August 19, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
United States Senate
511 Hart Senate Office Building
Washington, DC 20510-2602

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
United States Senate
104 Hart Senate Office Building
Washington, DC 20510-4402

The Honorable Dave Camp
Chairman
House Ways and Means Committee
United States House of Representatives
341 Cannon House Office Building
Washington, DC 20515-2204

The Honorable Sander M. Levin
Ranking Member
House Ways and Means Committee
United States House of Representatives
1206 Longworth House Office Building
Washington, DC 20510-0001

RE: June 19th Congressional Letter Requesting Comment on Post-Acute Care Reform

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

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") in response to the Senate Finance Committee's and House Ways and Means Committee's **June 19th Congressional Letter Requesting Comment on Post-Acute Care Reform ("Congressional Letter")**.[1] Thank you for this opportunity to comment on the critical issues facing post-acute care providers under health care reform.

About the Alliance for Home Health Quality & 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 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/.

[1] The Honorable Max Baucus, Chairman, Senate Finance Committee, et al., *June 19 2013 Letter to Post-Acute Care Providers*, Committee on Ways and Means – House of Representatives (Aug. 2, 2013, 11:55 a.m. ET), http://waysandmeans.house.gov/uploadedfiles/pac_letter_final_w_signatures.pdf.

Alliance Comments in Response to the Congressional Letter to PAC Providers:

The Alliance supports current efforts to strengthen Medicare post-acute care by improving quality and efficiency of care, and heightening beneficiary protections. We appreciate the opportunity to provide comments on this critical matter of post-acute care ("PAC") reform.

I. Quality: 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.

As an organization focused on improving quality of care for patients, the Alliance commends the current work being done by policymakers and others to improve quality of care. Variation in health care quality and spending is a well-documented phenomena[2] and the Alliance supports efforts to address variation that will simultaneously improve the patient outcomes and experience. As described below, gaps in current quality measures across PAC settings undercut the efforts to improve quality of care, and we ask that your offices consider the need to foster the development of cross-setting PAC measurements where possible.

a. Harmonizing 30-day hospital readmission measures across acute and PAC settings would improve patient care and health system efficiency.

The Congressional Letter asks providers to clarify gaps in post-acute quality measures and the steps that can be taken to ensure continued improvement of the same. The development of harmonized, 30-day hospital readmission measures across multiple care settings including hospitals, physicians, home health, skilled nursing facilities ("SNFs"), long-term acute care hospitals ("LTCHs"), and inpatient rehabilitation facilities ("IRFs") would greatly improve quality of care for patients.

The two quality measures for home health that have been proposed by the Centers for Medicare and Medicaid Services (CMS) do not appear to align completely across PAC or acute care settings. 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 emergency department use, these measures align only with the All-Cause Unplanned Readmissions Measure for hospitals[3] and need further refinement before implementation.[4] Similar measures proposed for IRFs and LTCHs are likewise an All-Cause

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[2] *See e.g.*, *Variation in Health Care Spending: Target Decision Making, Not* Geography, Institute of Medicine of the National Academies (Aug. 2, 2013, 4:18 p.m. ET), http://www.iom.edu/Reports/2013/Variation-in-Health-Care-Spending-Target-Decision-Making-Not-Geography.aspx (hereinafter "IOM Variation Report") and *Reflections on Variations*, The Dartmouth Atlas of Health Care (Aug. 2, 2013, 12:02 p.m. ET), http://www.dartmouthatlas.org/keyissues/issue.aspx?con=1338 (discussing regional, quality, and spending variation between hospitals).

[3] 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.

[4] *See* MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS Final Report, National Quality Forum, 191-92 Table A26 (Feb. 2013),

Unplanned Readmissions Measure.[5] First, these proposed 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.[6] Many hospitals, including those partnering with PAC providers for new models of care like Accountable Care Organizations ("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.[7] 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 on the subsequent page:[8]

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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).

[5] *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.

[6] 42 C.F.R. §§412.150 - 412.154.

[7] *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.

[8] *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.

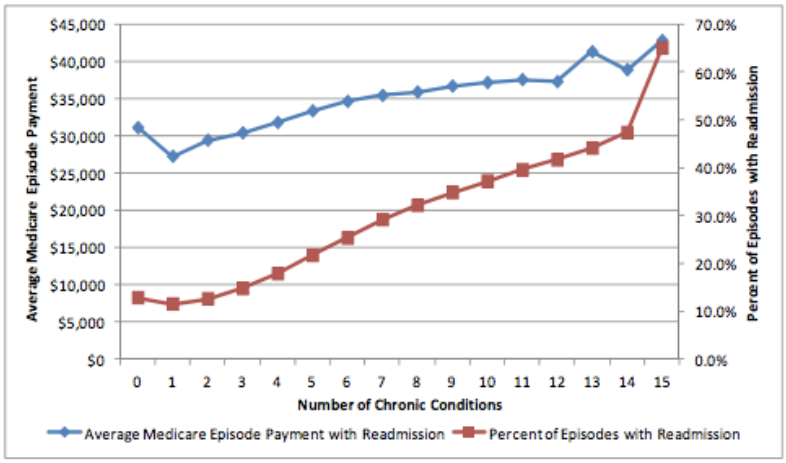
If implemented, condition-specific readmission measures should take into consideration for risk adjustment purposes the number of conditions that a patient is managing, and account for the severity of each condition. Data from the Alliance's Clinically Appropriate and Cost-Effective Placement ("CACEP") Working Paper #4 on hospital readmissions[9] found that a high number of chronic conditions per patient strongly correlated with an increase in hospital admissions.[10] As the chart on the following page describes,[11] 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, those developing condition specific measures should consider risk adjusting based on the number and severity of conditions.

[9] *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.

[10] *Id.* at 11-12.

[11] *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 policymakers foster the development of condition-specific, PAC 30-day hospital readmission measures that risk adjust based on the severity and number of conditions. These measures should: (1) align with measures for hospitals and physicians; and (2) be harmonized across PAC settings.

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

In addition to measuring unnecessary hospital *readmissions*, policymakers should consider inclusion of 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.[12] Hospitalized patients with lower-severity chronic conditions had Medicare costs almost five times higher than patients with similar conditions and no hospital admission.[13] 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.

[12] *Id.* at 65-88.
[13] *Id.* at 12.

c. The National Quality Forum may be able to support improvement and evolution in PAC Quality Measures.

As you may know, the National Quality Forum (NQF) Measures Application Partnership ("MAP") Report on Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement[14] defines a series of goals for PAC providers to better coordinate care across settings. The Coordination Strategy report appropriately acknowledges that PAC providers often have overlapping, but distinct, care goals for patients that make it difficult to compare quality across settings.[15] Even so, NQF's measure priority framework identifies common elements across settings: function, goal attainment, patient and family engagement, care coordination, safety, and cost/access.[16] This framework, and the additional elements of NQF's coordination Strategy for PAC providers, provides a potential road map for PAC quality measures. In general, the Alliance supports the NQF endorsement process as a method to evaluate and endorse measures.

II. Assessment Tools

a. The OASIS, MDS, and IRF-PAI data sets may serve as a strong foundation to determine the most appropriate and cost-effective care settings for patients.

Alliance research has found that the existing patient assessments (OASIS, MDS, and IRF-PAI) can be critical tools to assist in modeling bundling and other new care delivery models. The CACEP project, mentioned above, analyzed a five percent sample of Medicare claims data (Parts A, B, and D) and linked the Medicare claims data with corresponding data from the OASIS, MDS, and IRF-PAI data sets.[17] Using this data, the CACEP project modeled various potential episodes of care within the existing Medicare program to determine how policymakers could better meet beneficiary needs and improve the quality and efficiency of care provided.

The project modeled three different types of healthcare delivery episodes: (1) a "post-acute" care episode that begins with the index acute care hospitalization and follows a patient for 60-days post-hospital discharge; (2) a "pre-acute" care episode that captures the 60 days preceding an index hospitalization through the end of the hospitalization; and (3) a "non-post-acute" community-based episode that begins with a home health admission that was not preceded by a hospital stay, and that follows the patient for nine months following discharge from home health.[18] The researchers were able to cross-walk the OASIS, MDS and IRF-PAI data in order

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[14] *Measure Applications Partnership Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement*, National Quality Forum (NQF), (Feb. 2012), http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69884.
[15] See id. at 11-12.
[16] *Id.* at 13.
[17] For all working papers related to the CACEP project, please visit http://ahhqi.org/research/efficient-care. You can view the Final Report, which models potential payment arranges and bundling, at http://ahhqi.org/images/pdf/cacep-report.pdf and the Final Paper's Appendices at http://ahhqi.org/images/pdf/cacep-report-appendices.pdf. Information about the Data and Methods of the CACEP project begins on page ES-3 of the Final Report.
[18] Allen Dobson, et al., *Improving Health Care Quality and Efficiency ("Final Report"), Clinically Appropriate and Cost-Effective Placement (CACEP) Project*, Dobson | DaVanzo, ES-4 (Nov. 9, 2012), http://ahhqi.org/images/pdf/cacep-report.pdf.

to create a uniform method of analyzing functional status for all patients receiving post-acute care in home health, SNFs and IRFs. The use of these data sets in such a comprehensive way indicates that existing assessments like OASIS, MDS, and IRF-PAI could be a good starting point to identify new models of care that would be clinically appropriate for patients.

Recommendation: That policymakers can build on the existing OASIS, MDS, and IRF-PAI assessment tools to identify clinically appropriate and cost-effective care settings for PAC patients.

b. The CARE tool offers great potential to determine appropriate settings of care, but needs further refinement before widespread use.

The Continuity Assessment Record and Evaluation ("CARE") item set shows great potential for assessing patients across post-acute care settings and possibly using the information to determine patient placement in appropriate settings. However, the tool as it currently exists does not fully align with the information being collected by the OASIS[19] and consequently, policy-makers should consider to what extent modifications might be needed if the CARE tools will be used in the future to replace OASIS. For example, an analysis of the differences between the CARE tool and OASIS-B revealed that there are significant variances in the way that the following are reported: pain, functional status, and mobility (ambulation and locomotion).[20] While this comparison between the CARE tool and OASIS indicated that the tools collected substantially similar information, the Alliance would urge policymakers to compare the current version of the CARE tool with the proposed OASIS-C1 data elements to ensure that any new assessment tool captures the data needed to provide high quality care.

Other recent CMS analysis from 2012 of the CARE tool further indicates that the tool is not yet ready to replace assessment and payment tools like the OASIS and that much work remains, as the report describes (emphasis added below):

> "Further work will need to occur in the following areas, among others:
>
> - **Continuing to develop quality measures that can be generated from standardized, electronic CARE data for use across the spectrum of patient care settings and provider types**;
> - Taking the exploratory payment work performed under PAC-PRD and developing formal and implementable payment models through the rule making process and/or future legislative proposals,
> - Expanding the evaluation of CARE based payment models to Medicaid settings and providers,

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[19] *See* Barbara Gage et al., *Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on CARE Item Set and Current Assessment Comparisons: Volume 3 of 3*, CMS.gov (Sept. 2012), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/The-Development-and-Testing-of-the-Continuity-Assessment-Record-and-Evaluation-CARE-Item-Set-Final-Report-on-the-Development-of-the-CARE-Item-Set-and-Current-Assessment-Comparisons-Volume-3-of-3.pdf.

[20] *Id.* at 23 – 27.

- Revise the CARE items in response to the work in the PAC demonstration and other projects, and,
- **Testing whether the CARE tool variables are strong episode-based risk adjusters to inform the larger discussion of payment bundling."** [21]

If policy-makers were to require use of the CARE tool, the Alliance would recommend that there first be additional pilots to test the tool among PAC providers, and that CMS offer a public comment period specifically for this tool to allow for public input that could inform improvements to the instrument.

With regard to the use of the B-CARE tool, the Alliance will be following the use of this tool in the Bundled Payments for Care Improvement Initiative Model 3 implementation as a means of assessing whether the B-CARE tool might be an appropriate quality and placement assessment tool for use in the future. Should policymakers decide to adopt the CARE tool and/or the B-CARE tool, the Alliance would ask that any requirements be implemented in phases to give providers time to be trained and to implement the new tool.

Finally, the Alliance encourages policymakers to use a least burdensome approach in putting any new assessment tool in place. The current OASIS tool already presents a considerable expense of time, energy, and resources for home health providers. Changes in this area should not increase burden for providers, but rather should lessen burden where possible.

Recommendation: That the CARE tool is premature for implementation broadly and that policymakers should delay the implementation of the CARE tool as a cross setting assessment tool until further, critical refinements are made. Further, any migration to the CARE tool should begin with pilots by PAC providers and be implemented in phases, over a period of years.

III. Beneficiary Protections and Issues: PAC reforms should continue to protect beneficiary access and beneficiary choice.

a. Cost-sharing proposals for home health beneficiaries impose a significant cost-burden on a vulnerable patient population and disincentive the use of home health, which offers a cost-effective, clinically appropriate alternative to institutional care settings.

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 is a collection of descriptive statistics compiled by Avalere Health LLC for the Alliance, summarizing and analyzing 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

[21] *Report to Congress: Post-Acute Care Payment Reform Demonstration (PAC-PRD)*, CMS, 37-38 (June 2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Flood_PACPRD_RTC_CMS_Report_Jan_2012.pdf (emphasis added).

Reports, Home Health Compare, Medicare fee-for-service claims, and other data from the Centers for Medicare and Medicaid Services.[22]

As the data below describes, home health users are a vulnerable population characterized by advanced age, low annual incomes, difficulty managing activities of daily living ("ADLs") and more multiple chronic conditions as compared with the overall Medicare population.[23] Perhaps most significant to payment issues, home health users tend to have much lower incomes than the average Medicare beneficiary[24], with 62.5% of home health users living on an annual income of $25,000 or less. With respect to protecting the needs of beneficiaries and their access to care, the typical patient who uses Medicare home health services is in need of special care, as demonstrated by the snapshot below[25]:

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%

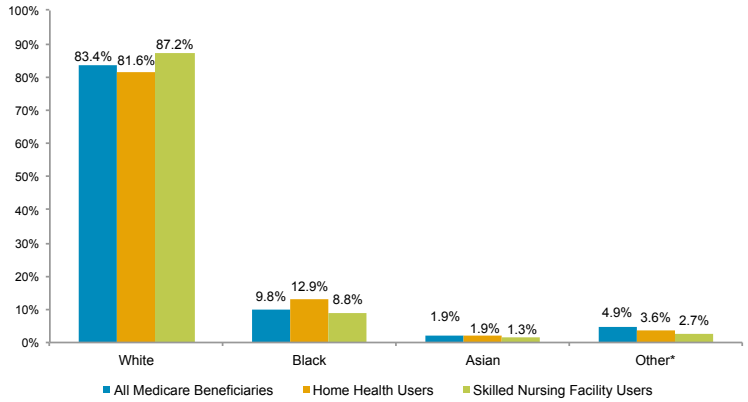
Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is is considered a measure of moderate to severe disability and is often the eligibility threshold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

[22] Avalere Health LLC, *Home Health Chartbook, 2013*, Alliance for Home Health Quality and Innovation (Aug. 2013), http://ahhqi.org/images/uploads/AHHQI-AVALERE_Home_Health_Chartbook_FINAL_081513.pdf.
[23] *See id.* at 14.
[24] *Id.* at 13.
[25] *Id.* at 14.

Home health users also tend to be more racially diverse than both the overall Medicare population and SNF users:[26]

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

Payment cuts may adversely impact Black and Hispanic home health beneficiaries who are, in many ways, some of the most vulnerable home health users as described below[27]:

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%

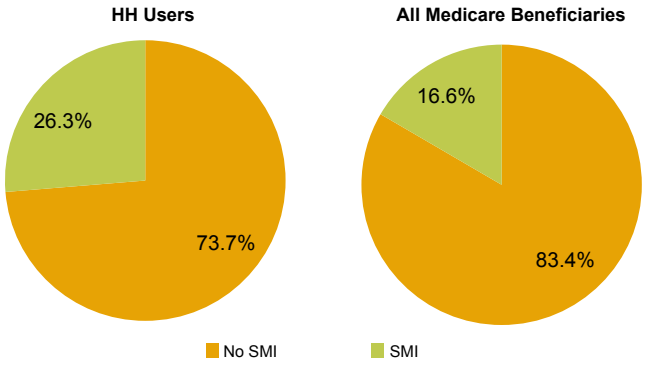
Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is is considered a measure of moderate to severe disability and is often the eligibility threshold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

[26] *Id.* at 12.
[27] *Id.* at 17.

In addition, payment cuts to home health also disproportionately threaten access to care for mentally ill patients. More than a quarter of all home health users are managing severe mental illnesses, as compared to only 16.6% of all Medicare beneficiaries[28]:

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 patients who have severe mental illness also tend to be more vulnerable than the Medicare population at large, as demonstrated below[29]:

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.

[28] *See id.* at 27, with "Severe Mental Illness" defined as depression or another mental disorder such as bipolar disorder, schizophrenia, and other psychoses.
[29] *Id.* at 26.

Current proposals for cost-sharing threaten patients who are in greatest need of protection. As Joe Baker, President of the Medicare Rights Center, described in testimony before the House Ways and Means Committee's Subcommittee on Health, introducing a co-payment for home health patients is "most alarming" because it would hurt "the most vulnerable: the poorest, the oldest and the sickest."[30] Congress repealed a copayment for home health services in 1972, in part because removing the copayment would encourage "home health usage instead of more costly institutional care" and keeping the copayment created "a financial burden to many elderly persons living on marginal incomes."[31]

If the goal of Medicare reform is to improve efficiency and reduce health care costs, it does not make sense to implement a policy that may harm beneficiaries and encourage unnecessary use of higher-cost, institutional settings. A key example of this is the use of home health for patients after major joint replacement surgery.[32] A recent paper published in the *Cleveland Clinic Journal of Medicine* concluded that patients could receive clinically appropriate rehabilitation services in the home following knee replacements. The authors found that such patients need not receive post-acute care in facility-based settings. A co-payment, however, might have the effect of deterring patients from home health as a setting of care post-knee replacement surgery. Moreover, as noted above, research from the CACEP project found that on average, when home health is used as the first PAC setting following an acute hospitalization for MS-DRG 470 (major joint replacement), the Medicare program saves an average of $5,411 per patient. This is just one example of how incentivizing more efficient care is better for patients and saves the Medicare program money.

Recommendation: (1) That policymakers consider reforms that reduce inefficiencies in the health care system, rather than imposing cost-sharing policies that will threaten patient access to care; and (2) That policymakers take into account how cost-sharing will have a disproportionately negative impact on access to care for home health patients who are older, sicker and poorer than the average Medicare beneficiary.

b. PAC Reform should continue to honor beneficiary choice by providing additional consumer tools to help patients make informed decisions, and examining how innovative models of home-based care can be applied to current health care reforms.

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[30] 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.

[31] 118 Cong. Rec. 33,933, 33,939 (1972) (statement of Sen. Nelson).

[32] *See e.g.*, 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) and 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 PAC setting following a major joint replacement, the Medicare program saves, on average $5,411 per beneficiary compared to other PAC settings).

The Congressional Letter asks how beneficiary choice should be accommodated. It is the Alliance's position that any type of bundling or alternative health care delivery model should continue to allow patients the right to choose their preferred setting of care. The Alliance would encourage policymakers to consider expanding tools like Home Health Compare to include cross-setting information, allowing patients to compare quality across different PAC providers. Providing additional patient and consumer information is a powerful way to encourage Medicare beneficiaries to vet and select PAC services appropriate to their needs.

Additionally, the Alliance recommends that policymakers foster continued development of home-based models of care available through ACOs, the Independence at Home Demonstration ("IAH"), bundled payment initiatives, the Patient-Centered Medical Home ("PCMH"), and other Center for Medicare and Medicaid Innovation ("CMMI") grant programs. In general, ACOs, IAH, PCMH, and bundling programs permit patient preference and protect beneficiary choice. Many of these programs offer innovative, cost-effective solutions to improve care while still putting the patient at the center of care and looking to the patient's preference to be closer to their home and family. For example, the Innovation Advisors Program through the CMMI featured Innovation Advisor Erin Denholm of Centura Health at Home who was able to implement a home-based telemonitoring program that would function under an ACO or bundled payment structure. Initial data from the program reveals improved outcomes for patients managing Chronic Obstructive Pulmonary Disorder (COPD).[33] Other Innovation Advisors, like Wake Forest Baptist Medical Center's Dr. Pamela Duncan used home health to assist with heart failure patient transitions from hospital-to-home, finding that home health presents the opportunity to keep patients safe and independent at home.[34] The Congressional Letter even acknowledges that patients have a preference to be closer to their home and family, and we would encourage policymakers to support alternative models of care delivery that are home-based and have been shown to improve outcomes while reducing Medicare costs.

Recommendation: That PAC reforms continue to honor beneficiary choice and support consumer decision support tools like Home Health Compare in addition to looking toward innovative models of healthcare-at-home that put the patient at the center of care.

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

Sincerely,

Teresa L. Lee, JD, MPH
Executive Director

[33] *Challenging Chronic Disease Through Telehealth*, Alliance for Home Health Quality and Innovation (Aug. 19, 2013, 11:31 a.m. ET), http://ahhqi.org/images/pdf/innovation-erin-denholm.pdf.
[34] *Connecting Home Health Care to the Care Continuum*, Alliance for Home Health Quality and Innovation (Aug. 19, 2013, 11:34 a.m. ET), http://ahhqi.org/images/uploads/Revolutionizing_Healthcare_Pam_Duncan_Article_05-08-13.pdf.