four chronic conditions.²³

²² Avalere Health LLC, *Home Health Chartbook, 2013*, Alliance for Home Health Quality and Innovation (Aug. 2013), http://ahhqi.org/images/uploads/AHHQI-AVALERE_Home_Health_Chartbook_FINAL_081513.pdf.

²³ *Id.* at 24.



Dual eligible beneficiaries are an example of the types of vulnerable patients, susceptible to higher risk of hospitalization and morbidity, that home health serves. Such patients are at higher risk due to social determinants of health. To adequately serve these patients in home health care, their socio-economic and sociodemographic profiles should be adequately assessed and factored into risk adjustment in the home health quality indicators that are used for value based purchasing.

Factoring in socio-economic and sociodemographic risk adjustments is critical to assuring patient access to these patients who are at higher risk of poor outcomes as a consequence of factors related to their socioeconomic status. In VBP, where payment to providers will depend on performance against specific measures, appropriate socioeconomic risk adjustment of those measures will be critical to protecting patient access.

- b. Quality measures to support VBP should be endorsed by a qualified consensus development body, such as the National Quality Forum, before being used by CMS for VBP.**

In order to ensure that appropriate quality measures are used in determining VBP for home health, a qualified consensus development body should be used to endorse measures pertinent to care in the home. The Alliance recommends that CMS look to the National Quality Forum for endorsement of quality measures before the measures can be used in home health VBP.

- c. The selection process for states that will participate in value-based purchasing needs to be transparent, and those states selected should be representative of the clinical and demographic profile of home health patients in the United States.**

Finally, the state selection process for value-based purchasing should be transparent and involve home health community input. Initial state selection is critical to mapping out a plan

that can be implemented successfully at a national level. Organizations such as the Visiting Nurse Associations of America (VNAA), the National Association for Home Care & Hospice (NAHC), and the many state home care associations are best able to assist CMS in determining which states are most representative of the country as a whole for purposes of the value based purchasing pilots. Having an open and transparent dialogue with these associations will improve the process of transitioning to value-based purchasing.

In addition, the Alliance has compiled state-by-state data that may be informative to CMS in the context of understanding the clinical profile of home health patients in each state. Every year, the Alliance publishes a Home Health Chartbook of descriptive statistics drawn from government data sources and the state-by-state data therein could be of relevance to CMS's program development efforts. The Alliance offers these resources to CMS if it is of interest and use.

Recommendation: CMS should work with respected home health organizations, such as NAHC, VNAA, and the state home care associations, to select appropriate states for the initial program so as to ensure the most representative states are participating in the value based purchasing pilots. Furthermore, the Alliance offers data from the Home Health Chartbook, which looks at clinical data on patients at a state-by-state level in order to provide additional insight into state-level home health trends.

The Alliance looks forward to continuing the discussion of a home health VBP model with CMS in future rulemaking, and once again lauds the efforts to move future payment models to those which reward quality over quantity of care.

VI. The Alliance supports the home health quality reporting program, but urges CMS to consider using only traditional Medicare OASIS submissions in assessing the proposed 70% threshold and subsequent increases.

The Alliance supports the continued use and submission of the OASIS assessment tool for purposes of payment and quality measurement. However, the proposed rule is unclear regarding whether the OASIS assessments considered in the home health quality reporting program will include only the OASIS assessments for traditional Medicare, or whether it will also include OASIS assessments for Medicare Advantage and Medicaid home health care. The scope of inclusion is a critical matter to clarify up-front. The Alliance recommends that only the OASIS assessments for traditional Medicare be considered in the home health quality reporting program, because traditional Medicare, Medicare Advantage, and Medicaid vary significantly both in terms of payment and program guidance. Moreover, the patient populations served vary considerably.

In addition, the Alliance recommends that once the scope of OASIS assessments is clarified, CMS should share with each home health provider their current compliance percentage. This will enable home health providers to assess and understand their compliance to date and will create a benchmark against which providers can seek to improve over time. Furthermore, the Alliance suggests that CMS provide a suitable time period, no less than two weeks, for home

health agencies to review their compliance assessment. This period should not only allow for home health agencies to make any corrections and submit them for consideration, but is also in line with other CMS quality reporting programs.

Recommendation: Traditional Medicare alone should be used for the new reporting submission threshold given the programs and populations with Medicare Advantage and Medicaid.

VII. The Alliance supports continued and furthered use of Health Information Technology (HIT) as a means of improving Health Information Exchange (HIE) across health care settings.

Per the Alliance's February 2014 comments to the HIT Policy Committee Certification and Adoption Workgroup, the Alliance supports the development of a voluntary LTPAC Electronic Health Record (EHR) Certification program.²⁴

HIE helps facilitate enhanced communications and optimized patient outcomes for patients throughout care transitions and across various settings of care. Improved HIT is one avenue through which HIE can attain improved function, safety, and security. Movement toward standards across players in the continuum of care, along with interoperability, is key to continually innovating and improving the health care delivery system.

The Alliance supports further innovation in HIT, and looks forward to continuing to work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), and others to promote safe and effective exchange of information for the purposes of improved patient care.

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The Alliance greatly appreciates the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at (202) 239-3671 or tlee@ahhqi.org.

Sincerely,



Teresa L. Lee, JD, MPH
Executive Director

²⁴ Alliance for Home Health Quality and Innovation, *HIT Policy Committee Certification and Adoption Workgroup Certification for Long-Term and Post-Acute Care Virtual Hearing*, Alliance for Home Health Quality and Innovation (Feb. 2014), http://ahhqi.org/images/uploads/Alliance_Response_to_HIT_Policy_Comm_on_Certification_FINAL_v022414.pdf