



September 25, 2017

Via Regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Dear Administrator Verma:

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; CY2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements ("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) the proposed Home Health Groupings Model (HHGM); (2) the impact of Medicare home health payment rate changes and patient access to care; (3) proposed changes to the Home Health Value Based

¹ Medicare and Medicaid Programs; CY2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based

Purchasing Program; (4) the proposed changes to the Quality Reporting Program; and (5) additional areas for consideration.

I. Home Health Groupings Model (HHGM)

The Alliance, along with our peers in the industry, and pursuant with comments previously submitted by our colleagues at the National Association for Home Care and Hospice (NAHC) and the Partnership for Quality Home Health Care (the Partnership)², is concerned about the impact and process of HHGM. These concerns primarily relate to the impact of the model on access and quality of care, as well as an inadequacy of information about the model, and a lack of transparency in the process.

a. **HHGM, in its current iteration, threatens access to high quality care for patients who are poorer, sicker, and older than the general Medicare population, and threatens the efficiency of the health care system.**

Data from the 2015 update to the Home Health Chartbook, a compilation of descriptive statistics from government data sources that includes the Medicare Current Beneficiary Survey, the 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, paints a descriptive and important picture of Medicare home health patients. The charts below show that between 2010 and 2013, the number of home health users with two or more Activities of Daily Living (ADL) limitations has increased significantly. As the proceeding chart illustrates, in 2010, just 2.5% of home health users lived with two or more ADL limitations, compared to 31.9% just four years later in 2013. The percentage of home health users with incomes under 200% of the Federal Poverty Level (FPL) have also risen significantly over this period of time, going from 62.6% to 67.2% from 2010 to 2013.³

The overall increase in patient severity from 2010 to 2013, coupled with an increase in the number of home health users who are dual eligibles, as well as the percentage of home health users who have severe mental illness, signals that the need for access to high-quality home health care is rising.⁴ HHGM threatens that access by reducing patient expenditures and forcing providers to spend resources instead adapting to a new and unnecessary model, rather than continuing to place the focus on patients.

Other major concerns with regard to specific patient populations include significant underpayment for patients admitted from the community and those with chronic conditions. As demonstrated in the below tables, more than 85 percent of home health users have three or more chronic conditions. Therefore, the estimated underpayment for patients with chronic

² “RFI-- Partnership for Quality Home Healthcare and National Association for Home Care & Hospice—DC” Sept. 2017. file:///Users/jenniferschiller/Downloads/HomeHealthPaymentRule-PreCommentLetter-FINAL-9-1-17.pdf

³ Excerpt from Home Health Chartbook, 2015: Prepared for the Alliance for Home Health Quality and Innovation, Chart 1.23 (http://ahhqi.org/images/uploads/EXCERPT_2015_AHHQI_Chartbook_Section_1.pdf).

⁴ *Id.*

conditions impacts a significant majority of the home health population and interferes with providers' ability to properly address and care for these patients.

Demographic Trend of Home Health Users

Table 1.23: Selected characteristics of Medicare Home Health Users, 2010 – 2013

	2010	2011	2012	2013
Have 3 or more chronic conditions	86.0%	83.2%	85.9%	85.1%
Have 2 or more ADL limitations*	22.5%	28.7%	34.2%	31.9%
Have incomes under 200% of the Federal Poverty Level (FPL)**	62.6%	64.5%	67.9%	67.2%
Have incomes under 100% of the Federal Poverty Level (FPL)**	30.2%	34.8%	32.6%	31.2%
Are dual eligibles***	N/A	29.9%	29.9%	31.7%
Have SMI****	N/A	26.3%	27.0%	27.2%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care files 2010 – 2013

*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.

**100 percent of FPL for a household of was \$10,830 in 2010, \$10,890 in 2011, \$11,170 in 2012 and \$11,490 in 2013. 200 percent of FPL was double each amount.

***Dual eligibles are defined as individuals with any state buy-in at any point during the year. Beneficiaries were classified as requiring assistance with an ADL (bathing, walking, transferring, dressing, toileting, and eating) if they reported needing at least stand-by assistance with that ADL.

****Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

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Demographics of Home Health Users

Table 1.6: Selected Characteristics of Medicare Home Health Users and All Medicare Beneficiaries, 2013

	All Medicare Home Health Users	All Medicare Beneficiaries
Age 85+	24.0%	12.0%
Live alone	36.7%	28.8%
Have 3 or more chronic conditions	85.1%	62.5%
Have 2 or more ADL limitations*	31.9%	12.0%
Report fair or poor health	48.7%	27.2%
Are in somewhat or much worse health than last year	41.9%	22.2%
Have incomes at or under 200% of the Federal Poverty Level (FPL)**	67.2%	52.1%
Have incomes under 100% of the Federal Poverty Level (FPL)**	31.2%	21.3%

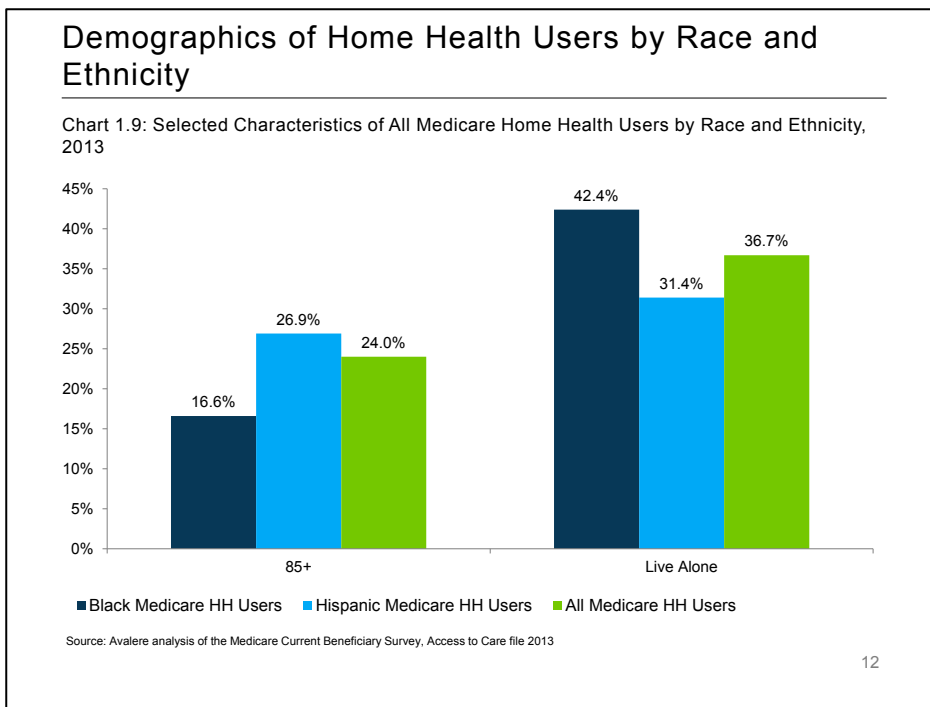
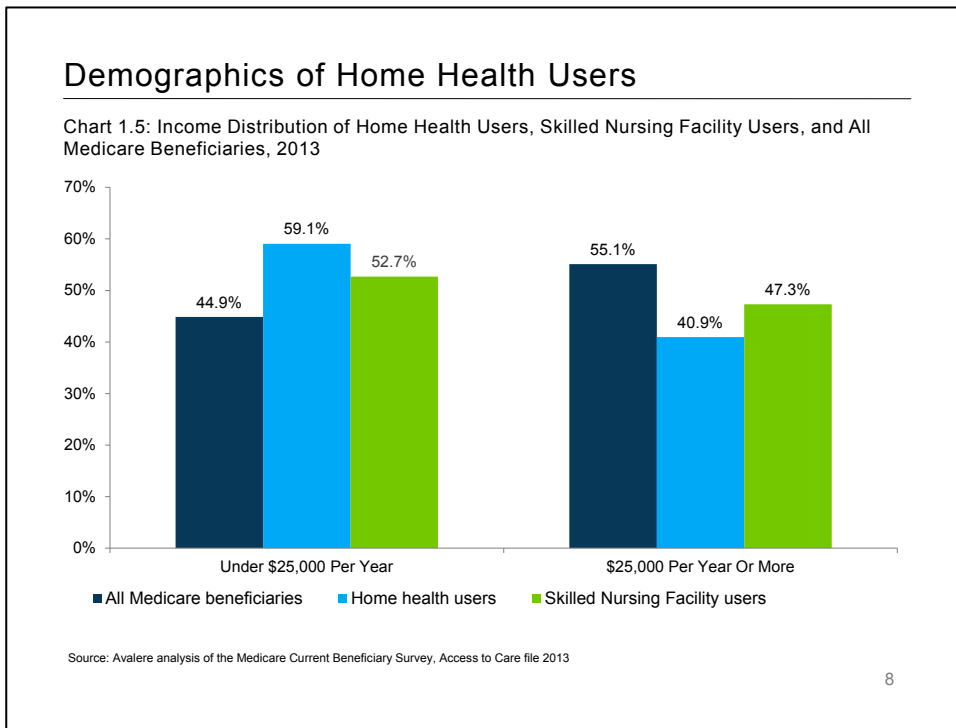
Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2013

*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 2013, 100 percent of FPL for a household of 1 was \$11,490, a household of 2 was \$15,510, a household of 3 was \$19,530, and household of 4 was \$23,550. 200 percent of FPL was double each amount.

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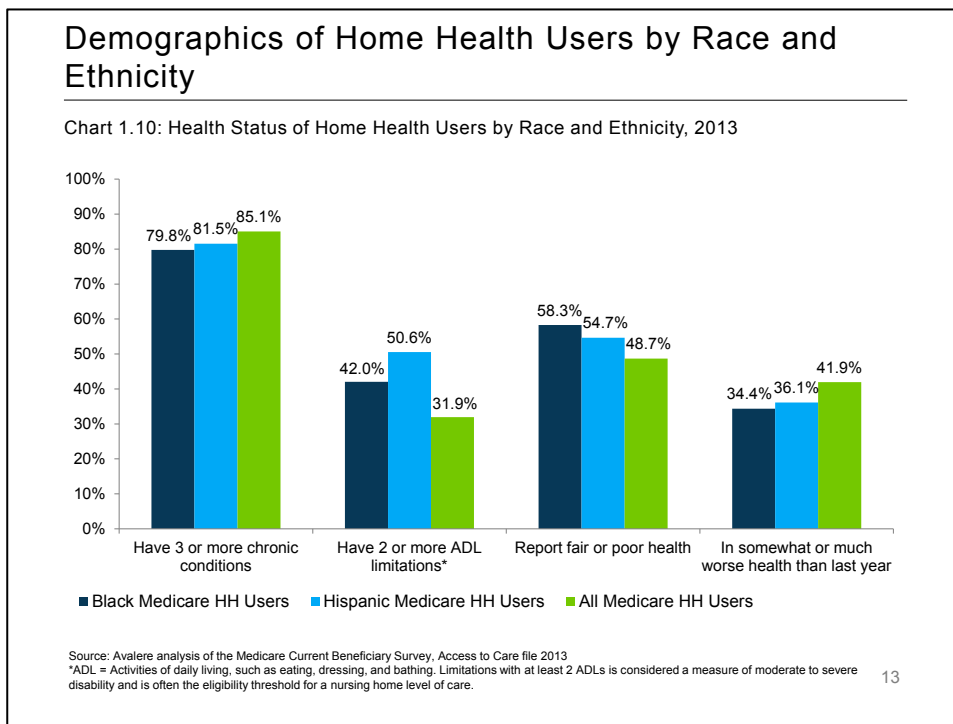
The Alliance urges CMS to consider the following demographic and clinical data on home health patients, as the data demonstrates the vulnerability of the home health patient population.⁵



⁵ All of the Charts inserted in the Alliance’s comments below can be found at http://ahhqi.org/images/uploads/EXCERPT_2015_AHHQI_Chartbook_Section_1.pdf

Medicare home health patients tend to be older, sicker, and poorer than the general Medicare population. Among Medicare home health beneficiaries, nearly one in four is over 85 years of age, and more than one in every three lives alone. By comparison, only 12.0% of all Medicare beneficiaries are aged 85 or older. Additionally, 67.2% of home health users have income below 200% of FPL; by comparison, only 52.1% of general Medicare beneficiaries have income under 200% of the FPL. Furthermore, as reflected in the preceding chart, 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 Chart 1.5 demonstrates that home health agencies tend to serve a greater percentage of those making less than \$25,000 per year than SNFs and all Medicare beneficiaries.

Additionally, home health agencies tend to serve a higher proportion of racial minority patients as compared with skilled nursing facilities.⁷ Black and Hispanic home health users tend to be even 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. They are also older and more likely to live at home⁸, making care even more difficult.

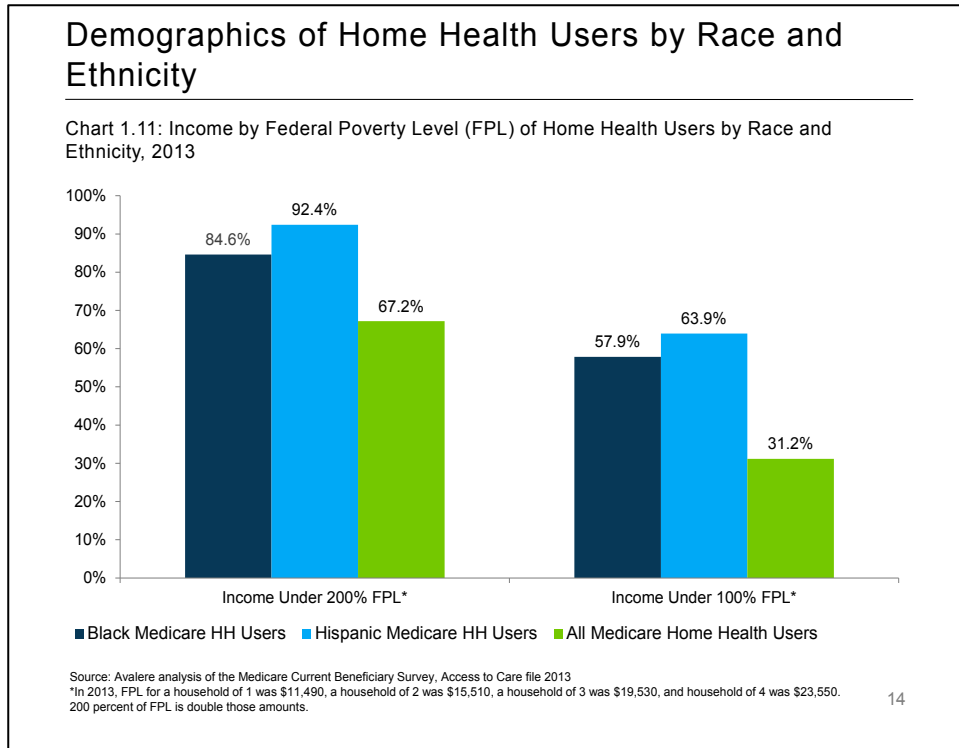


⁶ *Id.* at 9.

⁷ *Id.* at 7 (Chart 1.4 shows that racial minorities comprise 21% of home health users, compared to 15.3% of skilled nursing facility users).

⁸ *Id.* at 12.

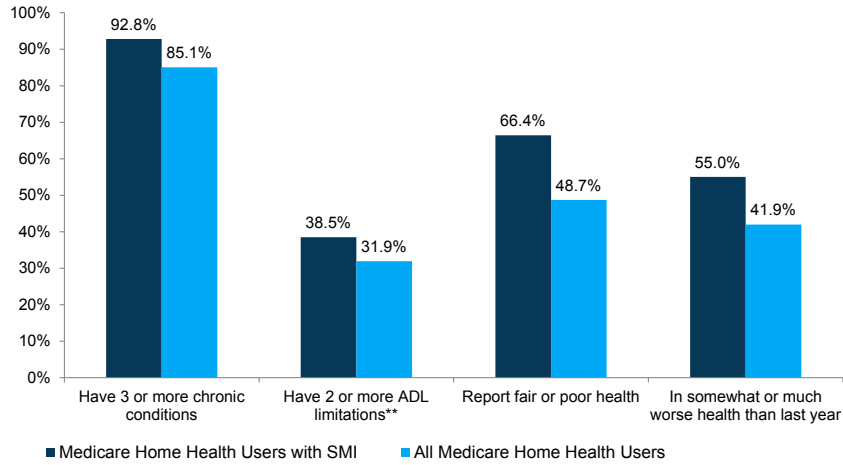
Given the over-representation of these groups in the home health patient population, the Alliance is concerned HHGM may have a disproportionately negative impact on racial and ethnic minority populations, and urges CMS to consider these populations when considering implementation of such a model.



Similarly, HHGM may threaten access to care for patients with severe mental illness. More than a quarter of all home health beneficiaries are managing severe mental illnesses, as compared to just 18.7% of all Medicare beneficiaries. Home health beneficiaries who have severe mental illness also tend to be more vulnerable than the Medicare population at large, as described in Chart 1.19.

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

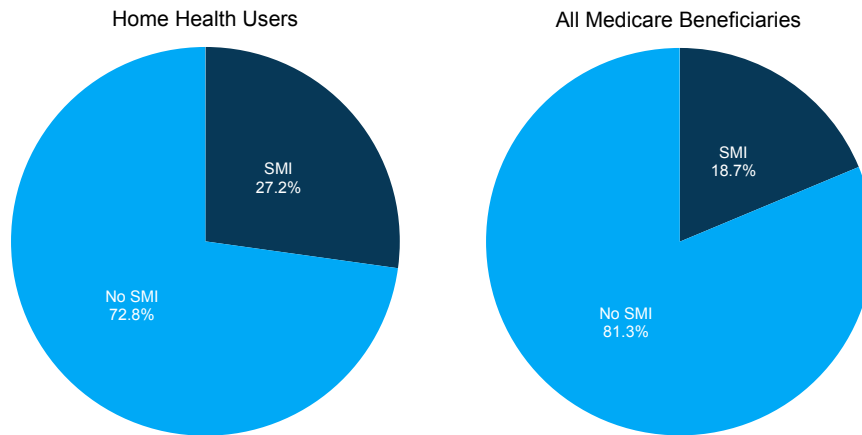
Chart 1.19: Selected Characteristics of All Medicare Home Health Users and Medicare Home Health Users with SMI, 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2013.
 *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.

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

Chart 1.21: Percentage of Medicare Home Health Users with SMI Compared to the Percentage of Medicare Beneficiaries with SMI, 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.
 *Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

For further analysis on the impact of HHGM on sub-populations of home health patients, the Alliance refers CMS to the comments submitted by ElevatingHOME and analysis conducted by its member organizations.

The bottom line is that the burdens placed upon providers within the groupings model threaten access to high-quality care for some of the most vulnerable patients and populations. The needs of the patients must be taken into account when deciding to enact a change of this magnitude, and the Alliance feels these concerns are not properly addressed in the both the Proposed Rule and the supplemental materials. Further concerns, related to access, quality of care, and process are outlined below.

b. A non-budget neutral model poses serious threats to patient access, and is inconsistent with the Balanced Budget Act of 1997.

Consistent with the comments submitted by NAHC and the Partnership referenced previously, the Alliance shares concerns on the overall lack of budget neutrality in the Proposed Rule. CMS itself estimates a 4.3 percent reduction in payments for the year 2019 alone, a reduction of just under one billion dollars in payment to providers.

Per analysis done by Dobson | DaVanzo, even in a budget neutral model HHGM represents an immense redistribution of Medicare payments for home health services, with 27 percent of HHAs seeing a shift of +/- 20 percent in revenue for the same cases in the existing model.⁹ This kind of de-stabilization will radically impact the ability to provide care to patients, not accounting for the lack of budget neutrality and additional cuts in the Proposed Rule.

A non-budget neutral model creates further burden on the home health care system and providers, hindering access to care for patients. Given that the groupings model is also untested, and knowing that wholesale implementation of a model of this magnitude without budget neutrality will negatively impact patients as cuts to the system will threaten access and quality care, it is therefore even more concerning that the impact will be far more devastating than initially predicted.

c. The Alliance is also concerned with the move to 30-day episodes, as there is insufficient information available to properly assess such a drastic change.

There is simply not enough information to fully assess the impact of a move to 30-day episodes given the tools and information laid out in the proposed rule and supplemental materials. This model is still untested, and we cannot ascertain how the move to 30-day episodes will impact patient care and payment. At the very least HHGM and the move to 30-day episodes need to be piloted on a smaller scale before being thrust upon agencies with no more than rough modeling from which to prepare. Significant refinement and engagement is critical, and the Alliance feels neither is represented in this move to 30-day episodes.

⁹ The Home Health Groupings Model, 2017. Dobson | DaVanzo
http://www.nahc.org/assets/1/7/Dobson_DaVanzo_briefing.pdf

Therefore, the Alliance recommends that CMS table this model until it has been properly tested and analyzed.

- d. Within the HHGM proposal, a number of the diagnosis codes identified are inappropriate to be coded as a primary diagnosis, leading to inaccurate and potentially harmful coding.**

Firstly, the Alliance is concerned about the costs associated with coding changes and the fact that while modeling was done with ICD-9, HHGM implementation will use ICD-10. The Alliance strongly urges CMS to consider these changes and the associated costs and concerns, and provide substantial and guidance on these changes and the impact.

Additionally, the Alliance has concerns that the model may not accurately adjust for a primary diagnosis for the Clinical Grouping if the primary diagnosis does not sufficiently establish a Clinical Grouping.

The Alliance would ask that CMS refer to the Association of Home Care Coding and Compliance and ElevatingHOME for more substantive analyses of the concerns related to coding, and offers support for these concerns overall.

- e. Finally, the Alliance would like to offer our support and expertise to CMS as further work is done to refine the proposed model.**

The Alliance appreciates the opportunity to comment, and would like work with CMS and our industry colleagues via meetings or possibly a working committee to address and refine the proposed model.

There has simply not been enough analysis and stakeholder engagement throughout the process to adequately assess the very significant changes to patient and access care that would result from any implementation of the proposed groupings model. This process is not conducive to providing high-quality patient care, and in fact hinders the ability to do so through cumbersome rules and changes, which have not been proven through analysis, and major cuts that threaten patient access.

Therefore, the Alliance urges CMS to delay any and all implementation of HHGM until such time as proper testing (beyond the rushed modeling provided in supplement), discussions, reimbursement, and a transparent process are completed and provided to the public with a reasonable period for additional comments and evaluation.

Recommendation: The Alliance strongly recommends that CMS not finalize HHGM in the CY2018 final rule, as significant changed clarifications are needed before such a rule could be properly implemented without substantial access and quality concerns.

- II. Additional payment cuts, coupled with the aforementioned proposed implementation of HHGM, pose a threat to access to quality and efficient care for beneficiaries.**

The Alliance offers comments from the perspective of how patient access to quality care may be impacted by the proposed payment changes articulated in the proposed rule, as outlined in the preceding section specifically with respect to HHGM but applicable to access issues associated with dramatic across the board cuts beyond just those proposed in HHGM such as the proposed case-mix changes and the sunseting of the rural add-on. We encourage CMS to consider the comments submitted by NAHC, ElevatingHOME, and the Partnership with regard to specific rate-setting concerns.

Recommendation: Due to the risk for reduced access to critical care for the most vulnerable population, the Alliance urges CMS to consider the potential impact of payment cuts on a generally, older, sicker, poorer, and more vulnerable population, and mitigate these risks where possible.

III. Home Health Value Based Purchasing (HHVBP)

Overall, the Alliance supports the changes made within the value based purchasing program to move to a minimum of 40 completed surveys to receive a performance-based score for Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) measures, and continues to offer support in the assessment of measures.

However, the Alliance has concerns about what the impact of potential implementation of HHGM does to HHVBP and other, existing payment and care models. Serious consideration must be made of the potential effects and burdens placed on care providers already operating within these alternative models. There is currently no supporting guidance on the impact, and therefore it is impossible to once again truly understand the impact and burden of HHGM placed on providers in these existing models.

Recommendation: Further clarity on the impact of the potential groupings model to HHVBP is necessary before there can be further discussion of the program as a whole. These discussions must also focus on the impact of the groupings model to other alternative payment and care models currently being run by CMS which will be impacted by any wholesale changes to the delivery care such as the groupings model.

IV. Quality Reporting Program (QRP)

The Alliance continues to appreciate CMS's effort to work with stakeholders on quality measures, and further appreciates the addition of social risk factor into the QRP, though the Alliance would like to see education and community support systems included to the list of social risk factor.

However, the Alliance is concerned with increased burden on providers with the addition of several fairly duplicative assessment measures without clear benefit.

Furthermore, the proposed standardized assessment items must be completed within three days, which does not align with the five day timeframe in which HHAs must complete additional OASIS items. There is no inherent benefit in this distinction, and instead creates an added layer of complexity and burden for providers trying to comply.

Finally, while CMS estimates a decrease of approximately \$3700 per agency per year as a result of the changes to QRP, this may in fact be an underestimate and creates further strain for agencies in the care of patients.

The Alliance refers CMS to NAHC's comments for a complete list of concerns related to specific proposed measures and assessment data.

Recommendation: The Alliance asks CMS to consider the substantial burdens, both administrative and financial, associated with the proposed changes to QRP.

V. Additional Comments

Finally, the Alliance would like to reiterate a commitment to working with CMS on the areas addressed in the proposed rule and beyond.

Several existing barriers for home health agencies remain unaddressed, including but not limited to the face-to-face requirement, the Pre-Claim Review Demonstration, and the homebound requirement. These significant issues, addressed in previous comment letters¹⁰¹¹ and communications continue to present challenges to optimizing care for a growing and vulnerable patient population.

The Alliance looks forward to continued collaboration with CMS and other stakeholders in order to address the concerns outlined above in sections I-IV and those briefly mentioned in the preceding paragraph.

* * *

The Alliance greatly appreciates the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at (571) 527-1532 or jschiller@ahhqi.org.

Sincerely,

/s/

Jennifer Schiller
Director, Policy Communications & Research

¹⁰ Alliance Comments to CMS on Medicare Shared Saving Program. Feb. 2015.

http://ahhqi.org/images/uploads/Alliance_ACO_Comments_20615_FINAL_WEB.pdf

¹¹ Alliance Comments to CMS on the Pre-Claim Review Demonstration. July 2016.

http://ahhqi.org/images/uploads/AHHQI_PCRD_Comments_72116.pdf