August 26, 2013

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; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses

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; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses ("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. We are also 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 the following recommendations and considerations:

[1] Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses, 78 Fed. Reg. 40,272 – 308 (July 3, 2013) (herein after "Proposed Rule"), http://www.gpo.gov/fdsys/pkg/FR-2013-07-03/pdf/2013-15766.pdf.

I. Payment Concerns: The Alliance is concerned that Medicare home health payment changes may undercut beneficiary access to quality care and diminish health care system efficiency.

As a non-profit research organization, 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 only from the perspective of how these cuts will affect access to quality patient care. For issues more closely related to the method of implementing payment changes, the Alliance would ask 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. Home health payment cuts pose access issues for home health beneficiaries – a vulnerable population characterized by advanced age, lower annual incomes, and more chronic conditions than the general Medicare beneficiary population – and threaten health care system efficiency.

As policymakers consider payment changes for home health care, the Alliance urges CMS to take into consideration the demographic and clinical profile of patients who receive home health care services. The Home Health Chartbook, a collection of descriptive statistics compiled by Avalere Health LLC, summarizes and analyzes statistics on home health from a range of government sources, including 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.[2] We have provided some of the most relevant data as background information on the demographic makeup of home health users.

Home health beneficiaries are a vulnerable population characterized by advanced age, lower annual incomes, greater difficulty managing activities of daily living ("ADLs"), and more chronic conditions as compared with the overall Medicare population.[3] Moreover, home health beneficiaries tend to have much lower incomes than the average Medicare beneficiary,[4] with 62.5% of home health beneficiaries living on an annual income of $25,000 or less. Patients who use Medicare home health services are homebound and, as reflected in the demographic data below, are in need of special care:[5]

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[2] 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.
[3] *See id.* at 14.
[4] *Id.* at 13.
[5] *Id.* at 14.

Demographics of Home Health Users

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

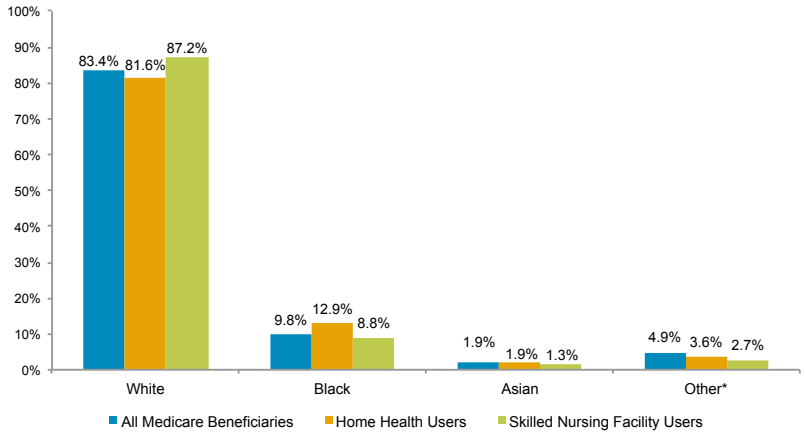
	All Medicare Home Health Users	All Medicare Beneficiaries
Over age 85	24.2%	12.5%
Live alone	35.6%	29.4%
Have 3 or more chronic conditions	83.2%	60.5%
Have 2 or more ADL limitations*	28.7%	10.6%
Report fair or poor health	45.8%	26.6%
Are in somewhat or much worse health than last year	41.3%	23.0%
Have 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 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.

Home health beneficiaries also tend to be more racially diverse than both the overall Medicare population and SNF users:[6]

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

[6] *Id.* at 12.

Furthermore, Black and Hispanic home health beneficiaries face great challenges with ADL limitations, generally poorer health status, and lower incomes. The Alliance is concerned that payment cuts may have a disproportionately adverse impact on Black and Hispanic home health beneficiaries who are, in many ways, some of the most vulnerable home health beneficiaries:[7]

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%

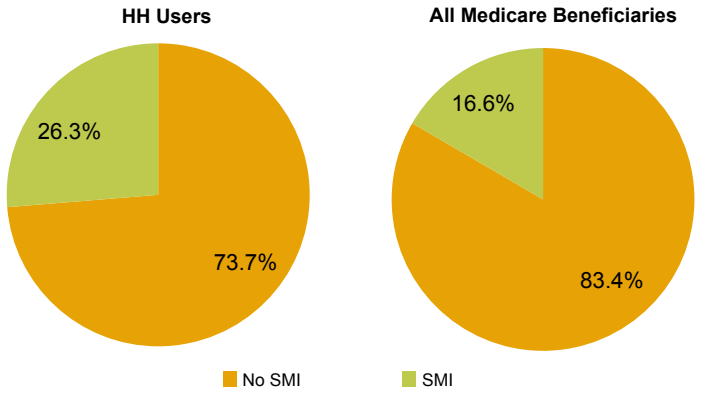
Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is is considered a measure of moderate to severe disability and is often the eligibility threshold 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:[8]

[7] *Id.* at 17.
[8] *See id.* at 27, with "Severe Mental Illness" defined as depression or another mental disorder such as bipolar disorder, schizophrenia, and other psychoses.

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

Chart 2.19: Percentage of Home Health Users who Have SMI Compared to the Percentage of Medicare Beneficiaries with SMI, 2011



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2011
Note: Severe mental illness (SMI) is defined as having depression or other mental disorder, including 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:[9]

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 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.

Reducing home health payments jeopardizes access to quality care for patients who are in greatest need of protection. As Joe Baker, President of the Medicare Rights Center, described

[9] *Id.* at 26.

in recent testimony before the House Ways and Means Committee's Subcommittee on Health, Medicare home health patients are "the most vulnerable: the poorest, the oldest and the sickest."[10]

Moreover, reducing payments for Medicare home health care may inadvertently increase use of institutional care like hospitals, working against the goals of Medicare reform to improve outcomes and reduce costs. Efficient use of home health offers a solution to rising Medicare costs. For example, the use of home health after major joint replacement surgery, where clinically appropriate, can yield Medicare savings. When home health is used as the first formal post-acute care setting following an acute care hospitalization for MS-DRG 470 (major joint replacement), the Medicare program saves an average of $5,411 per patient.[11] 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.[12]

Home health offers, where clinically appropriate, a lower-cost alternative to institutional care settings. Home health care providers have been partnering with other care providers and payers in new payment models such as the accountable care organizations ("ACOs"), bundled payment arrangements, patient-centered medical homes, and population health management initiatives to improve patient outcomes and lower health care costs.

However, if Medicare payment cuts continue threaten home health providers' ability to offer health care services, this highly efficient, high value alternative may no longer be available as an option. Delivering high quality care to Medicare's homebound population requires home health providers to 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 viability of home health providers that make such costly, but necessary, investments to provide better care for patients and the entire health care system.

Recommendation: That CMS and policymakers consider that payment cuts and rebasing may have a disproportionately negative impact on access to quality care for home health beneficiaries who are older, sicker, and poorer than the average Medicare beneficiary, and on health care system efficiency.

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[10] Joe Baker, Testimony of Joe Baker, President, Medicare Rights Center, Committee on Ways and Means Website, 10 (May 21, 2013), http://waysandmeans.house.gov/webreturn/?url=http://docs.house.gov/meetings/WM/WM02/20130521/100874/HHRG-113-WM02-Wstate-BakerJ-20130521.pdf.

[11] Allen Dobson, et al., Working Paper #2: Baseline Statistics of Medicare Payments by Episode Type for Select MS-DRGs and Chronic Conditions, *Clinically Appropriate and Cost-Effective Placement Project ("CACEP") Project*, Dobson | DaVanzo, 29 (April 4, 2012), http://ahhqi.org/images/pdf/cacep-wp2-baselines.pdf (finding that when home health is used as the first formal post-acute care (PAC) setting following a major joint replacement, the Medicare program saves, on average $5,411 per beneficiary compared to other PAC settings).

[12] *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.ccjm.org/content/80/e-Suppl_1.toc (stating that patients recovering from knew replacements can receive in-home care comparable to institutional care).

b. The proposed elimination of the following ICD-9-CM codes from the Home Health PPS Grouper does not acknowledge the current role that home health providers play in managing complex and high-acuity conditions.

In the Proposed Rule, CMS has proposed removing some ICD-9-CM codes on the basis that these codes represent conditions that are "too acute" for home-based treatment.[13] Home health providers have been providing safe and appropriate care to patients who have diagnoses reflected in some of these ICD-9-CM codes (see the codes enumerated below). It is not clear what methodology CMS used to come to the conclusion that these specific ICD-9-CM codes should be eliminated from the grouper and the Alliance is concerned that access to clinically appropriate care may be hindered if these codes are removed.

Many diagnoses, such as gastroenterological hemorrhaging and wound care, are not completely resolved and rehabilitated in the acute care setting. In these cases, home health providers treat these conditions within the home and finalize the treatment that began in the acute care setting. Related to the conditions listed below, home health nurses and clinicians provide skilled, medical treatment such as: tracking signs and symptoms of a disease's exacerbation; supporting and reconciling the patient's medications; monitoring lab work; administering home infusion therapy for hydration; and wound care and drainage.

It is appropriate for post-acute care to receive compensation for the treatment required to adequately address a patient's acute condition and recovery. Take, for example, a patient with a minor upper gastrointestinal bleed. Literature has shown that the best practice for treating this condition is to monitor the patient after returning home as it requires a full seven (7) to ten (10) days to resolve the condition.[14] The Medicare program should provide payment for the treatment provided.

The post-acute management of these disorders also allows home health to screen patients for the possibility that the acute condition is actually a symptom of a different disease. A patient with esophageal reflux (530.81) may exhibit symptoms very similar to those of more serious illnesses, such as cardiac or respiratory disease. At-home management of these conditions allows the home health nurse to rule out more complex diseases or to provide treatment where these diseases are present.

Moreover, removal of ICD-9 codes for which home health patients receive needed and appropriate services reduces the accuracy of the information reported for payment. If a patient arrives home for post-acute care but their condition is not fully resolved, removing the coding for follow-up treatment creates confusion. For example, it would be inaccurate for a home health provider to change the code for a patient still recovering from a gastrointestinal bleed to "without hemorrhage" simply because the doctor had discharged the patient home to finalize recovery.

The Alliance recommends that CMS clarify its methodology and analysis related to the ICD-9-CM codes that are being proposed for elimination and that CMS consider retaining the following ICD-9 codes that are consistent with appropriate clinical treatment of home health beneficiaries:

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[13] *See* Proposed Rule at 40,276.

[14] *See* Loren Laine and Dennis Jenson, *Management of Patients with Ulcer Bleeding*, 107 Am. J. Gastroenterol 345–60 (2012), http://gi.org/guideline/management-of-patients-with-ulcer-bleeding.

- 285.1 Post-Hemorrhagic Anemia
- 333.94 Restless leg syndrome
- 530.81 Esophageal reflux
- 531.00 – 535.71 Gastroenterological/Intestinal Hemorrhaging
- 562.02, 562.03, 562.12, 562.13 – Diverticulitis/Diverticulosis
- 567.0 – 567.9 Peritonitis and related conditions
- 578.9 Hemorrhage of gastrointestinal tract, unspecified
- 572.0 Abscess of liver
- 577.0 Acute pancreatic

Recommendation: That CMS and the CMS Medical Team reconsider the elimination of the ICD-9 codes enumerated above and publicly provide the methodology used by the CMS Medical Team that suggested the elimination of these codes.

II. Home Health Care Quality Reporting Program: The Alliance recommends harmonizing quality measures across post-acute settings as a means to facilitate better coordination of care across care settings and improve healthcare outcomes for patients.

On July 15th, the Alliance submitted comments in response to CMS' request for Public Comment on the **Proposed Measures for Home Health Claims-Based Rehospitalization and Emergency Department Use Quality Measures.**[15] Since submitting these comments, additional concerns have arisen regarding the following proposed home health measures: (1) Rehospitalization during the first 30 days of home health (hereinafter "Rehospitalization Measure"); and (2) Emergency Department Use without Hospital Readmission during the first 30 days of Home Health (hereinafter "ED Use Measure").[16] Although we support CMS's general direction of these measures for home health, the existing measures, as proposed, are not yet ready for implementation and do not fully align across post-acute care or acute care settings. We agree with the National Quality Forum's ("NQF") assessment that these measures are incomplete and need further refinement before application.[17]

It is our recommendation that CMS gain NQF endorsement of the proposed home health measures prior to incorporating these measures into the Final Rule.[18] In the interim, we ask CMS to consider the following recommendations and modifications to the proposed measures before implementation.

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[15] *See* Centers for Medicare and Medicaid Services, *2. Rehospitalization During the First 30 Days of Home Health, and Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health*, CMS Quality Measures Public Comment Page, CMS.gov (Aug. 8, 2013, 4:35 p.m. ET), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html.

[16] *Id.*

[17] *See* MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS Final Report, National Quality Forum, 191-92 Table A26 (Feb. 2013), http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx (stating that NQF did not endorse the proposed home health measures as structured but supported the overall direction policymakers are taking to create a 30-day readmissions measures for post-acute care settings).

[18] *See* Proposed Rule at 40,292 (stating that CMS "intend[s] to seek NQF endorsement" of the measures).

a. Consistent with the Alliance's comments to CMS on July 15, 2013, we support using Medicare claims data as a basis for home health measures to assess 30-day rehospitalization rates and Emergency Department use.

We agree with the conclusions in CMS's Technical Briefing Memo that Medicare claims data is often a "more reliable" means of measurement than the OASIS data set.[19] Recently commissioned Alliance data analysis has similarly found that measuring a 30-day acute care rehospitalization rate from home health yields varying results depending on whether the data source is Medicare claims or OASIS.[20]

Our analysis compared 30-day home health readmission rates calculated from Medicare claims to those reported in OASIS-C, using a five percent sample of Medicare beneficiaries with an index hospitalization and subsequent home health admission on or before January 1, 2010. Key findings from this data analysis indicated that both data sources independently produced similar 30-day aggregate readmission rates. However, the readmissions data reported in the claims were substantially incongruent with the same measure using OASIS data, as evidenced by the fact that only sixty percent of readmissions identified in Medicare claims had corresponding OASIS assessments capturing the readmission.

The primary reason for this disconnect is that home health agencies do not always receive complete information to determine whether a patient has been admitted to the acute care hospital (or whether, for example, the patient was held in observation). Consequently, using Medicare claims is more reliable in determining whether patients have been admitted to the hospital, used the Emergency Department, or been placed in observation.

Moreover, the Alliance supports the creation of Rehospitalization and ED Use Measures as an effort to harmonize home health quality measures with those of hospitals, although the proposed measures do not fully capture this ideal.

The Alliance further supports continued reporting of acute care hospitalization (ACH) with OASIS data. The current ACH measure is over a 60-day episode and captures both hospitalization and rehospitalization within the standard Medicare home health episode. We believe that this measure continues to be valuable because it captures hospitalizations that are not preceded by an acute care hospitalization.

Recommendation: That CMS retain the use of Medicare-claims data in the proposed home health measures and continue to use the OASIS-based Acute Care Hospitalization measure.

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[19] Acumen, *Draft: Home Health Claims-Based Rehospitalization Quality Measures Technical Briefing Memo*, CMS.gov (June 1, 2013) (hereinafter "Technical Briefing Memo"), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/HH-Claims-Based-Rehospitalization-Measures-for-Public-Comment-.zip (Opens File Packet).

[20] A. Dobson et al., *Validation of an OASIS-Based Home Health 30-Day Readmission Measure with Medicare Claims Data*, Alliance for Home Health Quality and Innovation (June 18, 2013), http://ahhqi.org/images/uploads/1_Dobson_DaVanzo_Readmission_Validation_Findings_-_Final_6.19.13.pdf.

b. In adopting the proposed home health quality measures, CMS should consider further analysis of its risk adjustment methodology to incorporate risk-adjusted data points from the OASIS-C1 data set.

Both the Proposed Rehospitalization and ED Use Measures incorporate three measures of health status for risk adjustment, including CMS' Hierarchical Condition Categories ("HCC"), Diagnosis-Related Groupings, and Activities of Daily Living ("ADLs").[21] The Alliance supports the inclusion of condition-related information, but asks that CMS consider including additional functional, medical, cognitive and social support data from the OASIS data set that are already known to be potential quality measure risk adjustment factors.

In particular, the proposed measures include the following ADLs for risk adjustment: Dressing upper or lower body (OASIS fields M1810 or M1820); Bathing (M1830); Toileting (M1840); Transferring (M1850); and Ambulation (M1860). It is not clear why only these ADLs have been chosen for the purposes of risk adjustment.

There are other data points in OASIS that may be strong predictors of risk for hospitalization and it is similarly unclear why these data points were excluded. The OASIS-C1 draft documents include a comparison of OASIS-C and OASIS-C1 items, and marks risk-adjusted items in the far right column with the notation "PRA."[22] Current materials accompanying the proposed measures do not indicate whether these items were taken into consideration.

In addition, existing research on home health care suggests that certain risk factors could be particularly significant predictors of the risk of rehospitalization. For example, researchers have found that factors associated with risk of rehospitalization included dyspnea severity at the home health admission in addition to the number of prior hospital stays.[23] Based on this research, the OASIS-C questions related to cardiac status (e.g. M1500, M1510) may be effective data points for risk adjustment. Social environmental factors, like the frequency of caregiver services, can function as predictors of rehospitalization.[24] The OASIS-C Care Management question provides an indication of whether a caregiver is present and able to assist the patient with care (e.g., OASIS-C M2100 or OASIS C-1 M2102) and potentially denotes risk of

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[21] CMS, *Draft: Rehospitalization During the First 30 Days of Home Health*, CMS.gov (June 1, 2013), at 7 (File Name "HH_HH_Rehospitalization_Draft"); and CMS, *Draft: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health*, CMS.gov (June 1, 2013), at 7 (File Name "HH_HH_ED Use without Hospital Readmisson_Draft"), both available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/HH-Claims-Based-Rehospitalization-Measures-for-Public-Comment-.zip (Opens File Packet).

[22] See File "508_Attachment B_OASISC1 Timepoints_Uses 2.8.13.pdf", *Details for CMS Form Number: CMS-R-245*, CMS.gov (Aug. 8, 2013, 4:50 p.m. ET), http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS-R-245.zip (Opens Packet).

[23] *See e.g.*, E.A. Madigan et al., Rehospitalization in a national population of home health care patients with heart failure, 47 *Health Services Research* 2,316-38 (Dec. 2012); abstract available at: http://www.ncbi.nlm.nih.gov/pubmed/22524242.

[24] Hong Tao et al., The Influence of Social Environmental Factors on Rehospitalization Among Patients Receiving Home Health Care Services, 35 *Advances in Nursing Science* 346-58 (2012); abstract at: http://journals.lww.com/advancesinnursingscience/Abstract/2012/10000/The_Influence_of_Social_Environmental_Factors_on.7.aspx.

rehospitalization. These examples indicate that there might be additional data in the OASIS assessment that could potentially provide meaningful information for risk adjustment.

The Alliance recommends that CMS consider additional OASIS items, described above, for risk adjustment in the proposed measures. Further, the Alliance recommends that CMS publicly provide a clear list of the risk adjustment factors used to calculate the measure, with an explanation as to why certain OASIS items have been included or excluded.

Finally, it is important to note that in some cases, patients may be discharged from the hospital prematurely. In such cases, rehospitalization would be appropriate for that patient. CMS should consider whether there is any means to assess whether patients have been discharged from the hospital prematurely and if risk assessment may account for this factor.

Recommendation: That CMS consider the inclusion of additional risk-adjusted data items from the OASIS-C1 data set and publicly provide the methodology for selecting new data items for inclusion in the proposed home health measures.

c. The Alliance supports the exclusion of LUPAs from the denominators in the proposed home health quality measures.

The Alliance supports the exclusion of Low Utilization Payment Adjustment ("LUPAs") from the denominator calculation in both proposed measures, but notes that there may be multiple factors leading to the decision for such early discharges from home care. The Alliance recommends that CMS provide more detail to explain the decision to exclude LUPAs.

In addition, the Alliance supports CMS's decision to exclude planned hospitalizations from the numerator of both measures. In the calculation algorithm for the 30-day rehospitalization measure, the Alliance recommends that the Rehospitalization Measure explicitly exclude planned hospitalizations (as they are in the ED Use calculation algorithm). Further, the Alliance recommends that CMS publicize the list of planned admissions so that home health agencies are aware of exactly which types of admissions the measure will exclude.

Finally, it is not clear from the proposed measures and materials describing the 30-day Rehospitalization Measure whether patients discharged from home health prior to 30 days would be included or excluded. We recommend including patients discharged from home health within the 30-day measurement period, and ask that CMS clarify this point.

Recommendation: That CMS exclude LUPAs and planned hospitalizations from the home health measures and provide clarity on whether patient discharged within the 30-day measurement period will be included or excluded in the proposed measures.

d. The Alliance would ask that CMS consider adopting condition-specific measures that would better align quality measurement across care settings, including both acute and post-acute care providers.

Although we support the general direction proposed by the Centers for Medicare and Medicaid Services ("CMS") to create Medicare claims-based measures for home health for 30-day Rehospitalization and ED Use, these measures align only with the All-Cause Unplanned

Readmissions Measure for hospitals[25] and need further refinement before implementation.[26] Similar measures proposed for IRFs and LTCHs are likewise an All-Cause Unplanned Readmissions Measure.[27] Our first concern is that these proposed post-acute care (PAC) 30-day rehospitalization measures are not fully harmonized across *all* PAC settings and currently appear to exclude SNFs from measurement. Policymakers looking to improve PAC quality measurements and cross-setting coordination of care should consider a standardized, cross-setting measure for all PAC providers.

Second, the proposed PAC measures for home health, SNFs, and IRFs include an All-Cause Readmissions Measure but do not include diagnosis-specific measures that would enable PAC providers to better coordinate care and track the impact of condition-specific quality initiatives. The Hospital Readmission Reduction Program, in addition to measuring all-cause hospitalizations for hospitals, separately measures rates of rehospitalization for patients managing acute myocardial infarction (heart attack), heart failure, and pneumonia.[28] Many hospitals, including those partnering with PAC providers for new models of care like ACOs, are looking for comparable 30-day rehospitalization measures to determine the quality of care provided by the PAC setting. At present, these condition-specific measures do not have corresponding measures in the PAC settings, presenting a barrier to collaboration between PAC providers and hospitals.

Recent data analysis suggests that condition-specific approaches to assessing quality and cost effectiveness may prove instructive to helping the Medicare program improve both quality and cost.[29] For example, analysis of Medicare claims data for patients managing major joint replacement (MS-DRG 470) has shown that home health is the least costly setting compared with the other formal post-acute care settings (such as SNF, IRF, and LTCH) for clinically similar Medicare patients, as described in the chart below:[30]

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[25] Centers for Medicare and Medicaid Services, *2. Rehospitalization During the First 30 Days of Home Health, and Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health*, CMS Quality Measures Public Comment Page, CMS.gov (July 10, 2013, 3:44 PM ET), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html.

[26] *See* n. 16 MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS Final Report (stating that NQF did not endorse the proposed home health measures as structured but supported the overall direction policymakers are taking to create a 30-day readmissions measures for post-acute care settings).

[27] *See, e.g.*, the Proposed IRF Measures here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/DRAFT-Specifications-for-the-Proposed-All-Cause-Unplanned-30-day-Post-IRF-Discharge-Readmission-Measure.pdf and the Proposed LTCH measure here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Readmissions-Measure-Specifications.pdf.

[28] 42 C.F.R. §§412.150 - 412.154.

[29] *See* Allen Dobson, et al., Working Paper #2: Baseline Statistics of Medicare Payments by Episode Type for Select MS-DRGs and Chronic Conditions, *Clinically Appropriate and Cost-Effective Placement Project ("CACEP") Project*, Dobson | DaVanzo, 24 (April 4, 2012), http://ahhqi.org/images/pdf/cacep-wp2-baselines.pdf.

[30] *Id.* at 30.

Exhibit 1.16: Average Medicare Episode Paid by Select First Setting for MS-DRG 470 for 60-Day Fixed-Length Post-Acute Episodes (2007-2009)

First Setting	Number of Episodes	Medicare Episode Paid[a] (in millions)	Average Medicare Episode Paid	Average Overall Paid	Difference
HHA	366,140	$6,616	$18,068	$23,479	$5,411
SNF	430,240	$11,557	$26,861	$23,479	($3,382)
IRF	128,680	$4,316	$33,538	$23,479	($10,059)
LTCH	1,080	$63	$57,896	$23,479	($34,417)
STACH	2,580	$78	$30,302	$23,479	($6,823)
Community	134,240	$2,328	$17,340	$23,479	$6,140
Total	**1,062,960**	**$24,958**	**$23,479**	**$23,479**	**$0**

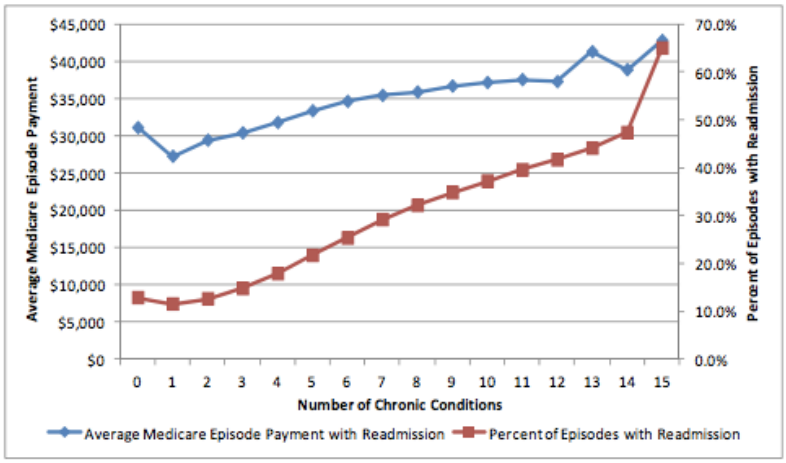
Source: Dobson | DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2007-2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars. All episodes have been extrapolated to reflect the universe of Medicare beneficiaries.
[a] Medicare Episode Paid includes care from all facility-based and ambulatory care settings and excludes beneficiary co-payments.

If implemented, condition-specific readmission measures should take into consideration for risk adjustment purposes the number of conditions that a patient is managing, and account for the severity of each condition. Data from the Alliance's Clinically Appropriate and Cost-Effective Placement ("CACEP") Working Paper #4 on hospital readmissions[31] found that a high number of chronic conditions per patient strongly correlated with an increase in hospital admissions.[32]

As the chart on the following page describes,[33] post-acute care (PAC) trends in readmissions for 60-day PAC episodes are closely related to the number of chronic conditions that a patient is managing. As the number of chronic conditions increases, patients are more likely to experience a readmission and the cost of the episode increases. Consequently, policymakers developing condition specific measures should consider risk adjusting based on the number and severity of conditions.

[31] *See* n. 11 and Allen Dobson et al., Working Paper #4: Baseline Statistics of Acute Care Hospital Readmissions by Episode Type for Select MS-DRGs and Chronic Conditions, *Clinically Appropriate and Cost-Effective Placement (CACEP) Project*, Dobson | DaVanzo (July 18, 2012), http://ahhqi.org/images/pdf/cacep-wp4-baselines.pdf.
[32] *Id.* at 11-12.
[33] *Id.* at 28.

Exhibit 1.11: Percent of Episodes and Average Medicare Episode Payment for Episodes with Readmissions by Number of Chronic Conditions for 60-day Fixed-Length Post-Acute Episodes (2007-2009)



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. Average Medicare Episode Payment includes care from all facility-based and ambulatory care settings and excludes beneficiary co-payments.

Recommendation: That CMS consider creating condition-specific, post-acute care 30-day hospital readmission measures that risk-adjust based on the severity and number of chronic conditions. These measures should: (1) align with measures for hospitals and physicians; and (2) be harmonized across PAC settings.

a. Policymakers should consider enhancing incentives to reduce use of unnecessary institutional care.

In addition to measuring unnecessary hospital *readmissions*, policymakers should consider including measures that will capture unnecessary *admissions* to institutional facilities (like hospitals) from community-based settings of care. Research has found that better management of community-based patients with low-severity primary chronic conditions could yield significant savings for the Medicare program where such management prevents avoidable initial (or index) hospitalizations.[34] Hospitalized patients with lower-severity chronic conditions had Medicare costs almost five times higher than patients with similar conditions and no hospital admission.[35] If the health care system can leverage community-based providers of care, such as home health, to improve management of these types of patient and avoid unnecessary institutional care (including unnecessary hospital admissions), the Medicare program can significantly reduce spending and improve quality of care for these patients.

Recommendation: That policymakers examine how community-based care, including home health, can be leveraged to reduce unnecessary institutional care improve quality of care and reduce Medicare costs in the treatment of patients with multiple chronic conditions.

[34] *Id.* at 65-88.
[35] *Id.* at 12.

III. The Alliance supports the extension of Home Health CAHPS requirements as a means to create a patient-centered health care system.

The Alliance supports the continued use of the HHCAHPS tool to support a patient-centered health care system. Measures of patient satisfaction captured in HHCAHPS have been shown to indicate overall wellness or risk of hospitalization. For example, Alliance member providers have used the HHCAHPS to identify patients at high-risk of hospitalization and to provide additional care support in order to help high-risk patients manage their illnesses.[36] For this reason, the HHCAHPS assessment is a useful tool for quality improvement campaigns and for empowering patients as equal partners in their plans of care.

* * *

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

[36] *See e.g.*, Putting the Patient at the Center of Care, CMMI Innovation Advisor Profile: Paula Suter, Sutter Care at Home, Alliance for Home Health Quality and Innovation, 5 (Aug. 8, 2013, 5:08 p.m. ET), http://ahhqi.org/images/pdf/innovation-paula-suter.pdf (describing the use of the HHCAHPS in a transitional care program to indicate patient risk for rehospitalization).