September 4, 2015 via Electronic Submission

The Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore M.D. 21244-8016

Re: CMS-1625-P: Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Dear Acting Administrator Slavitt:

On behalf of Almost Family, Inc. (AFAM), we appreciate the opportunity to provide comment to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule that would update the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2016 and implement the home health value-based purchasing (HHVBP) Model.

Section I -- Executive Summary of Our Comments

The following is a summary of our recommendations and comments which are developed more fully in the pages that follow:

1. With regard to **Case-Mix proposals (Section II)**:
   a. The proposed case-mix creep adjustments should be suspended pending the development of a new case-mix model. **In particular combining proposed rate cuts with HHVBP can lead to total rate cuts of 8.5% to 11.5% which are untenable on top of the cumulative effects of rebasing.**
   b. **We have serious concerns about the validity of the calculations supporting the proposed case-mix creep adjustments. Due to its high-importance but relatively technical nature we have embodied our work in Exhibit #2 which we urge you to review in detail.**
   c. CMS should proceed with all deliberate haste in the development of new case-mix model that is consistent with the objectives of the HHVBP
2. With regard to the **HHVBP (Section III)**:
   a. The program should be down-sized both in withhold amount and in scope and redesigned so as to avoid unanticipated outcomes and ensure greater demonstrative power through a better control group.
   b. The HHVBP should be implemented with a two year "Shadow Check" or phantom payment approach to give providers time to implement necessary changes. Additionally, CMS would have the benefit of studying results and provider behavioral changes.
   c. CMS should consider simply using the Home Health Stars Rating System as the basis for making VBP incentive payments as is done in the Medicare Advantage program
3. With regard to **IT Interoperability and Provider Access to Information (Section IV)**:
   a. CMS should implement policies to include HHA's in Meaningful Use standards and bonus payment programs to encourage better participation in IT interoperability.
   b. CMS should grant providers access to available patient level information on the same basis as ACO's via the "Blue Button" technology for all patients admitted to home health.
4. With regard to **Collaboration, Statutory Authority and Process (Section V)**:

a. CMS should consider suspending the proposed HHVBP to permit better collaboration with the Congress and avoid a "false start" or competing models.
b. The statutory authority of CMS to implement the HHVBP as proposed seems questionable given the mandatory nature and size of the program, contrasted with its grant of authority for "testing innovative payment models."
c. CMS should adopt an appeals mechanism PRIOR to implementation of the HHVBP as opposed to committing to do so AFTER implementation.
d. CMS should consider interviewing stakeholders and soliciting their written comments before issuance of proposed rules, as the Senate Finance Committee recently did in anticipation of developing chronic care management legislation.

Framework for Our Comments

Reform and regulation should be "purpose built" around the desired goals. Policy makers should establish the desired goals first then build consistent, deliberate and well thought-out policy to achieve those goals. The contextual framework for our comments is included in Exhibit #1.

Recent CMS Policies and Actions Consistent with Goals

We applaud much of the progress that has been driven by CMS in that it largely and directionally has taken actions that are consistent with this framework. We note that each of these areas can be improved upon and implementation details are critical to success:

- **Recent innovations in the areas of ACO's and bundled payment demonstrations**, including as documented in the recent Lewin BPCI report have established incentives to move higher acuity patients into home health care. Home health use increases when providers are incentivized to collaborate and find the best lowest cost ways to provide appropriate care.
- **Value-based Purchasing programs** require the Program to establish desired outcomes and goals for Providers. With these programs Medicare clearly states what it wants providers to do and establishes financial incentives for providers to do those things.
- **Cost containment efforts**, including for example the recent rebasing of home health rates and the proposed rebasing of SNF rates help maintain some sense of alignment of payments and providers costs of providing care. While we take issue with some of the particulars, these efforts can help allay concerns about over-payments.
- **Demonstration projects** that are well-designed, permit appropriate control group comparisons and are moderate in their ambition, provide very useful information to policy evolution.
- **Program integrity efforts**, including for example, the Outlier payment limitation imposed in home health, and moratoria on new providers in over-served areas, help to contain abusive practices.

Section II – Case-Mix Policies in Conflict with Desired Goals

While we understand some of the underlying drivers, we believe historically implemented, and currently proposed, HH Case-Mix policies are at cross-purpose with desired outcomes or in direct contravention of available evidence. These should be reconsidered:

- **Proposed HH Case-Mix Creep Adjustment Contrary to Move Toward Risk-Based Programs. –** Innovative ACO and BPCI programs ***are designed to, and are,*** driving higher acuity patients into home health. This is supported by the CMS-sponsored Lewin report on BPCI programs. However, when this is reflected in higher HH case-mix scores, CMS we believe erroneously, ascribes this reality to provider "up-coding". This leaves providers no choice but to assume that if they care for higher acuity patients in the future CMS will reward them with additional payment cuts.
- **Continued Rate Cuts, Case-Mix or otherwise, are Contrary to Necessary Investments. –** In order for home health providers to participate in risk-based models and IT interoperability development, significant financial investments must be made to increase their sophistication. Continual rate cuts are completely contrary to achieving these goals. A much better policy would be to mandate that HHA's make the appropriate investments a condition of participation in the Medicare Program. This would have the effect of addressing margin concerns AND help achieve goals, rather than cutting margins, and making it more difficult to achieve goals.
- **Proposed HH Case-Mix Creep Adjustment Pursues the Wrong Goal –** CMS efforts with regard to case-mix adjustments in home health have long been focused on the goal of aligning future reimbursement with where historical costs have been incurred. The proposed adjustments are based on backward-looking analyses rather than on forward-looking considerations. Given the current emphasis on innovation toward quality and away from volume this antiquated approach stifles progress and preserves the status quo at the very time other CMS initiatives ask providers to innovate.
- **Proposed HH Case-Mix Creep Adjustment Calculations Raise Validity Concerns –** We take issue with a number of the fundamental data elements and approaches CMS has historically used to calculate its case-mix adjustments for home health. **As more fully explained in Exhibit #2, our analyses suggest that more than all of the historical increases have been driven by increased therapy utilization that is, in turn, based on real needs of the patients.** We also raise questions as to the validity of the historical analyses upon which such adjustments have been based, and as to some of the rationale cited in the current proposed rule. We question whether the criteria in the Act for making such payment adjustments have been met in this case.
- **Need for a New and Improved Case-Mix Model.** – We agree with CMS commentary that a new case-mix model must be developed and we have several ideas that would be helpful in that regard. We believe a new model should be developed around a different definition of "payment accuracy" and the old definition of "aligning with costs" is inhibiting innovation and progress. In a new model more emphasis should be placed on patient conditions and risk models that predict the probability of undesirable outcomes or improvement in functionality.
- **Historical Cost Focus is Flawed and Inhibits Innovation.** – Historical over-emphasis on aligning payments with historical costs, rather than with value added to the program, are inhibiting innovation and good program design. The primary flaw is the implication that historical costs are in the right place and consistent with where we want costs to be incurred going forward. While this is getting partially addressed with the HHVBP proposal, it remains a key weakness in the case-mix model and in rate setting exercises such as rebasing. Medicare cost reports and the definitions of reasonable and allowable costs are antiquated in that they exclude material categories and amounts of costs that are necessary to operate a home health agency in modern times. Notable among definitional problems is the exclusion of tele-monitoring/technology costs.

Anchoring payment policies too firmly on historical costs creates a significant impediment to changing behaviors.

- **Recommendation:** Given concerns over the validity of the adjustments, and since they function at cross-purposes with other CMS goals, the proposed case-mix creep adjustments in the rule should be eliminated until a new case-mix model can be fully vetted and implemented.
- **Recommendation:** CMS should proceed with all deliberate haste to develop a new case-mix model consistent with the objectives of the HHVBP and the principles outlined above.
- **Recommendation:** CMS should renovate home health cost reports and allowable cost definitions to properly incorporate more modern business principles.

Section III – HH Value-Based Purchasing Policies in Conflict with Desired Goals

In both our August 2013 and June 2015 stakeholder response letters to House and Senate committees of jurisdiction, we specifically supported the adoption of VBP at the earliest possible date. In fact, our most recent stakeholder response emphasized the importance of aligning payments with value and stated: "We must be far more interested in driving better outcomes at lower costs over time, more interested in the value we receive for the payments we make."

Therefore, we strongly support CMS's broad goal, embodied in the HHVBP Model, of tying Medicare payments to overall quality performance. However, as set forth below in greater detail, we suggest the rule be refined to make it simpler, narrower in scope and with a geographic basis that allows for comparisons between a control group and the proposed model. We are convinced fewer quality measures and a gradual introduction of the program with a "shadow check" will more powerfully demonstrate success.

Proposed HHVBP Demonstration Project Too Large, Too Fast and Without Appropriate Control Groups. – We applaud the principles and goals behind the HHAVBP and are on record that value-based purchasing should be pursued with all deliberate haste. However, the program as proposed has the following flaws:

- The **Project is too large**, approximately one-fourth of all Medicare beneficiaries will be impacted. With no opt-out provisions for beneficiaries, the risk of unanticipated outcomes is simply too large.
    - **Recommendation:** Reduce the size of the Project substantially, perhaps to about 5%-10% of HHAs.
- Implementing the Project in entire states creates significant ***control group problems*** that will hamper proper evaluation of the program design. Using only 9 states but requiring state-wide participation will make it impossible to isolate the impact of the program from well-documented state-level issues that affect comparability of practice patterns and outcomes. An example of such a potential problem is the inclusion of Florida, where Miami-Dade is known to have significant numbers of abusive providers that significantly skew state results. It is at least possible that resourceful bad actors in Miami-Dade could take advantage of the HHVBP Project in ways contrary to the public interest and adversely affect the Project's demonstrative value.
    - **Recommendation:** Replace the state approach with two-groups: a) a statistically-random selection of providers across the nation mandated to participate, and b) a volunteer group of providers incentivized to drive upside bonuses with minimal down-side risk.
    - **Recommendation:** Implement the first year with full information and financial calculations publicly displayed, but only impact payments in the second year to allow providers to adapt. This is the "shadow check" approach referred to above and explained more fully below.

- The amount of **reimbursement at risk is too large and may drive undesired provider outcomes**. The unprecedented 5%-8% reimbursement withholds have never been tried and thus are likely to drive unanticipated outcomes.
    - **Recommendation:** Start at a lower level (2%) and implement increases more slowly.

Combination Effect of Multiple Programs Seems Under-Contemplated. – CMS is currently implementing demonstrations and innovations at an incredibly fast rate. The combination effect of these multiple initiatives must be considered just like clinicians must contemplate drug interactions in a patient's care plan. Poor coordination and reconciliation of medications is well documented as a cause of poor patient outcomes because one prescriber did not know what the other prescriber was doing. The same risk applies here. Simultaneously implementing a 9-state mandate for HHVBP and a 75-MSA mandate for CCJR-joint bundling, for example, must be considered in overlay. Each will have some effect on the other.

Table 1. HHVBP-CCJR Overlapping MSAs		
MSA	**State**	**MSA Title**
32820	TN	Memphis, TN-MS-AR
34980	TN	Nashville-Davidson--Murfreesboro--Franklin, TN
23540	FL	Gainesville, FL
33100	FL	Miami-Fort Lauderdale-West Palm Beach, FL
34940	FL	Naples-Immokalee-Marco Island, FL
36740	FL	Orlando-Kissimmee-Sanford, FL
37860	FL	Pensacola-Ferry Pass-Brent, FL
38940	FL	Port St. Lucie, FL
42680	FL	Sebastian-Vero Beach, FL
45300	FL	Tampa-St. Petersburg-Clearwater, FL
11700	NC	Asheville, NC
16740	NC	Charlotte-Concord-Gastonia, NC-SC
20500	NC	Durham-Chapel Hill, NC
24780	NC	Greenville, NC
47260	NC	Virginia Beach-Norfolk-Newport News, VA-NC
38900	WA	Portland-Vancouver-Hillsboro, OR-WA
42660	WA	Seattle-Tacoma-Bellevue, WA
30700	NE	Lincoln, NE
HHVBP-CCJR Overlapping MSAs:	**18**	
Total CCJR MSAs:	**75 (24%)**	

As shown in Table 1 above, 18 out of 75 (24%) Joint program MSA's overlap with the HHVBP states. Also, 5 out of 9 (56%) of HHVBP states overlap with Joint program MSA's.

Throwing on top of that numerous bundles for other disease states implemented at the hospital PAC level, and the rapid growth of ACO's in most marketplaces, sets up competition among a variety of CMS plans rather than providing for comprehensive coordination of patient care and outcomes. Dealing with many different programs all at once could serve to actually *increase* rather than decrease providers' costs, and *decrease* rather than increase their success rates.

Additional Commentary on HHVBP

To better gauge success of the HHVBP Model, we believe CMS should consider implementing a two year "shadow check" before any money starts flowing through the program. During the shadow check period, HHAs would be required to track and report the VBP quality measures but would face no financial risk as a result. This would give HHAs more time to plan and ensure readiness for the risks and rewards involved in implementing a VBP program. In addition, CMS would benefit by having more time to study the results of the model, as well as provider behavioral changes.

An example of the use of a shadow check in Medicare can be found in the recently proposed Comprehensive Care for Joint Replacement (CCJR) Model. There, CMS proposes "to phase in the requirement that participant hospitals whose actual episode payments exceed the applicable CCJR target price pay the difference back to Medicare beginning in performance year 2. Under this proposal, Medicare would not require repayment from hospitals for performance year 1 for actual episode payments that exceed their target price in performance year 1."[i] As part of its explanation for including a shadow check in the CCJR Model, CMS stated: "[W]e believe hospitals may need to make infrastructure, care coordination and delivery and financial preparations for the CCJR episode model, and that those changes can take several months or longer to implement." Since HHAs chosen to participate under the HHVBP Model will face at least as many planning challenges as hospitals participating in the CCJR Model, we propose imposing a shadow check at the outset of the HHVBP Model, as well.

In addition, a shadow check period may also have the effect of improving overall quality and patient outcomes by taking advantage of a well-established phenomenon known as the **"Sentinel Effect."** The Sentinel Effect suggests that human performance tends to improve when a person becomes aware that his or her behavior is being monitored. In the context of HHVBP, this means that through the use of a shadow check CMS's HHVBP Model could benefit from the savings and positive behavioral changes associated with increased monitoring of the home health industry without immediately exposing the Program to unanticipated outcomes or exposing HHAs to significant downside risk.

Next, we note CMS has had success in the past starting value-based purchasing programs with much smaller withhold amounts than are proposed in the current rule. The Hospital VBP program, for example, began in 2012 with just a 1% withhold. In 2015 that amount increased to 1.5%, and it will eventually max out at 2% in 2017 (see Table 2). Therefore, the total amount withheld for the Hospital VBP program started at 1% and only increases 1% over 5 years.

Table 2. Hospital VBP Model Withhold Amounts	
Year	**Withhold Amt.**
2012	1%
2013	1%
2014	1%
2015	1.5%
2016	1.5%
2017	2%

On the other hand, the proposed HHVBP Model debuts a much larger withhold amount (5%), which increases at a much faster rate (3% over 3 years) than the Hospital VBP program. For this reason, we are concerned the size, rate of increase and untested nature of the proposed HHVBP Model withholds are not sufficiently sensitive to the planning needs of HHAs and may lead to unintended consequences.

One potential unintended consequence could be provider discrimination in favor of, or "cherry picking," beneficiaries with less severe conditions, potentially leaving some higher-cost beneficiaries without care. This would be an undesirable outcome and would potentially violate the Budget Neutrality provisions in Section 1115A of the Social Security Act. This states in part: "The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines…after testing has begun, that the model is expected to—(i) improve the quality of care…without increasing spending...(ii) reduce spending under the applicable title without reducing the quality of care; or (iii) improve the quality of care and reduce spending."[ii] Any potential incentives that would reward providers for dropping patients with complex disease states could degrade the quality of care for this subset of patients and must be carefully considered by CMS before moving forward with the HHVBP Model.

A. Size and Impact of the Model

CMS proposes to implement the HHVBP Model in 9 states. The 9 states chosen are Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee. When added together, these 9 states contain nearly 25% (802,000 of 3.39 million) of all Medicare beneficiaries who utilize home health services in the U.S. They also account for approximately 22% of the total Medicare spend in the U.S (see Table 3). **We are concerned that the selection process resulted in a meaningfully disproportionate percentage of the population being included in the "demonstration" (25% of all beneficiaries are impacted but only 18% of the 50 states have been selected for mandatory participation).**

Table 3. Total Medicare Beneficiaries Receiving HH and Total Medicare Expenditures in HHVBP Model Testing States

Proposed Testing States	Total Medicare Beneficiaries receiving HH Services (in thousands)[iii]	Total Medicare Expenditures (in millions)[iv]	
Massachusetts	105	11,721	
Florida	339	39,119	
Tennessee	80	10,337	
Maryland	59	8,748	
Washington	40	7,971	
Arizona	36	8,451	
Iowa	25	4,329	
Nebraska	14	2,519	
North Carolina	104	14,105	
Total Medicare Beneficiaries Receiving HH in Proposed Testing States	**802**	**Total Medicare Expenditures in Testing States**	**107,300**
Total Medicare Beneficiaries Receiving HH in U.S.	**3,390**	**Total Medicare Expenditures in U.S.**	**471,260**
Proportion of Medicare Beneficiaries Impacted by Proposed HHVBP Model	**23.65%**	**Proportion of Medicare Spend in Testing States**	**22.76%**

As Table 3 demonstrates, the proposed HHVBP Model would significantly impact the home health sector because nearly one quarter of all Medicare home health consumers would be affected by the program.

B. Quality Measures

While we support CMS's push to implement and track quality measures for HHAs and introduce VBP to the sector, we are concerned by the number of quality measures HHAs must track and report under the new program together with its sudden and immediate start. As proposed, the baseline year for the program has actually already begun (it started January 1, 2015, or six months before the release of the proposed rule) and Performance Period 1 would start January 1 of next year. To borrow language from **Chairman Brady and Ranking Member Kind** in their letter to Secretary Burwell: "Providers need a significant transition time to prepare for change. CMS' proposal is not respectful of the need for a transition period."[v] This statement by the leaders of the Subcommittee reflects an understanding that large scale changes such as those proposed under the HHVBP Model do not happen overnight.

Providers need time to build proper infrastructure in their organizations and train employees. As indicated above, we reiterate the use of a shadow check of two years in which quality metrics would be tracked and reported, but without fiscal implications for HHAs. **Moving too fast, too soon with extraordinary cuts to agencies and up to 25 quality metrics may perversely incentivize providers to over-steer patients away from proper care.** We are convinced HHAs can reliably use a narrower group of quality measures that more powerfully describes the sector's success in improving outcomes and reducing spend. The hospital VBP model initiated in 2013, in a clearly more complex space, contained only four quality domains implemented over a period of four years. The domains in that system are: clinical processes of care, patient experience of care, outcomes of care and efficiency. The weight of each domain as a percentage consideration in performance was phased-in over a four year period. CMS should also consider Medicare Spend Per Beneficiary (MSPB) as a quality measure, but properly weighted among a simplified set of other measures.

C. Consider Use of Home Health Star Ratings for HHVBP

A much simpler approach would be to use the recently introduced Home Health Star Ratings system for value-based payments. Since HHAs have already begun tracking and reporting on these measures, it seems to be the easiest, most cost effective and logical grouping of quality measures to use under the HHVBP Model. Adding another layer of complexity to an already robust reporting program for HHAs seems counterproductive to the Program. More than simply being administratively convenient, this would align payments with consumer-friendly quality measures.

We believe Value-Based Purchasing is right for our sector, but caution unprecedented withhold amounts of the HHVBP Model, particularly when coupled with the 3.5% case-mix adjustment, jeopardizes home health's ability to deliver on the promise of avoiding hospitalizations and emergent care, keeping patients at home, and restoring previous functionality. We urge your careful consideration of the changes contained herein, which we think would greatly improve the rule.

Section IV -- Desire for IT Interoperability

We endorse the commentary in the proposed rule in which CMS expresses a desire to see home health agencies more involved in increasing the use of IT resources and driving IT interoperability. We agree with the goal and note that while CMS has effectively directed the attention and actions of other provider categories through "Meaningful Use" payments and requirements, no such steps have been promulgated with regard to home health. We believe better access to data through electronic information interchange would serve to drive better care coordination, better outcomes and lower costs for all providers. However, currently there is virtually no electronic data flowing to providers outside the MA and ACO arenas.

- **Recommendation:** Establish specific requirements for Meaningful Use for home health and implement bonus payments for those who comply.
- **Recommendation:** In addition, CMS should provide participating HHAs with the right to access "Blue Button" historical claims data on patients upon admission. As HHAs are held increasingly accountable for outcomes under the HHVBP Model, they should be allowed to see the Medicare claims history on patients for use in framing better care plans to produce high value service. This is particularly important in a new system where quality is paramount.

Section V – Collaboration, Statutory Authority and Process

A. Increased Collaboration between CMS and Congress

Less than three weeks after CMS released the current proposed rule, Chairman Brady and Ranking Member Kind introduced their own version of a home health VBP proposal in the "The Medicare Post-Acute Care Value-Based Purchasing Act of 2015" (H.R. 3298). We are concerned by the strident reaction CMS' HHVBP Model has generated among some members of Congress. In their letter to Secretary Burwell, Chairman Brady and Ranking Member Kind write: "CMS did not provide any detail on how the measures proposed for the home health VBP program align with the bipartisan IMPACT Act…It seems as if CMS crafted the home health VBP proposal with an utter disregard for the IMPACT Act."[vi] When the IMPACT Act was introduced in 2014 we came out in support for the bill. In a letter sent to House and Senate committees of jurisdiction, we stated: "AFAM wholeheartedly supports [the IMPACT Act] and considers it a good first step toward giving providers, and particularly home healthcare providers, the tools and incentives they need to offer specialized care to patients in their homes." We ask that CMS and the Congress increase their collaborative efforts to build a comprehensive VBP plan for Medicare HHAs that incorporates the best elements from both proposals, irons out all inconsistencies and aligns post-acute VBP programs with measures in the bipartisan IMPACT Act.

B. Statutory Authority – Demonstration or Phased Roll-Out?

As a final note, we question CMS's authority to implement the HHVBP Model using Section 1115A of the Act as its sole grant of authority. Section 1115A establishes the Center for Medicare and Medicaid Innovation (CMI) within CMS for the purpose of "test[ing] innovative payment and service delivery models to reduce program expenditures."[vii] The mandatory nature of the HHVBP Model combined with its size and breadth (affecting 1 in 4 Medicare beneficiaries) raises doubts as to whether CMS is actually testing a VBP Model, or creating a "full-blown" mandatory VBP program which would place its actions outside the scope of its statutory authority.

C. Appeals Process

CMS proposes to create and implement an appeals process under the HHVBP Model "through future rulemaking in advance of the application of any payment adjustments."[viii] If CMS chooses to adopt the HHVBP Model in the final rule, we encourage it to add an appeals mechanism at the same time. Medicare is replete with examples of beneficiary and provider appeals processes (with the curious exception of the MSSP ACO program). Any HHVBP Model adopted in the final rule should, at a minimum, include these same due process protections and the appeal process should be developed and implemented at the same time as the HHVBP itself.

D. Solicitation of Stakeholder Views in Development of Proposed Rules

While we appreciate the opportunity to comment on proposed rules, we urge CMS to consider adopting an additional step in the rulemaking process to improve the design and implementation of future rules. Recently, the Senate Finance Committee solicited stakeholder responses on innovative ways to care for patients with chronic conditions. As part of the process, the Committee invited stakeholders to come in and discuss their proposals in person with staff. We encourage CMS to adopt a similar process as a part of developing proposed rules rather than just soliciting comments after a rule has been proposed. We believe this more open and democratic process would result in better rulemaking.

We appreciate this opportunity to share our comments and look forward to continuing to work with you and your staff. We would welcome the opportunity to participate in further stakeholder discussions of these and other policy options to improve the proposed rule. If you have any questions, please do not hesitate to contact us by phone at 502-891-1000 or email at WBY@AlmostFamily.com or SteveGuenthner@AlmostFamily.com.

Sincerely,

William B. Yarmuth
Chairman and CEO
Almost Family, Inc.

C. Steven Guenthner
President
Almost Family, Inc.

Exhibit #1 -- Framework for our Comments

Reform and regulation should be "purpose-built" around the desired goals. Policymakers should establish the desired goals first then build consistent, deliberate and well thought-out policy to achieve those goals. The context for our comments is set forth below.

With Regard to Home Health:

Home health is critical to controlling overall healthcare costs and improving lives. The highest and best uses of home health are to:

- Eliminate avoidable inpatient facility use (hospitalization, Emergent Care, SNF and other PAC IP settings)
- Restore whenever and to the extent possible, patients' previous level of functionality
- Maintain patients in their preferred AND lowest cost settings, their homes, and improve their quality of life

In our view the following tenets are key to good policy design and these tenets also provide context for our comments:

1. Containing costs on an overall basis, not just within a given payment or provider silo
2. Program integrity must always be protected to avoid fraud, abuse and excess utilization
3. Changes should be thoughtful, deliberate, well-tested and designed with a full comprehension of provider behaviors and responses (not just within a given silo) to avoid undesirable or unanticipated consequences. In this regard the impact of multiple changes upon each other must also be carefully considered.
4. Patient choice, beneficiary access to care and the promises of the Traditional Medicare program must be maintained
5. Payment policies will shape provider responses regardless of the tax-paying status of the providers. **This should be embraced and used to the advantage of the Program** in designing payment policies that drive desired behaviors. To do otherwise would be to establish opposite incentives and employ expensive and ineffective enforcement efforts to drive provider behavior in contravention of the payment incentives.

Exhibit #2 – Increases in Home Health Case-Mix

For some time, CMS has been tracking home health case-mix increases and attributing the vast majority of the increases to coding practices not related to changes in patient conditions. CMS has then used this as the basis for cutting home health reimbursement rates through "case-mix creep" adjustments, and proposes to do so again in its CY2016 HH rule. This has been a subject of significant debate between CMS and home health providers.

Do Case-Mix Creep Adjustments Use Less-Powerful Variables to Suggest More-Powerful Variables are Inaccurate?

As we understand the process, in development and revision of its case-mix model, CMS, through its contractor Abt Associates, performs regression analyses on the OASIS data set, demographic information, claims files and linked cost reports. The output of the analyses is the selection of those data elements that are shown to have the highest explanatory power with regard to home health resource utilization. CMS implements the use of these most-powerful-variables in the HHPPS and bases provider payments on these most-powerful-variables.

Periodically, Abt is contracted to assess whether increases in case-mix are related to actual patient conditions or are "nominal increases" not related to changes in patient conditions. Historically, although published much later than the proposed or final rules they are used to support, the technical analyses used to conclude that case-mix increases are "not real" have been based on the non-case-mix variables. Given that, by definition, those non-case-mix variables were found to have a lower explanatory value, we are troubled Abt and CMS are able to conclude they somehow prove that the case-mix increases produced by the most-powerful-variables (those with the highest explanatory power) are somehow not real.

We ask that CMS address this question in the final rule to better inform our understanding of its conclusions as to how "real" versus "nominal" determinations are made.

The Dominant Impact of Therapy in the Case-Mix Model Appears to Explain MORE THAN ALL of the Historical Case-Mix Increases

We obtained from CMS the entire national claims datasets from 2005-2013. We used these datasets to calculate the impact of changes in therapy utilization on case-mix during this period. In its CY2012 rule, CMS made "manual adjustments" to the case-mix model, outside the output of the regression analyses used to develop the model, to address concerns that the model over-weighted episodes with high levels of therapy utilization. Accordingly, in our analyses we studied the period 2005-2011 separately from the period 2012-2013. Claims data for CY2014 have not yet been released by CMS and thus could not be incorporated in our study.

To assess the impact of therapy utilization on total case-mix, we recalculated for each claim in the dataset what the case weight would have been if therapy visits had been zero. The difference between the actual and recalculated case weights could thus only be attributable to therapy utilization. We present the results of our calculations in Table 1 below. According to our calculations, from 2005 to 2011, the total case-mix increased 9.8%, from 1.2364 to 1.3570. Over that same period of time the therapy case-mix increased 49% from 0.3006 to 0.4489. The non-therapy case-mix actually *decreased* 3.0% from 0.9358 to 0.9081, as shown in Table 1.

Table 1 – Changes in Case-Mix (CM) and Visit Utilization 2005-2011.

	Non-Therapy CM	Therapy CM	Full CM	TH Visits	SN Visits	Total Visits
2005	0.9358	0.3006	1.2364	5.7	8.2	17.8
2006	0.9439	0.3064	1.2503	5.7	8.2	17.8
2007	0.9531	0.3269	1.2800	5.8	8.3	17.6
2008	0.8956	0.4172	1.3128	5.9	8.3	17.7
2009	0.8950	0.4541	1.3491	6.2	8.4	17.9
2010	0.8933	0.4693	1.3626	6.4	8.3	17.6
2011	0.9081	0.4489	1.3570	6.3	8.2	17.3
Growth	-3.0%	49.3%	9.8%	10.6%	0.1%	-3.4%

This would indicate that <u>more than all</u> of the increase in case-mix during the period is directly related to the utilization of therapy. This indication is reinforced by the increase in therapy visits during that same period of time while the number of total visits actually declined slightly.

In its CY2012 HHPPS regulations, CMS manually recalibrated the case-mix to address concerns that therapy was over-weighted in the model. This was achieved in a budget-neutral manner by redistributing the impact of the manual adjustments across the balance of the case-mix model. As evidenced in Table 2 below, the case-mix trend in the 2012-2013 period shows a similar therapy-dominated impact. Case-Mix in the 2012-2013 comparison shows the 1.5% increase in total case-mix is driven by the increase in therapy more than the increase in non-therapy case-mix. Therapy case-mix grew 3.8% while non-therapy case-mix grew less than 1.0%.

Table 2 – Changes in Case-Mix (CM) and Visit Utilization 2012-2013.

	Non-Therapy CM	Therapy CM	Full CM	TH Visits	SN Visits	Total Visits
2011	0.9081	0.4489	1.3570	6.3	8.2	17.3
2012	1.0130	0.3603	1.3733	6.3	8.1	16.9
2013	1.0207	0.3716	1.3923	6.5	8.2	16.9
Growth 2012-2013	0.8%	3.8%	1.5%	4.6%	0.4%	-0.2%

Again, the increase in therapy case-mix coincides with an increase in therapy visits. This table suggests that substantially all the increase in total case-mix is being driven by therapy utilization. The changes in therapy and non-therapy case-mix between 2011 and 2012, when there was no change in therapy visit utilization, appear to highlight the "manual adjustments" made to the model by CMS in CY2012.

Implications of these Analyses

These analyses raise meaningful questions about the proposed case-mix "creep" adjustments and indicate that substantially all of the historical increases in case-mix have been driven by increased therapy utilization.

This in turn would seem to require any conclusion that the case-mix changes are not related to "real" changes in patient conditions be supported by evidence that the increases in therapy utilization on a broad and national basis, across 11,000 providers, 3.5 million beneficiaries, and hundreds of thousands of certifying physicians, were not medically necessary. In the absence of such evidence, we suggest that the proposed case-mix creep adjustments do not have appropriate foundational basis and thus should be deferred pending further analysis. Conversely, we believe that national trends moving higher-acuity patients into lower-cost settings, including home care, are in fact "real" and are causing the therapy-driven case-mix increases. Thus the criteria of Section 1895(b)(3)(B)(iv) of the Act, cited as the basis upon which the case-mix creep adjustments are proposed, do not appear to be met.

We note also that in the context of rationalizing its proposed case-mix creep adjustment, CMS references MedPAC's report on their assessment of the impact of the mandated rebasing adjustments on quality of and beneficiary access to home health care. We are concerned about this reference and ask that CMS help readers understand its relevance in the context of a discussion about whether case-mix increases are "real" or "nominal".

More importantly, however, we believe these analyses demonstrate the primary flaw that has been present in the case-mix model since its inception – that it is dominated by the impact of therapy services. This in turn is caused by an understandable, but in our view errant, desire to have the model use inputs to predict HISTORICAL resource utilization. Because therapy costs in the marketplace are higher than nursing costs, using linked cost reports produces this dominant effect.

We fully endorse CMS' comments and activities to renovate the case-mix model and welcome the opportunity to provide further input.

Footnotes

[i] Rule proposed by CMS, "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Hospitals Furnishing Lower Extremity Joint Replacement." 7/14/2015. 80 FR 41197, 41197 -41316 (120 pages), 42 CFR 510, CMS-5516-P. https://www.federalregister.gov/articles/2015/07/14/2015-17190/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals.

[ii] Section 1115A(b)(3)(B) of Social Security Act [42 U.S.C. 1315a], "Center for Medicare and Medicaid Innovation Established."

[iii] Table 7.3 Medicare and Medicaid Statistical Supplement, 2013 Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html.

[iv] Centers for Medicare & Medicaid Services (2011). "Health Expenditures by State of Residence." Retrieved (December 2011) at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.

[v] Letter from U.S. Representatives Kevin Brady and Ron Kind, Chairman and Ranking Member of the House Health Subcommittee of Ways and Means respectively, to Secretary of Dept. HHS Sylvia Burwell, dated July 29, 2015.

[vi] Ibid.

[vii] Section 1115A [42 U.S.C. 1315a], "Center for Medicare and Medicaid Innovation Established."

[viii] Dept HHS, CMS 42 CFR Parts 409, 424, and 484. CMS-1625-P. Proposed Rule. Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements.