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August 25, 2016

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1648-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements; CMS-1648-P

Dear Acting Administrator Slavitt:

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP appreciates the opportunity to comment on the Medicare home health proposed rule for CY 2017. Our comments focus on beneficiary access to home health care, the Home Health Value-Based Purchasing (HHVBP) Model, proposed quality measures, and our recommendations to include additional measures to better assess person-and family-centered care and support family caregivers.

Medicare Beneficiary Access to Home Health Care

In its proposed rule, the Centers for Medicare & Medicaid Services (CMS) notes a number of potentially disturbing trends in use of Medicare home health services:

- preliminary analysis of 2015 claims shows a 1.7 percent decrease in the number of episodes following a 3.8 percent reduction in 2014;

- the number of home health users fell 0.5 percent following a 2.95 percent decline in 2014;
- the portion of fee-for-service beneficiaries using home health services has declined from 9.2 percent in 2011 to 8.7 percent in 2015; and
- the number of home health agencies billing Medicare dropped by 2.7 percent following a 1.6 percent decrease in 2014.

Whether these trends may be attributed to rebasing Medicare payments or other reasons remains to be seen. We note that the Medicare Payment Advisory Commission (MedPAC) has reported a steady decline in Medicare spending for home health services since 2010 even before the start of rebasing payments in 2014 (MedPAC Data Book 2016; Chart 8-8).

We are concerned that these declines suggest that beneficiaries may be experiencing difficulty in accessing Medicare home health services. We urge CMS to continue to monitor the potential impact of rebasing and other payment adjustments on Medicare home health services and to take appropriate action as may be necessary to maintain beneficiary access to and utilization of these important services. Finally, we also urge CMS to ensure that unnecessary documentation requirements do not impede beneficiary access to necessary home health services.

Home Health Value-Based Purchasing (HHVBP) Model

As CMS continues to move forward with implementation of a Medicare HHVBP Model with all Medicare-certified home health agencies in nine states participating, it will be essential for CMS to closely monitor Medicare beneficiary access to home health care and ensure that beneficiaries receive necessary and appropriate care. We are concerned that HHVBP could reduce access to home health care for some beneficiaries, either because home health agencies (HHAs) leave the market and there is not sufficient supply, or because HHAs avoid beneficiaries whom they think will reduce their performance scores. Monitoring access will be important to determine whether Medicare beneficiaries experience problems with access, and then if they do, how to address this issue within the HHVBP Model to ensure beneficiaries receive the services they need. Surveys of Medicare beneficiaries may be one way to help measure access and ensure pro-active monitoring. We also note that low-performing agencies may close and possibly reopen at a later date. CMS should consider how this may impact care and HHVBP.

Quality Measures. CMS proposes some modifications to the proposed measure set for the HHVBP Model. We commend CMS for proposing measures from the Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS) that provides insights on the beneficiary experience of care, an important part of quality measurement. We are also pleased that CMS is considering various public reporting platforms for the HHVBP Model, as public reporting of quality measures and data can help individuals and their family caregivers make more informed decisions when choosing an HHA.

In addition, AARP recommends that CMS include two measures in the HHVBP Model related to HHAs' work with and support of family caregivers, who are often providing care to their loved ones at home. About 40 million family caregivers provide unpaid care valued at about $470 billion annually to adults who need help with daily activities, such as eating, bathing, dressing, transportation, managing medications, and wound care. Family caregivers help their loved ones live independently in their homes and communities, delaying and preventing more costly institutional care and unnecessary hospitalizations, and saving taxpayer dollars. Specifically, AARP recommends a measure regarding home health agencies documenting whether the beneficiary has a family caregiver, whether the care or discharge plan relies on the family caregiver to provide assistance, and, if so, whether the family caregiver was provided supports they need as part of the plan after determining a need for such supports. In addition, we recommend a measure of family caregiver experience of care, where applicable.

Quality Measures in the Home Health Care Quality Reporting Program (HH QRP)

For CY 2018, CMS proposes to adopt four new measures for the HH QRP. As one of these measures, CMS proposes to assess the facility level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare fee-for-service (FFS) beneficiaries that take place within 30 days of a home health discharge.

AARP is pleased that CMS proposes to hold HHAs accountable for the quality of care delivered to beneficiaries throughout their use of home health care and for 30 days following discharge, at least in the case of the preventable readmission measure.

However, we have concerns about the use of readmission measures for HHAs, as well as hospitals. The sickest individuals are most likely to be readmitted, but they are also the most likely to die. Persons who die cannot be readmitted and are excluded from the readmission measure. Therefore, hospitals and HHAs with excessive mortality rates may have lower readmission rates. We are concerned that HHA readmission measures could create incentives for HHAs to delay necessary and appropriate hospital care to avoid including readmissions in their performance scores. We note that readmission measures only count inpatient admissions, not emergency room (ER) visits. Thus, we suggest including ER visits, as well as inpatient readmissions, in the measure. We acknowledge there is an existing quality measure for ER visits without hospital readmission during the first 30 days of home health. However, beneficiaries and their family caregivers may more easily understand having one readmissions measure that captures all hospital visits – including unplanned inpatient and ER visits – throughout their use of home health and for 30 days following discharge.

We support the required Discharge to Community measure in the HH QRP, as most older adults want to live independently in their homes and communities. However, like the readmission measure, we suggest that the discharge to community measure include ER visits. As CMS will already be collecting all the data necessary to compute this, adding ER visits would not impose an administrative burden on HHAs or hospitals.

Finally, AARP commends CMS for proposing a new quality measure for payments beginning in CY 2018 to address medication reconciliation as called for under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. AARP strongly supports efforts to minimize preventable medication-related problems and encourage appropriate prescribing, monitoring, and safe use of medications. The proposed quality measure would assess whether post-acute care providers were responsive to potential or actual clinically significant medication issues when such issues were identified. As noted in the proposal, this would include a drug regimen review to identify drug discrepancies that may lead to adverse drug events, which can occur during transfers from acute care facilities to post-acute care providers and lead to unnecessary health care utilization and costs.

HH QRP: Quality Measures and Measure Concepts under Consideration for Future Years

CMS solicits comments on the proposed quality measures for future years in the HH QRP. CMS is developing a measure related to the IMPACT Act domain, accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual when the individual transitions. This is an important domain that recognizes the vital role of the individual, family caregiver, and providers in caring for the individual and communicating and sharing information among all these parties, including around care transitions. It also acknowledges the importance of knowing and communicating an individual's care preferences among all the parties, so they can be respected and acted upon. This domain provides an opportunity to measure person-and family-centered care provided by HHAs and at care transitions, as well as the coordination, communication, and team approach needed to effectively provide this care. It is hard to capture this domain in a single measure, unless it is a composite measure made up of multiple measures.

AARP appreciates and supports the idea of adding quality measures that include consumer reported experience of care. The proposed four measures focusing on function that rely on data reported by the consumer may be helpful. In addition, AARP suggests that CMS include experience of care data from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Surveys that examine beneficiary experience of care. These are important data that would provide insights into whether consumer care preferences were respected.

Person-and family-centered care is at the heart of this domain. Very often, smooth care transitions and successful discharge planning depends on the active involvement of family caregivers (defined broadly) who voluntarily provide support and assistance to their loved ones before, during, and after discharge. Once home, the family caregiver may be implementing a discharge plan or care plan so that the individual does not return to a skilled nursing facility or to a hospital unnecessarily.

The assistance provided by family caregivers can also be complicated and demanding. In a national survey conducted by the AARP Public Policy Institute and the United Hospital Fund, almost half (46 percent) of family caregivers reported performing medical and nursing tasks for care recipients with multiple chronic physical and cognitive conditions.[1] These tasks include managing multiple medications, providing wound care, preparing food for special diets, using monitors, and operating specialized medical equipment. These tasks were in addition to the assistance they were already providing with bathing, dressing, eating, and other household tasks. Most caregivers said that they received little or no training to perform these medical and nursing tasks.
CMS recognized the important role that family caregivers play in discharge planning in last year's proposed rules revising the requirements for long-term care facilities (skilled nursing facilities and nursing facilities) to participate in Medicare and Medicaid (CMS-3260-P) and discharge planning requirements for hospitals, critical access hospitals, and home health agencies to participate in Medicare and Medicaid (CMS-3317-P). Both proposed rules require consideration of caregiver/support person availability and capability to perform required care. Given the important role family caregivers play in care transitions and the need to support them to help ensure quality outcomes and prevent unnecessary and costly care, AARP strongly urges CMS to include a quality measure or measures in this domain that measure:

- How often the HHA has clearly documented in the discharge summary and plan if the individual has a family caregiver(s) and their contact information (with the consent of the individual and family caregiver(s));
- How often this information is appropriately communicated to other providers of services furnishing items and services to the individual;
- How often the HHA has clearly documented if the family caregiver will be available to provide assistance to the individual under the care/discharge plan or post-discharge;
- How often prior to discharge the family caregiver was provided with or referred to supports they need to carry out their responsibilities post-discharge, including training to perform tasks that are part of the care/discharge plan (after determining a need for such supports prior to discharge); and
- Whether the HHA is willing to provide alternative times to meet to discuss the discharge plan with the individual and the family caregiver(s).

We note services provided by family caregivers should only be included in the discharge plan if family caregivers have agreed to provide these services and have indicated their ability to carry out the actual tasks. In addition, family caregivers can also be vital to ensuring that the individual's care preferences are communicated and carried out. This is yet another reason they are critical to this domain of care and why there should be a measure(s) regarding HHA interaction with and support of family caregivers.

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[1] [1] S. Reinhard., C. Levine, & S. Samis, *Home Alone: Family Caregivers Providing Complex Chronic Care* 1 (AARP PPI and United Hospital Fund, 2012), *available at* http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf.

AARP appreciates the opportunity comment on this proposed rule and important quality measures. We urge CMS to address the concerns we raise and include our recommendations in the final rule to improve the quality of care and help ensure person- and family-centered care. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Affairs