September 8, 2014

The Honorable Andy Slavitt
Acting 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 Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services**

Dear Administrator Slavitt:

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 Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services ("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. The Alliance supports the overall concept of a bundled payment program focused on comprehensive care for major joint replacement patients and offers the following recommendations and considerations to CMS on the following topics: (1) home health care's value; (2) quality measures; (3) data accessibility; (4) alternative approaches to bundled payments; (5) waivers; and (6) beneficiary protections.

[1] Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services, 80 Fed. Reg. 41,198 (July 14, 2015) (hereinafter "Proposed Rule"), https://federalregister.gov/a/2015-17190

## I. Home Health Care's Value

### a. Clinically-Appropriate Cost-Effective and Placement (CACEP) Project Findings

In 2012, the Alliance commissioned the CACEP project, which analyzed traditional Medicare claims data (linking Medicare Part A, B and D claims linked with OASIS, MDS and IRF-PAI assessment data) over a three-year period to better understand patient care for Medicare beneficiaries across settings and evaluate opportunities for improving the delivery of clinically-appropriate and cost-effective care.

The researchers of the CACEP project from Dobson DaVanzo and Associates focused on major joint replacements for lower extremity as a particularly important opportunity for improvement. The researchers found significant differences in episode expenditures for MS-DRG 470 Medicare beneficiaries depending on their first setting post-hospital discharge. As shown in the chart below, for an episode that begins with inpatient hospitalization and ends 60 days post-discharge, if a patient goes to home health care as the first setting post-discharge, overall Medicare expenditures are significantly less as compared to episodes when care is first delivered in a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH).

**Medicare Episode Payment for MS-DRG 470 (major joint replacement w/o MCC) for Post-Acute Care Episodes by Select First Setting (2007-2009)**

| First Setting | Number of Episodes | Average Medicare Episode Payment | Difference from Overall Payment |
|---|---|---|---|
| HHA | 366,140 | $18,068 | $5,411 |
| SNF | 430,240 | $26,861 | ($3,382) |
| IRF | 128,680 | $33,538 | ($10,059) |
| LTCH | 1,080 | $57,896 | ($34,417) |
| STACH | 2,580 | $30,302 | ($6,823) |
| Community | 134,240 | $17,340 | $6,140 |
| **Overall** | **1,062,960** | **$23,479** | **$0** |

Source: Dobson | DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2007-2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars. All episodes have been extrapolated to reflect the universe of Medicare beneficiaries. Medicare Episode Payment includes care from all facility-based and ambulatory care settings and excludes beneficiary co-payments, DME, and Part D payments.
Note: ER, OP, OP Therapy, Hospice and Other IP first setting episodes are not included in the overall.

The researchers also studied patient pathways of care, identifying readmissions as triggers that almost doubled Medicare expenditures and led to significantly worsened patient outcomes. The researchers concluded that better care coordination and management that would lead to placing patients in the

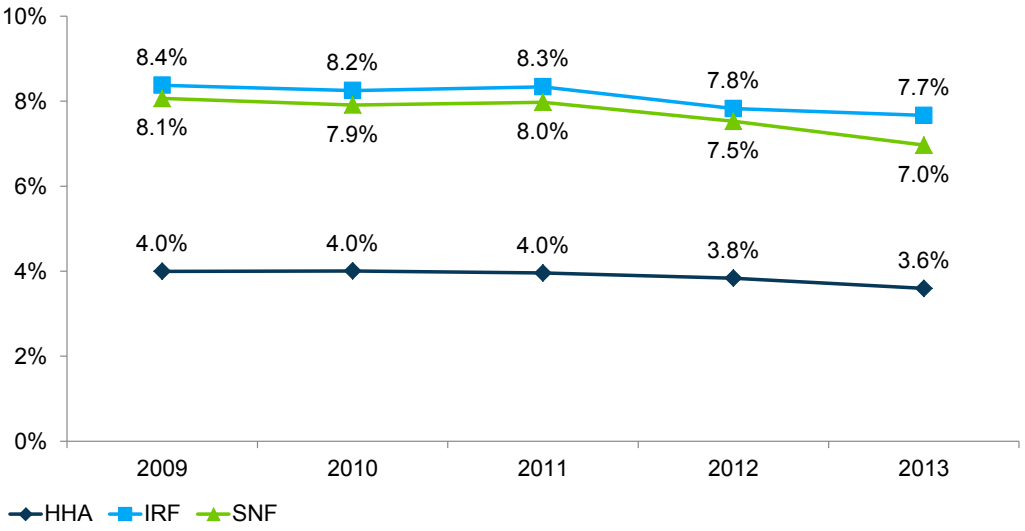
most clinically-appropriate and cost effective setting could yield savings of approximately $34.7 billion over ten years.[2]

**a. For both MS-DRG 469 and MS-DRG 470, home health care has a low rate of 30-day rehospitalizations as compared with other post-acute care settings.**

Furthermore, Medicare claims data show that when patients are referred to home health care as the first setting of post-acute care after receiving major joint replacement (lower extremity), such patients tend to have lower rates for rehospitalization within 30 days as compared with patients discharged first to skilled nursing facilities and inpatient rehabilitation facilities. This is true for both MS-DRG 470 and 469.

## Outcomes: Major Joint Rehospitalizations Among Post-Acute Care Users

Chart 7.3: 30-day Rehospitalization Rates for MS-DRG 470* Discharged from Hospital to Selected PAC Settings, by Care Setting, 2009 - 2013

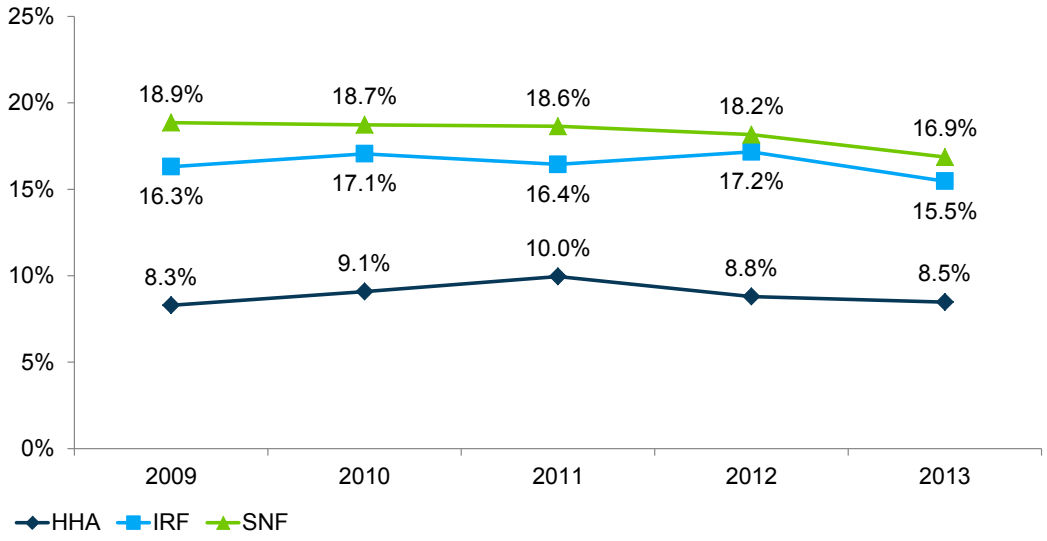



Source: Avalere Health, LLC, analysis of Medicare Standard Analytic Files, 2009 – 2013
*MS-DRG 470: Major joint replacement or reattachment of lower extremity with out major complication or comorbidity

[2] A. Dobson et al., "Clinically Appropriate and Cost-Effective Placement: Improving Health Care Quality and Efficiency," www.ahhqi.org, October 2012.

## Outcomes: Major Joint Rehospitalizations Among Post-Acute Care Users

Chart 7.2: 30-day Rehospitalization Rates for MS-DRG 469* Discharged from Hospital to Selected PAC Settings, by Care Setting, 2009 - 2013




Source: Avalere Health, LLC, analysis of Medicare Standard Analytic Files, 2009 – 2013
*MS-DRG 469: Major joint replacement or reattachment of lower extremity with major complication or comorbidity

Although there may be multiple factors underlying these rates, the data suggest that home health care offers tremendous value to patients and the health care system writ-large and can be a critical setting of care for reducing unnecessary, painful and costly readmissions.

**II. With regard to the quality measure requirements in the proposed rule, the Alliance urges CMS to ensure appropriate risk adjustment in its quality measures and to monitor provider behavior.**

CMS has proposed the use of only three, hospital-centric quality measures that target quality through 30 days post-discharge from the hospital. To achieve shared savings, hospitals will need to perform at the 30$^{th}$ percentile or higher for all three measures.

The Alliance is concerned that where procedure volume is relatively low and where some patients' conditions may be particularly severe or complex, there may be provider incentives to "cherry-pick" patients. Patients who might be more costly to treat may be at risk of not being able to access high quality care. It will be critical to appropriately risk adjust quality measures to mitigate such provider incentives. Moreover, over time, appropriate stop-loss will also protect against such risks. Because the CCJR model is new, the Alliance strongly recommends that CMS closely monitor and evaluate provider behavior to ensure that access to quality patient care is not compromised.

In addition, the Alliance urges CMS to evaluate over time the appropriateness of the measures identified in the proposed rule. Given the many quality reporting and value-based purchasing programs in effect and planned for the providers of care included in the CCJR model bundle, CMS

will need to take multiple factors into account in assessing performance measurement for the CCJR model. Moreover, CMS will need to determine what changes will be needed in the future to ensure quality of care given the many programs in place and planned for so many different health care providers and professionals. The Alliance urges CMS to find ways to harmonize measures so that the goals of care will be consistent across the care continuum.

## III. Data Accessibility

The Alliance urges CMS to share data equally among providers and professionals of services in the CCJR geographic catchment areas identified in the proposed rule. Transparency and openness in sharing of data will enable all providers and professionals to better understand their performance in relation to others involved in CCJR sites across the country, and it will foster a level playing field that ultimately will improve the quality and efficiency of patient care.

## IV. CMS should continue to consider alternative approaches to bundled payment that would permit a post-acute care only bundled payment approach.

The CCJR model episode is structured to include the short-term acute care inpatient hospitalization for MS-DRG 470 and 469 patients and will extend to include 90 days of care delivered post-discharge. The Alliance supports use of this model's episode structure, but urges CMS to continue to consider the use of other types of episodes. CMS is continuing its bundled payments for care improvements (BPCI) initiative in which four different models are being tested. Most relevant to the CCJR proposed rule are the "Model 3" BPCI arrangements, which are triggered by a short-term acute care inpatient hospitalization, but the episode only begins if there is use of care in a formal post-acute care setting (e.g., SNF, IRF, home health, or LTCH).

The BPCI initiative is still underway and many innovative programs show great promise for achievement of the Triple Aim. Many Alliance members have been involved in BPCI in varying capacities. The Alliance urges CMS to evaluate the CCJR model while also considering the results of the BPCI initiative, and to compare and contrast the results to inform long-term health care delivery system and payment policy for the Medicare program.

## V. Waivers

*Post-Discharge Home Visits.* The Alliance appreciates the recognition of the need for, and the value of, post-discharge home visits, even for those who would not otherwise qualify for the Medicare home health benefit.

However, as currently proposed, the waiver of the direct supervision requirement for services incident to a physician's services for post-discharge home visits will limit the ability to use home health nurses for the very work that they have been trained to do. Requiring billing under the physician fee schedule will limit the types of organizations and professionals who can bill for such visits. Home health agency professionals are specifically trained to make home visits after discharge from the hospital and the expertise of home health professionals should be leveraged, even for patients who would not otherwise qualify for the home health benefit. As proposed, CMS will erect a barrier to accessing high quality care at home.

The Alliance recommends that CMS enable home health agency professionals to provide post-discharge home visits to patients who would not otherwise qualify for the home health benefit, and

that home health agencies be paid at the low utilization payment adjustment (LUPA) rate for such visits. To enable such billing, CMS could clarify that a hospital or community physician or non-physician practitioner may contract with a home health agency so that its professionals may perform such post-discharge home visits.

*Telehealth.* In addition, the Alliance commends CMS's proposed waiver of the originating site and geographic service area requirements for telehealth services. The Alliance urges CMS to use its waiver authority to further enable home health agency professionals to offer telehealth services outside of the Medicare home health benefit. At present, many home health agencies use telehealth services within the context of the Medicare home health benefit. However, there are many patients who would not qualify for the home health benefit, but would benefit from telehealth offered by experienced home health professionals. The Alliance urges CMS to consider including such situations in its waiver for telehealth.

## VI. Beneficiary Protections

The use of bundled payment arrangements is an appropriate and powerful tool to align incentives among providers and professionals that otherwise operate in siloes (for both payment and health care delivery purposes). The Alliance supports the effort to shift away from the traditional, siloed Medicare payment system, and towards bundled payment approaches that will incent coordinated care to support the Triple Aim.

Notwithstanding, the use of bundled payments raises questions about whether the financial incentives inherent in bundled payments will have the unintended consequence of incentivizing stinting of care (thereby compromising both access and quality of care) and/or have the effect of limiting beneficiary freedom of choice. The Alliance urges CMS to consider putting in place beneficiary protections such as providing notices to beneficiaries regarding their freedom to choose any qualified provider of care, and offering an appeals and complaint mechanism. As stated above, CMS or its contractors should closely monitor and evaluate the care delivered by providers in CCJR geographic areas to assess whether the model is leading to issues with quality of care, access to care, and issues with beneficiary choice.

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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