Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

VIA E-MAIL:
postacutecarereform@mail.house.gov; and
postacutecarereform@finance.senate.gov

August 19, 2013

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

The Honorable Dave Camp
Chairman
Ways and Means Committee
1102 Longworth House Office Building
United States House of Representatives
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
Ways and Means Committee
1106 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

Dear Chairmen Baucus and Camp and Ranking Members Hatch and Levin:

The Partnership for Quality Home Healthcare appreciates the opportunity to provide our views to the Senate Finance and House Ways and Means Committees regarding Medicare post-acute care reform. The Partnership, which was established in 2010 to support government officials in ensuring access to skilled home healthcare services, is a national coalition representing nearly 2,000 community- and hospital-based home healthcare agencies. Partnership members are dedicated to developing innovative reforms to improve the quality, efficiency, and integrity of home healthcare for seniors and disabled Americans.

The Partnership commends the Committees for their focus on improving Medicare post-acute care ("PAC") policy to enhance quality, patient assessment, outcomes and efficiency. We also appreciate the Committees' considerable attention to other PAC-related issues – including program integrity improvement and utilization of appropriate and accurate regulatory analyses. We believe these issues are equally integral to strengthening the Medicare program, preserving beneficiaries' access to the care they need, and achieving billions in taxpayer savings that will help secure the fiscal future of this vital program. As a result, we would like to take this opportunity to comment on these varied but related issues.

Options for Reforming PAC

In the June 19, 2013 letter, the Committees requested "information and ideas on the types of long-term PAC reforms that will help advance the goal of improving patient quality of care and improving care transitions, while rationalizing payment systems and improving program efficiency." In an effort to assist the Committees in their exploration of post-acute care reforms that may better meet the needs of Medicare beneficiaries and taxpayers, the Partnership for Quality Home Healthcare offers the following for your consideration. This vision reflects our perspective that the success of PAC reform will be dependent on its ability to promote system alignment, care coordination, improved outcomes, greater efficiency, enhanced program integrity, and taxpayer savings.

Establishment of Clinical Condition-specific, Site-Neutral, Bundled Payments

The Partnership for Quality Home Healthcare recommends that the Committees examine the creation of a clinical condition-specific, site-neutral, bundled payment model for PAC services. Based on historical local (Hospital Referral Cluster, or HRC) pricing in order to be sensitive to existing practice patterns, this model would utilize site-neutral bundled payments for each specific post-acute clinical condition, include risk adjustors such as for a patient's age and functional status, and incorporate risk corridors.

Although there are numerous ways in which such a model could be structured, we believe that one spanning a 90-day episode may be most stable. Such an episode would begin on the date of a patient's discharge and be contingent on a physician's order for PAC as well as acceptance of the patient's admission for PAC services. Upon initiation, the bundle would be managed by a risk-bearing convener (which could include any of the following: hospitals, insurers, third-party benefits managers, or PAC providers, per below), which would manage patient assignment, care coordination, and provider reimbursement under the bundle.

This model utilizes two mechanisms to ensure its scope is conducive to implementation and sustainability: First, it consists of multiple discrete bundles, each of which targets a specific clinical condition (or "category of service") and includes the relevant site-neutral pricing and benefits coverage to meet the patient's needs without either over- or under-paying the providers who meet those needs. Second, the scope of each clinical condition-specific bundle would be limited to PAC and outpatient physical therapy services related to the care received by the patient in the hospital and would not include index hospital care. Except as noted below, each bundle would exclude physician, hospice, outpatient, and ambulance services.

To reduce avoidable hospital readmissions, this model would also include a readmission penalty, in which the risk borne by PAC conveners and providers would include the cost of readmissions stemming from the care provided under the PAC bundle. As a result, the valuation of each clinical condition-specific bundle would include all PAC and readmission costs. If a patient were readmitted to a hospital under a qualifying readmission, the cost would be paid under the bundle, which would cover post-hospitalization care (if still within the 90 day episode). Further, if a patient is not readmitted to a hospital for treatment stemming from the care provided during the PAC bundle episode, the discharging hospital(s) would be credited.
With respect to reimbursement for PAC services within the bundle, this model would provide for payments to PAC providers using existing fee-for-service ("FFS") codes. In this manner,

implementation of the bundle would foster predictability for providers and not be delayed by the negotiation of new payment arrangements. Due to the critical role that physicians play in managing their patients' post-acute care, payment for PAC-managing physician services would also be made, using either a new Transitional Care Management (TCM) code to be established or by expanding the use of existing TCM codes 99495 and 99494. In either case, payment would be made by the Centers for Medicare & Medicaid Services ("CMS") outside of the bundle, as this service would not have been included in the baseline.

To ensure efficiency, risk and gain would both be assumed and managed by the convener. Each authorized convener would establish a network of outpatient therapy and PAC providers, would manage patient assignment to them, and would oversee CMS' reimbursement of them under the bundle using FFS codes. If the total cost for the care of the assigned patient exceeded the bundle amount, the convener would assume the risk. If, by contrast, the convener's use of such tools as care coordination proved successful in maintaining costs below the bundle's limit, the savings (or gain) would be distributed as follows (with actual shares to be set at the convener's discretion):

- The convener would receive not more than 70% of any shared savings;
- The PAC Provider Network would receive not less than 10% of any shared savings (with the distribution of savings within the network determined at the convener's discretion);
- The PAC-managing physician(s) would receive not less than 10% (in addition to payment under the new or expanded TCM code, per above); and
- The discharging hospital(s) would receive not less than 10% of the shared savings.

Under this "shared-savings-and-risk" model, the convener would also be authorized to use shared savings, prior to distribution, to provide supplemental payments to providers for services or investments that improve the prospects for quality improvement and cost reduction, such as advanced technology, nutrition services, and care coordination services.

As referenced above, this model would utilize conveners to manage such key functions as patient assignment, care coordination, provider reimbursement and gain-sharing under the bundle. As envisioned, the convener could be a hospital, insurer, third-party benefits manager or PAC provider, each of which would be certified as meeting established criteria and governance standards. For example, entities wishing to serve as a convener would have to demonstrate sufficient credit-worthiness and establish an advisory board comprised of PAC provider and patient stakeholders (as per the ACO model) to provide internal oversight.

Further, conveners would be subject to a new safe harbor for PAC, could be safeguarded by a risk corridor to protect them from downside risk deemed by Congress to be excessive, and would be expected to promptly collect pertinent medical information for the patient and make it available to its contracted PAC providers. Finally, conveners would be subject to network adequacy rules requiring them to meet a specified standard for contracting with PAC providers and, if necessary, authorizing them to contract with providers outside the immediate region.
To ensure the delivery of traditional as well as innovative services and supplies under the bundle, the model would authorize participating providers to offer, directly or via contract, services that will contribute to patient care, safety, and readmission avoidance, including but

not limited to: medication management, telehealth technologies, home environment services, transportation services, and durable medical equipment. Similarly, restrictive vestiges of the current PAC 'silos' including eligibility criteria would be lifted and Conditions of Participation would be modified to ensure seamless care criteria for providers and conveners.

Furthermore, to foster the selection of conveners and providers alike on the basis of their quality, efficiency, and customer service, the model would vest in patients the freedom to choose a convener and, thereby, the convener's contracted providers as well as the freedom to choose any provider that is available within the convener's contracted network. Further, each patient's PAC-managing physician would also remain free to choose from among the providers that are available through the convener.

The Center for Medicare & Medicaid Innovations ("CMMI") is evaluating many of these concepts, and their work is valuable in refining various issues regarding timing of the episode, role of the convener, and ensuring access to quality providers. Members of the Partnership participate in these efforts and look forward to providing input to ensure that Medicare beneficiaries receive access to the clinically appropriate and cost-effective care they need.

Assessment Tool

With respect to patient assessment tools and information management, the model would utilize a common patient assessment tool for all providers. A condensed version of the Continuity Assessment Record and Evaluation ("CARE") tool is worth consideration for this purpose, provided it is adjusted from the tested version in order to improve ease of use on the part of providers.

In its assessment of the CARE tool, CMS found that implementation of a single, PAC-specific tool is feasible and has the potential to support a site-neutral payment system across PAC settings. CMS continues to calibrate this tool, as testified to recently by CMS Medicare Office Director Jonathan Blum, and has adjusted the CARE tool for use under the Bundled Payments for Care Improvement ("BPCI") Initiative. For these reasons, the CARE tool may serve as a useful platform from which CMS can finalize and implement a single, PAC-specific assessment tool that is both accessible to the range of providers and comprehensive enough to ensure sufficient data collection, aggregation, and observation.

Improving Quality and Efficiency

As discussed above, a clinical condition-specific, site-neutral bundle incorporates multiple elements designed to improve quality and efficiency. Nevertheless, additional elements may prove effective complements, including a Quality Improvement Program (QIP). Like other similar models already in statute, a PAC QIP could be funded by a withhold and used for performance bonus payments to those conveners meeting the QIP's specified criteria.

On a macro level, this bundled payment model could also incorporate a mechanism to ensure scorable savings and secure system-wide efficiency. Specifically, the model could include a Congressional directive to the Secretary of Health and Human Services that total Medicare PAC payments under the bundle not exceed a specified percentage of baseline spending (defined as

all current Medicare PAC and OPT spending and applicable readmissions). The dialysis bundle utilizes such an 'overall cost control' mechanism (in which total spending under that bundle is statutorily prohibited from exceeding 98 percent of the baseline) and thereby generated a score attributable to two percent of applicable spending.

A similar mechanism could be deployed here which, according to savings projections included in the Alliance for Home Health Quality and Innovation ("AHHQI") *Clinically Appropriate Cost Effective Placement* ("CACEP") study by Dobson | DaVanzo Associates, could result in scorable savings of tens of billions of dollars. Importantly, such savings are secure, since they are achieved prior to the pricing of the clinical condition-specific bundles and are realized without explicit provider cuts, thereby making the model potentially more palatable to policymakers than alternative approaches may be.

We note that some PAC reform proposals have suggested the re-imposition of a home health beneficiary co-payment or other cost-sharing mechanism, ostensibly to promote the efficient use of care. As discussed below, the Partnership agrees with patient groups, Governors, policy experts, and community leaders that a home health copayment, which Congress wisely repealed in 1972, should not re-imposed. Similar concerns relate to establishment of a uniform cost-sharing structure, which could impose substantial cost burdens on the most economically vulnerable Medicare beneficiaries. Additionally, a home health copayment and uniform cost-sharing would equate to a new unfunded mandate on States, since their Medicaid programs would have to cover the cost-sharing for dual-eligibles and Qualified Medicare Beneficiaries (QMBs). Finally, we note the recent decision by the U.S. Department of Veterans Affairs to *eliminate* a copayment for home-based telehealth services due to the obstacle it imposed between patients and the most cost-effective care available. For these reasons, we urge careful consideration about the impact that a copayment or uniform cost-sharing would have on home health beneficiaries as well as on net Medicare and Medicaid program spending.

Finally, while the focus of this response is on improving quality and efficiency in the post-acute care space, many PAC providers play a role in serving patients before they enter a hospital setting. For example, physicians and providers of skilled home healthcare services are often able to prevent costly hospital admissions through services provided within the home and community. We therefore encourage the Committees to consider reforms that improve quality and efficiency in the health care system through the avoidance of institutional admissions, and we look forward to working with the Committees on policy options supportive of this goal.

Implementation

Due to the complexity of any transition between the status quo and a bundled payment system, the Partnership believes a structured implementation process spanning four years has proven effective in transitions such as the initial Inpatient Prospective Payment System ("IPPS") and the dialysis bundle and may be suitable for this purpose, as well.

The Partnership also notes that while implementation of a bundle encompassing the universe of PAC-related DRGs may be the ultimate objective, an incremental approach may be deemed most suitable for a variety of reasons. Should such be the case, the Partnership recommends consideration of a site-neutral bundle model encompassing PAC stays following hospitalization for conditions related to hips and knees. Since MS-DRG 470 (major joint replacement without

major complication or comorbidities) is one of the single most expensive in the Medicare program and most frequently treated in PAC settings, an incremental approach focused on hips and knees may allow policy makers to take an initial step towards broader PAC bundling while still tackling a significant program cost center.

PAC Reform in the Context of SGR Reform

The Partnership would also like to note our support for sustainable growth rate ("SGR") reform, due to the vital role played by physicians in the Medicare program. We also wish to commend Congressional leaders for recognizing the value of payment models that bundle payments for PAC services. For example, current draft legislation would allow physicians to use alternative payment models, such as accountable care organizations ("ACOs") and the Bundled Payments for Care Improvement ("BPCI") Initiative. Home health providers are actively engaged in such alternative payment models, which emphasize coordination of care across providers and are already testing ways in which bundled PAC payments can improve efficiency and quality of care. We encourage Congress to embrace this thoughtful approach to reforming physician payments and to continue its bipartisan support for bundling PAC payments as a means to breaking down provider silos, fostering improvements in care, and achieving Medicare savings.

Program Integrity

We wish to commend the Committees for your longstanding focus on strengthening Medicare program integrity. This is an objective the Partnership believes should be the overarching priority when any Medicare program change is contemplated. Although progress has been made in combatting fraud and abuse, much more work is required so that every beneficiary and taxpayer can be confident that the program they depend on and fund is secure.

The task of eradicating fraud and abuse is aided by considerable evidence that the problem is largely isolated in defined pockets of the country. Indeed, federal data pinpoints where healthcare fraud and abuse is occurring. For example, analysis of MedPAC data show that abusive episode billing practices occur primarily in 25 counties where excessive Medicare utilization is taking place. Further, data show that nearly 90 percent of all improper payments for home healthcare services are occurring in a small number of counties in just five states.

As a result of these data, we firmly believe policy makers should undertake action to address fraud and abuse in a targeted manner. Towards this end, home health leaders developed a comprehensive set of proposals called the Skilled Home Healthcare Integrity and Program Savings (SHHIPS) Act that is as targeted as the problem. As detailed in the letter we submitted to the Finance Committee on June 27, 2012 and summarized in the table below, SHHIPS includes reforms that would prevent the payment of aberrant claims before they are made, improve claims review processes, and strengthen conditions of participation standards.
SHHIPS builds on a successful precedent that was proposed by the home health community and went into effect January 1, 2010. To prevent the payment of aberrant claims, the community proposed a 10 percent limit on Medicare outlier claims. This proposal was adopted as part of the Affordable Care Act (ACA) and has been estimated as saving $853 million in savings in 2010 alone and an estimated $11 billion over 10 years. Just as important, by preventing aberrant

claims from being paid in the first place, this reform successfully replaced the troubled "pay and chase" model with a simple and logical "aberrant payment prevention" mechanism.

SHHIPS Reform Proposals

Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse	• **Prevent entry of individuals with criminal backgrounds:** Require criminal background checks for all employees with direct patient contact or access to patient records. • **Verify competency through improved standards:** Require background screening of owners and managing employees. • **Enforce provider integrity:** Require providers to have a compliance and ethics program to prevent and detect criminal violations. • **Ensure operational capacity to serve beneficiaries:** Require all new providers entering the market to secure a $100,000 surety bond. • **Temporary entry limitations to prevent excess growth:** Suspend issuance of new provider numbers in over-saturated counties.
Payment Integrity Reforms to Ensure Accuracy, Efficiency and Value	• **Prevent payment of aberrant claims:** Limit reimbursement of episodes to an aggregate annual per-provider average based on beneficiary location and establish a minimum annual low-utilization payment adjustment claim rate. • **Ensure accuracy of all claims:** Establish a uniform process to verify the validity of all claims prior to their payment.
Quality Outcomes Improvement	• **Improve care planning for Medicare skilled home healthcare services:** Permit non-physician providers, operating a physician's direct supervision, to complete initial patient assessments and coverage certifications.

While SHHIPS' proposed reforms are presented in the context of the current fee-for-service system, we believe they can be equally constructive for a restructured PAC system because safeguards of the type we recommend for the home health benefit are applicable to other PAC settings, as well. Further, adoption of such protections will help ensure that only qualified entities have the privilege of serving Medicare beneficiaries and that Medicare's resources are expended solely for the payment of valid and appropriate claims. As a result, we would recommend that consideration be given to SHHIPS-style payment, claims review, and conditions of participation reforms as PAC reform is undertaken.

We also urge consideration of program integrity reforms due to the breadth of support that exists for them. The *Fight Fraud First!* Coalition is an important example: a collaborative effort on behalf of seniors, persons with disabilities, military veterans, and other concerned citizens, *Fight Fraud First!* members include AARP, Easter Seals, the National Grange, National Hispanic Coalition on Aging, and the Veterans Health Council, among other leading organizations. The Coalition advocates for the elimination of waste, fraud and abuse rather than the imposition of across-the-board cuts or increased financial burdens on Medicare beneficiaries as a means to reduce federal costs and protect vulnerable beneficiaries.
Similarly, a recent survey by Public Policy Polling of more than 1,100 American seniors who are registered voters found that the vast majority of them think Congress should prioritize program integrity reform over Medicare cuts and beneficiary cost-sharing burdens:

- 93 percent of seniors surveyed think Congress should advance reforms to stop Medicare fraud instead of cutting Medicare funding or charging seniors higher costs.
- 77 percent of seniors approve of Congress doing all it can to combat Medicare fraud as a means to reduce federal spending.

In light of the proven utility of program integrity reform and the breadth of its support, we believe its inclusion in a bundle spanning all PAC services would help attract support for such a model while protecting it from fraud and abuse.

Beneficiary Cost-Sharing and Protections

We also wish to comment on questions posed in your June 19 letter concerning beneficiary cost sharing and needed protections. We share the concern expressed by many Members of Congress, Governors, policy experts, and patient advocates in our and other communities about any re-imposition of cost sharing on Medicare home health beneficiaries.

As you know, the Medicare program originally included a copayment for its home health services. Congress wisely repealed it in 1972, however, because it led to patients being served in more expensive facility-based settings and was found to create "a financial burden to many elderly persons living on marginal incomes."[1]

Today, the imposition of higher costs on Medicare beneficiaries is no more popular than it was when the home health copayment was repealed 40 years ago. Indeed, the aforementioned poll of registered seniors found that:

- 74 percent disapprove of making seniors pay higher fees for healthcare services as a means to cut Medicare spending.
- 86 percent of seniors agree increased out-of-pocket Medicare costs will cause financial strain for low-income seniors.
- 82 percent of seniors would be less likely to support a lawmaker who votes to increase the out-of-pocket costs paid by seniors.

These findings underscore analyses by Avalere Health, which determined that increased-out-of-pocket costs would put significant financial strain on the Medicare home health population, which is poorer, older and sicker than the Medicare beneficiary population as a whole. For example, while nearly 40 percent of all Medicare beneficiaries without supplemental coverage have annual incomes below 200 percent of the Federal Poverty Level (FPL), nearly 75 percent of all Medicare home health beneficiaries do so. It is therefore not surprising that a report by the bipartisan Economic Policy Institute (EPI) found that a large portion of 'economically vulnerable' elderly Americans would be significantly impacted by entitlement changes such as cost sharing. State Governors are also aware of the risks associated with re-imposition of a home health copayment. Due to the Medicare home health beneficiary population's generally low income, a home health copayment would impose higher costs on States, as patients shift to more expensive settings and because their Medicaid programs would have to cover the cost of the copayment for dual-eligibles and Qualified Medicare Beneficiaries (QMBs). In a July 2011 letter

[1] Congressional Record, United States Senate; October 5, 1972

sent to Congress, Georgia Governor Nathan Deal wrote that "a copayment requirement would only serve to shift thousands of low-income seniors out of home-based care into much more costly nursing homes and impose billions of dollars in additional Medicaid costs onto the states." In a letter to the White House, Maryland Governor Martin O'Malley expressed a similar sentiment, stating "imposition of a home healthcare copayment could seriously impact frail seniors and actually result in increased Medicare and Medicaid costs."

In light of these factors, we urge consideration within the context of PAC reform of program integrity reforms in lieu of beneficiary costs as the most appropriate means for preventing abusive behavior without burdening vulnerable beneficiaries.

Notwithstanding the above, if uniform cost sharing of any kind is pursued, we would appeal for protections for low-income beneficiaries. No one size fits all, and that truism is certainly applicable to Medicare beneficiaries, who range from some of America's most affluent citizens to some of its poorest. As a result, an income-sensitive model exempting all beneficiaries under 200 percent of FPL would be vital if Congress were to pursue what we believe would be counterproductive policy because it would protect low-income beneficiaries and State Medicaid programs. Similarly, coverage for the bad debt that home health agencies will inevitably incur, due to the low income of many beneficiaries, would be essential and would ensure equity, since other PAC settings receive bad debt coverage but no such safeguard exists for home health.

Home Health Economics

Before closing, we wish to respectfully address what we believe to be the impartial picture of home health economics presented in your June 19 letter. Specifically, Table 1 presents MedPAC's estimate (using 2011 data) that the Medicare margin for home health agencies is 14.8 percent this year. However, that estimate has been questioned due to several key factors:

- The calculation of home health agency costs is incomplete, in that it excludes costs that HHAs routinely bear (such as Telehealth, marketing and bad debt) and that HHAs are compelled to bear (such as the cost of complying with regulations issued since 2011, and the payment of local, state and federal taxes, where applicable.) Indeed, an Avalere Health analysis of the financial statements that publicly-traded home health operators file with the Securities and Exchange Commission (SEC) – which must be independently audited and accurate – found that such companies had actual margins in 2012 of just 2.8 percent, despite their size, sophistication and economies of scale.
- The calculation excludes hospital-based home health agencies, even though they constitute more than 1-in-10 of all HHAs nationally. According to the National Association of Home Care and Hospice, including hospital-based agencies in the calculation of sector margins – as is done in the case of other sectors – would reduce MedPAC's estimate by approximately 2.5 percentage points.
- The calculation does not account for reimbursement cuts already in current law, such as sequestration and the implementation of annual productivity adjustments beginning in 2015, let alone the impact that proposed changes to the Home Health Prospective Payment System ("HHPPS") would have on the home healthcare delivery system.

According to an analysis by Avalere Health and Dobson DaVanzo Associates, Medicare funding for home health has already been reduced by an estimated $72.51 billion between 2011-2010, and the proposed HHPPS changes will remove an additional $21.98 billion over the same period for an unprecedented $94.49 billion in total cuts. These cuts are projected to drive Medicare home health margins to negative territory in nearly every state, placing patient access to home health in real jeopardy.

- Finally, the estimate presents only a partial picture of the home health sector's financial sustainability. Like most health sectors, Medicaid payments for home health services are lower than Medicare reimbursement. Unlike most sectors, however, private insurer payments are also typically lower than Medicare. As a result, HHAs' actual margins are lower than a Medicare-only estimate would suggest, and negative (or near-negative) Medicare margins cannot be offset via cross-subsidization from other payers.

That said, we would be remiss if we did not note one aspect of Table 1 which, despite the mechanical issues noted above, is indeed accurate: as shown below, the cost per beneficiary of care provided by home health agencies is substantially lower than in other settings. Again, we respectfully submit that Table 1 presents an impartial picture, but its depiction of cost-effectiveness is accurate and has been extensively documented.

Cost Per Beneficiary in PAC Setting

PAC Setting	Annual Medicare Expenditures	Annual Medicare Beneficiaries	Average Cost Per Beneficiary (est.)
Home Health	$18.4 billion	3.4 million	$5,500
SNF	$31.3 billion	1.7 million	$18,500
IRF	$6.5 billion	371,000	$17,500
LTCH	$5.4 billion	123,000	$44,000

Conclusion

On behalf of the Partnership for Quality Home Healthcare, thank you for your consideration of our perspective on the critical issues articulated in your June 19, 2013 letter. We look forward to working with you as you develop post-acute care reforms that strengthen the Medicare program and better serve beneficiaries across the country.

Sincerely,

Eric S. Berger
CEO, Partnership for Quality Home Healthcare