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Chairman of the Board

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Val J. Halamandaris, JD
President

August 16, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
219 Dirksen Senate Office Building
U.S. Senate
Washington, D.C. 20510

The Honorable Dave Camp
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
U.S. House of Representative
Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1106 Longworth House Office Building
Washington, D.C. 20515

Dear Chairmen and Ranking Members:

Thank you for the opportunity to provide feedback as you weigh options for the reform of post-acute care (PAC) payment system in Medicare. We want to continue being constructive partners in finding savings in the Medicare program as we understand the urgency around deficit reduction and ensuring value for taxpayers. We believe the answer to reducing costs and

improving quality is in new care delivery models and program integrity measures rather than more blunt cuts or beneficiary cost sharing.

As you know, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies and public corporations. They have been enthusiastically participating in demonstrations that test new payment models, as well as investing in new technologies to improve care transitions and enhance care coordination with physicians. They have also been working with hospitals to reduce readmissions and funding research to analyze Medicare claims data to help find opportunities for improving efficiency and lowering costs.

Our past experience and the evidence from new promising models reinforces our belief that a system that shifts patients from inpatient services and institutional care to home and community-based settings provides the best chance at extending the fiscal viability of the Medicare program while providing high-quality, clinically appropriate services. In addition to exploring new ways to improve care for patients moving from acute settings, our members are helping keep people with chronic disease out of the hospital. Chronic disease is a major driver of health care costs currently and in the future. Without the critical services that home health agencies provide, more hospitalizations of patients with chronic disease would be necessary.

Therefore, at the outset, we would emphasize that home health services should be viewed as much more than a post-acute service. Today, nearly a half of all Medicare beneficiaries using home health services do not have a prior hospitalization. Home health services are much broader than just a service for post-acute care needs. Instead, it is an alternative to inpatient care in many situations, a primary care service that manages the care of individuals in their community settings, a means of addressing chronic care needs clinically and economically and an end-of-life care service. The original and continuing home health service benefit design encompasses a much wider range of care than post-acute care alone. See Attachment A for more detail.

Our goals in this letter are to balance the need to find immediate savings that CBO will score with the reality that long term change that promotes both quality and cost effectiveness is going to emerge from the demonstrations currently taking place. It would be optimal if the demonstration projects currently testing new payment models could be given time to show results, but we understand the need for quick action to reduce costs in the Medicare program. We have therefore put forth proposals that we believe show promise for reducing costs based on existing evidence. These proposals encompass home health as a post-acute benefit, but also as a way to reduce inpatient costs by using home health to manage patients who are pre-acute or managing chronic disease. We encourage the Committees to monitor the innovative programs being tested, including the Independence at Home Demonstration, the Community-based Care Transitions Program and consider supporting the care coordination of chronically-ill patients with home telehealth technology as outlined by the Fostering Independence Through Technology Act of 2013.

Specifically, this letter will 1) demonstrate the evidence emerging around care pathways for patients that optimize quality and patient satisfaction while reducing costs; 2) detail several proposals for reform that build on existing evidence; 3) provide feedback on the specific proposals made by the Medicare Payment Advisory Commission (MedPAC), Simpson Bowles and others; 4) propose ideas to combat fraud, improve payment rate accuracy, and address variation in utilization; 5) answer the specific questions outlined in the bulleted sections of your letter.

We appreciate your thoughtful consideration of new solutions and our goal is to be focused and constructive. Our members cannot sustain more cuts if we want to continue innovating and investing in technology to improve the delivery of care. We sincerely hope the Committees will look at new ideas because the underlying data driving the proposals for cuts are flawed. The MedPAC reported 14.8 percent margins for home health, as referenced in the

Committees' letter, is inaccurate and outdated. We address this in more detail later in this letter. The fact is that home health reimbursements have been dramatically reduced since 2009 and the rebasing of rates along with sequestration will further those reductions. In addition, we have deep concerns about the proposal to impose a home health copayment. A copay would be counterproductive in reducing costs because it would actually lead to increased use of more costly institutional care. Evidence-based ideas rather than arbitrary cuts will serve Medicare beneficiaries and taxpayers better.

I. Evidence Around Home Health in Improving Patient Outcomes and Achieving Savings

As your letter notes, Medicare beneficiaries have historically received widely varying services at varying costs, making it difficult to analyze whether the patient is receiving the right care in the right care setting at the right time. However, we were encouraged by the findings of the Centers for Medicare & Medicaid Services' (CMS) PAC Payment Reform Demonstration, which found that consistent measurement across settings with adjustments for case complexity is possible, thereby allowing comparison of patient outcomes provided in different settings.

Over the long term, we believe that outcome measurement across care settings will consistently demonstrate the superior value of home health care. We also believe that home health will become increasingly valuable and appropriate for greater numbers of patients as technological innovation continues to expand the ability of home health care to address patient needs, creating increased demand for home-based services.

Indeed, an examination of a growing body of evidence suggests that a vision of high-quality PAC is already emerging with home health care at the center. At every step of a patient's care pathway, home health care helps avoid costly institutional care. We encourage the

Committees to examine this evidence as you consider the design of PAC payment incentives and structures, as it is our firm belief that any episode or bundled payment policies should recognize the central role that home health can and should play in improving health outcomes and reducing costs.

Following is a description of the patient care pathway and the evidence around the effectiveness of home health care. We follow this description with a series of proposals that can further the vision of a system with incentives aimed providing clinically appropriate care outside of costly inpatient settings.

a. Pre-Acute: Avoiding Hospitalizations

Many studies have found that home health care can prevent expensive hospitalizations and nursing home stays while providing cost effective care in the home setting that people prefer. Pre-acute care episodes are concentrated among patients with the highest severity chronic conditions, including congestive heart failure, diabetes, chronic obstructive pulmonary disease

(COPD) and osteoporosis. Research has shown that each of these chronic conditions can be effectively managed at home. For example, the Clinically Appropriate and Cost-Effective Placement Project of the Alliance for Home Health Quality and Innovation analyzed the use of home health care over three years of Medicare claims data, for three distinct episodes, and including pre-acute care. They found that home health care can be used to better manage pre-acute episode patients with multiple chronic conditions and prevent avoidable hospitalizations.[1]

The patient-centered medical home (PCMH) has emerged among primary care practices as a way to improve patient outcomes and keep patients out of the hospital by changing routine delivery of ambulatory care. PCMHs employ an active, planned process of patient education and motivation, and delivery of care through a multi-disciplinary team of care providers who are responsible for the "whole patient." Home care providers can be an effective partner to PCMHs by providing lower cost care coordination and home-based disease management.

In the next section, we detail a proposed home-based chronic care model, which we believe can maximize the care of "pre-acute" patients in their primary care and home-based settings and thereby reduce costs associated with institutional care. We also discuss a risk-based telehealth proposal, which targets high-cost patients who can avoid hospitalization with focused home care.

b. Post-Acute: Home Health is Cost Effective

Home care is a fraction of the cost of institutional PAC settings, and is likely to become an option for even more patients as technology-enabled home care increases. Soon, the delivery of health diagnostics or therapeutics in a patient's home will prevent or reduce the need for institutional care even further, thereby reducing the financial commitment needed for high-quality, clinically appropriate PAC.

In addition to being less costly than institutional care, home health care can address some of the key drivers of readmissions, including providing a continuum of care through transitions, improving medication adherence, improving nutrition and identifying depression and other behavioral health challenges associated with chronic disease and PAC.

Following are several studies showing the cost effectiveness of home care as it is currently provided. We are hopeful that the multiple technology-enabled home care pilots currently underway will demonstrate the increased ability of home care to deliver high-quality, clinically appropriate care to even more complex patients that have traditionally been treated in institutional settings.

[1] "Payments for home healthcare, SNF, IRF, and LTCH account for only 2.3 percent of all pre-acute care Medicare episode payments, whereas hospital and physician services account for 92 percent of payments. These data suggest that there may be opportunities to invest in improved chronic care management to avoid preventable hospitalizations, thereby improving care and reducing cost. Home healthcare providers are well positioned to provide chronic care management in this context and have experience with managing patients with multiple chronic conditions."

HOMECARE & HOSPICE
National Association for Home Care & Hospice

A 2009 Avalere study found that the early use of home health was associated with a $1.71 billion reduction in Medicare post-hospital spending over the 2005-2006 period (in aggregate). If the lower period-of-care costs associated with early use of home health were applied to the periods of care for non-home health users, Medicare post-hospital spending over the 2005-2006 period (in aggregate) could have been further reduced by $1.77 billion. The use of early home health is associated with an estimated 24,000 fewer hospital readmissions. The fewer readmissions are associated with a $216 million reduction in Medicare spending over the 2005-2006 period (in aggregate). The $216 million reduction is a component of the $1.71 billion reduction.[2]

A second Avalere study in 2011 quantified the impact of PAC home health use, by comparing Medicare spending and readmissions for chronically ill beneficiaries who receive home health care* after a hospitalization with Medicare spending and readmissions for comparable beneficiaries who use other PAC services** after a hospitalization.

Home health use was associated with a $2.81 billion reduction in post-hospitalization Medicare Part A spending over the 2006-2009 period. That is, Medicare Part A spending on these home health users was $2.81 billion less than it would have been if they had received other PAC services. This estimate controls for differences in beneficiaries' age, sex, race, urban/rural location, condition, severity of illness, dual-eligible status, and hospice utilization.*[3]

Savings Per Beneficiary**

Time Period 1: October 2006 – March 2008		Time Period 2: April 2008 – September 2009	
Diabetes	$6,281 – $12,267	Diabetes	$7,383 – $9,225
COPD	$6,098 – $11,928	COPD	$7,106 – $11,441
CHF	$5,020 – $7,879	CHF	$5,514 – $8,.883

* The extent of risk adjustment is still limited
** Savings vary by severity of illness level

Finally, a 2010 article in the New England Journal of Medicine entitled, "Why Healthcare is Going Home," Dr. Steven H. Landers of the Cleveland Clinic says "in the past century, health care became highly concentrated in hospitals, clinics, and other facilities. But I believe that the venue of care for the future is the patient's home, where clinicians can combine old-fashioned sensibilities and caring with the application of new technologies to respond to

[2] Medicare Spending and Rehospitalization for Chronically Ill Medicare Beneficiaries: Home Health Use Compared to Other Post-Acute Care Settings, May 2009, Avalere LLC.
[3] Medicare Savings and Reductions in Rehospitalizations Associated with Home Health Use, June 2011, Avalere LLC.

major demographic, epidemiologic, and health care trends." He describes demographic, clinical, economic, and technological forces that make home-based care "imperative." He cites oxygen as an example of advances in portable medical technology and cites parenteral nutrition and infusion as examples of care that are less expensive than and as equally effective as institutional care. "Many of these older adults will have limitations on their activities, including difficulty walking and transferring from bed to chair, that make leaving their homes difficult. Bringing care to the home improves access for such people."[4]

c. Transition from Inpatient to Post-Acute: Streamline Pathway to Home

The transition from hospitalization to PAC has been undermanaged and presents a continuing area of opportunity for cost savings in Medicare. A major national study spanning more than two decades tested better integration of home health with hospitals to form a "health care bridge" from hospital to home for four weeks after hospital care showed a 50 percent reduction in the re-hospitalization rate and a cost savings of approximately $3,000 per patient over 24 weeks.[5]

Involving home health with discharge planners early in the hospitalization process can reduce transition challenges and readmission rates. One example is detailed in a recent paper published by the Cleveland Clinic. The paper described in-home care after knee replacement. It found that patient preferences often drive choices on PAC, not individual clinical need. The team at Euclid Hospital implemented instituted a "Cleveland Clinic Total Knee Care Path" that puts home health aides in the lead in discharge planning and the transition of care management. "Every patient envisions a safe return home as a primary goal, with as short an exposure to

inpatient acute and post-acute settings as is necessary." Since the implementation of the program, the average acute care hospital length of stay has been reduced by an average of 0.9 days, the discharge to home rate has risen from 32 percent to 74 percent and the readmission rate for patients discharged to home is significantly lower than before implementation of the home care protocol.[6]

Another example of integrating home health with hospital discharge is the success of Amedisys, a home health provider in Louisiana. Amedisys placed "care transitions coordinators" (CTCs) in acute care facilities to meet with patients before their transition out of the hospital. The CTC works with the patient in the hospital to help them understand medication, diet, lifestyle needs and identification of "red flags." The CTC also makes post-discharge follow up appointments for the patients. The CTC is available to the patient 24 hours per day in the hospital, during their transition and until the first home nursing visit, which typically takes place 24 hours after hospital discharge. The Amedisys model was tested in three

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[4] Landers, S. "Why Health Care Is Going Home," New England Journal of Medicine, October 20, 2010.

[5] Naylor, MD, Brooten D, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. J Am Geriatr Soc 2004; 52: 675-684.

[6] Froimson, Mark, MD, MBA, "In-home care following total knee replacement, Cleveland Clinic Journal of Medicine, Volume 80, January 2013.

large academic institutions for 12 months. The 12-month average readmission rate decreased from 17 percent to 12 percent.[7]

A final example comes out of the Virginia Commonwealth University Medical Center (VCU), which implemented a hospital-based transitional care program serving 500 patients. In this intervention, transitional care nurse practitioners (NPs) meet patients in the hospital to ensure appropriate referral, verify medical care plans and build report with the patient and family. After discharge, the NPs work with the home health agency very closely, sometimes conducting joint visits. A comparison of utilization data for 199 patients six months before and after enrollment in the intervention over a period of four years showed a decreased use of hospital resources, fewer inpatient dates, shorter lengths of stay, fewer intensive care unit days. Aggregate cost was 38 percent less than the six month pre-enrollment baseline.[8]

Payment reforms that encourage better integration of home health and the hospital can reduce costs and overcome some of the system fragmentation contributing to costly readmissions and preventable institutional care. In the next section, we detail a payment bundling proposal that incentivizes the early and continuous partnership of hospital discharge planners and home health agencies.

II. Specific Proposals to Achieve Evidence-based Reform

While we believe it would be best to wait for the results of the demonstration projects testing many new integrated care models and payment structures before reforming the PAC system, below are several proposals that could help achieve the evidence-based reform that

realizes the promise of cost-effective, clinically appropriate care structures that avoid expensive institutional care.

a. Post-Acute Community Based Care Bundling: Improving Care Transitions and Maximizing PAC

We believe it is important that bundling arrangements for PAC allow PAC providers to hold and administer the risk-adjusted PAC benefit, not the acute care provider. The expertise related to managing patients in a post-acute setting lies with PAC providers, not hospitals, and the payment and accountability should be structured to reflect that. We are encouraged that CMS is testing a post-acute care bundling program where all provider payments are managed by home health agencies. We believe this will ultimately deter unnecessary re-hospitalizations, thus reducing administrative burden and cost. This approach is comparable to the tried and tested Medicare hospice program where payment is bundled to a community-based hospice program

7 Fleming, Michael, Haney, Tara, “Improving patient outcomes with better care transitions: The role for home health,” Cleveland Clinic Journal of Medicine, Volume 80, January 2013.

8 Boling, Peter, et al, “Improving outcomes and lowering costs by applying advanced models of in-home care,” Cleveland Clinic Journal of Medicine, Volume 80, January 2013.

where hospitalization is the exception rather than standard practice.

Given the evidence described above regarding the importance of involving home health providers early in the care transitions process, the most effective bundling model would integrate home health providers into hospital discharge planning process upon the admission of a qualified patient to the hospital. The home health agency would be responsible for a comprehensive evaluation and PAC planning process that is designed to determine whether a patient is medically appropriate and feasible for discharge to the community.

Where the home health agency, in close coordination with the hospital, determines that community based care is not appropriate immediately upon hospital discharge, the responsibility for discharge to a post-acute inpatient setting is returned to the hospital. At that point, a post-acute inpatient care bundling may be triggered, if available.

With this model, the home health agency is responsible for any community-based care related to the patient's inpatient treatment including home health services, physician services, outpatient rehabilitation services, and any intervening stay in an inpatient rehabilitation facility (IRF), long term care hospital (LTCH), or skilled nursing facility (SNF). Post-acute inpatient stays immediately following hospital discharge are outside of the home health agency responsibility.

Benchmarks could be based on existing measurements of quality and patient outcomes in combination with cost avoidance outcomes that relate to re-hospitalizations and use of emergent care.

Under a post-acute community based care bundling approach, providers would receive a case mix related per capita payment that is calculated on the basis of the combination of services in the bundle, adjusted for performance in a positive or negative manner.

One key aspect of making a bundled payment work is ensuring the technological means to share information among providers. Seamless care transitions depend on physicians, hospitals

and home health agencies having access to patient information. The home care community has been an integral partner within the Standards and Interoperability (S&I) Community-Led Initiatives, such as the Longitudinal Coordination of Care (LCC) workgroup, to develop standards for interoperable transitions of care and care plans additions to the Consolidated Clinical Document Architecture (CCDA). Our goal is to leverage the support of these important editions to the CCDA to encourage the adoption of electronic health records (EHR) and also to support the interoperable exchange of health information that is the foundation for building new models of care delivery in home care.

b. Value-Based Purchasing Proposal: Improving Performance & Achieving Savings

MedPAC recommended application of a "pay for performance" system for home health and other Medicare provider payments. Starting in 2008, Medicare began the Medicare Home Health Agency Pay for Performance Demonstration project operating in seven states. Under the

demonstration, home health agencies qualified for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending.

CMS shared more than $15 million in savings with 166 home health agencies based on their performance during the first year of the Medicare Home Health Pay for Performance demonstration in 2009. Another $15 million in savings was shared with the agencies in 2010.

As a result of demonstration's success, we believe that the Committees should consider authorizing a program that provides performance-based incentive payments to home health providers, taking into account readmissions rates and adherence to quality measures.

Unlike the CMS demonstration, the proposal we are putting forth contains both "carrots" and "sticks," i.e. home health agencies will see reductions in reimbursements if quality metrics are not met. If implemented, we believe this proposal could produce $2.5 billion in direct savings over 10 years. The estimate is based on a CBO projected spend of $250 billion between 2014 and 2023.

This estimate does not include the savings that the CMS demonstration showed would be generated from deterred impatient services. We believe overall Medicare savings, outside of the direct savings we propose, would be at least $600 million in the first year and more than $7 billion over ten years. That is calculated roughly based on demonstrated savings from the CMS initiative. The Medicare Home Health Agency Pay for Performance Demonstration showed $15M in savings with 166 HHAs. Currently, there are over 12,000 HHAs. If we conservatively assume that those HHAs generate a half of such savings, we would be looking at $50,000 per HHA in 2014 X 12,000 HHAs= $600M. Alternatively, if you assume that half of the HHAs garner equivalent savings to those in the demonstration it would come to the same dollar result.

This estimate includes a small annual increase in savings due to the higher payments rates annually to hospitals, etc. and growth in Medicare enrollment.

We do not propose this value-based purchasing arrangement lightly, and given the drastic cuts in home health payments since 2009, we are hesitant about offering a payment withhold. However, we believe strongly that cuts must not be blunt or arbitrary. They must incentivize quality and maintain access to critical services for beneficiaries.

Proposal:

- Implement a 1.5 percent reduction in payments to skilled home health services over a 10 year period;
- Assess the total performance of a skilled home health provider using a methodology developed by the HHS Secretary and based on the Home Care Compare Hospital Rate

and Emergent Care Rate established during the performance period, taking readmissions into account;

- Determine quality incentive payments for a skilled home health provider using the median performance score of all home health agencies, using a sliding scale such as:
  - Scores equal to or greater than 75 percentile nationwide would receive a quality incentive payment equal to the full 1.5 percent withheld plus an additional 1 percent payment;
  - Scores equal to or greater than median, but less than the 75 percentile nationwide would receive a quality incentive payment equal to the full 1.5 percent amount withheld plus an additional .25 percent payment;
  - Scores equal to or greater than the 25 percentile median, but less than the median score nationwide, would receive a quality incentive payment equal to 50 percent of the amount withheld; and
  - Score below the 25 percentile shall not be eligible to receive a quality incentive payment and will have no opportunity to recoup the 1.5 percent cut.
- The Secretary should be given the opportunity to develop a waiver to ensure access to care, particularly for those living in health professional shortage areas.

Any legislative action in this area must be fair in its assessment of the quality of care provided to home health patients and incorporate pending changes to the OASIS assessment tool, as well as a mix of process and outcome measures. It should also be appropriately risk-adjusted and limit any expansion of data collection requirements and fully reimburses agencies for the costs of any additional data collection requirements that are imposed.

c. Telehealth Risk-sharing Proposal: Reducing Inpatient Care through Technology

We believe that the use of telehealth should be a high priority as Congress considers evidence-based reform proposals to advance the nation on the fast track toward a highly functioning, technologically enabled, modernized health care delivery system. When deployed in

the home as a service of home health care, remote patient monitoring technologies greatly enhance the cost savings potential of PAC. Seniors are able to remain in their homes longer, delaying costly transfers to higher acuity settings, are more engaged with their care and have higher levels of care satisfaction. Providers are able to better manage the care of patients with chronic conditions by monitoring changes in health status with increased frequency and employing advanced analytic tools and data trends to improve service delivery, care coordination and reduce unnecessary emergency room visits and hospital admissions.

These benefits have already been demonstrated in a number of home health agencies across the country. When telehomecare interventions for chronically ill Medicaid patients were deployed at Windsor Place Home Health in Windsor, Kansas, for example, hospital readmissions, emergency room visits and nursing home admissions were reduced to zero over a one year period. Total cost savings over the same time period were approximately $1.3 million, while the per patient cost of the intervention was just $6 per patient per day. Similarly, at Forrest

General Home Care and Hospice in Mississippi, targeted telehomecare interventions for patients with congestive heart failure and chronic obstructive pulmonary disease caused hospitalization rates to drop from 20 percent to 3 percent and emergent care rates to fall from 7 percent to 2.5 percent over the course of a year.

We believe that results like those seen in Kansas and Mississippi could be experienced on a large scale if Medicare reimbursement policies supported the targeted use of telehealth in the home for both homebound patients and chronically ill patients who would benefit from "pre-acute" homecare.

To that end, we recommend that Congress consider legislation providing authority to CMS to test the value of care models that rely on the use of telehealth in home care settings.

One such bi-partisan legislative proposal is the Fostering Independence Through Technology Act of 2013 (S. 596), introduced by Senators Amy Klobuchar and John Thune. It would provide authority for CMS to implement a shared savings pilot program for home care agencies using remote patient monitoring technology. Under this legislation, participating agencies would receive a 75 percent share of the total Medicare cost savings realized over a year relative to a performance target set by the Secretary of HHS. The legislation limits payments to the amount that would have otherwise been expended if the pilot project had not been implemented, making this proposal cost-neutral. This integration of telehealth combined with the use of health information technology would greatly modernize the service delivery of home health care and provide for additional cost savings.

d. Home-based Chronic Care Model – Integrated Care Model

The Home-based Chronic Care Model is a patient-centered, evidence-based model with care coordinated and supported across providers, sectors, and time. This model would benefit both homebound post-acute patients and pre-acute chronically ill patients. However, its real promise and source of cost savings lies in keeping chronically ill patients out of inpatient

settings. The model is a partnership between home health agencies and patient centered medical homes that more fully treat the "whole" patient. The home health agency shares responsibility for patient outcomes with the primary care provider. The home health agency carries out the physician care plan and orders for guideline-level assessments and therapies (i.e. blood glucose monitoring, lipid analysis, flu and pneumonia vaccines.) The home health provider also conducts in-home health coaching, motivational interviewing and patient education, as well as provides ongoing support and monitoring.

Over time, the Home-based Chronic Care Model has evolved to incorporate new evidence, including a greater focus on patient empowerment and patient-centered care principles and methods to support care transitions. This model is now referred to as the "Integrated Care Model," (ICM) as best practices are integrated into model tenets and care is integrated across providers and settings.

We encourage the Committees to look at integrated care models that include home health care at the center as a way to improve care and reduce costs. Following are three specific homecare agency results from implementing ICM as a care delivery model:

Baptist Health Home Health Network, Little Rock, Arkansas

The ICM program was initially implemented in one HHA in 2007. Specific outcomes in re-hospitalization rates and patient satisfaction were tracked over 2,000 patients. At this agency, re-hospitalization rates declined from 29 percent to 13 percent, and patient satisfaction increased from 93 percent to 97 percent the year following training. The ICCM model's authors have described model focus areas, outcomes data, and lessons learned in articles published in peer review journals (Suter, et al., 2008; Hennessey, et al., 2010), and this work was highlighted in a Joint Commission Case Study (2009).

FirstHealth Home Care , North Carolina

FirstHealth has embedded ICM best practices across a continuum of services in their system, including complex care management and telehomecare. Standardizing the delivery of care for patients with chronic disease led to the development of clinical pathways that incorporate the principles of ICM and also include use of the Patient Activation Measure and specific nutritional and therapy interventions for patients with heart failure, COPD, diabetes and cardiac surgery.

This approach has led to significant improvement in the home health hospitalization rate as well as the home health 30 day hospitalization rate as noted below: (fiscal year 2011, 2012 are October through September; 2013 is year to date October through June)

Home Health Hospitalization Rate (data not risk adjusted)
2011 26.47%
2012 23.87%
2013 20.76%

Home Health 30 day Re-hospitalization Rate (data not risk adjusted)
2011 17.41%
2012 16.92%
2013 10.85%

White County Medical Center Home Health , Searcy, Arkansas

The White County Medical Center Home Health trained all their clinical staff in ICM starting in 2011. They utilize ICM best practices in home care, care transitions, and for care coordination with other team members including physicians, pharmacists, and hospital case managers. Having a chronic care management program and requisite staff competencies has led to significant improvement in their acute care hospitalization (ACH) rates. The risk adjusted ACH rate has improved from 24.4 percent in June 2011

to 12.9 percent in April 2013. The agency is currently in the 1st percentile for the state rankings and 3rd in the nation for preventing acute care hospitalizations.

III. Feedback on Specific Deficit-cutting Proposals

Your letter mentioned proposals put forth by MedPAC, Simpson-Bowles, the Obama Administration and the Bipartisan Policy Center. Our feedback related to these proposals centers around the underlying premise that home health margins are too high. The data on margins is incomplete and we respectfully request that the Committees consider the flaws in this data as outlined below.

The Committees' letter requesting input on PAC reforms references home health agency Medicare margins at 14.8 percent in 2011. This figure is not a reliable indicator of the current and projected financial status of home health agencies. More recent data shows that beginning in 2011, Medicare margins have started a steep decline in margins triggered by rate reductions and increased costs due to new regulatory requirements. Specifically, data from more than 7,000 Medicare cost reports (2012) show a margin decline to 8.4 percent. This follows a 2.5 percemt decline from 2010 to 2011. A further decline is projected in 2013 as the combined effect of a nearly 11 percent rate reduction and regulatory costs take hold. In addition, Medicare has proposed an additional 14 percent cut from 2014 to 2017. Overall, this means that the referenced 14.8 percent Medicare margin is ancient history.

Attachment B provides a detailed explanation of the current and projected Medicare margins for home health agencies. Beyond the outdated margin reference, the MedPAC data analysis on margins is incomplete and we respectfully request that the Committees consider the flaws in this data as outlined below:

First, MedPAC intentionally excludes approximately 1,200 very important providers from its margin calculation: hospital-based home health agencies. Ostensibly, MedPAC excludes these home health agencies because of concerns about unwarranted allocation of overhead costs

from the hospitals. However, MedPAC includes hospitals with home health agencies in its hospital analysis. These home health agencies are crucial to care access because they are often the primary home health agency in the geographic area served, they are essential to care integration, and they are often part of a critical access hospital. Including hospital-based home health agencies in the margin calculation reduces the national average by 3-4 points.

In addition, MedPAC does not consider routine clinical costs and normal business costs in its evaluation of the home health agencies. These include telehealth, respiratory therapy, and nutritionist services that home health agencies are permitted to provide during an episode of payment. In additional, typical business expenses such as taxes and marketing are not included. All of these costs are disregarded due to the use of antiquated cost reimbursement rules that have not applied otherwise since 1999. In total, these costs can increase an episode cost by 15-20 percent.

Next, the margin display is limited to averages: provider size, broad geographic areas, and provider type (i.e., for profit/nonprofit). However, detailed data shows that averages are totally misleading in that the margin range is very high. For example, in some years, 30 percent of providers have margins in excess of 25 percent while 30 percent have margins less than zero. The imprecise payment distribution of the payment model leads very efficient providers to still lose money because of such factors as sparseness of patient population and staff visit productivity due to travel time or other factors. When examining the margin range, particularly on the more local level, issues of access to care are better understood.

Finally, MedPAC uses "weighted" averages in its calculations. This means that all provider Medicare revenue and costs are combined into a single calculation. An "unweighted" average that is based on the average of individual provider margins is more informative. While weighting may make some sense, it loses its value when comparing home health agencies that can be large because of the large populations in their service areas while others can only be small for the opposite reason.

For your reference, we have attached a series of data reports we produced regularly. These show margins of freestanding, hospital-based, and combined home health agencies. In addition, we have include reports that show margin distribution. We have these reports down to the congressional district level.

IV. Specific Proposals on Fraud, Payment Accuracy and Variation in Utilization

It is essential that Medicare operate with integrity and compliance as millions of Americans depend on this program every day to meet their health care needs. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare. NAHC fully supports efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards of the limited

resources available to Medicare. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

In recent years, new policies and administrative practices have been instituted to address care overutilization concerns. For example, Medicare has added oversight and "real-time" predictive modeling to target aberrant providers, using its contractors such as the Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs) in addition to its longtime claims reviews by the everyday Medicare Administrative Contractors (MACs). Also, an industry-developed restriction on home health outlier episodes in home health services eliminated abusive claims, reducing unnecessary Medicare spending by $1 billion in in its first year, 2010.

Other measures have been instituted by Medicare, including more stringent provider participation standards, a periodic professional therapist assessment requirement prior to continued care, and a physician face-to-face encounter requirement to initiate covered home health services. These and other changes have led to an actual reduction in Medicare home health spending, a phenomenon unique in the Medicare program in recent years. In fact, home health spending and utilization is less today than in 1997. In today's dollars, Medicare home health spending is about 40 percent lower than in 1997 while all other sectors have significantly increased. Still, home care and hospice wish to lead rather than follow in program integrity innovations.

a. Reducing Fraud, Waste and Abuse

Below are recommendations that we believe can further reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that concerns about fraud and abuse exist – the system permits bad actors and parties without adequate competencies to enter Medicare program. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are designed to address both deliberate fraud and abuse and harm caused by ignorance or lack of competence.

1. Leverage the Use of Technology to Identify Fraud and Abuse

- Congress should support the use of technology in home care as a means to proactively identify patterns of fraud and abuse providing means of capturing a more comprehensive and complete account of a patient encounter. A number of technologies that are currently in use by home care agencies such as electronic visit verification (EVV), electronic visit documentation (EVD), electronic health records (EHRs), point of care technologies and remote patient monitoring can be leveraged to provide data points such as date, time location, services provided, task completed, and other discipline specific information that would provide a more complete record of the patient encounter. The yield of data used

  for the purpose productivity reporting, efficient payroll processing, and accurate claims submissions could also be leveraged to identify patterns of fraud and abuse.

2. Improve Standards for Provider Admission to Medicare

- Implement an expanded temporary moratorium on new home health agencies. While we applaud CMS's temporary moratoria on the enrollment of new home health provider and ambulance supplier enrollments in Medicare, Medicaid and CHIP in three "fraud hot spot" areas of the country, we encourage a broader moratoria. Congress should mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area. It should apply certain standard exceptions to a

moratorium such as where the state has a Certificate of Need program and the state determines that there is a need for additional providers; the provider is establishing a branch office or multiple locations within its geographic service area; or the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.

- Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors. CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end. Congress should increase the initial capitalization requirements to the equivalent of one year operation; establish a "probationary enrollment" for new providers during which all new home health agencies are subject to 100 percent medical review for at least 30 days, followed by a minimum of 10 percent medical review for the first year in the program; establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions; conduct State Agency full resurveys of all new home health agencies at 6 months of operation; and require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.

- Require credentialing of home health agency executives. Strengthen Medicare program participation standards to include experience, credentialing and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.

- Require criminal background checks on home health agency owners, significant financial investors, and management. A key to program integrity in Medicare and Medicaid home care starts at the top. Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency. Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.

3. Implement Preventive Measures to Improve Compliance

- Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan. Congress should require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following: corporate compliance plan frameworks based on the elements put forth in the Sentencing Guidelines; tailored to address specific risk areas; periodically re-evaluated; taken into consideration by CMS when making payment rate changes; outreach and education activities by CMS for providers to implement a compliance plan; and 12 months to fully implement a compliance plan following the publication of any rule.

- Enhance education and training of regulators and their contractors alongside home health agencies to ensure a uniform and consistent understanding of the application of program standards. The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. Congress should ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors by taking the following steps: develop education sessions to be conducted nationally and open to all stakeholders; provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies; require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies; and abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

4. Strengthen Enforcement

- Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries. Congress should establish a Medicare Home Health Benefit

  Program Integrity Advisory Council appointed by the Secretary of HHS with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice. Its purpose is to: evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; recommend compliance oversight system improvements that should be developed and implemented by the Secretary; evaluate and assess existing compliance oversight systems within home

health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; and recommend compliance oversight system improvements that should be developed and implemented by home health agencies.

- Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight. Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. Congress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency. The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance. The entities would have audit authority in order to engage in an investigation of alleged noncompliance.

- Utilize targeted provider edits for application of claims reviews and oversight activities. In Medicare home health services, the variation in utilization warrants careful attention. While the benefit may offer a wide range of services to be covered and permit coverage of extended periods of care, extreme instances of high levels of utilization should be subject to increased scrutiny. For example, MedPAC has highlighted the 25 counties with the highest level of utilization. In some instances, providers have twice the national average in the number of episodes per beneficiary per year. Although beneficiaries can qualify for an unlimited number of 60 day episodes in a calendar year, the extraordinary difference between national average utilization and these providers should trigger claims reviews, including a prepayment authorization process. Such an episode volume process edit will require providers to prove that their claims meet coverage standards.

5. Remove systemic incentives for overutilization

- Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care. The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with more therapy visits. Reimbursement for episodes increases incrementally as the number of therapy visits increase. Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. The current case mix adjustment model for home health services payment should be modified to eliminate the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

b. Addressing Variation in Utilization through New Team Approaches

There are two strategies currently employed voluntarily by many home health agencies that should be considered as standard Medicare conditions of participation for all home health agencies. These two strategies require up-front and ongoing investment in resources and time on the part of home health agencies. However, as we have stated, we believe that changes need to encourage quality and these two strategies could reduce fraud and abuse while improving quality.

First, consistent with requirements for hospices and skilled nursing facilities, home health agencies should be required to include a Medical Director as part of its professional staff management. There is currently limited direct medical supervision of home health care services provided by non-medical personnel. A Medical Director would change that by participating in the formation of clinical policies and procedures while also assisting in utilization review to ensure necessary and appropriate level of care is provided to patients. Further, the Medical Director would act as a liaison with the physician community to improve proper patient care transitions. A Medical Director does not necessarily have to be a full time staff member to fulfill the role. There are many forms the inclusion of a Medical Director could take, including an affiliation or part-time clinician.

Second, the use of an interdisciplinary team approach to care planning, utilization, and oversight has proven valuable in hospice care and can have comparable value in home health services. A team approach would be useful in determining the right combination of care at the right time for the patients to achieve optimal outcomes. Quality of care would be enhanced along with an improved process in care utilization. Specifically, the interdisciplinary team would be an added gatekeeper to guard against the provision of unnecessary care.

We have included draft legislative language the Committees can consider including in any legislation advanced to address the challenges of the Medicare PAC payment system (see Attachment B).

c. Improving Payment Rate Accuracy

Our members recognize that accurate and reliable data is critical to ensuring payment rate accuracy. As such, we are troubled that CMS eliminated nearly two in five home health agency cost reports in its proposed rebasing of the home health prospective payment system. To ensure that CMS has access to reliable home health provider data, and that home health payments are based on the cost of providing home care, we recommend establishing a new program to penalize home health agencies that are delinquent in submitting complete cost reports. We do not take the proposal of penalties lightly, but we are committed to ensuring accurate data.

Under such a proposal, agencies that submit cost reports without a provider number, total payments, total costs, number of episodes, or number of visits would be subject to payment cuts.

Existing providers would be given a one-time, 30-day grace period during the first year of this policy where CMS would notify the agency of the missing information and the agency could submit a corrected cost report. New agencies would be afforded a similar one-time opportunity when they submit their first cost report. Given that cost reports are submitted electronically, CMS could seamlessly incorporate such edits into its existing automated process, reducing the administrative burden on the Medicare program. The payment cuts for incomplete cost reports would start at 1 percent for the first year, rising to 3 percent for the third year and beyond, similar to the readmissions proposal. Such cuts would be applied across all payments during that calendar year.

We also recommend Congress commission a Government Accountability Office (GAO) study to recommend improvements to hospital-based home health agency cost reports so that such reports may be included in comprehensive home health agency data analysis. MedPAC has repeatedly expressed concerns about comparing cost reports between freestanding and hospital-based agency cost reports. Given the large number of hospital-based agencies, it is critical that data from these facilities be deemed useful by Congress and its support agencies.

V. Specific Answers to Bulleted Questions

a. Quality

As previously indicated, we support payment reforms that incentivize quality improvement across the care spectrum, We believe, however, that these reforms must go hand-in-hand with policies that remove barriers to quality measurement and improvement in PAC settings. For example, the Home Health Care Planning Improvement Act of 2013 (H.R. 2504 and S. 1332) would allow certain providers, such as nurse practitioners, physician assistants, and certified nurse specialists, to provide the requisite certification needed before home health services may be provided to a patient under the Medicare program. As it currently stands, only physicians are able to certify that a homebound patient needs skilled nursing services, which often results in delayed access to care thus negatively impact the overall quality of care the patient receives.

In addition to addressing barriers to quality care, we believe that one of the most effective ways to improve health care is to link payment for acute and PAC services to a patient-centered measurement system that assesses outcome-based measures across episodes of care. As such, we have suggested several options for re-structuring the current PAC payment system to align more closely with acute care quality-based payment programs, including post-acute, community-based care bundling; value-based purchasing; and a homecare readmissions penalty. We stand ready to work with the Committees to further develop any of these policies.

Although Medicare home health payments are not currently tied to quality measurement, there are established reporting initiatives that could be partially leveraged to provide a starting point for further measure development for home-based care settings. CMS currently posts home health performance data on its Home Health Compare website, deriving HHA-specific performance ratings from data collected through the Outcome Assessment Information Set

(OASIS) assessment tool and the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. While the OASIS tool collects patient-specific information on outcome, process and potentially avoidable event measures at the point of care, the HHCAHPS survey assesses patient satisfaction through survey responses provided by the patient, a family member or a friend at a later date.

Given these two data sources, we encourage the Committees to use the data collected through the OASIS tool as the primary starting point for the new measure development needed to advance PAC payment reforms. Our members have reported that there are some limitations associated with the HHCAHPS survey, as a patient's satisfaction with the care they receive may not reflect the quality of care provided in some instances (for example, if a patient has multiple chronic conditions and the clinical goal is to maintain or slow the decline of the patient's health rather than improve it). Additionally, responses provided by a patient's friend or family member may not provide a true picture of the care received by the patient as many patients may not share complete details regarding their health condition(s) with others. As such, we believe that HHCAHPS results should be a small component of any system that links payment to quality, if at all.

Despite these reporting initiatives, gaps in PAC quality measurement continue to exist. The Measures Application Partnership (MAP), a public-private partnership between the National Quality Forum (NQF) and the Department of Health and Human Services (HHS), examined existing PAC measures, identifying areas where existing Home Health Compare measures should be updated, as well as six priority areas for new measurement development.

As an initial matter, MAP stakeholders recommended that Home Health Compare measures be updated to align with quality measurement principles being used in other care settings. The MAP advisory committee indicated that existing Home Health Compare measures should be revised to reflect data collected over a period of time rather than a single point in time, and be flexible enough to allow for customization to reflect the unique care provided within the home health care setting. Stakeholders also recommended that existing measures be modified to take into account health disparities, to reflect key structural and cost goals for home health care, and to address the unique care required by specific subpopulations who receive home health in significant numbers (e.g., patients with chronic disease, cancer patients, patients with dementia).

In addition to its examination of existing home health measures, MAP stakeholders also identified six priority areas for new measure development, focusing on those areas where current measures are either insufficient or non-existent, including:

- Function, including an assessment of functional and cognitive status;
- Goal attainment, including the establishment and attainment of patient/family/caregiver goals and advanced care planning and treatment;
- Patient and family engagement, including care experience and shared decision-making;
- Care coordination, including transition planning;
- Safety, including measures related to falls, pressure ulcers, and adverse drug events; and

- Cost/access, including measures examining inappropriate medication use, infection rates, and avoidable readmissions.

While we support efforts to update the home health quality measurement system, we would also like to draw the Committees' attention to two additional factors that significantly impact the viability of a system that links PAC payment structures to quality measurement: the establishment of appropriate PAC benchmarks and the adoption of technologies that can be used to provide a consistent data platform for the collection and measurement of quality information across PAC settings.

Establishing appropriate PAC quality benchmarks is challenging, as the patient population is very heterogeneous even within care settings. In home health, for example, the patient population is split between older individuals struggling with chronic disease and other patients who are recovering from a single acute episode. Although the same measures might be

used to evaluate the quality of care provided to both of these patient groups, the use of same benchmarks or targets may not be appropriate given the diverse health needs of the two groups.

Likewise, varying levels of technological advancement within and among PAC settings make it challenging to consistently electronically capture and exchange the critical health information needed for quality measurement. This is a key barrier to the development of an outcomes-based quality system that spans episodes of care, including acute care. PAC providers, including home health agencies, are not eligible for "meaningful use" incentives under the Health Information Technology Economic and Clinical Health (HITECH) Act and have thus lagged behind in health IT adoption, implementation and health information exchange..

We believe that key measurement gaps and barriers must be addressed before the health care system will be able to realize the Committees' vision of coordinated, patient-centric value-based care across care settings. We agree that the use of harmonized measures (or families of measures) at each level of the system could be useful in assessing care not only during an episode, but also in providing a comprehensive picture of the quality of care a patient has received throughout the course of a lifetime. We look forward to working with the Committees to advance this goal.

b. PAC Assessment Tools

As the Committees undoubtedly know, several different assessment tools and data collection systems have been required in PAC settings over the years, including OASIS, the Minimum Data Set (MDS), and the Continuing Assessment Record Evaluation (CARE) patient assessment tool (albeit on a limited, demonstration basis).

Although these tools play an important role in streamlining care in the home, the variance across tools makes it a challenge to create technology standards that align these mechanisms with other types of health IT, including electronic health records (EHRs). Because many home health agencies have already made significant investments in the standards development and

technology infrastructure needed to upgrade and modernize their electronic systems, including those that integrate with these assessment tools, we believe it would be preferable to add new questions to existing tools rather than develop new resources. Many home health agencies may find the costs of developing and deploying new systems untenable, as it would likely be very costly to purchase and implement.

If, however, CMS determines that a new tool is needed to support quality measurement across PAC settings, we would support deployment of the CARE tool at a national scale. Although a relatively small number of home health providers had the opportunity to use the CARE tool during the CMS PAC Demonstration Program, feedback was generally positive.

Overall, demonstration program participants found the CARE tool as useful as the OASIS assessment tool, with some finding it more useful. Participants reported that the CARE tool was easier to work with, allowed greater insight into the providers the patient may have been

seeing in other care settings, better supported homebound status in complex patients, and better captured improvement in transferring and ambulating patients. Participants also reported that the CARE tool accurately and appropriately measured cognitive status (including mood and level of pain), as well as functional status.

Despite many positives, however, participants also identified some areas where the CARE tool could be improved. For instance, some participants reported concerns with the usability of the tool, indicating that the formatting was inconsistent across sections, making it difficult to quickly find key pieces of information. Participants also believed that the tool could be streamlined to eliminate repetitive questions such as those requesting demographic patient data that is unlikely to change (e.g., date of birth, race/ethnicity, gender, etc.).

c. Readmissions

Although we have not fully studied the potential for a broader readmissions reduction program for home health, as a general principle we believe readmission rates are important markers of quality of care. As such, we believe successful efforts to reduce preventable readmission rates will improve quality of care while decreasing costs. One such readmission reduction program we are currently monitoring is the Hospital Readmissions Reduction Program ("HRRP"), established by Section 3025 of the Affordable Care Act. The HRRP was designed to provide incentives for hospitals to implement strategies to reduce the number of costly and unnecessary hospital readmissions. Specifically, the incentives are escalating payment penalties that decrease a hospital's payments from all of its Medicare cases. The payment penalties began October 1, 2012 and are as much as 1 percent of every Medicare payment for a hospital that was determined to have "excessive readmissions" for three identified measures. In October 2013, the penalty will increase to 2 percent and in October 2014 to 3 percent.

While the a home health readmission program should – to the extent feasible – be consistent with definitions established for the HRRP, the focus should be on preventable readmissions that are directly related to the reason home health care was prescribed or for a

condition that was developed as a result of care received during the home health episode. Additionally, consistent with the HRRP, the program should target preventable readmissions that occur within 30 days of completion of the last home health visit or episode. Also consistent with the HRRP payment penalty, we believe that the payment penalty should be phased in (1 percent, 2 percent, and 3 percent cut over 3 years), assessed on the following year's payments, and should impact all Medicare payments to an affected agency. We also believe, consistent with the HRRP, any readmission rate analysis should be risk-adjusted, whereby differences in the severity of illness of the patients are considered when comparing readmissions rates. Most importantly, we believe that any standards CMS develops for such a readmission reduction program, including our suggestions above, should be fully transparent and comply with appropriate notice and comment rulemaking. Home health agencies must also have access to timely data so that the agencies can make real-time adjustments and improvements to understand which patients are being readmitted.

Ultimately, we believe that a readmission reduction program for home health, if implemented properly, can provide additional incentives for hospitals to decrease readmissions by coordinating transitions of care and increasing the quality of care provided to Medicare beneficiaries. Such a program is part of CMS's stated goal to move towards value-based purchasing and thus we support it in principle. We also acknowledge the link between a penalty-only readmission reduction program for home health and a PAC value-based purchasing ("VBP") program that would allow high performing PAC providers earn a bonus payment.

d. Site neutral payments

As the Committees consider equalizing payments between sites of care, NAHC urges the Committees to rectify the unfair disparities that have long existed between home health and hospital wage payments. Home health agencies and hospitals compete for the same nurses in their respective communities. However, hospitals often times receive Medicare wage reimbursements that are far higher than what home health agencies in the same county/area receive. That is because hospitals are able to increase their wage payments by reclassifying into other counties while home health agencies wage reimbursements, while tied to the hospital wage index, are not allowed to benefit from such reclassifications. This differential treatment puts home health agencies as a distinct disadvantage, trying to retrain and attract nursing staff with fewer resources than hospitals who compete for the same staff. NAHC respectfully requests the Committees enact a site neutrality wage index payment by affording home health agencies the opportunity to receive the same post-reclassification wage indices that hospitals receive.

e. Beneficiary Protections

If Congress alters payment incentives for PAC providers, we believe that it should also take steps to ensure that beneficiaries are protected and receive care in the appropriate setting. Although some policymakers have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services, we believe that a copayment would deter Medicare beneficiaries

from accessing home health care and instead create an incentive for more expensive institutional care. Numerous studies have concluded that a copayment would discourage the use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. For these and the reasons outlined below, we respectfully ask the Committees to protect Medicare beneficiaries by choosing not to implement cost-sharing policies that would impose a copayment for home health and hospice services.

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health copays "…would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays."[9] Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.[10] The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, "may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long run."[11] Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher Medicaid overall costs.[12] The Veterans Administration recently eliminated copays for in-home video telehealth care to prevent avoidable hospitalizations of veterans.[13] According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[14]

- **The burden of a home health copayment would disproportionately impact the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30

[9] Urban Institute Health Policy Center, "A Preliminary Examination of Key Differences in Medicare Savings Bills," July 13, 1997.
[10] Trivedi, Amal N., Husein Moloo and Vincent Mor, "Increased Ambulatory Copayments and Hospitalizations among the Elderly," *New England Journal of Medicine*, January 2010.
[11] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental Insurance First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).
[12] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Findings," Center on Budget Priorities (July 7, 2005).
[13] U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Eliminates Copayment for In-Home Video Telehealth Care," May 8, 2012.
[14] Avalere Health LLC, "Potential Impact of a Home Health Co-Payment on Other Medicare Spending," July 12, 2011.

percent 85 or older. Sixty-three percent are women.[15] Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.[16] The Commonwealth Fund cautioned that "cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs."[17]

- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes

  below $22,000, just under 200 percent of the federal poverty level.[18] Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.[19]

- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100 percent of poverty ($11,412 for singles, $15,372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.[20]

- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated $450 billion a year in unpaid care to their loved ones,[21] and too frequently having to cut their work hours or quit their jobs.

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15 CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.

16 Avalere Health LLC, "A Home Health Copayment: Affected Beneficiaries and Potential Impacts," July 13, 2011.

17 The Commonwealth Fund, "One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," September 2001.

18 "Medicare at a Glance," Kaiser Family Foundation, November 2011.

19 "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare households"—Kaiser Family Foundation.

20 "Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment," GAO-12-871 (September 2012).

21 L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, "Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving," AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not "order" home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.[22]

- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.

- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 17 percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.[23] Likewise, the 25 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care. Home health agencies cannot absorb these costs as nearly 50 percent of home health agencies are projected to be paid less than their costs by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.[24]

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[22] CMS Research, Statistics, Data, and Systems/Statistics, Trends and Reports, Medicare Medicaid Stat Supp/2011 (Tables 3.1 and 7.1).

[23] Kaiser Family Foundation, "Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007," August 2009.

[24] National Association for Home Care & Hospice (NAHC) Cost Report Data Compendium, Updated 2012.

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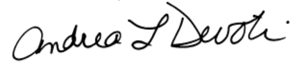
In closing, we appreciate the opportunity to submit our comments as you consider ways to reform post-acute care. If you have any questions or need any further information, please do not hesitate to contact us.

Sincerely,



Andrea L. Devoti
Chairman of the Board

Val J. Halamandaris
President