



May 9, 2014

Chairman Dave Camp and Ranking Member Sandy Levin
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Chairman Ron Wyden and Ranking Member Orrin Hatch
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Discussion Draft on the “Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014)”¹

Dear Representative Camp, Representative Levin, Senator Wyden, and Senator Hatch:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the “Alliance”) in response to the discussion draft titled, “**Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014).**” The Alliance appreciates the invitation to provide comments on the discussion draft, which involves standardization of patient assessment data, quality and efficiency measurement, and development of post-acute care (PAC) reform recommendations across settings.

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. We are a membership based organization comprised of home health care providers, both not-for-profit and proprietary, 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/>.

¹ Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014) (March 18, 2014) http://waysandmeans.house.gov/uploadedfiles/pac_leg_text_final.pdf

The Alliance has four recommendations regarding the proposed draft legislation: (1) support for standardized PAC assessment data collection across settings; (2) unique considerations for home health care; (3) implementation considerations; and (4) public input and timeline.

I. The Alliance supports standardization of PAC assessment data collection across settings.

Increasingly, home health providers are involved and engaged in post-acute care bundling and accountable care arrangements. Such arrangements drive greater coordination of care and improved care transitions. These arrangements are also beginning to seek achievement of clinically appropriate and cost effective placement in post-acute care. The value proposition of home health care from a cost effectiveness standpoint is clear.

In terms of post-acute care Medicare expenditures, home health care is generally the most cost-effective formal post-acute care setting. Home health care is the least costly alternative, representing 38.7% of all Medicare episodes using formal post-acute care first settings, but comprising only 27.8% of payments.² Moreover, data shows Medicare beneficiaries with the same diagnosis in the acute care hospital are receiving care in various post-acute care settings including: home health, skilled nursing facilities (SNFs), and to a more limited extent, inpatient rehabilitation facilities (IRFs), and long-term acute care hospitals (LTCHs). Across all Medicare diagnosis groups, the average 60-day episode expenditures (including the preceding acute care hospital admission) vary widely by formal first setting. For example, Medicare expenditures for a patient treated in home health after hospital discharge average \$20,345, compared to an average of \$28,294 across all settings.³

This trend holds true for patients when we look at specific MS-DRGs. In the context of a post-acute care episode (for inpatient hospital care plus 60 days post-acute care), the average Medicare payments for providing care to patients discharged after a major joint replacement under Diagnosis Related Group (MS-DRG) 470 vary considerably by which formal post-acute care setting the patient is admitted post-discharge. For all MS-DRG 470 episodes, the overall average episode payment is \$23,479 per patient. Where home health care is the first setting post-discharge, Medicare episode payments are \$5411 less than the overall average. By contrast, where the patient is discharged to SNFs, IRFs and LTCHs, Medicare episode payments are more than the overall average. LTCH first setting episodes are \$34,417 more than the overall average.⁴

It is critical, however, to identify which patients can appropriately be cared for at home. To ascertain clinically appropriate placement for patients, standardized patient assessment data

² Clinically Appropriate and Cost Effective Placement Project, Study Highlights for Working Papers #1 and 2, <http://www.ahhqi.org/images/pdf/cacep-wp1-highlights.pdf>

³ A. Dobson, et al., *Improving Health Care Quality and Efficiency ("Final Report")*, Clinically Appropriate and Cost-Effective Placement (CACEP) Project, Dobson | DaVanzo (Nov. 9, 2012), <http://ahhqi.org/images/pdf/cacep-report.pdf>.

⁴ 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://ahhqi.org/images/pdf/cacep-wp2-baselines.pdf>, October 2012.

would play an important role. Currently, each post-acute care provider collects assessment data, but the variation in the data makes comparing patients very challenging. Standardization of key parts of the assessment data across PAC settings, and for short-term acute care hospitals as well, is an important first step to enabling greater precision in identifying which patient can and should be cared for appropriately in each setting. Once we are able to standardize identification of which patients can appropriately be cared for at home from a clinical standpoint, then the cost-effectiveness of care in the home as compared with facility-based settings would suggest that care in the home should be incentivized. Patient preferences and freedom of choice are, and should be, respected as a critical factor and must also be built into any reformed construct for PAC reform. In the context of PAC reform, both legal and regulatory constructs should be revised with these factors in mind.

Particularly as policy-makers consider post-acute care bundling as an approach to health care delivery system reform, standardized patient assessment data and harmonized measures can facilitate achievement of the quality and efficiency goals. Earlier this year, the Alliance commissioned and released a toolkit and analysis on “bundling and coordinating post-acute care” (or “BACPAC”) as meant to identify key considerations for Medicare post-acute care bundling as a means to achieve both reformed delivery of PAC. Among the key considerations identified by the researchers at Dobson DaVanzo & Associates was the need for cross-cutting quality measures and standardized assessment data.

There is still a need for thorough analysis to identify what types of quality measures are needed across settings to best serve older Americans and those with disabilities in the future. Consideration should be given to identify and eliminate care that may be wasteful – those activities that do not add value in terms of achievement of optimal patient outcomes. The Alliance’s “Future of Home Health Project” will look at numerous issues, one of which is the measurement needs for the future. While quality is an area that is constantly improving iteratively, having constant and appropriate quality measures will enable all parties to work toward common goals. In the context of the Alliance’s Future of Home Health Project, we hope to begin identifying measurement needs to enable quality improvement in post-acute care, as well as longitudinal care management for older Americans and Americans with disabilities. We anticipate communicating with policymakers so that this work can be fully informed by needs identified by the government as a key stakeholder in health care.

II. Additionally, there are unique considerations for home health care.

Home health care is unique among post-acute care providers in that home health agencies provide more than just post-acute care. In addition to post-acute care, home health agencies provide care to patients in need of chronic condition management and admit patients from the community. In such cases, home health is used to support patient care in conjunction with primary care/patient centered medical homes and work to prevent avoidable index hospitalizations. The question that is raised by the IMPACT Act discussion draft is whether OASIS would change only for post-acute care home health episodes (Part A episodes) or if it would also change for community-based episodes (Part B episodes). To the extent that the standardized patient assessment data would have relevance to both Part A and Part B episodes, there would be reason to make any changes consistent.

III. The Alliance urges attention to key issues related to implementing the IMPACT Act.

Although the Alliance supports development of standardized PAC assessment data, a significant concern for providers is how the transition to new data collection standards would be carried out. Providers should be given the requisite support to make the transition.

Overall, the Alliance supports the domains identified in the IMPACT Act. In the context of those domain areas, the following characteristics should be tracked in order to improve the quality measures to be developed: (1) the degree of caregiver assistance available to the beneficiary in the home; (2) identification of poorly controlled and/or clinically chronic conditions; (3) whether the patient is considered “frail”; (4) whether the patient is receiving respiratory therapy, IV infusion, and/or parental nutrition; and (5) whether the patient suffers from urinary and/or bowel incontinence and problematic pressure ulcers.

Furthermore, one of the proposed domains is “accurately communicating the existence of and providing for the transfer of health information and care preferences when an individual transitions” from site to site in post-acute care. There is no mention, however, about health information *technology* (HIT) as a key enabler of such transfer of information. One critical aspect of the data to be standardized and collected is that those data elements should ultimately become part of standardized data elements in interoperable electronic health records (EHRs). Integration of key elements of standardized patient assessment data into interoperable EHRs will require a staged approach to implementation. Continuing to use the summary of care record as the basis for interoperable exchange of health information, the IMPACT Act should encourage a step-wise refinement of the data elements therein that will be standardized across settings to support transitions of care. Some of this refinement or expansion is already being addressed through the Massachusetts IMPACT project. These and other standardized patient assessment data elements would ultimately be used to develop the quality measures discussed in the IMPACT Act. Integration of these standardized data elements into interoperable EHRs will take time, but a key factor in driving progress in this area will be policies that require meaningful use providers to exchange higher percentages of the summary of care record electronically with non-meaningful use providers. Currently, meaningful use providers are only required to transmit 10% of their summary care records electronically – a higher percentage threshold would drive more health information exchange.

It is important to note, however, that changes in HIT systems will require considerable financial expense for home health providers. Although the IMPACT Act discussion draft includes monies (\$200 million) to be allocated to the Centers for Medicare and Medicaid Services (CMS) to fund the effort to standardize patient assessment data, it is not clear how these monies will be used. The Alliance recommends that some of this funding be used specifically to support provider efforts to update their processes and systems, and to enable workforce training, in light of assessment data collection changes. The Alliance supports a change toward standardized patient assessment data in general, but an unfunded mandate will put already strained providers in great distress. As you know, home health providers are not “eligible providers” for purposes of “meaningful use” and consequently, they have not received any funding for implementation of electronic health records. Using some of the funds to support home health providers in this vein will enable smooth implementation of the IMPACT Act.

In addition, home health providers are required to submit OASIS data as a condition of payment under HHPPS. One cannot make assessment data changes in complete isolation from payment concerns because the two are intertwined. For example, OASIS data are used to determine case mix adjustment for use in determining the home health prospective payment rates. As changes are made to OASIS as patient assessment data is standardized, it will be critical to take payment considerations into account so that as regulators or policy-makers make changes in the assessment data, they also appropriately adapt payment policy changes.

Finally, the Alliance recommends the addition of a provision in the legislation that would require CMS and HHS to implement these changes to standardize patient assessment data in the least burdensome manner possible for patients and providers. The Alliance recognizes the importance of this endeavor and the need for greater standardization and improved measurement of quality and efficiency of care. However, carrying out the changes in a fashion that minimizes unnecessary burden on providers will help make the changes actionable and reasonable.

IV. Finally, the Alliance supports extending efforts to evaluate the impact of data collection changes, emphasizing openness and transparency in implementing reforms, and consideration of the timeframe for reform.

In the context of the IMPACT act, both the Medicare Payment Advisory Commission (MedPAC) and the Secretary of Health and Human Services are to submit reports to Congress on post-acute care payment reform. In addition to these reports about post-acute care payment reform, the Alliance recommends that there be a report to assess or evaluate implementation of standardized patient assessment data collection for each PAC setting. Such a report should evaluate these changes from the perspective of: (1) the effect these changes will have had on patients and providers (including assessing the level of administrative burden); and (2) the effectiveness of the data collection effort in terms of assessing patient acuity, quality of care, and clinically appropriate patient placement. This would be in addition to the hospital report already included in the IMPACT Act.

In addition, the Alliance recommends that both MedPAC and HHS (or CMS) be required to hold open public meetings prior to developing their reports on PAC payment reform in order to ensure a well-informed perspective. Patients, providers, and multiple stakeholders have great interest in post-acute care reform and will have ideas on ways to shape these changes. Both MedPAC and HHS can benefit from hearing the diversity of suggestions and opinions in an open, public setting.

Furthermore, in the context of creating or modifying quality measures drawn from a common assessment tool, such changes should be made through formal rule-making processes that ensure notice and an opportunity for public comment.

Finally, the Alliance believes the current timeline should be analyzed to assess whether the changes in the IMPACT act could happen on a faster timeframe. At present, post-acute care is fragmented, and reforms to health care delivery and payment are needed to improve care coordination and care transitions in post-acute care. If standardized patient assessment is a critical stepping stone toward the end of PAC payment and health care delivery reform, we

should address it as quickly as reasonably possible so that key reforms to delivery and payment can be made.

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Thank you again for the opportunity to provide comments. Should you have any questions about the Alliance's comments, please contact me at (202) 239-3671 or tlee@ahhqj.org.

Sincerely,

/s/
Teresa L. Lee, JD, MPH
Executive Director