

September 25, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building 200
Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

CMS 1672-P: Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements; July 25, 2017.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 900 hospital-based home health (HH) agencies, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2018 proposed rule for the HH prospective payment system (PPS), which includes the proposal to redesign the system in CY 2019. This letter addresses our concerns about this new model as well as proposed quality reporting changes.

PROPOSED REDESIGN OF THE HH PPS

The AHA appreciates the effort by CMS to develop an alternative to the current HH case-mix system. We recognize that the current system has been widely criticized by policymakers for, among other issues, incentivizing overutilization of therapy services. **We support the broad goals for the alternative system, known as the home health groupings model (HHGM), and appreciate that it would improve payment accuracy for hospital-based HH agencies.** However, we urge CMS to address key issues with the model prior to finalizing any policy. **When this has occurred, the agency should share its mature proposal and comprehensive implementation plan with stakeholders through a future, separate notice of proposed rulemaking, rather than finalizing the current, incomplete proposal. In summary, given the scope of concerns with the current iteration of the HHGM proposal, it would be inappropriate for CMS to finalize this proposal in the CY 2018 final rule.**



The HHGM, with its five key payment elements and shorter episode length of 30 rather than 60 days, is far more complex than the current HH PPS. The intent of the new approach, which CMS proposes to implement in CY 2019, is to increase payment accuracy by basing payment on a more comprehensive assessment of patients' characteristics. We support this goal, which would, at least in part, address the substantially negative Medicare margins for hospital-based HH agencies.

However, the HHGM represents a transformational change from the current HH payment system. Our members report that the scope of the change combined with their inability to replicate the model, render them unable to assess the potential impact of the HHGM on their organizations. Further, they found that the calculator provided by CMS to help individual providers estimate the impact of the HHGM was unworkable. This has left the AHA and our members with no method to meaningfully assess impact at the provider level, greatly hindering our ability to provide meaningful comments. As such, our comments focus on the areas that clearly require further development and communication by CMS in order to enable the field to conduct a meaningful and comprehensive assessment of a fully fleshed out model. Specifically, we urge CMS to first address the outstanding implementation issues, in collaboration with stakeholders, to:

- Ensure that if the model is implemented, it is done so in a budget-neutral manner;
- Use the most up-to-date data possible as the foundation for the model;
- Communicate additional information on the construction of the model and its impacts, such as on high-acuity patients; and
- Develop and set forth comprehensive implementation and transition plans.

CMS lacks the authority to implement the HHGM reform in a non-budget neutral manner. CMS's HHGM proposal would implement a material payment cut relative to CY 2018 payment levels. Specifically, the rule estimates that the HHGM model, in combination with a 30-day episode, would reduce payments by 4.3 percent (\$950 million) in CY 2019 if it is implemented without transition assistance. We are concerned that, when CMS asserts that it has the authority to implement HHGM in this manner, the agency overlooked congressional intent. Congress has been very specific in its instructions and authorization of permanent provider payment reductions. We point specifically to the two occasions Congress took explicit action to authorize significant, permanent reforms and reduction:

- 1) The Balanced Budget Act of 1997 mandate for the transition from TEFRA reasonable cost payment to the current prospective payment system; and
- 2) The rebasing of the HH PPS – a substantial 15 percent payment cut – authorized by the Affordable Care Act (ACA).

We note that Congress also has explicitly authorized other payment changes to the HH PPS, including annual market-basket increases, adjustments for case-mix changes, an adjustment for not submitting quality data, a productivity adjustment and an outlier adjustment.

This history of substantial HH payment guidance from Congress, together with the lack of any congressional direction for CMS to proceed with a major HH PPS reform in a non-

budget neutral manner, suggests that – notwithstanding the substantial concerns we have with the proposal’s current lack of readiness – any effort by CMS to propose a future, mature iteration of the HHGM must be pursued in a budget-neutral manner.

HHGM’s underlying data are dated. We are concerned that the HHGM was built using older data from CY 2013, which raise questions about the ability of the model to accurately and reliably project current costs. Specifically, the HHGM’s use of 2013 claims data does not account for the 15 percent rebasing reduction to the HH PPS, which occurred in annual installments from CY 2014 through 2017. Further, our members report that the impact of alternative payments models (APMs) is raising the average medical complexity of their HH patients beyond 2013 levels. As noted, the payment accuracy of this model is paramount to ensuring access to care for all patients requiring HH services, especially for patients with high-resource needs. As such, we encourage CMS to use the most up-to-date data to improve the cost estimates that are the foundation of the payment system and to ensure a mechanism to assess and adjust for changing trends in the future. Moreover, we urge CMS to share such an update, including fiscal impact estimates, with the field for replication and comment.

Lack of information about access to care for higher-acuity patients. Given the role played by hospital-based HH agencies in treating higher-acuity patients, a top concern of the AHA is the ability of the HHGM to correctly estimate the resource needs of medically complex patients. While the technical report CMS issued prior to the proposed rule indicates that the HHGM would improve payment accuracy for cases with higher clinical acuity, it does so only at a high level and falls short of explaining how, in practice, patient access to care would be affected. Given the importance of ensuring access for this population, we urge CMS to discuss in greater detail how beneficiaries’ access to care under the HHGM would be protected for each of the key elements of care: nursing, therapy, non-therapy ancillary and other services.

We also ask CMS to provide far greater detail about the appeals process that will be available to help patients address any shortcomings in their care and/or coverage. In addition, providers also should be able to appeal any inaccurate assignments to payment classifications.

Lack of details on HHGM’s behavior assumptions. A footnote in the proposed rule’s Table 55 refers to the model’s “assumptions on behavioral responses.” However, the agency provides no further discussion of these assumptions. We urge CMS to provide detailed specifications of these assumptions, describe why and how they were applied to the model, and discuss how they affect HHGM payments and impact estimates.

The use of these behavioral adjustments raises concerns due to the significantly inaccurate adjustments made when the HH PPS was implemented in 2000. In that case, the Congressional Budget Office (CBO) used behavioral assumptions and other factors to estimate that HH PPS implementation would reduce Medicare spending on home health services by \$49.6 billion from 1998 through 2007, but the actual reduction for that period was far greater – \$210.4 billion. This differential was caused by the field’s behavioral response that was underestimated by CBO – the result was the closure of approximately 2,000 home health agencies, which led to 500,000 fewer HH users in 2007 compared to 1997. Given the precedent of this highly inaccurate behavioral

adjustment, we call on the agency to fully explain its rationale and methodology for the proposed HHGM adjustment.

Proposed transition to a 30-day episode. Based on language in the proposed rule, it appears that CMS plans to maintain 60-day timeframes for the patient plan of care, physician certification of patient eligibility for HH services, and Outcome and Assessment Information Set (OASIS) patient assessments. However, the agency does not describe how these timeframes would be integrated with the new 30-day episode proposed as part of the transition to the HHGM case-mix methodology. We are concerned that these misaligned timeframes would create additional administrative burdens and confusion for patients and providers alike. As such, we urge the agency to provide greater information on how it envisions these protocols being tied together in a cohesive manner.

In addition, as CMS works on the next iteration of the HHGM, we ask the agency to account for all 30-day episodes and, if the agency is unable to use every 30-day episode in its modeling, to identify all exclusions from the model and impact estimate calculations. Based on a Dobson-DaVanzo evaluation of the rule's Table 24, it appears that approximately 15 percent of current cases were *not* captured in the HHGM due to CMS's methodology of converting 60-day episodes to 30-day episodes. This methodology, in addition to shortening the duration of an episode, altered other episode parameters, which resulted in the exclusion of a material portion of episodes – a step that was not explained in the rule. It is imperative that the next iteration of the HHGM and impact analyses include all 30-day episodes to avoid an incorrect impact estimate. In other words, moving forward, HHGM impact analysis should use all episode to capture the total HH PPS revenue from the current system. Further, the agency's estimate of administrative burden should account for increases in billing activities for the full set of 30-day episodes.

Lack of technical expert panels (TEP) during HHGM development. As it continues to develop the HHGM, it would be useful for CMS to borrow a key strategy from the agency's recent policy development protocol used to redesign the skilled nursing facility (SNF) PPS, which involved five years of analysis by a contractor and three stakeholder TEPs, in which AHA participated. While the SNF TEPs were not, on their own, able to achieve the full degree of transparency and collaboration sought by the field, they were a very worthwhile investment by CMS. The TEPs allowed CMS to discuss in depth with stakeholders key design elements of the model prior to presenting the policy to the field for comment. We were encouraged that input from the TEPs led to meaningful consideration and influenced decision-making on key elements of the model. Another key distinction between this SNF policy-making process and CMS's approach in this proposed rule is that following the lengthy SNF development process and TEPs, CMS chose as its next step an advanced notice of rule-making (ANPRM) to announce its intent to, *in the future*, propose a new model for SNF payment. This SNF ANRPM stands in stark contrast to the HHGM proposal, which lacks TEP input, is incomplete and represents a premature step by CMS. Moving forward, as the agency works to address the gaps in the current iteration of the HHGM, we call on CMS to incorporate several TEPs in its policy development plan, in order to collect and optimize guidance from the field prior to presenting the next iteration of the HHGM to the field for another round of public comment.

Develop a comprehensive implementation plan. The proposed rule focuses on providing a technical description of the model's design but includes little detail on how it and the many inter-related regulations, would be operationalized and overseen. CMS bears the responsibility to go beyond simply building the new model to also set forth a comprehensive implementation plan to enable a transparent evaluation by stakeholders. Such a plan also should address the practical challenges providers would face in implementing a new payment system. For example, the HHGM model would be a dramatic shift away from payments being primarily determined by therapy volume. In practical terms, the new model would change therapy to a cost center – which would represent a major paradigm shift for the field and has the potential to reduce patients' access to medically necessary therapy.

On a related note, we recognize that HHGM's greater linkage of payments and patient characteristics aligns with the direction of other post-acute care payment reforms, such as the Improving Medicare Post-Acute Care Transformation (IMPACT) Act-mandated, in-development post-acute care PPS, and the broader movement to APMs, such as bundled payment. However, we note that, thus far, CMS has not shared how the proposed implementation of HHGM fits with these broader payment reform initiatives. Thus, we also ask the agency to explain how HHGM would fit with these concurrent policy development and reform efforts.

Develop a comprehensive transition plan. We are concerned about potential transition difficulties for hospital-based HH agencies if the new system is quickly implemented, given the relatively small size of their operations and correspondingly fewer resources to support a complex payment system transition. Specifically, agencies will need to ensure that they have the technology infrastructure and vendor support necessary for a successful transition to a new payment model. Experiences in acute care hospitals highlight the substantial amount of time needed to proactively ensure timely, comprehensive and reliable communication with providers and technology vendors about finalized measurement and reporting protocols. Specifically, providers need time to:

- ensure vendor readiness;
- adequately train staff;
- optimize workflows;
- update related systems; and
- account for other processes needed for successful change management.

As such, we urge CMS to explain in detail how it would provide proactive education and assistance to patients, providers, payment contractors and IT vendors to help manage this transformative change. We also note that this transition would raise the need for ICD-10-CM coding due to the elevated importance of diagnostic information under the new model, and likely the need for some HH agencies to, for the first time, hire certified coders.

HH QUALITY REPORTING PROGRAM (QRP)

The Deficit Reduction Act of 2005 required CMS to establish a program under which HH agencies must report data on the quality of care delivered in order to receive the full annual update to the HH PPS payment rate. Since CY 2007, HH agencies failing to report the data have incurred a reduction in their annual payment update factor of 2.0 percentage points.

For the CY 2020 HH QRP, CMS proposes the replacement of one measure, the addition of two new measures, and the removal of several data elements from OASIS. In addition, CMS also would require HH agencies to collect certain standardized patient assessment data for admissions and discharges beginning Jan. 1, 2019 to meet requirements of the IMPACT Act of 2014.

While the AHA appreciates that the proposed measures are intended to address significant patient health outcomes, all three new measures need significant improvement before they would be suitable for use in the HH QRP. Furthermore, CMS’s proposal to report standardized patient assessment data is too much, too soon, and we believe the data elements require further testing prior to implementation. Therefore, we urge CMS to delay its proposal to report standardized patient assessment data.

CY 2020 MEASUREMENT PROPOSALS

Changes in skin integrity post-acute care: Pressure ulcer/injury. **The AHA urges CMS not to adopt this measure for the HH QRP until it has conducted further testing around the inclusion of unstageable pressure ulcers and deep tissue injuries (DTIs) in the measure calculation.** The HH QRP already includes a measure examining the percentage of patients that have new or worsened pressure ulcers. Yet CMS would replace this measure with one that asks HHAs to capture data on both “stageable” pressure ulcers (i.e., those that can be assigned a numerical score of 1 to 4), and unstageable pressure ulcers, including DTIs, assessing which ones at each stage are unhealed. CMS suggests this change is appropriate because it would capture a fuller range of skin integrity issues. CMS further posits that this measure would help the agency meet its IMPACT Act mandate to implement “interoperable measures” across post-acute settings because this same measure is proposed for other post-acute settings.

However, the AHA is concerned that the definition of pressure ulcers included in the measure may be too subjective to collect reliable, accurate measure data across HHAs and other post-acute care providers. As a result, the measure could provide misleading portrayals of HH performance. As CMS admits in the proposed rule, there are few studies that provide information regarding the incidence of unstageable ulcers in post-acute care settings. In addition, there is no universally accepted definition for DTIs; in fact, studies have shown that a significant proportion of DTIs are initially misdiagnosed as stage 1 ulcers or other dermatological diagnoses with similar symptoms that are not intended to be captured by this measure. As a result, the measure may be subject to surveillance bias in which providers have higher rates of DTIs because their surveillance systems are more sensitive to capturing them.

Furthermore, the AHA is concerned that the measure change would result in artificial distinctions between HH agencies that are attributed solely to the way injuries are counted,

not in the quality of care provided. CMS believes one of the benefits of implementing this revised measure is that it would increase the variation in measure scores across providers, “thereby improving the ability to discriminate among poor- and high-performing HHAs.” However, the purpose of changing a measure is not to create performance variation. It is especially troubling when one considers that this increased variation may not stem from differences in quality, but rather from differences in the interpretation of the definitions and differences in the rigor in counting. Any measure changes should be rooted in evidence that specifications are inconsistent with current science, or that specifications need further clarity to ensure consistent data collection across providers.

Thus, the AHA strongly urges CMS to undertake additional testing of the measure to ensure it consistently collects accurate data. We believe this testing should assess whether the measure is subject to surveillance bias and other unintended consequences that could affect how HH performance is reported.

The AHA also urges CMS to make substantive plans around the promised “additional training opportunities and educational materials” prior to implementation. CMS proposes significant changes to the measure data collection approach. Rather than assessing the number of new or worsened pressure ulcers at each stage (as in the current measure), CMS would ask HH agencies to count the number of unhealed pressure ulcers at each stage and subtract the number present upon admission. We believe excluding those pressure ulcers that are present on admission is an appropriate improvement to the measure, but it adds complexity in coding that will be essential to explain to HH agencies. Furthermore, HH performance on the revised measure is likely to look quite different from the current measure. Thus, CMS should prepare consumer-facing educational materials explaining why HH performance is different.

Application of percent of long-term hospital patients with an admission and discharge functional assessment and a care plan that addresses function. In order to fulfill the IMPACT Act requirement to address the domain of “functional status, cognitive function, and changes in function and cognitive function,” CMS proposes to adopt this measure for the HH QRP beginning with the CY 2020 program year. This process measure reports the percentage of patients with an admission and discharge functional assessment and treatment goal that addresses function.

The AHA understands that CMS is statutorily required to address the functional status domain of the IMPACT Act and realizes that this measure already has been implemented in the other post-acute care settings. However, **we urge CMS to pursue National Quality Forum (NQF) endorsement of this measure for the HH setting prior to implementing it in the HH QRP.** In addition, we believe that the items associated with the new measure are duplicative of those already required for collection by HH agencies. CMS contends “the current OASIS function items evaluate current ability, whereas the proposed functional items would evaluate an individual’s usual performance at the time of admission and at the time of discharge for goal setting purposes.” This distinction is tenuous at best; further, it is unclear how the proposed functional status items provide better or more complete patient information than the current items do, and how collection of both sets of data would result in a more meaningful assessment of patient status. Thus, **we urge**

CMS to require the reporting of only one of these sets of data so as to reduce burden and superfluous data collection.

Percent of residents experiencing one or more falls with major injury. The IMPACT Act also requires that quality measures address the domain of “incidence of major falls, including falls with major injury.” To meet this requirement, CMS proposes to adopt the measure “Application of Percent of Residents Experiencing One or More Falls with Major Injury,” for which HH agencies would be required to begin submitted data on Jan. 1, 2019. While this measure has been in place in the SNF setting since 2011, it is not endorsed by NQF for the HH setting. As with the previous measure, **we encourage CMS to pursue NQF endorsement of this measure for the HH setting prior to implementation in the HH QRP.**

In addition, several stakeholders, including the NQF’s Measure Applications Partnership (MAP), raised concerns about attributing falls to particular providers, as well as the difficulty of collecting data on falls given that HH clinicians are not present with the patient at all times. CMS has suggested stratifying the measure rates by referral origin when publicly reporting this measure’s data. But, we are skeptical that all HH agencies will have sufficient volumes to have their rates stratified, and do not believe that stratification alone is sufficient to ensure a fair and accurate comparison of HH agency performance.

HH agencies are evaluated on a falls measure, “Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate.” This is a process measure that assesses a HH agency’s efforts to determine the risk of and mitigate falls in the home. Because a HH agency clinician is not present with the patient at all times the way a SNF clinician is, the extent of a HH agency’s ability to prevent falls is limited. HH agencies should absolutely be held accountable for preventing falls when a clinician is present, and for doing all that the HH agency can to prevent falls when a clinician is absent. However, subjecting HH agencies to the same standards as those for post-acute facilities is inherently unfair. **Thus, we encourage CMS to develop a rigorous risk-adjustment methodology to account for the fundamental differences in settings prior to adoption of this measure.**

Removal of data elements from OASIS. CMS proposes to remove 247 data elements from 35 OASIS items collected at various points during the episode of care, as the agency notes that these elements are not being used to calculate quality scores or aspects of care planning. **We support the removal of data elements that do not contribute to high-quality patient care, and appreciate CMS’s efforts to reduce unnecessary data collection.**

STANDARDIZED PATIENT ASSESSMENT DATA REPORTING

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. The reporting of these data is a requirement of the post-acute quality reporting programs; as a result, failure to comply with the requirements would result in a 2.0 percentage payment reduction. In an attempt to facilitate data sharing and comparisons across post-acute settings, CMS proposes to introduce the required

reporting of standardized data elements into each setting's respective assessment tools; for the HH setting, this would entail the addition of several new data elements to OASIS. Specifically, the agency would require HH agencies to collect data on functional status, cognitive function, medical conditions, impairments, and several types of special treatments and services. While post-acute providers would fulfill the FY 2019 requirement by reporting data elements already implemented in the various quality reporting programs (namely, those used to calculate the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened, Short Stay), HH agencies would be required to report data based on several new elements starting on Jan. 1, 2019.

As we commented on the proposals for the other post-acute care settings, the AHA believes the implementation of these data elements is too much, too soon; a full discussion of our concerns can be found in our [comment letter](#) regarding the FY 2018 inpatient rehabilitation facility proposed rule. The AHA encourages CMS to adopt the same final provisions for the home health setting as were finalized in the skilled nursing, inpatient rehab and long-term care hospital settings: to require reporting only for the domains of functional status and medical conditions/comorbidities.

HH VALUE-BASED PURCHASING (VBP) PROGRAM PROPOSALS

Invoking its authority under the ACA to test payment models intended to improve quality and/or reduce cost, CMS launched a HH VBP program on Jan. 1, 2016. Participation in the HH VBP program is mandatory for all CMS-certified HH agencies in nine states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington. HH agencies in these states are subject to maximum upward and downward payment adjustments of 3 to 8 percent based on performance on selected measures. The scoring approach recognizes HH agencies for both their level of achievement versus benchmarks, as well as improvement over their own baseline performance. The program will adjust payments to the affected HH agencies in CYs 2018 through 2022.

The AHA continues to support the concept of a HH VBP program. We agree that a mix of public quality reporting and pay-for-performance measures can align the health care delivery system – including HH providers – toward continuous quality improvement, and reward providers for excellence. We also support the changes proposed for the HH VBP in this proposed rule.

However, we continue to be concerned by the level of payment at risk under the program. The AHA believes placing up to 8 percent of HH agency payment at risk for performance is too much, especially in light of the significant Medicare payment reductions HH agencies have endured in recent years. The AHA is especially troubled by the potential impact of the large payment adjustments on hospital-based HH agencies, whose average Medicare margins were negative 22.4 percent in 2014. Thus, we urge CMS to monitor the performance of HH agencies under the model, and to consult with the HH field about whether the payment risk under the model is affecting access to HH services. To the extent the model is driving adverse effects on HH care access, the agency should consider either lowering the amount of payment at risk or suspending the model altogether.

Minimum number of completed Home Health Care Consumer Assessment of Healthcare Providers and System (HHCAPHS) surveys. The AHA supports **increasing minimum sample sizes to calculate HHCAPHS measures and agrees with CMS’s reasoning behind this change.**

Currently, HH agencies need to have at least 20 episodes of care resulting in an HHCAPHS survey during a performance year to generate a performance score based on these surveys for at least five measures. CMS proposes to increase this minimum number of surveys from 20 to 40 in order to better align the HH VBP model with the HHCAPHS policy for the Patient Survey Star Ratings on the *Home Health Compare* website (which requires a minimum of 40 surveys to generate ratings). In addition, CMS believes that using more surveys to calculate measures would result in meaningful and less random variations in measure performance.

However, the AHA would like to see additional documentation of CMS’s analysis of the effects of changing the sample size on performance scores. In the proposed rule, CMS explains that in its limited analysis (i.e., the data used did not cover the full 2016 calendar year), the average change in statewide total performance scores for larger-volume HH agencies could be between -0.4 and +2.2 percent, depending on the state. Considering the level of payment at risk under this program, it is important that HH agencies have a clear understanding of the impact this change might have. CMS notes that a comparison of scores using the current minimum of 20 surveys and the proposed new minimum of 40 surveys was available in the August 2017 Annual Total Performance Score and Payment Adjustment reports; **the AHA urges CMS to provide a clear and separate announcement regarding the change in survey minimum, how to interpret changes in total performance scores, and how to engage in the appeals process, if this provision is finalized.**

Removal of drug education measure. CMS proposes to remove the OASIS-based quality measure, Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care. CMS noted that this measure is “topped out,” as many providers have achieved full performance and few demonstrated poor performance. In addition, a TEP expressed concern that the measure only determines whether education was provided, not whether the education provided was meaningful. **The AHA agrees that topped out measures should be removed from quality programs and also encourages CMS to review whether there are other “check the box” measures that merely show whether a provider complies with a task rather than whether the provider has given high-quality and responsive patient care.**

Measures for future consideration. CMS explains that the agency is identifying measures for possible inclusion in the VBP program in future rulemaking to address stakeholder concerns that the current measures are primarily focused on outcomes and clinical improvement, and thus do not address common issues exhibited by HH patients including chronic illness and deteriorating status. In order to highlight the value of stabilization measures in the program, CMS outlines four potential measures that might be developed.

Total Change in Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) Performance by HHA Patients. This composite measure would replace the finalized—and subsequently removed—Change in Daily Activity Function as Measured by Activity Measure for Post-Acute Care (AM-PAC) measure, and would capture all three potential outcomes for home

health patients: stabilization, decline and improvement. The measure would be calculated by comparing scores for the 11 ADL/IADL OASIS items from the start or resumption of care to scores at discharge and normalized into a total change score that would range from -11 to +11—that is, maximum decline on all items to maximum improvement on all items. The HH agency would be evaluated based on the average score across all eligible episodes, and the score would be risk-adjusted based on other OASIS items to account for case-mix variation and other factors that affect functional decline but are beyond the influence of the HH agency.

In general, the AHA supports the concept of using outcome measures rather than less meaningful process measures to evaluate quality of care. We appreciate CMS's acknowledgment that the scores must be carefully risk-adjusted to reflect patient-level factors that HH agencies cannot influence. As noted by CMS in the proposed rule, however, this measure would rely upon other OASIS items; yet, in this same rule, CMS proposes to remove over 200 items and add or modify dozens more. Because the OASIS item set has undergone and will continue to experience significant change, **the AHA encourages CMS to develop a type of risk-adjustment method that relies either on items that are expected to be static in the OASIS or is based on other patient-level data not subject to the changing list of OASIS items.**

Composite Functional Decline. This measure, which is similar to the composite ADL decline measure used in the SNF QRP, would show the percentage of HH agency episodes where there was a decline on one or more of eight ADL items. The measure would use a risk-adjustment model that predicts whether a patient will have a length of stay greater than 60 days and combines that prediction with a number of patient clinical conditions and other characteristics to estimate the predicted percent of ADL decline at the HH agency level. To calculate case-mix adjusted values, the percentage of HH agency episodes where there was a decline reported would be adjusted by the difference between the HH agency predicted percent and the national predicted percent. Again, the AHA appreciates CMS's efforts to include measures that reward providers for avoiding functional decline. Again, **we encourage CMS to carefully consider the factors included in the risk-adjustment methodology and to use the recent work done by the Assistant Secretary for Planning and Evaluation and the National Academy of Medicine to appropriately account for social risk factors in this outcome measure.**

Behavioral Health Measures. The HH VBP program does not include behavioral or mental health measures. CMS notes that it is important to include behavioral health measures in this program as many persons served by HH agencies may have behavioral health needs; we agree that this is a vital area to address.

CMS identifies two process measures assessing whether a HH agency correctly identifies a patient's need for or access to mental or behavioral health supervision. If a HH agency notes that a patient demonstrates mental or behavioral health impairments or was discharged from a psychiatric hospital prior to entering home care (based on positive answers to any one of a list of OASIS condition items), the HH agency would be required to note that the patient requires mental or behavioral health supervision or that the patient's caregiver can or does provide for the patient's mental or behavioral health supervision need.

As with many process measures, these measures are based upon reasonable assumptions but are unlikely to result in improved patient outcomes on their own. Similar to the Drug Education measure that CMS proposes to remove, these measures would likely reach “topped out” status quickly and would only reflect whether the HH agency identified a need for supervision or the ability of a caregiver to provide supervision, not whether the patient is actually receiving appropriate and meaningful mental or behavioral health supervision. Thus, while the AHA supports the idea of including mental and behavioral health measures in the HH VBP program, these process measures do not sufficiently evaluate the quality of care being provided. We encourage CMS to consider other such measures before proposing these measures in future rulemaking.

We thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy