March 5, 2018
Via electronic submission

Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

RE: **2019 Medicare Advantage and Part D Advance Notice Part II Proposed Rule and Draft Call Letter-CMS-2017-0163**

Dear Administrator Verma:

Thank you for the opportunity to provide comment on the 2019 Medicare Advantage and Part D Advance Notice Part II proposed rule, in particular, provisions proposing to expand health related supplemental benefits. We complement the Centers for Medicare and Medicaid Services (CMS) for publishing this proposal and appreciate the chance to provide feedback on innovative proposals to accelerate access to home-based services and improve quality outcomes for patients. We believe this proposal will help drive access to types of services Medicare Advantage (MA) patients do not have today including personal care services in the home. In addition, the outcomes realized from this proposal can be the first step in determining the best way to add these services for traditional Medicare beneficiaries.

By way of background, in November of 2017, Almost Family, Inc., a Kentucky-based company, and LHC Group, based in Louisiana, announced plans to merge their two companies to form the second largest homecare company in the nation that will operate in 36 states with 781 locations. Combined the two companies have provided a variety of services to people in their homes for over 65 years. The combined companies under the LHC Group name will provide Medicare skilled nursing services, hospice, rehabilitation and Medicaid home and community-based services to thousands of patients throughout the nation. Our two companies are submitting this comment letter to you jointly in anticipation of this merger.

The involvement of our companies in development of state and federal legislation, including home care access reforms, program integrity initiatives such as electronic visit verification and value-based purchasing, positions us well to provide informed feedback on issues raised in the CMS proposal. This viewpoint is enhanced by the experience of AFAM in the provision of personal care services to hundreds of thousands of patients for over 40 years. In addition, our participation in CMS technical expert panels including those responsible for developing a new case mix for home healthcare and quality measures for dual eligible beneficiaries lends useful background and perspective in caring for this unique population.

We strongly support expanding access to quality in home services including personal care services for MA and eventually all Medicare patients. Previously we have submitted several comments and responses to both Congress and CMS addressing ways in which homecare can help manage chronic conditions in the home. By removing barriers and increasing the ability of patients to move to the most appropriate care setting, these reforms are a useful step toward creating a healthcare delivery system centered on the needs of patients rather than providers. **We believe the expansion of home health services is directionally supportive of the reinterpretation of the statute proposed by CMS in this rule which is to "expand supplemental benefits which diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization".** Our comment letter provides first an Executive Summary and then additional comments in support of points in the summary.

Executive Summary

1. *We strongly support improving access to non-skilled personal care services for MA and all Medicare patients. We believe such services are patient preferred, least restrictive and the most cost-effective setting for patients. Simplified eligibility processes and patient assessment tools can shorten wait times and approvals for such services and help family caregivers.*
2. ***We believe the adoption of personal care benefits for MA, and eventually all Medicare, patients can reduce the total cost of both acute and long-term care and that such services should be available to all Medicare beneficiaries. Specifically, personal care services can help:***
    a. ***prevent or delay institutionalization for the near dual population,***
    b. ***delay spend down to Medicaid eligibility, and***
    c. ***reduce utilization of hospital and emergency hospital services.***
3. *We urge CMS to focus on restructuring the Medicare benefit in a way that focuses on the needs of patients rather than providers. This proposal is a step in that direction. We strongly support managing the patient rather than the provider type with a benefit package that includes non-skilled personal care services to assist with ambulation and activities of daily living combined, when necessary, with available wraparound skilled services for patients who might be post-surgical.*
4. *We urge CMS to develop value based reimbursement policies including the adoption of effective patient assessment tools in this initiative to reward providers with demonstrated higher patient success rates.*

Personal Care Services for MA Patients Can Prevent or Delay Institutionalization and Reduce Hospital Utilization

In our experience, the acceleration of non-skilled services to patients in the home can achieve a cost-effective and patient preferred balance with institutional services in the long term services and support area. **The application of non-skilled services to MA patients can improve quality, drive savings and provide necessary support for family caregivers, help re-balance Medicare expenditures and just as importantly state Medicaid budgets.**

A number of studies indicate the provision of non-skilled personal care services cost Medicaid programs less than institutional long-term care.[1] In our home state of Kentucky, for example, the average cost of Medicaid home and community-based waiver services annually is approximately $15,000 compared to $52,000 a year for nursing facility services.[2] In some states, institutionalization may cost up to $90,000 per year and a 2006 study found that among people admitted to nursing homes more than half were not Medicaid eligible prior to admission but most became Medicaid eligible within one year or less of admission.[3]

While Medicare does not pay for non-skilled personal care services, the federal government ultimately bears the burden once these individuals spend down assets and become Medicaid eligible. **The availability of personal care services to MA patients can reduce the Medicaid spend and thereby reduce institutionalization.**

In our experience, patients who drive the most cost include those with long term chronic conditions which Medicare home health does not cover. The application of non-covered, lower cost, in-home support services can effectively reduce total expenditures and avoid institutional care. In this regard, another recent study found that beneficiaries eligible for nursing home care that received personal care services had a 75% lower risk of having an extended nursing home stay than beneficiaries requiring the same level of care who did not receive personal care services.[4]

The validity of this premise is also supported by the results of a study by Avalere Consulting in connection with an application submitted to CMS by SCAN health plan for an innovation award through CMMI. As part of the proposal, and in support of recently introduced bi-partisan legislation creating a 5,000 patient demonstration pilot for personal care services for Medicare Advantage patients (HB 51), SCAN commissioned Avalere and a certified actuary to estimate the potential budget impact of such a demonstration.

These findings, attached, estimated that the demonstration proposed would generate a net savings of $59 million for 5,000 initial participants or $12,000 per participant per year with the savings largely coming from the Medicaid program in the avoidance of spend down. Further savings in the Medicare program of $18 million in the first three years and another $10 million in year four were achieved through the reduction of hospitalizations and the increased risk of nursing home residents and mortality following a hospital stay but mitigated by personal care services. [5]

<u>Adopting Policies to Accelerate Patient Access to Personal Care Services</u>

In the consideration of this policy regarding personal care services, we urge CMS to adopt processes to accelerate patient, access to personal care. In our experience with regard to Medicaid eligible patients they often wait weeks to obtain home care services burdening family caregivers and resulting often in expensive emergency room and hospital visits.

Providing MA patients and providers the opportunity to access such services should contribute to reductions in expensive emergency room and hospital admissions resulting in better outcomes and lower costs. While this proposal addresses MA benefits, should Medicare transition to provide personal care services under the traditional benefit, processes to quickly determine eligibility with simplified patient assessment tools can contribute to better outcomes and reduced expenditures. In this regard we recommend CMS:

1. Require all inpatient facilities to inform primary care physicians in a timely fashion regarding admission and discharge processes to enable physicians to participate in clinical decision-making particularly in regard to the availability of in-home services.
2. Require clinical certification as part of admission attestation that in the ordering clinicians judgment a patient cannot be cared for in a lower care setting making use of clinical indicators developed from empirical claims and assessment data to guide ordering clinicians toward utilization of lower cost settings.
3. Maintain cost sharing strategies and lower cost settings with directionally higher patient responsible portions in higher cost settings.

4. Incentivize Medicare advantage programs to utilize value-based purchasing models to reward providers demonstrating higher success rate with patient outcomes with higher payments or bonus structures.

C. Updating the MA Benefit Package – As a Precursor to Traditional Medicare – AND with Transparency

We support updating the MA benefit package to improve access to an enhanced array quality services. We urge CMS, in addition to expanding supplemental benefits, to consider structuring the benefit in a way that focuses on the needs of patients and their ability to function and improve in the home. Our view would be to enhance the ability of MA to manage the patient rather than provider type with a benefit package that includes non-skilled personal care services to assist with ambulation and activities of daily living (ADLs) in combination with available in-home skilled services for patients who might be post-surgical.

Ultimately, we believe, expanded services should also be added to the Traditional Medicare Benefit. However, we recognize concerns about the appropriateness of utilization in Traditional Medicare – the so called "woodwork effect". MA provides the Program with the opportunity to use MA innovation and experimentation to see what works in a controlled environment. Medicare Advantage plans should be allowed to expand their bundle of "waiver-like" services – providing less expensive non-covered services to avoid or replace higher cost covered services, thus lowering the total spend per Medicare beneficiary. This comes with an important quid pro quo though: Because the plans are funded with public money, the public deserves, and must receive, total transparency in whether the alternative models actual work, and to what degree they work. We encourage CMS quantitative and qualitative reporting back to CMS on the relative value of these additional services in controlling spending against medical benchmarks.

CMS should also consider making these same services, under the same reporting requirements, available to ACOs as a supplemental service to them as they strive to manage their patient population.

We appreciate this opportunity to share our comments and look forward to continuing to work with CMS to ensure the provision of timely and quality Medicare home based services. As always, we welcome the opportunity to participate in further stakeholder discussions and hope the Agency will not hesitate to contact us with questions by phone or email.

Sincerely,

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(footnotes follow)

[1 -2] In 2012, the national average price for a private room in a nursing home paid for out of pocket or thru long term care insurance was $90,520. In Kentucky in 2013, the annual yearly cost for Medicaid nursing home annual per person expenditures was $58,000 as opposed to $15,840 for Medicaid personal care in home waiver services. Wiener JW, Anderson WL, (2013) "Medicaid spend down: New Estimates and implications for long term services and supports.

[3] KY: Deborah Anderson, Commissioner of KY. Dept of Aging and Independent Living 2013 Waiver Policy Slide Presentation.

[4-5] "Community Based Institutional Special Needs Plans: Improving Care for Medicare Beneficiaries-An Estimated Budget Impact" January 2015