September 25, 2017
Via Electronic Submission

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1672-P
P.O. Box 8016
Baltimore M.D. 21244 -8016

Re: CMS-1672-P: CY 2018 Home Health Prospective Payment System Rate Update; Home Health Value Based Purchasing Model; and Home Health Quality Reporting Requirements

Dear Administrator Verma:

On behalf of Almost Family, Inc. (AFAM), we appreciate the opportunity to provide comment to the Centers for Medicare & Medicaid Services (CMS or the Agency) on the proposed rule to update the Medicare Home Health Prospective Payment System (HHPPS) rates and implement the Home Health Groupings Model (HHGM). AFAM is the nation's third largest provider of Medicare-certified home health services, operating in 27 states with over 320 branches and nearly 17,000 employees. We believe our experiences in the provision of skilled in-home nursing care, personal care services, ACO management and health innovation strategies give us a unique perspective on Medicare and in particular post-acute care and chronic conditions. Following our summary commentary, and incorporated as an integral part of this letter, is a series of Exhibits and Appendices documenting our underlying analytical work in support of our conclusions.

Overview

The HHGM portion of the proposed rule contains a massive rate cut and is overly complex changing far too many variables at one time. It appears to be a fundamental reconstruction of the entire home health benefit, driven solely by payment policy, without any appropriate corresponding changes in Medicare Conditions of Participation, benefit coverages, policy manuals and quality components. It is too much too fast and likely will result in substantial disruption of how home health is delivered resulting in meaningful negative impact to the post-acute care delivery system.

"Behavioral responses", which were veiled and undisclosed in the preliminary rule, are unlikely to be positive nor in the best interests of the Program or beneficiaries. We expect actual "behavioral responses" to this Rule to include sharp reductions in services in the critical first 30 days of a 60-day episode of care and elongated service periods. This would lead to slower recovery for patients with acute care episodes resulting in higher readmissions to institutional care. Vulnerable patients with the most intense care needs will likely be directed to higher cost inpatient settings (SNF's) because the resources allocated to the home health setting will be insufficient to meet their needs. This is bad for America's seniors and bad policy for America's Medicare Program.

In all candor, we find misleading the impact table that projects a 4% reduction in home health spending when in fact the proposal is an across the board rate cut of over 14%; a rate cut that reaches its peak at 18% for females over the age of 85. While home health spending will be cut sharply, in our opinion, the HHGM as proposed would actually drive ***total*** Medicare spending ***up***.

We agree with the goal of removing the retrospective element of therapy visits from the case mix model. However, combining this change with the sharp and severe rate cut and the shift to shorter payment periods, will leave providers no choice but to limit services in order to drive their costs below the reimbursement levels proposed. This may well gut the therapy element of the home health benefit.

We also like the HHGM's distinction between institutional and community patients. We are excited to see this first step in the journey to a bifurcation of the home health benefit, recognizing that "chronic-care" and "post-acute" are not the same thing and a "one-size" model may not fit all.

We strongly encourage the Agency not to finalize this "not-yet-ready-for-prime-time" proposal, but rather to launch an immediate effort, in combination with providers to find a better way to affect the changes the Agency seeks. To this end we have included in our comment letter a specific proposal for an alternative case mix model that can serve as exactly the kind of example of an industry contribution to policy that is needed. We encourage this course of action with a target start date of January 1, 2020 phased-in to be able to assess the impact of elements of any new rule in an orderly manner.

In the balance of this letter we provide our more detailed commentary and a number of exhibits and appendices intended to assist the Agency and others in gaining a more balanced perspective on the value of home health care.

AFAM Primary Comments on CMS' Proposed HHGM

All considerations involving payment policy in Medicare must be patient-focused. The impact on providers is relevant but the better question is **"What impact will this policy have on beneficiaries?"**

1. The HHGM as proposed is bad policy for patients. It is a large and inappropriate rate cut that will lead directly to a reduction in services to these highly vulnerable patients when they need it most. It is, in fact, a rate cut larger in scope and implication (14%) than was phased-in-rebasing under the ACA. Our modeling confirms patients with multiple chronic conditions such as COPD, congestive heart failure and stroke victims will experience dramatic reductions in care. ***See Exhibits II for proof of the rate cut and IV for more on patient impact.***

2. Home health users have needs nearly as high as those patients cared for in Skilled Nursing Facilities at a much higher cost. Home health patients average 2.11x vs. 2.32x for SNF and 1.0 for the overall Medicare population according to CMS' measure of clinical needs (HCC scores). Home health serves a relatively small portion of the sickest Medicare FFS beneficiaries, just under 10%, who are older, more dependent on the social-safety net and much sicker than the average Medicare beneficiary. ***See Exhibit I for more details on the high clinical needs of home health patients.***

3. The HHGM is particularly contrary to the Jimmo v. Sebelius settlement and is exceptionally harmful to the very types of patients Jimmo seeks to protect. Patients with chronic neurological conditions such as Parkinson's Disease and Stroke will see reimbursement cuts of nearly 25% and reimbursement rates set about 20% below cost. This will almost certainly force many to seek care in much higher cost Skilled Nursing Facilities as it will be financially impossible for home health agencies to provide needed levels of care. ***See Exhibit IV for disease state impacts.***

4. HHGM sets reimbursement rates well below Medicare Allowable Costs as calculated by CMS failing to meet the statutory standard of aligning payments with costs. (Note additionally that significant reasonable and necessary costs recognized under SEC/GAAP rules are not included in Medicare Allowable Costs). ***See Exhibit III for more on the misalignment of payments with costs.***

5. As a result, the HHGM will drive a substantial reduction of services to patients as providers are forced to lower their operating costs below the new reimbursement rates to have survivable margins. This is especially true in the first 30-day period of a 60-day episode of care when patients' needs and resources requirements are highest. ***See column i and note 9 of Exhibit III. We expect HHGM implemented in its current form would drive sharp service reductions (approximately 20%) to patients most at risk of re-hospitalization, particularly in the first 30-days post-hospital discharge.***

6. Inexplicably, after cutting reimbursement well below cost for nearly all categories of patients, the HHGM provides massive rate increases and margins for wound care, catheter care and patients classified as low intensity (LUPA) under the current model. ***See Exhibit IV for details -- including the nearly 18% rate cut for females over age 85.***

7. We agree with the goal of removing the current retrospective measure (actual therapy visits provided) from the case mix model but not with replacing it with a different retrospective measure (length of stay). In the initial implementation of the Home Health PPS the number of therapy visits would literally double episodic reimbursement if a certain threshold (10 visits) was met ***retrospectively***. The move from 60 to 30 day episodes simply replaces the current retrospective measure (therapy) with a new retrospective measure (length of stay). Under the HHGM the length of stay will nearly double episodic reimbursement if a certain threshold (31 days) is met ***retrospectively***. In both cases the retrospectively determined element counts for about 40% of total reimbursement. As a result the length-of-stay-dependent HHGM has the exact same vulnerability to manipulation, and accusations of manipulation, as the existing therapy-dependent HHRG model.

8. We believe the 30-day element of HHGM moves the home health benefit directionally to a shorter-term and more limited benefit at the exact time it is needed to serve the chronically-ill. While we realize some, including MedPac, believe this is a desirable direction, we emphatically do not agree. As a result of the 30-day element and lack of budget neutrality, HHGM is at cross-purposes with the efforts of the Senate Finance Committee Chronic Care Work Group and the efforts of the House Ways & Means Committee to move to more value-based payment models. It is more likely to increase overall spending and lower patient outcomes and satisfaction by driving many chronically ill patients to inpatient settings. ***See Exhibit III for problems with rate setting in the first 30 days of a 60-day episode of care and Exhibit IV for the impact on the most significant categories of chronically-ill patients.***

9. **There is a Better Way**. We are proposing an alternative case mix model that would excel at aligning payments with costs while also encouraging desirable provider responses. Rather than focusing on patient "characteristics" (for example disease states or the presence of a wound), our model focuses on patient "goals" – staying out of hospitals and improving or maintaining patients' ability to care for themselves. Our alternative uses only the OASIS data set, NO retrospective measures and produces an exceptionally high R^2 value or "goodness of fit". It has the added benefit of flowing naturally into value-based payment models where providers can be rewarded or penalized for performance against benchmarks. ***See Exhibit V for an overview of how our Risk-Based Grouper Model works.***

   Additionally, we have evaluated the implications of our model on patients whose access to care is protected by the Jimmo settlement. While our model already does a better job ensuring access than does the HHGM, modification to provide additional case weight to patients qualifying for "maintenance" services is feasible within our framework.

AFAM Specific Recommendations

We strongly encourage the following course of action **for the protection of Medicare Beneficiaries and their right to access appropriate and necessary home health service**:

- Defer action on the HHGM in the 2018 final rule
- Address the case mix model in the 2019 regulatory cycle in an open and completely transparent process with mandated industry participation
- Fully vet whether alternative case mix models (including, but not limited to, our proposed model) may in fact present a better approach
- Establish a target date of January 1, 2020 to begin implementation of a new model
- Phase-in any new model in a blended process of 2-4 years to permit CMS to monitor provider and market place responses for the protection of patient access
- Implement the new system with a budget-neutral approach to rate setting.

In the absence of these actions, if HHGM were to be implemented in the final rule, at an absolute minimum the 30-day payment rate must be changed from the proposed ~$1,500 to a budget-neutral payment rate of ~$1,750 to prevent dramatic service reductions to patients.

If Spending Reductions Are the Goal, There is a Better Way to do That Too

To the extent the proposed HHGM is being driven primarily by a desire to generate savings in the Medicare Program, we point out AFAM has been a long-standing proponent of program-integrity efforts that would produce billions of dollars of savings without endangering highly vulnerable patients early in their recovery periods. Specifically, since we first began advocating our proposals in 2011, over $5B has been unnecessarily expended on excess utilization in very narrowly-focused geographic areas. ***See Appendix A for a description of our proposals and the savings we believe they would produce.***

Home Health Spending Is Slow-Growing

We point out the following, which is explained more fully in ***Appendix B "CBO: Home Health Growing Slower than Other Venues"***

- According to CBO, even before the HHGM rate cuts, home health spending is already growing slower than hospitals, physician services or skilled nursing facilities.
- Home health episodic use, spending and percent of total Medicare, have declined for five consecutive years
- Hospitalization rates and patient functionality outcomes in home health have improved over the same period. (MedPac)

Home Health Compliance is Good, Rate Cuts have Been Severe, Therapy has Been Recouped

CMS-CERT reporting has materially overstated the error rate in home health claims as we testified before the House Ways and Means Health Subcommittee in September 2016. In ***Appendix E "Poor Face-to-Face Implementation Responsible for Over-Reported Error Rate"*** we show that home health actually has the lowest confirmed error rate in years and is the lowest across the reported venues once the impact of untenable face-to-face documentation standards has been removed.

In ***Appendix D "Home Health Subjected to Long and Severe Rate Cuts"*** we show that even prior to the HHGM proposal home health has been subjected to a long series of particularly sharp rate cuts amounting to over 30% in the period 2009-2018. Adding the proposed HHGM would increase this to a total of almost 45% in the period 2009-2019. No other sector has ever been subjected to such sustained reimbursement and service reductions while at the same time adding significant value to the Medicare Program.

In ***Appendix F "Therapy Accounts for More than All the Case Mix"*** increases, we prove that the perceived increases in case mix in home health were entirely driven by increased therapy utilization in the period 2005-2013. Since that time, therapy utilization has plateaued. Case-mix "creep" adjustments (shown in Appendix D) have recouped substantially all of that case mix increase through lower payment rates. Nonetheless, patients continue to benefit from the higher level of therapy services. This analysis was first provided via comment letter in September 2015.

AFAM Technical Commentary

Recognizing that there are numerous audiences with different interest levels we have organized our more technical commentary in a series of exhibits and appendices to this comment letter as indicated in the following table:

Exhibit	Description
Specific to the HHGM Proposal	
I.	CMS: Home Health Patients Needs Are Real
II.	Proof of Rate Cut Embedded in HHGM
III.	HHGM Rates Are Below Medicare Costs and Will Force Service Reductions
IV.	HHGM Bad for Nearly All Patients – Except Wound Care…and Low Utilizers
V.	AFAM Alternative Case Mix Model Offers a Better Way
Appendices: Other Related Technical Information	
A.	AFAM Long-Standing Proposal for Program Integrity – Payment Safeguard against excess episode utilization could save billions
B.	CBO: Home Health Growing slower than other venues
C.	Margins of publicly traded home health companies – Bank of America Merrill Lynch
D.	Home Health Subjected to Long and Severe Rate Cuts
E.	Poor Face-to-Face Implementation Responsible for Over-Reported Error Rate
F.	Therapy Accounts for More than All the Case Mix increases in home health and has been recouped through case mix creep adjustments

We appreciate this opportunity to share our comments and look forward to continuing to work with you and your staff. We would welcome the opportunity to participate in further stakeholder discussions of these and other policy options to improve the proposed rule. If you have any questions, please do not hesitate to contact any of us at the email addresses or phone numbers below.

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- Lisa Grabert, Sarah Levin, House Ways & Means Health Subcommittee

September 25, 2017

In this exhibit we present irrefutable evidence from CMS' own data sources that home health serves patients with real and high clinical severity. Home health patients are MUCH sicker than the Medicare FFS population, with nearly as high needs as those patients cared for Skilled Nursing Facilities at a much higher cost.

		Post-Acute Care				Hospital Services			
CMS Public Use File (1)	**MCR**	**MCR**	**(2) HH**	MCR		MCR	MCR	MCR	MCR
Data on Spend by Venue	**FFS Pop**	**HH**	**% FFS**	SNF	**Commentary**	Inpatient	LTACH	IRF	IP Total
Beneficiaries in 000s	**34,065**	**3,154**	**9.3%**	1,699	Home health serves ~2x as many patients as SNF's…	5,829	113	327	5,829
Episodes or stays in 000s		**6,064**		2,350		9,368	136	375	9,879
Episodes/Beneficiary		**1.92**		1.38		1.61	1.21	1.14	1.69
Visits or Days in millions		**101.6**		63.0	…provides substantially more days of care…	50.6	3.4	4.6	58.6
Days of care per 1000		**2,983**		1,849		1,485	99	135	2
Total Spend in $B	**$ 305.9**	**$ 16.4**		$ 26.5		$ 107.8	$ 4.8	$ 6.6	$ 119.2
% Using		**9.3%**		**5.0%**		**17.1%**	**0.3%**	**1.0%**	**17.1%**
$ Per User		$ 5,209		$ 15,607		$ 18,492	$ 42,484	$ 20,295	$ 20,453
$ Per Episode		$ 2,709		$ 11,285		$ 11,506	$ 35,131	$ 17,725	$ 12,068
$ Per FFS Beneficiary	**$ 8,979**	$ 482		$ 779	…at a much lower cost than SNF's by any measure.	$ 3,164	$ 141	$ 195	$ 3,500
$ Per Visit or Day		**$ 162**		**$ 421**		**$ 2,131**	**$ 1,419**	**$ 1,444**	**$ 2,036**
Dually Eligible in 000	**7,048**	**1,071**		1,182	Compared to the MCR FFS Population home health serves a				
% of total	**20.7%**	**34.0%**	**164%**	69.5%	much greater portion of the dually eligible who rely heavily on social safety net programs….				
Average									
Age	**71.0**	**75.8**	**107%**	78.9	…home health patients are older…				
HCC Score (3)	**1.00**	**2.11**	**211%**	**2.32**	**...with a MUCH higher HCC score than MCR FFS as a whole,**				
Diff in HH vs SNF HCC		**9%**			**very nearly as high as those in MCR SNF.**				
Percent of Beneficiaries with									
Atrial Fibrillation	**9%**	**21%**	**243%**	27%	Home health patients have MUCH higher prevalence of disease				
Alzheimer's	**8%**	**32%**	**395%**	45%	states anywhere from 2x to 4x the Medicare average.				
Asthma	**7%**	**13%**	**196%**	13%					
Cancer	**8%**	**14%**	**164%**	16%					
CHF	**12%**	**42%**	**351%**	51%	Home health patients' disease state prevalence rivals that of				
Chronic Kidney Disease	**17%**	**44%**	**260%**	55%	Skilled Nursing Facilities but manages these patients at a much				
COPD	**10%**	**32%**	**327%**	37%	lower average cost.				
Depression	**13%**	**39%**	**295%**	47%					
Diabetes	**25%**	**45%**	**184%**	46%					
Hyperlipidemia	**46%**	**58%**	**128%**	56%					
IHD	**26%**	**54%**	**205%**	54%					
Osteoporosis	**6%**	**16%**	**266%**	19%					
RA/OA	**29%**	**52%**	**178%**	54%					
Schizophrenia	**2%**	**10%**	**531%**	17%					
Stroke	**4%**	**12%**	**344%**	18%					
Other primary									

(1) 2014 is the latest period for which all data sets were available in the public use files.

(2) HH users have much greater needs than the average Medicare FFS population.

(3) The CMS hierarchical condition categories (CMS-HCC) model, implemented in 2004, adjusts Medicare capitation payments to Medicare Advantage health care plans for the health expenditure risk of their enrollees. It is calculated **BY CMS** on all Medicare beneficiaries including the FFS population and is a measure of the clinical severity and needs of each patient.

September 25, 2017

In this Exhibit we provide Proof of the Rate Cut Embedded in the HHGM Proposal. What appears at first to be a logical "halving" of the rate is in fact a large cut that will constrain services to beneficiaries. The rate should be ~$1,750 not ~$1,500.

Proper Rate Conversion - Doing it Right…	60 Days	30 Days
Current Spend in $B	$ 18.0	$ 18.0
Episodes in Millions	6.0	10.3
Rate in whole $	**$ 3,000**	**$ 1,748**
Results: budget neutral rate and spending		

How It is Proposed - Flawed Logic…		
60 Day Episode Rate	$	3,000
Divide by Two for 30 day rate	**$**	**1,500**
Number of 30-day Episodes		10.3
Resulting Spend in $B	$	15.4
Current Spend in $B	$	18.0
Rate Cut in $B	$	(2.6)
Rate Cut % of $18B		-14.2%
Results: sharp cut in rates and services		

Notes:

1. Numbers are simplified and rounded from exact amounts to facilitate easier understanding.
2. Our calculations indicate that the proposed case mix model is not sufficiently powerful to correct this error or logic flaw.
3. In our figures above, 1.7M episodes (10.3M - 6M = 1.7M or 28%) don't extend into the second 30 days. This is what causes the proposal to not be budget neutral (6 million episodes x2 would be 12 million 30 day periods; actually there are only 10 million).
4. Cutting the 60 day rate in half would be correct only if one of the following conditions were met (neither are):
   a. the number of 30 day periods was 2.0x the number of 60 day periods (it is actually 1.7x)
   b. the case mix model corrected the error (it does not).
5. Detailed patient-level calculations have confirmed this work. Additionally, replacing the erroneous $1,500 rate with the corrected $1,750 rate eliminates the rate reductions at the individual patient level.

September 25, 2017

In this Exhibit we prove that the HHGM as proposed sets rates well BELOW COST. As shown in the four right-most columns and as explained in Notes 7-9, the move to a 30-day period is ill-advised. In combination with the proposed payment rate the HHGM will FORCE providers to reduce service levels to the 75% of patients who need 60 days of care, especially in the most vulnerable FIRST 30-day period.

Calculated Impact of the Proposed HHGM Before Any "Behavioral Responses"

Ln		Current HHRG	Change to HHGM			All Episodes Under HHGM			HHGM Drives Shorter Stays and Service Reductions				
									Episodes <=	Episodes >30 days			
			Change	% Chg	Notes	1st 30 days	2nd 30 days	Total	30 days (7)	1st 30 days	Notes	2nd 30 days	Total
1	Episodes	87,667			(1)	87,667	65,043	152,710	22,624	65,043	(8)	65,043	65,043
2	Case Mix	1.0729	(0.0044)	-0.4%	(2)	1.1775	0.8627	1.0685	1.2372	1.1568		0.8627	1.0098
	Average Per Episode												
3	Reimbursement	2,856	(414)	-14.5%	(3)	1,599	1,137	2,442	1,534	1,621		1,137	2,758
4	Allowable Cost (4)	2,606	-	0.0%	(4)	1,744	1,161	2,606	1,296	1,900		1,161	3,061
5	"Medicare" Margin (5)	251	(414)	-165.3%		(145)	(25)	(164)	238	(278)	(9)	(25)	(303)
6	"Medicare" Margin %	8.8%	-15.5%		(5)	-9.1%	-2.2%	-6.7%	15.5%	-17.2%	(9)	-2.2%	-11.0%
7	Avg. LOS in days	45.9	-	0.0%	(6)	27.5	24.8	45.9	20.3	30.0		24.8	54.8
8	Avg. Visits	17.0	-	0.0%	(6)	11.3	7.6	17.0	8.3	12.3		7.6	20.0
	column	a	b	c	d	e	f	g	h	i	j	k	l

Notes:

(1) This was produced from detailed calculations on AFAM's book of episodes completed in the first half of 2017. Consistent with national data ~25% of episodes do not go into the second thirty day period. AFAM's episodic metrics overall very closely mirror the national averages and thus should be considered representative of the impact on the entirety of the home health provider segment.

(2) The case mix for HHGM is using the proposed CMS formulas and then averaging the two 30 day periods. The HHGM case mix model, separate from the rate, appears to be "budget neutral".

(3) As indicated in Exhibit II, and our narrative, the HHGM as proposed is actually a ~14% rate cut due to the 30 day rate being set incorrectly low.

(4) "Medicare Allowable Costs" and margins follow CMS cost reporting rules and do not include all costs necessary to running a business as recognized by GAAP/SEC rules.

(5) Line 6 "column a" shows a Medicare Margin of 8.8% at the CMS published national cost per visit, wage-index adjusted to the location of individual patients. For contrast, Appendix C shows the "EBITDA Margins" of the publicly traded home health care companies from a recent Bank of America Merrill Lynch research report at 8.2%. Clearly businesses with GAAP/SEC basis (i.e. real) margins of 8% cannot sustain a ~14.5% rate cut without sharply reducing services to patients.

(6) Average length of stay and visits per period are before any of the "Behavioral Responses" referenced but not disclosed by CMS in the preliminary rule.

(7) The HHGM places notably higher reimbursement value on short stay episodes (<=30 days) signalling providers to seek more of these (lines 5&6 column h). They currently make up ~25% of all episodes. This includes most "LUPA" episodes ~60% of which end in hospitalization of the patient. These are among the highest margin of all episodes under the HHGM.

(8) Approximately 75% of all patients in home health require most or all of a 60-day episode of care and about 30% even need a second 60-day episode. It is irrational to move to 30-day payment periods when only 25% of the patients' needs can be appropriately met in that shorter time frame.

(9) The HHMG places a lower reimbursement value on longer stay episodes, especially during the first 30 days of 60-day episodes when patients are most at-risk. The HHGM will FORCE providers to reduce service levels by about 20% during that time frame.

September 25, 2017

In this Exhibit we show the effect of the proposed HHGM on different patient categories. HHGM as proposed is an indiscriminant across the board rate cut that will drive sharp reductions in services for nearly every category of patient. In addition to sharp reductions in service for joint replacement patients, for reasons we cannot currently comprehend the model massively devalues home health for Parkinson's and Stroke patients and massively overvalues wound care patients with Medicare margins of 24%.

It is reasonable to expect meaningful movement of patients from home health to higher cost SNFs as a result of this rule.

Box #1 Rate Cuts By Primary Diagnosis of Patients in Top-30 Home Health Diagnoses

	HHRG Episodes	% Top 30	HHRG Case Mix	HHRG Avg Rate	HHRG Margin %	HHGM Pds	HHGM Case Mix	HHGM Margin %	HHGM Avg Rate/30 Day	HHGM Avg Rate/60 Day	HHGM Rate Cut	HHGM Rate Cut %
Chronically Ill - Neuro												
Stroke	1,565	4.9%	1.5169	4,102	7.6%	2,680	1.2475	**-22.6%**	1,806	3,092	(1,010)	**-24.6%**
Parkinsons	1,284	4.1%	1.3732	3,728	12.3%	2,228	1.1412	**-15.7%**	1,628	2,825	(903)	**-24.2%**
	2,849	9.0%	1.4521	3,933	9.6%	4,908	1.1996	**-19.6%**	1,725	2,972	(962)	**-24.4%**
Chronically Ill - Non-Neuro												
CHF/MI/A-Fib	7,961	25.1%	0.9873	2,555	3.5%	13,769	0.9720	**-10.0%**	1,296	2,241	(314)	**-12.3%**
COPD	5,875	18.5%	1.0366	2,636	2.2%	10,269	1.0128	**-9.5%**	1,346	2,352	(283)	**-10.7%**
Diabetes	3,347	10.6%	0.9686	2,720	-5.3%	6,852	0.9530	**-16.2%**	1,204	2,464	(255)	**-9.4%**
	17,183	54.2%	1.0005	2,615	1.3%	30,890	0.9822	**-11.1%**	1,292	2,323	(292)	**-11.2%**
Ortho/Joint Aftercare	4,230	13.3%	1.1274	3,083	**25.5%**	7,025	1.2405	**-6.1%**	1,304	2,166	(917)	**-29.7%**
Wound & Catheter Care (1)	1,710	5.4%	0.8592	2,200	3.8%	3,031	1.2075	**24.2%**	1,574	2,791	590	**26.8%**
All Other Top 30 Diagnoses	5,719	18.0%	1.1144	3,136	12.5%	9,770	1.0726	**-12.1%**	2,447	2,447	(688)	**-21.9%**
Total	31,691	100.0%	1.0802	2,867	8.1%	54,662	1.0643	**-9.4%**	1,396	2,408	(459)	**-16.0%**
% of All HH Episodes	36.1%											

(1) Inexplicably, wound and catheter care patients are singled out for massive rate increases and outsized margins in the HHGM.

Rate cuts increase as age increases and are highest for FEMALES over Age 85 at nearly 18%

Box #2 - Rate Cut by Age and Gender	Age Cohort	<75	75-85	**>85**	Gender	M	**F**		**F >85 Yrs**
	Rate Cut	-10.5%	-15.8%	**-17.3%**	Rate Cut	-12.6%	**-15.6%**		**-17.9%**

The table below shows that the HHGM drives sharp rate reductions for every diagnosis related group, and negative margins for all except wound care and low utilizing blood conditions.

HHGM Impact By ICD GROUP -- ALL Patients

Diagnosis Group	HHRG Episodes	% Total	HHRG Case Mix	HHRG Avg Rate	HHRG Margin %	HHGM Pds	HHGM Case Mix	HHGM Margin %	HHGM Avg Rate/30 Day	HHGM Avg Rate/60 Day	HHGM Rate Cut	HHGM Rate Cut %
BLOOD AND BLOOD-FORM	948	1.1%	0.7939	$ 1,790	8.9%	1,760	0.8378	**9.6%**	$ 972	$ 1,805	$ 15	**0.8%**
CIRCULATORY SYSTEM	18,909	21.6%	1.0762	$ 2,829	4.7%	33,960	1.0215	-11.4%	$ 1,346	$ 2,418	$ (411)	**-14.5%**
CONGENITAL ANOMALIES	49	0.1%	1.0466	$ 2,715	10.3%	85	1.1079	-0.8%	$ 1,393	$ 2,416	$ (299)	**-11.0%**
DIGESTIVE SYSTEM	1,747	2.0%	1.0088	$ 2,625	7.9%	3,004	1.0481	-4.1%	$ 1,351	$ 2,323	$ (302)	**-11.5%**
ENDOCRINE,NUTRITIONAL	5,524	6.3%	0.9657	$ 2,646	-3.8%	10,035	1.0251	-9.3%	$ 1,383	$ 2,513	$ (133)	**-5.0%**
GENITOURINARY SYSTEM	2,507	2.9%	0.9832	$ 2,516	7.0%	4,382	1.0434	-0.9%	$ 1,327	$ 2,319	$ (198)	**-7.9%**
INFECTIOUS AND PARASITIC	634	0.7%	1.0423	$ 2,772	9.0%	1,074	1.1288	-1.6%	$ 1,466	$ 2,483	$ (290)	**-10.4%**
INJURY AND POISONING	8,534	9.7%	1.1599	$ 3,175	6.2%	14,846	1.1145	-14.3%	$ 1,498	$ 2,607	$ (569)	**-17.9%**
MENTAL DISORDERS	2,576	2.9%	0.9173	$ 2,372	10.1%	4,696	0.8225	-8.6%	$ 1,076	$ 1,962	$ (410)	**-17.3%**
MUSCULOSKELETAL SYSTEM	8,902	10.2%	1.2322	$ 3,290	16.2%	15,433	1.0459	-15.2%	$ 1,380	$ 2,393	$ (897)	**-27.3%**
NEOPLASMS	2,117	2.4%	0.9289	$ 2,334	13.8%	3,571	1.0214	6.2%	$ 1,271	$ 2,144	$ (190)	**-8.1%**
NERVOUS SYSTEM	4,413	5.0%	1.2292	$ 3,298	13.3%	7,864	1.1442	-4.9%	$ 1,529	$ 2,724	$ (574)	**-17.4%**
RESPRIATORY SYSTEM	8,578	9.8%	1.0416	$ 2,696	3.2%	15,280	1.0267	-9.7%	$ 1,335	$ 2,379	$ (317)	**-11.8%**
SKIN, SUBCUTANEOUS	5,579	6.4%	0.9581	$ 2,720	-0.2%	10,060	1.3182	**13.8%**	$ 1,753	$ 3,161	$ 441	**16.2%**
SUPPLEMENTARY V CODES	11,987	13.7%	1.0221	$ 2,685	17.7%	18,584	1.1330	0.6%	$ 1,434	$ 2,223	$ (462)	**-17.2%**
SYMPTOMS,SIGNS,ILL-DEF	4,663	5.3%	1.1859	$ 3,284	18.1%	8,052	1.0264	-10.5%	$ 1,409	$ 2,433	$ (851)	**-25.9%**
Grand Total	87,667	100.0%	1.0729	$ 2,856	8.8%	152,686	1.0685	-6.7%	$ 1,402	$ 2,442	$ (414)	**-14.5%**

LUPA Episode Implications In the proposed rule CMS changes the determination of when episodes should be subjected to a "Low Utilization Payment Adjustment" or LUPA. As a result some episodes currently classified under the HHRG as LUPA's will be paid under the HHGM as full episodes and some will remain LUPAs. In BOTH cases the proposal substantially increases the reimbursement on these episodes as indicated in the following table:

Episodes currently classified as LUPAs under the HHRG	HHRG Episodes	HHRG Case Mix	HHRG Avg Rate	HHRG Margin %	HHGM Pds	HHGM Case Mix	HHGM Margin %	HHGM Avg Rate/30 Day	HHGM Avg Rate/60 Day	HHGM Rate Cut	HHGM Rate Cut % (1)
Paid as full episodes under the HHGM	2,670	0.7008	494	-8.8%	3,224	0.9559	63.4%	1,214	1,466	972	**196.9%**
Paid as LUPA episodes under the HHGM	4,571	0.7312	367	5.7%	5,611	1.1845	32.8%	420	516	149	**40.5%**
Total	7,241	0.7199	414	-0.7%	8,845	1.0997	**51.9%**	710	867	453	**109.4%**

(1) Episodes currently classified as LUPA episodes under the HHRG will receive substantial reimbursement increases and very high margins under the HHGM.

In this Exhibit we describe our proposed case mix model, which we call a Risk-Based Grouper Model (RBGM) as a superior alternative to the HHGM. The primary benefit of this approach is that it clearly articulates the value proposition of home health: a) keeping patients out of hospitals and b) restoring their dignity and independence through their ability to care for themselves. The model uses existing OASIS data elements, proven CMS risk formulas and NO RETROSPECTIVE measures to deliver an exceptionally high "R2 goodness of fit" in aligning payments with costs

By Case Mix Group

			From CMS Risk Models Based on OASIS Data							Potential New Model					
RBGM Case Mix in 10 point cohorts	HHRG Episodes	HHRG Case Mix	Avg Hosp Risk	Avg Improve Prob.	**Avg Total Risk Score**	**Avg RBGM Case Mix**	Avg SNV	Avg THV	Tot Vsts	Avg of RBGM Reimb	HHRG Avg Rate	HHRG Margin %	RBGM Rev Change %	RBGM Avg Cost	RBGM Margin %
0.5-0.6	997	1.0346	16.0%	30.8%	**21.9%**	**0.5442**	7.2	7.2	14.9	$ 1,666	$ 2,869	19.0%	-41.9%	$ 2,326	-39.6%
0.6-0.7	1,950	1.0627	16.8%	42.2%	**27.0%**	**0.6583**	6.9	8.1	15.7	$ 1,997	$ 2,881	15.1%	-30.7%	$ 2,446	-22.5%
0.7-0.8	4,989	1.0234	17.3%	51.7%	**31.0%**	**0.7567**	7.0	7.7	15.3	$ 2,156	$ 2,765	13.7%	-22.0%	$ 2,388	-10.7%
0.8-0.9	10,692	1.0250	17.9%	60.9%	**35.1%**	**0.8556**	7.0	7.6	15.5	$ 2,424	$ 2,725	12.0%	-11.0%	$ 2,399	1.1%
0.9-1	18,336	1.0424	19.2%	68.9%	**39.1%**	**0.9528**	7.2	7.7	15.9	$ 2,732	$ 2,780	11.8%	-1.7%	$ 2,450	10.3%
1-1.1	19,407	1.0671	22.3%	74.1%	**43.0%**	**1.0478**	7.8	8.0	17.0	$ 3,022	$ 2,868	9.3%	5.4%	$ 2,601	13.9%
1.1-1.2	11,753	1.0988	27.6%	75.8%	**46.9%**	**1.1437**	8.7	8.5	18.6	$ 3,312	$ 2,989	5.2%	10.8%	$ 2,833	14.5%
1.2-1.3	4,873	1.1585	34.3%	75.9%	**50.9%**	**1.2419**	9.4	9.4	20.3	$ 3,603	$ 3,179	2.4%	13.3%	$ 3,103	13.9%
1.3-1.4	1,709	1.1992	41.1%	76.0%	**55.0%**	**1.3415**	10.0	9.9	21.4	$ 3,878	$ 3,326	1.3%	16.6%	$ 3,283	15.3%
1.4-1.5	804	1.2380	50.2%	76.2%	**60.6%**	**1.4581**	9.9	10.7	22.3	$ 4,248	$ 3,433	0.1%	23.8%	$ 3,428	19.3%
Grand Total	75,510	1.0674	22.7%	68.5%	**41.0%**	**1.0000**	7.8	8.1	17.0	$ 2,880	$ 2,875	9.3%	0.2%	$ 2,607	9.5%

A Better Model Based on Patient Goals and Quality Is Available – Consider as a Replacement

Almost Family has analyzed the data and developed a case mix model, based on OASIS data that has a significantly higher R^2 "goodness of fit" than either the existing case mix model or the HHGM. Importantly, our model uses NO RETROSPECTIVE MEASURES to determine the case mix and better aligns with resource usage. This model, based on existing OASIS data and CMS risk formulas, results in: a) a better alignment of payments with costs, b) much better provider incentives that drive desirable rather than undesirable behaviors, c) natural linkage to value-based payment principles. This model could be designed to qualify the entire home health spend as "value based" under CMS standards. In essence our model embraces the "goal orientation" of home health.

The primary value add of home health is 1) keeping patients out of the hospital and 2) improving (restoring) their level of functionality so they can care for themselves. We used CMS' long standing risk adjustment scores to focus on these goals, selected 7 simple elements, and framed our model as shown in the table below.

We developed a weighted average risk/probability of improvement score for each patient and converted that to a case mix based on a national case mix score of 1.0000. Regression analysis of this new case mix model against total resource use (at national average costs) yielded an exceptionally high alignment of payments with costs. Most importantly this approach would focus provider attention and resources on patients with the highest risk of hospitalization and the highest probabilities of functional improvement.
Additionally, this model has a natural dovetail into performance based payment models. Basing a VBP model on each agency's actual performance against a risk-adjusted benchmark on these same variables provides an extremely consistent and cohesive reimbursement system that focuses provider attention on work that benefits patients and the Program.

Risk-Based Grouper Model based on CMS Probability Models*					
Risk of Adverse Event	**Weight**	**Probability of Improvement**	**Weight**	**Total Wt**	**Predictive Power (R2)**
Hospitalization	40%	Walking	10%		
ER Use	20%	Bathing	10%		
		Managing Medications	10%		
		Transferring	5%		
		Dressing	5%		
	60%		40%	100%	0.89
* Contains no retrospective elements such as therapy visits or length of stay					

Accomodating the Needs of Patients Whose Access is Protected by the Jimmo Settlement

Review of our proposed model with staff from the committees of jursidiction and CMS highlighted the need for modification to ensure continued access to home health for patients whose therapy and other care would serve to maintain rather than improve their funtionality.

Although not yet modified in the above proposal, our framework would facilitate relatively easy modification to accommodate such needs.

In our model, patients who have either a) a high to moderate risk of hospitalization OR b) high to moderate probability of improvement in functionality already receive sufficient case weight value to ensure appropriate access to resources.

By definition then, Jimmo-protected patients at risk would most likely be those with a relatively low probability of improvement in functionality AND high to moderate functional needs.

Our data analysis suggests that this is less than 5% of the patient population. However, our model framework has the granularity that would permit the addition of case weight points to ensure sufficient resources are made available for these types of patients IF it does not already do so.

We look forward to the opportunity to continue our conversations with CMS and other stakeholders in pursuit of an improved case mix model consistent with the recommendations included in the narrative body of our comment letter.

Home Health Program Integrity Payment Safeguard
Technical Kit Addendum #2
March 2016

Introduction

As a part of the PPACA, CMS and the Congress adopted a home health industry proposal implementing an "outlier" payment limit that has proven to save the Medicare Program over $900M per year in eliminated abuse. ***This has generated over $4.5B in savings since its implementation***.

For the last five years, Almost Family ("AFAM") and others in the home health industry have advocated for an additional home health payment safeguard that would limit excessive recertification of home health episodic payments. In February 2013, to assist lawmakers and regulators, AFAM published a program integrity "Technical Kit" in which we documented evidence regarding the potential effect of limits, along with technical guidance on how such limits could be implemented. The limits would be implemented by withholding payments to any home health agency whose AGGREGATE ratio of episodes to beneficiaries exceeds the selected limits of 2.7 in urban areas and 3.3 in rural areas. This would impose NO limit on the number of episodes of care any individual beneficiary could receive.

In 2014 we published an addendum updating the Technical Kit with another year of data. Now, in this 2016 document, we publish Addendum #2 to the Technical Kit updating our work product with two more years of data. ***We estimate that $4.1B in avoidable excess payments have been made in the five years we have been advocating for episode limits.***

Savings Opportunity

Starting in 2010 our proposed safeguards have been widely discussed in the home health industry among providers and trade groups. Since that time, the ratio of episodes to beneficiaries and the projected limit savings have declined from $929M in 2009 to $640M in 2014. Notably, most of this decline has come from agencies that were already relatively low utilizers. We believe this decline has occurred as a result of the "Sentinel Effect," whereby lower utilizers, aware of possible future limits and desiring to be of model compliance, further reduce their utilization. The remaining opportunity for savings would come from implementing the limits on high utilizers who have not voluntarily reduced their utilization.

We estimate remaining Program savings of $640M PER YEAR could be generated from implementation of our proposed payment safeguards.

Home Health Program Integrity Payment Safeguard
Technical Kit Addendum #2
March 2016

Our analyses show that the safeguards would impact only a very small number of isolated geographic areas where utilization patterns are well recognized to be obvious and abusive—not only by us, but by CMS and MedPAC, too.

Information Attached

The following nine page document presents our 2014 CMS dataset update:

Page		Title		Highlights
1 Exhibit 4		Correlation of utilization to population and number of providers		• Shows higher utilization of services closely related to supply of providers in the YELLOW highlighted columns • Shows $ savings from application of payment safeguard limits isolated to FIVE high utilizing states
3 Exhibit 4a		Correlation of STAR ratings to proposed limits		• Shows that proposed limits effectively target high utilizing, yet ineffective providers • Providers with 2 stars or less bill the program 22% MORE than providers with 4 or more Stars and generate 14% worse measurable outcomes
4		Pie Charts on effect of limits compared to enrollees		• Rather dramatic depiction that the proposed limits attack excess utilization in very targeted areas • Texas accounts for 53% of the savings and only 7% of the population – total savings $340M on 2.5M enrollees • US outside of targeted areas accounts for 80% of the population and only 9% of the limit savings
5 Exhibit 4b		Impact of payment safeguards on 18 Texas Counties		• Even within Texas the impact is isolated • 18 counties in Texas account for 80% ($270M)of the total Texas impact • Texas has 7% of enrollees and 22% of all US HHA's
6 Exhibit 8		Top 25 CBSAs (Cities) based on limit savings		• The top 25 cities with the highest limit impact account for 80% of the national total. Most are in TX, LA and OK. • Chicago and Los Angeles contribute more than most states
7 Exhibit 8a		Top 25 CBSAs (Cities) not producing high limit savings		• Demonstrates the broad and substantial integrity of providers in this group producing 0.6% reimbursement reduction • NYC, Washington-Baltimore and Atlanta total 2.5M enrollees equal to Texas yet COMBINED produce only $250,000 of excess utilization
8 Exhibit 3		Impact of 10% outlier limit		• Splits providers into Low (83%) and High (17%) utilizers, proves that low utilizers declined even further while payment limit stopped high utilizers from abusing • Proven savings of $900M PER YEAR • The HH outlier limit saves more in one year than MSSP ACO's have since inception
9 Exhibit 5		Impact of Episode payment safeguards		• Also splits providers into Low (70%) and High (30%) utilizers. Low utilizers decreased utilization even further just from "Sentinel Effect" of safeguard proposal • High utilizers have stayed about the same – Savings Opportunity >$600M

Exhibit 4

2014 Claims Data: Correlation of Utilization to Population and Number of Providers

State	Traditional Enrollees	Unique HH Users	Episodes	Total Reimb	# Providers	Providers Per 10K Enrolled	Users % of Enrolled	Epi Per User	$ Per User	$ Per Enrollee	Limit Savings	Limit Savings %	Adj $ Per User	Adj $ Per Enrollee	Avg Star Rating
AK	78,507	2,112	3,064	9,440,936	12	1.5	2.7%	1.45	4,470	120	381	0%	4,469	120	2.6
AL	723,563	73,467	144,504	330,744,916	148	2.0	10.2%	1.97	4,502	457	687,810	0%	4,493	456	3.5
AR	474,522	35,985	67,584	154,399,781	171	3.6	7.6%	1.88	4,291	325	400,096	0%	4,279	325	2.9
AZ	679,307	42,635	62,533	170,514,638	150	2.2	6.3%	1.47	3,999	251	238,994	0%	3,994	251	3.3
CA	3,305,378	305,080	532,409	1,738,050,654	1,192	3.6	9.2%	1.75	5,697	526	33,044,445	2%	5,589	516	3.6
CO	485,374	34,501	52,569	155,709,749	147	3.0	7.1%	1.52	4,513	321	433,581	0%	4,501	320	3.3
CT	471,368	50,119	81,593	252,486,395	87	1.8	10.6%	1.63	5,038	536	227,590	0%	5,033	535	3.1
DC	76,451	4,952	6,964	19,851,052	19	2.5	6.5%	1.41	4,009	260	116,966	1%	3,985	258	3.0
DE	162,192	14,021	20,451	57,002,019	19	1.2	8.6%	1.46	4,065	351	48,942	0%	4,062	351	3.5
Miami-Dade	162,348	51,175	117,111	484,923,095	450	27.7	31.5%	2.29	9,476	2,987	30,101,006	6%	8,888	2,802	3.7
Rest of FL	2,218,271	301,026	543,445	1,575,241,448	778	3.5	13.6%	1.81	5,233	710	15,595,235	1%	5,181	703	3.5
GA	1,047,810	87,309	147,450	384,896,556	104	1.0	8.3%	1.69	4,408	367	132,246	0%	4,407	367	3.2
HI	127,674	2,657	3,428	10,693,893	14	1.1	2.1%	1.29	4,025	84	0	0%	4,025	84	3.4
IA	484,289	25,953	38,085	91,483,901	157	3.2	5.4%	1.47	3,525	189	389,005	0%	3,510	188	3.2
ID	185,858	13,291	22,330	64,008,051	46	2.5	7.2%	1.68	4,816	344	85,125	0%	4,809	344	3.4
IL	1,646,896	184,812	395,622	1,043,510,437	786	4.8	11.2%	2.14	5,646	634	83,141,691	8%	5,196	583	3.3
IN	878,607	61,659	105,845	289,730,894	228	2.6	7.0%	1.72	4,699	330	5,135,108	2%	4,616	324	3.1
KS	417,006	27,746	45,867	120,835,179	121	2.9	6.7%	1.65	4,355	290	331,312	0%	4,343	289	3.3
KY	640,356	58,771	112,642	271,783,404	101	1.6	9.2%	1.92	4,624	424	2,724,498	1%	4,578	420	3.3
LA	555,319	72,142	198,971	442,518,980	207	3.7	13.0%	2.76	6,134	797	37,816,950	9%	5,610	729	3.0
MA	952,013	110,876	183,676	544,954,195	178	1.9	11.6%	1.66	4,915	572	2,579,426	0%	4,892	570	3.3
MD	834,752	66,229	94,817	267,317,210	53	0.6	7.9%	1.43	4,036	320	50,850	0%	4,035	320	3.6
ME	239,273	19,181	28,916	73,292,362	26	1.1	8.0%	1.51	3,821	306	39,911	0%	3,819	306	3.4
MI	1,295,238	147,164	253,503	677,396,744	633	4.9	11.4%	1.72	4,603	523	5,486,679	1%	4,566	519	3.4
MN	425,302	36,826	53,795	150,251,221	170	4.0	8.7%	1.46	4,080	353	879,892	1%	4,056	351	2.9
MO	821,326	67,130	102,938	256,657,638	173	2.1	8.2%	1.53	3,823	312	1,007,651	0%	3,808	311	3.3
MS	478,636	56,776	142,295	317,592,512	46	1.0	11.9%	2.51	5,594	664	2,447,850	1%	5,551	658	3.3
MT	162,833	5,990	8,230	21,148,720	28	1.7	3.7%	1.37	3,531	130	5,589	0%	3,530	130	3.3
NC	1,235,009	104,444	162,625	400,988,010	174	1.4	8.5%	1.56	3,839	325	13,722	0%	3,839	325	3.2
ND	99,171	3,973	5,124	10,250,748	17	1.7	4.0%	1.29	2,580	103	6,833	0%	2,578	103	3.3
NE	271,242	15,966	24,365	66,511,389	72	2.7	5.9%	1.53	4,166	245	622,272	1%	4,127	243	3.3
NH	241,635	20,032	30,747	82,076,325	33	1.4	8.3%	1.53	4,097	340	16,809	0%	4,096	340	3.3
NJ	1,248,238	100,340	144,789	411,033,520	46	0.4	8.0%	1.44	4,096	329	10,811	0%	4,096	329	3.7
NM	250,738	16,556	31,240	82,375,536	74	3.0	6.6%	1.89	4,976	329	648,428	1%	4,936	326	3.3
NV	293,845	27,773	53,193	159,042,848	118	4.0	9.5%	1.92	5,727	541	2,938,624	2%	5,621	531	3.3
NY	2,101,774	172,617	263,655	775,645,176	157	0.7	8.2%	1.53	4,493	369	73,709	0%	4,493	369	3.2
OH	1,298,830	120,862	215,950	545,841,907	684	5.3	9.3%	1.79	4,516	420	11,237,750	2%	4,423	412	3.0
OK	559,504	67,623	192,142	437,093,325	264	4.7	12.1%	2.84	6,464	781	47,719,666	11%	5,758	696	3.0
OR	412,710	22,004	34,642	95,591,851	59	1.4	5.3%	1.57	4,344	232	3,997	0%	4,344	232	2.9
PA	1,508,767	147,470	232,434	596,963,337	339	2.2	9.8%	1.58	4,048	396	2,288,066	0%	4,033	394	3.4
RI	131,394	13,680	21,604	59,680,650	30	2.3	10.4%	1.58	4,363	454	96,161	0%	4,355	453	3.7
SC	711,945	53,683	82,561	212,935,812	65	0.9	7.5%	1.54	3,967	299	0	0%	3,967	299	3.4
SD	127,825	4,616	6,123	15,655,642	34	2.7	3.6%	1.33	3,392	122	56,856	0%	3,379	122	3.6
TN	816,437	77,662	161,054	410,865,092	138	1.7	9.5%	2.07	5,290	503	2,964,397	1%	5,252	500	3.3

Exhibit 4

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State	Traditional Enrollees	Unique HH Users	Episodes	Total Reimb	# Providers	Providers Per 10K Enrolled	Users % of Enrolled	Epi Per User	$ Per User	$ Per Enrollee	Limit Savings	Limit Savings %	Adj $ Per User	Adj $ Per Enrollee	Avg Star Rating
TX	2,497,574	331,261	956,668	2,376,202,764	2,571	10.3	13.3%	2.89	7,173	951	339,953,515	14%	6,147	815	2.9
UT	222,519	21,269	37,945	113,438,624	105	4.7	9.6%	1.78	5,334	510	1,348,671	1%	5,270	504	3.7
VA	1,088,031	94,454	157,335	412,711,008	229	2.1	8.7%	1.67	4,369	379	3,276,881	1%	4,335	376	3.3
VT	119,923	10,416	17,608	43,921,927	12	1.0	8.7%	1.69	4,217	366	0	0%	4,217	366	3.3
WA	809,735	43,212	65,850	198,688,514	61	0.8	5.3%	1.52	4,598	245	27,128	0%	4,597	245	3.0
WI	663,807	35,510	53,671	138,176,675	103	1.6	5.3%	1.51	3,891	208	134,585	0%	3,887	208	3.1
WV	305,346	22,384	39,207	96,982,031	58	1.9	7.3%	1.75	4,333	318	76	0%	4,333	318	3.2
WY	89,955	3,309	5,511	14,869,149	28	3.1	3.7%	1.67	4,494	165	37,869	0%	4,482	165	2.9
Territories	212,816	7,142	12,203	20,173,746	47	2.2	3.4%	1.71	2,825	95	31,575	0%	2,820	95	
Total	**37,349,239**	**3,497,843**	**6,578,883**	**17,754,152,185**	**11,762**	**3.1**	**9.4%**	**1.88**	**5,076**	**475**	**636,657,233**	4%	4,894	458	3.2
Highlighted 5 States	7,639,912	1,008,038	2,403,959	6,359,490,049	5,056	6.6	13.2%	**2.38**	6,309	832	554,328,063	9%	5,759	760	3.1
% of Total U.S.	20%	29%	37%	36%	43%										
% of Rest of U.S.	26%	40%	58%	56%	75%	293%	157%	142%	138%	217%	673%	1206%	127%	200%	
Other 45 States	29,709,327	2,489,805	4,174,924	11,394,662,136	6,706	2.3	8.4%	**1.68**	4,577	384	82,329,169	1%	4,543	381	3.3

In 2014, 20% of Medicare traditional enrollees lived in the five highlighted states, yet 36% of home health reimbursement occured in these areas. States with a high provider density correlate to states with higher home health usage. The five highlighted states have a provider density which is three times the provider density of the rest of the U.S. (6.6 providers per 10,000 enrolled in five states compared to 2.3 in the rest of the U.S). Other metrics that are higher in these five states than the rest of the U.S. include: home health users as a percentage of those enrolled (13.2% compared to 8.4%); Average episodes per user (2.38 compared to 1.68); Average spend per user ($6,309 compared to $4,577); and Average spend per enrollee ($832 compared to $384).

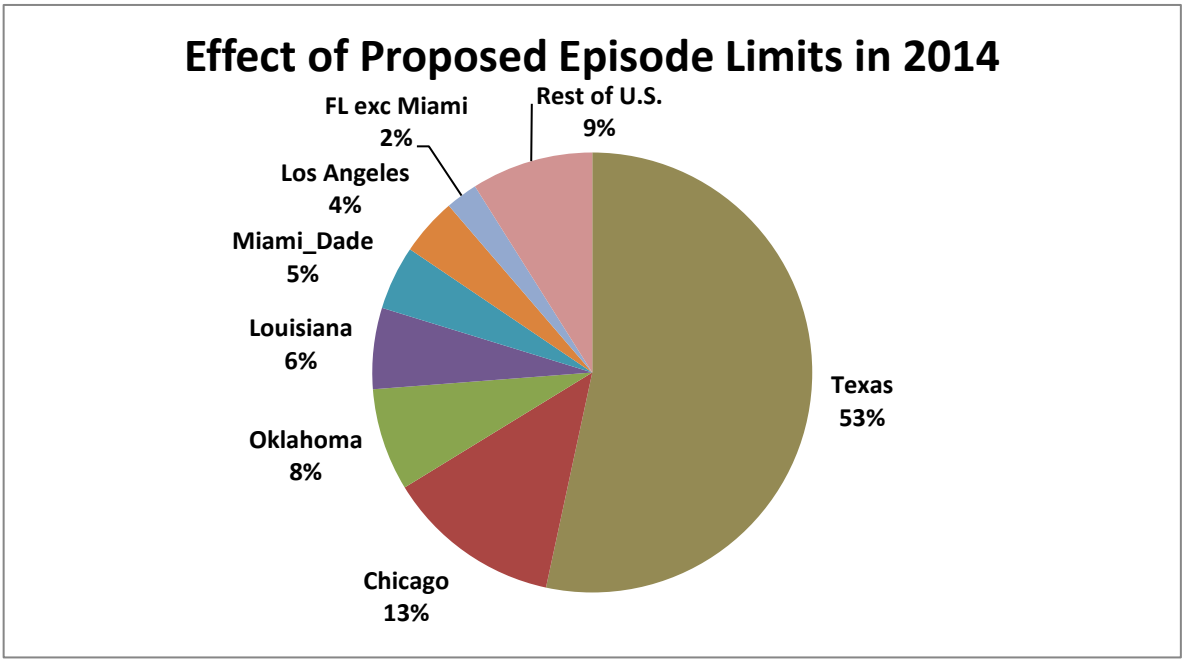
Exhibit 4a

2014 Claims Data: Correlation of STAR Rating to Proposed Episode Limits

STAR Rating	Unique HH Users	Episodes	Total Reimb	# Providers	Epi Per User	$ Per User	Limit Savings	Limit Savings %	Adj $ Per User
5	67,949	125,176	379,688,022	252	1.84	5,588	13,431,184	4%	5,390
4	978,979	1,699,466	4,800,535,343	2,230	1.74	4,904	93,953,214	2%	4,808
3	1,821,255	3,250,463	8,788,143,668	4,204	1.78	4,825	160,733,650	2%	4,737
2	523,521	1,216,619	3,049,403,696	2,391	**2.32**	5,825	253,752,327	**8%**	5,340
1	22,922	73,297	165,310,148	204	**3.20**	7,212	31,168,757	**19%**	5,852
Not Rated	83,403	214,419	572,624,976	2,483	**2.57**	6,866	83,647,266	**15%**	5,863
Total	**3,498,030**	**6,579,440**	**17,755,705,854**	**11,764**	**1.88**	**5,076**	**636,686,398**	4%	4,894
4 Star or higher	1,046,928	1,824,642	5,180,223,365	2,482	1.74	4,948	107,384,398	2%	4,845
2 Star or less	629,846	1,504,335	3,787,338,821	5,078	2.39	6,013	368,568,350	10%	5,428

							Avg Visits Per Reg Episode		
STAR Rating	Lupa %	OL %	Reg Case Mix	(1) HH Composite	% No Ther	% w/ Ther Reimb	SN	TH	Total
5	6.5%	2.8%	1.1287	83.45	37.3%	50.7%	8.48	7.46	17.45
4	8.7%	2.3%	1.0876	78.96	36.5%	48.4%	8.42	7.30	17.35
3	9.6%	2.7%	1.0425	75.22	38.8%	46.0%	8.53	7.19	17.76
2	8.0%	3.2%	0.9752	70.59	51.7%	37.4%	9.03	5.80	17.54
1	6.0%	3.7%	0.8948	65.53	69.3%	24.7%	9.73	3.78	16.74
Not Rated	5.2%	5.1%	0.9362	73.55	57.5%	35.7%	8.56	5.62	17.08
Total	**8.8%**	**2.8%**	**1.0471**	**74.93**	**41.5%**	**44.5%**	**8.61**	**6.87**	**17.58**
4 Star or higher	8.6%	2.3%	1.1081	81.20	36.6%	48.5%	8.42	7.31	17.36
2 Star or less	7.5%	3.5%	0.9354	69.89	53.3%	36.6%	8.99	5.68	17.43

(1) composite score of CMS Home Health Compare rankings (higher is better)


Effect of Proposed Episode Limits in 2014
FL exc Miami
2%
Rest of U.S.
9%
Los Angeles
4%
Miami_Dade
5%
Louisiana
6%
Oklahoma
8%
Chicago
13%
Texas
53%

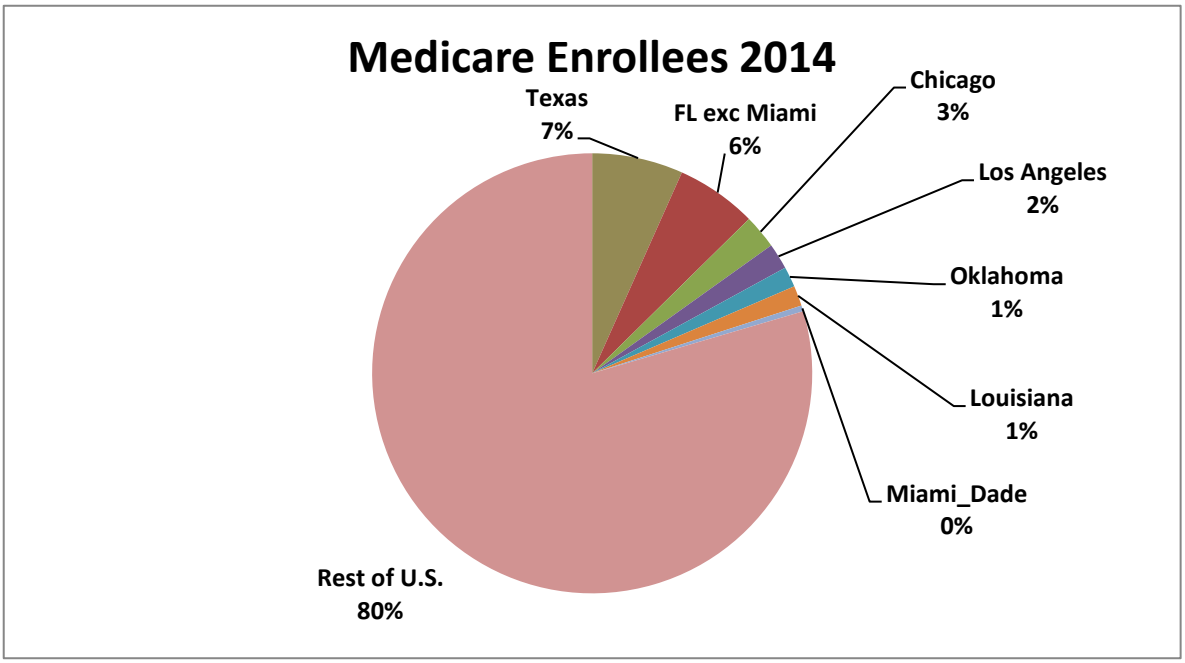

Medicare Enrollees 2014
Texas
7%
FL exc Miami
6%
Chicago
3%
Los Angeles
2%
Oklahoma
1%
Louisiana
1%
Miami_Dade
0%
Rest of U.S.
80%

Exhibit 4b

2014 Claims Data

Impact of Safeguards on Texas Counties

Lupa Min: 5.0%

Epi/User Cap: 3.30/2.70

		Savings from Safeguards				
County	**Total Reimb**	**Lupa**	**Episode**	**Total**	**% of Reimb**	**City**
TX-DALLAS	266,085,567	3,660,070	56,546,216	60,206,287	23%	Dallas/FTW
TX-HARRIS	341,501,648	4,129,992	59,768,612	63,898,605	19%	Houston
TX-HIDALGO	127,543,318	2,098,046	29,214,856	31,312,901	25%	McAllen
TX-FORT BEND	92,111,100	1,508,505	17,966,500	19,475,005	21%	Houston
TX-TARRANT	155,727,789	1,095,429	12,819,645	13,915,075	9%	Dallas/FTW
TX-WEBB	46,394,881	1,128,928	14,053,184	15,182,113	33%	Laredo
TX-EL PASO	69,625,375	475,831	9,110,496	9,586,326	14%	El Paso
TX-CAMERON	31,120,927	367,205	4,855,950	5,223,154	17%	Brownsville
TX-COLLIN	70,884,283	802,979	8,774,418	9,577,397	14%	Dallas/FTW
TX-BEXAR	119,903,640	417,057	5,796,607	6,213,665	5%	San Antonio
TX-DENTON	45,754,342	509,953	5,711,208	6,221,161	14%	Dallas/FTW
TX-LUBBOCK	43,781,669	159,060	3,840,752	3,999,811	9%	Lubbock
TX-NUECES	31,385,449	156,973	4,188,075	4,345,048	14%	Corpus Christi
TX-WICHITA	28,781,924	214,075	6,066,089	6,280,165	22%	Witchata Falls
TX-MIDLAND	20,928,752	81,677	3,510,255	3,591,932	17%	Midland
TX-GRAYSON	23,550,781	154,969	5,091,623	5,246,592	22%	Sherman
TX-KAUFMAN	16,695,263	121,860	2,438,137	2,559,997	15%	Dallas
TX-TRAVIS	59,178,057	207,606	1,815,142	2,022,748	3%	Austin
Subtotal 18 Counties	**1,590,954,765**	**17,290,215**	**251,567,765**	**268,857,981**	**17%**	
	67%	**76%**	**79%**	**79%**		
TEXAS TOTAL	**2,376,202,764**	**22,795,242**	**317,158,272**	**339,953,515**	**14%**	
REST OF TEXAS	**785,247,999**	**5,505,027**	**65,590,507**	**71,095,534**	**9%**	

Note that Lupa and Episode safeguards in the top 18 Texas counties represent 17% of their total reimbursement. This compares to 9% for the remaining Texas counties, 14% for Texas overall, and 4% nationwide. Texas has the highest percentage of reimbursement among all U.S. states.

Exhibit 8: Top 25 CBSAs Based on Limit Savings **Cities where excess utilization is prevalent**

CMS 2014 Data

CBSA	Traditional Enrollees	Unique HH Users	Episodes	Total Reimb	# Providers	Providers Per 10K Enrolled	Users % of Enrolled	Epi Per User	$ Per User	$ Per Enrollee	Limit Savings	Limit Savings %	Adj $ Per User	Adj $ Per Enrollee	Avg Star Rating
Houston-Sugar Land-Baytown, TX	467,479	62,022	182,168	491,349,545	756	16.2	13.3%	2.94	7,922	1,051	88,381,887	18.0%	6,497	862	2.9
Dallas-Plano-Irving, TX	379,129	56,045	170,097	433,545,884	647	17.1	14.8%	3.03	7,736	1,144	83,838,146	19.3%	6,240	922	2.8
Chicago-Naperville-Joliet, IL	934,017	140,722	327,736	873,504,767	664	7.1	15.1%	2.33	6,207	935	81,974,855	9.4%	5,625	847	3.3
McAllen-Edinburg-Mission TX	60,769	17,332	59,220	127,543,318	151	24.8	28.5%	3.42	7,359	2,099	31,312,901	24.6%	5,552	1,584	2.4
Miami-Miami Beach-Kendall, FL	162,348	51,175	117,111	484,923,095	450	27.7	31.5%	2.29	9,476	2,987	30,101,006	6.2%	8,888	2,802	3.7
Los Angeles-Long Beach-Glendale, CA	710,713	108,185	224,699	719,777,216	632	8.9	15.2%	2.08	6,653	1,013	26,959,978	3.7%	6,404	975	3.6
Oklahoma City, OK	159,085	21,719	58,586	141,906,657	72	4.5	13.7%	2.70	6,534	892	17,768,801	12.5%	5,716	780	3.0
Fort Worth-Arlington, TX	178,247	23,337	60,636	167,223,046	133	7.5	13.1%	2.60	7,166	938	15,308,776	9.2%	6,510	852	2.9
Laredo, TX	23,304	5,410	21,005	46,394,881	45	19.3	23.2%	3.88	8,576	1,991	15,182,113	32.7%	5,769	1,339	2.4
El Paso, TX	59,726	10,000	29,004	69,625,375	65	10.9	16.7%	2.90	6,963	1,166	9,586,326	13.8%	6,004	1,005	3.0
New Orleans-Metairie-Kenner, LA	100,397	12,217	31,937	74,213,367	44	4.4	12.2%	2.61	6,075	739	8,527,633	11.5%	5,377	654	3.1
Monroe, LA	25,109	5,919	19,620	40,701,210	16	6.4	23.6%	3.31	6,876	1,621	7,965,050	19.6%	5,530	1,304	2.5
San Antonio-New Braunfels, TX	212,915	24,629	56,408	145,224,063	112	5.3	11.6%	2.29	5,896	682	7,794,368	5.4%	5,580	645	2.9
Tulsa, OK	118,103	13,111	32,731	77,710,846	41	3.5	11.1%	2.50	5,927	658	7,524,515	9.7%	5,353	594	3.1
Beaumont-Port Arthur, TX	45,013	5,625	17,952	42,308,522	35	7.8	12.5%	3.19	7,521	940	7,287,869	17.2%	6,226	778	3.0
Wichita Falls, TX	23,102	3,589	11,967	29,070,098	17	7.4	15.5%	3.33	8,100	1,258	6,280,566	21.6%	6,350	986	3.3
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	133,185	23,440	49,358	166,150,792	131	9.8	17.6%	2.11	7,088	1,248	5,398,339	3.2%	6,858	1,207	3.3
Tampa-St. Petersburg-Clearwater, FL	310,363	54,800	105,367	307,126,724	144	4.6	17.7%	1.92	5,605	990	5,269,534	1.7%	5,508	973	3.6
Sherman-Denison, TX	20,325	2,882	9,721	23,550,781	14	6.9	14.2%	3.37	8,171	1,159	5,246,592	22.3%	6,351	901	2.4
Austin-Round Rock-San Marcos, TX	158,245	16,156	38,328	106,385,435	52	3.3	10.2%	2.37	6,585	672	5,233,337	4.9%	6,261	639	3.2
Brownsville-Harlingen, TX	35,268	4,857	15,006	31,120,927	40	11.3	13.8%	3.09	6,407	882	5,223,154	16.8%	5,332	734	2.7
Alexandria, LA	25,999	3,815	12,020	28,600,232	8	3.1	14.7%	3.15	7,496	1,100	4,992,767	17.5%	6,187	908	3.1
Gary, IN	105,410	11,440	24,938	64,698,178	66	6.3	10.9%	2.18	5,655	614	4,879,973	7.5%	5,229	567	2.9
Corpus Christi, TX	39,421	5,428	15,784	34,487,721	40	10.1	13.8%	2.91	6,354	875	4,833,500	14.0%	5,463	752	2.9
Baton Rouge, LA	68,804	8,102	20,361	45,277,091	26	3.8	11.8%	2.51	5,589	658	4,748,102	10.5%	5,003	589	3.0
Top 25 Subtotal	**4,556,476**	**691,958**	**1,711,760**	**4,772,419,770**	**4,401**	**9.7**	**15.2%**	**2.47**	**6,897**	**1,047**	**491,620,088**	**10.3%**	**6,187**	**939**	**3.2**
Ratio to US totals	12.2%	19.8%	26.0%	26.9%	37.4%	306.7%	162.2%	131.5%	135.9%	220.3%	77.2%	287.3%	126.4%	205.0%	
All of U.S.	**37,349,239**	**3,497,843**	**6,578,883**	**17,754,152,185**	**11,762**	**3.1**	**9.4%**	**1.88**	**5,076**	**475**	**636,657,233**	**3.6%**	**4,894**	**458**	**3.2**

Exhibit 8A: Top 25 CBSAs Based on Total Reimbursement NOT ON EXHIBIT 8 **Cities with minimal apparent excess utilization**

CMS 2014 Data

CBSA	Traditional Enrollees	Unique HH Users	Episodes	Total Reimb	# Providers	Providers Per 10K Enrolled	Users % of Enrolled	Epi Per User	$ Per User	$ Per Enrollee	Limit Savings	Limit Savings %	Adj $ Per User	Adj $ Per Enrollee	Avg Star Rating
New York-White Plains-Wayne, NY-NJ	1,142,045	102,414	157,345	513,421,983	61	0.5	9.0%	1.54	5,013	450	14,171	0.0%	5,013	450	3.0
Warren-Farmington Hills-Troy, MI	318,706	60,568	108,594	306,286,849	318	10.0	19.0%	1.79	5,057	961	3,115,774	1.0%	5,005	951	3.5
Philadelphia, PA	465,127	48,263	76,475	225,700,446	90	1.9	10.4%	1.58	4,676	485	1,553,309	0.7%	4,644	482	3.3
West Palm Beach-Boca Raton-Boynton Beach, FL	181,554	36,937	65,979	199,937,634	106	5.8	20.3%	1.79	5,413	1,101	1,233,545	0.6%	5,380	1,094	3.6
Atlanta-Sandy Springs-Marietta, GA	474,592	35,542	58,188	162,284,312	30	0.6	7.5%	1.64	4,566	342	248	0.0%	4,566	342	3.3
Orlando-Kissimmee-Sanford, FL	215,040	31,403	55,607	159,843,670	86	4.0	14.6%	1.77	5,090	743	2,096,899	1.3%	5,023	734	3.5
Cambridge-Newton-Framingham, MA	192,421	30,920	51,251	152,780,177	39	2.0	16.1%	1.66	4,941	794	762,042	0.5%	4,916	790	3.5
Nassau-Suffolk, NY	397,173	33,647	49,195	151,413,509	25	0.6	8.5%	1.46	4,500	381	10,252	0.0%	4,500	381	3.2
Baltimore-Towson, MD	405,315	35,926	51,868	148,449,014	25	0.6	8.9%	1.44	4,132	366	17,207	0.0%	4,132	366	3.5
Washington-Arlington-Alexandria, DC-VA-MD-WV	480,131	32,965	49,211	145,963,244	86	1.8	6.9%	1.49	4,428	304	222,564	0.2%	4,421	304	3.2
Oakland-Fremont-Hayward, CA	217,228	22,874	33,693	135,916,502	39	1.8	10.5%	1.47	5,942	626	139,222	0.1%	5,936	625	3.7
St. Louis, MO-IL	340,468	33,510	51,835	135,702,316	68	2.0	9.8%	1.55	4,050	399	806,293	0.6%	4,026	396	3.2
Las Vegas-Paradise, NV	182,586	21,272	43,336	131,617,030	105	5.8	11.7%	2.04	6,187	721	2,902,795	2.2%	6,051	705	3.4
Boston-Quincy, MA	259,267	23,621	40,404	124,123,242	46	1.8	9.1%	1.71	5,255	479	1,301,278	1.0%	5,200	474	3.3
San Diego-Carlsbad-San Marcos, CA	250,665	24,731	39,180	121,703,229	42	1.7	9.9%	1.58	4,921	486	301,085	0.2%	4,909	484	3.4
Jacksonville, FL	174,643	23,464	42,980	117,135,079	44	2.5	13.4%	1.83	4,992	671	209,805	0.2%	4,983	670	3.5
Minneapolis-St. Paul-Bloomington, MN-WI	218,096	26,917	39,708	112,882,958	57	2.6	12.3%	1.48	4,194	518	817,940	0.7%	4,163	514	2.8
Phoenix-Mesa-Glendale, AZ	377,820	27,217	39,513	111,213,603	88	2.3	7.2%	1.45	4,086	294	149,549	0.1%	4,081	294	3.3
Riverside-San Bernardino-Ontario, CA	252,578	20,610	37,976	107,693,152	108	4.3	8.2%	1.84	5,225	426	2,512,075	2.3%	5,104	416	3.4
Hartford-West Hartford-East Hartford, CT	157,730	22,723	36,290	107,663,248	29	1.8	14.4%	1.60	4,738	683	146,609	0.1%	4,732	682	3.2
Cleveland-Elyria-Mentor, OH	244,849	26,584	43,911	107,062,835	86	3.5	10.9%	1.65	4,027	437	735,053	0.7%	4,000	434	3.1
Cape Coral-Fort Myers, FL	110,952	22,310	36,618	105,887,905	29	2.6	20.1%	1.64	4,746	954	344,731	0.3%	4,731	951	3.8
Providence-New Bedford-Fall River, RI-MA	225,098	22,292	36,492	101,867,077	39	1.7	9.9%	1.64	4,570	453	150,489	0.1%	4,563	452	3.6
Pittsburgh, PA	191,972	24,596	41,184	98,509,752	66	3.4	12.8%	1.67	4,005	513	146,943	0.1%	3,999	512	3.4
Detroit-Livonia-Dearborn, MI	215,334	19,737	35,154	97,395,925	139	6.5	9.2%	1.78	4,935	452	1,757,427	1.8%	4,846	444	3.4
Top 25 Subtotal	**7,691,390**	**811,044**	**1,321,987**	**3,882,454,692**	**1,851**	**2.4**	**10.5%**	**1.63**	**4,787**	**505**	**21,447,306**	**0.6%**	**4,761**	**502**	**3.4**
All of U.S.	**37,349,239**	**3,497,843**	**6,578,883**	**17,754,152,185**	**11,762**	**3.1**	**9.4%**	**1.88**	**5,076**	**475**	**636,657,233**	**3.6%**	**4,894**	**458**	**3.2**

Exhibit 3
Impact of 10% Outlier Limit on Home Health Agencies - All of U.S.

												5yrs 2009 - 2014	
Provider Status	**Metric**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**# Avg Chg**	**CAGR**
	# Providers	7,014	7,363	7,698	7,972	8,378	8,202	8,056	7,867	7,646	7,429	-190	-2.4%
	Total Reimb	11,505,995,521	12,089,732,394	13,154,688,322	14,399,195,439	15,802,705,635	17,096,438,560	15,868,520,030	15,271,498,821	14,861,473,197	14,479,127,376	-264,715,652	-1.7%
	Avg Reimb/Prov	1,640,433	1,641,957	1,708,845	1,806,221	1,886,215	2,084,423	1,969,777	1,941,210	1,943,693	1,949,001	12,557	0.7%
	Outlier Reimb	205,501,808	221,023,304	253,130,857	182,112,067	124,714,016	168,598,023	152,300,527	173,455,215	197,952,633	177,929,555	10,643,108	7.4%
Providers	Outlier %	1.8%	1.8%	1.9%	1.3%	0.8%	1.0%	1.0%	1.1%	1.3%	1.2%		
Under	Non-OL Reimb	11,300,493,713	11,868,709,090	12,901,557,465	14,217,083,372	15,677,991,619	16,927,840,536	15,716,219,503	15,098,043,606	14,663,520,564	14,301,197,821	-275,358,760	-1.8%
10% Outlier	LUPA %	12.7%	11.7%	11.3%	10.8%	10.0%	9.7%	9.8%	10.0%	10.1%	10.2%		
Limit	Regular Case Mix (1)	1.2406	1.2557	1.2867	1.3246	1.3667	1.3806	1.4002	1.4615	1.5163	1.1722	-0.0389	-3.0%
in 2009	Regular Episodes	4,089,926	4,221,831	4,430,906	4,823,669	5,164,982	5,402,186	5,299,656	5,149,809	4,979,619	4,840,606	-64,875	-1.3%
	Episodes	4,820,056	4,921,796	5,127,860	5,489,986	5,810,892	6,087,816	5,971,479	5,810,078	5,669,692	5,477,840	-66,610	-1.2%
	Undup Benes	2,804,374	2,798,086	2,725,188	2,919,659	3,044,004	3,126,728	3,107,897	3,099,960	3,138,842	3,009,421	-6,917	-0.2%
	Episodes/Bene	1.72	1.76	1.88	1.88	1.91	1.95	1.92	1.87	1.81	1.82	-0.02	-0.9%
	Episode Savings	217,677,205	286,516,019	476,218,048	556,327,721	659,285,328	709,924,794	625,146,730	507,912,240	402,008,029	358,242,395	-60,208,587	-11.5%
	# Providers	842	1,055	1,220	1,433	1,734	1,678	1,618	1,538	1,418	1,293	-88	-5.7%
	Total Reimb	1,305,584,154	1,651,293,040	2,409,198,499	2,666,887,681	2,962,132,155	2,178,094,526	1,892,095,842	1,726,418,506	1,591,133,515	1,427,502,276	-306,925,976	-13.6%
	Avg Reimb/Prov	1,550,575	1,565,207	1,974,753	1,861,052	1,708,265	1,298,030	1,169,404	1,122,509	1,122,097	1,104,023	-120,848	-8.4%
	Outlier Reimb	321,503,204	468,818,155	842,816,349	971,543,302	1,103,563,851	197,562,878	121,150,024	121,781,064	109,876,826	96,818,881	-201,348,994	-38.5%
Providers	Outlier %	24.6%	28.4%	35.0%	36.4%	37.3%	9.1%	6.4%	7.1%	6.9%	6.8%		
Over	Non-OL Reimb	984,080,950	1,182,474,886	1,566,382,150	1,695,344,379	1,858,568,304	1,980,531,647	1,770,945,818	1,604,637,442	1,481,256,689	1,330,683,395	-105,576,982	-6.5%
10% Outlier	LUPA %	6.1%	5.3%	4.6%	4.5%	4.4%	4.4%	4.8%	4.8%	4.9%	5.0%		
Limit	Regular Case Mix (1)	1.1734	1.1787	1.2023	1.1820	1.1586	1.3001	1.3142	1.3564	1.3993	1.0340	-0.0249	-2.2%
in 2009	Regular Episodes	274,150	318,729	382,044	435,000	476,264	554,001	536,860	486,855	437,628	402,641	-14,725	-3.3%
	Episodes	368,285	438,782	559,652	631,994	694,467	699,619	640,736	572,510	520,819	472,460	-44,401	-7.4%
	Undup Benes	160,677	182,984	206,464	233,584	258,511	264,267	247,127	234,297	222,189	197,828	-12,136	-5.2%
	Episodes/Bene	2.29	2.40	2.71	2.71	2.69	2.65	2.59	2.44	2.34	2.39	-0.06	-2.3%
	Episode Savings	63,482,702	96,902,871	233,317,055	242,375,511	266,874,206	240,100,509	207,452,979	147,955,621	111,602,790	99,708,222	-33,433,197	-17.9%
	# Providers	7,856	8,418	8,918	9,405	10,112	10,875	11,390	11,701	11,876	11,764	330	3.1%
	Total Reimb	12,811,579,676	13,741,025,435	15,563,886,821	17,066,083,120	18,764,837,790	19,437,503,286	18,397,819,485	18,056,911,807	17,917,665,831	17,755,705,854	-201,826,387	-1.1%
	Avg Reimb/Prov	1,630,802	1,632,338	1,745,222	1,814,576	1,855,700	1,787,357	1,615,261	1,543,194	1,508,729	1,509,326	-69,275	-4.0%
	Episodes	5,188,341	5,360,578	5,687,512	6,121,980	6,505,359	6,838,385	6,822,473	6,737,788	6,681,860	6,579,440	14,816	0.2%
	Undup Benes	2,965,051	2,981,069	2,931,652	3,153,243	3,302,515	3,416,779	3,448,866	3,497,411	3,592,806	3,498,030	39,103	1.2%
	Traditional Enrollees	36,204,964	35,291,924	35,346,059	35,004,234	34,968,097	35,290,166	36,361,748	36,944,218	37,253,278	37,349,239	476,228	1.3%
	Reimb/Episode	2,469	2,563	2,737	2,788	2,885	2,842	2,697	2,680	2,682	2,699	-37	-1.3%
	Episodes/Bene	1.75	1.80	1.94	1.94	1.97	2.00	1.98	1.93	1.86	1.88	-0.02	-0.9%
	Avg Length of Stay	101.35	104.39	112.64	114.00	117.14	117.57	116.84	115.38	113.82	112.85	-0.86	-0.7%
	Outlier Reimb	527,005,012	689,841,459	1,095,947,206	1,153,655,369	1,228,277,867	369,646,124	286,228,984	319,898,059	342,843,843	316,457,219	-182,364,130	-23.8%
	Outlier %	4.1%	5.0%	7.0%	6.8%	6.5%	1.9%	1.6%	1.8%	1.9%	1.8%		
	Outlier Episodes	190,354	219,499	268,513	243,314	254,817	212,877	177,924	170,441	218,034	181,696	-14,624	-6.5%
All	Non-OL Reimb	12,284,574,663	13,051,183,976	14,467,939,615	15,912,427,751	17,536,559,923	19,067,857,161	18,111,590,501	17,737,013,748	17,574,821,988	17,439,248,635	-19,462,258	-0.1%
Providers	Regular Case Mix	1.2364	1.2503	1.2800	1.3128	1.3491	1.3626	1.3478	1.3733	1.3923	1.0471	-0.0210	-1.8%
	Reg Visits/Epi	17.8	17.8	17.6	17.7	17.9	17.6	17.5	16.9	16.9	17.6	-0.06	-0.3%
	Reg SN Visits/Epi	8.2	8.2	8.3	8.3	8.4	8.3	8.2	8.1	8.2	8.6	0.04	0.5%
	Reg TH Visits/Epi	5.7	5.7	5.8	5.9	6.2	6.4	6.5	6.3	6.5	6.9	0.13	2.0%
	Outcomes - Hospital (2)	28	28	28	29	29	29	27	17	16	16	-2.60	-11.2%
	Outcomes - Walk	37	39	41	44	45	47	55	55	57	63	3.60	7.0%
	Outcomes - Transfer	51	52	53	53	54	54	53	52	52	58	0.80	1.4%
	Outcomes - Pain	61	62	63	64	64	64	66	65	65	68	0.80	1.2%
	Outcomes - Bath	61	62	63	64	64	65	64	63	63	68	0.80	1.2%
	Outcomes - Meds	39	40	41	43	43	43	46	45	46	52	1.80	3.9%
	Outlier Savings	274,846,606	409,781,371	777,252,200	851,199,265	897,056,261	18,774,629	1,661,851	268,794	505,956	622,682	-179,286,716	-76.6%
	LUPA Savings	33,062,096	54,107,558	84,528,223	93,515,041	107,946,798	94,411,020	88,288,688	85,314,365	84,659,347	80,922,666	-5,404,826	-5.6%
	Episode Savings	281,159,907	383,418,890	709,535,103	798,703,233	926,159,535	954,836,224	875,328,007	715,045,522	588,394,979	555,763,732	-74,079,160	-9.7%
National Payment Rate (1)		2,264.28	2,327.68	2,339.00	2,270.32	2,324.31	2,366.28	2,249.28	2,191.80	2,153.82	2,921.88	119.51	4.7%
Avg Reimb Regular Ep		2,799.56	2,910.30	2,993.92	2,980.48	3,135.73	3,224.29	3,031.58	3,010.00	2,998.76	3,059.50	28.88	1.0%

(1) CMS recalibrated the case mix model by a factor of 1.3464 in 2014

(2) CMS recalibrated its hospitalization measure in 2012

Exhibit 5
Potential Impact of Episode Per Beneficiary Limit on Home Health Agencies - All of U.S.

												5yrs 2009 - 2014	
Provider Status	**Metric**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**# Avg Chg**	**CAGR**
Providers Under 2.7/3.3 Episodes Per Beneficiary Limit in 2014	# Providers	6,639	6,897	7,214	7,486	7,931	8,362	8,655	8,763	8,776	8,623	138	1.7%
	Total Reimb	11,213,274,802	11,776,346,409	13,214,062,071	14,350,962,726	15,606,233,212	16,078,240,265	15,150,738,661	14,936,319,324	14,871,324,046	14,752,192,238	-170,808,195	-1.1%
	Avg Reimb/Prov	1,689,001	1,707,459	1,831,725	1,917,040	1,967,751	1,922,774	1,750,519	1,704,476	1,694,545	1,710,796	-51,391	-2.8%
	Outlier Reimb	422,202,233	543,038,498	875,606,072	901,279,271	914,523,477	270,240,388	209,567,773	238,157,491	261,562,810	237,098,825	-135,484,930	-23.7%
	Outlier %	3.8%	4.6%	6.6%	6.3%	5.9%	1.7%	1.4%	1.6%	1.8%	1.6%		
	Non-OL Reimb	10,791,072,569	11,233,307,911	12,338,455,998	13,449,683,455	14,691,709,735	15,807,999,878	14,941,170,888	14,698,161,833	14,609,761,236	14,515,093,413	-35,323,265	-0.2%
	LUPA %	13.1%	12.2%	11.6%	11.2%	10.4%	10.2%	10.1%	10.1%	10.0%	9.9%		
	Regular Case Mix (1)	1.2428	1.2578	1.2873	1.3365	1.3820	1.3921	1.3790	1.4116	1.4315	1.0777	-0.0609	-4.9%
	Regular Episodes	3,821,242	3,890,671	4,091,550	4,362,111	4,619,110	4,849,440	4,830,715	4,782,589	4,714,252	4,675,322	11,242	0.2%
	Episodes	4,580,676	4,634,727	4,875,829	5,124,067	5,369,590	5,576,217	5,524,385	5,463,567	5,428,876	5,340,557	-5,807	-0.1%
	Undup Benes	2,750,802	2,735,567	2,680,843	2,851,900	2,965,075	3,053,120	3,074,636	3,123,780	3,220,836	3,138,124	34,610	1.1%
	Episodes/Bene	1.67	1.69	1.82	1.80	1.81	1.83	1.80	1.75	1.69	1.70	-0.02	-1.2%
	Episode Savings	92,242,786	126,414,645	293,794,932	308,355,178	339,763,936	265,755,805	211,058,757	114,972,961	40,693,899	0	-67,952,787	-100.0%
Providers Over 2.7/3.3 Episodes Per Beneficiary Limit in 2014	# Providers	1,217	1,521	1,704	1,919	2,181	2,513	2,735	2,938	3,100	3,141	192	7.6%
	Total Reimb	1,598,304,873	1,964,679,025	2,349,824,750	2,715,120,394	3,158,604,578	3,359,263,020	3,247,080,824	3,120,592,483	3,046,341,785	3,003,513,616	-31,018,192	-1.0%
	Avg Reimb/Prov	1,313,315	1,291,702	1,379,005	1,414,862	1,448,237	1,336,754	1,187,232	1,062,149	982,691	956,228	-98,402	-8.0%
	Outlier Reimb	104,802,779	146,802,960	220,341,134	252,376,098	313,754,390	99,405,737	76,661,211	81,740,568	81,281,033	79,358,394	-46,879,199	-24.0%
	Outlier %	6.6%	7.5%	9.4%	9.3%	9.9%	3.0%	2.4%	2.6%	2.7%	2.6%		
	Non-OL Reimb	1,493,502,094	1,817,876,065	2,129,483,616	2,462,744,296	2,844,850,188	3,259,857,283	3,170,419,613	3,038,851,915	2,965,060,752	2,924,155,222	15,861,007	0.6%
	LUPA %	5.6%	5.0%	4.8%	4.7%	4.4%	4.4%	4.4%	4.3%	4.4%	4.3%		
	Regular Case Mix (1)	1.1911	1.2055	1.2388	1.1976	1.2004	1.2384	1.2221	1.2178	1.2315	0.9219	-0.0557	-5.1%
	Regular Episodes	542,834	649,889	721,400	896,558	1,022,136	1,152,837	1,198,432	1,178,762	1,148,780	1,141,179	23,809	2.2%
	Episodes	607,665	725,851	811,683	997,913	1,135,769	1,262,168	1,298,088	1,274,221	1,252,984	1,238,883	20,623	1.8%
	Undup Benes	214,249	245,503	250,809	301,343	337,439	363,658	374,230	373,631	371,969	359,906	4,493	1.3%
	Episodes/Bene	2.84	2.96	3.24	3.31	3.37	3.47	3.47	3.41	3.37	3.44	0.02	0.4%
	Episode Savings	188,917,121	257,004,246	415,740,170	490,348,054	586,395,599	689,080,419	664,269,250	600,072,561	547,701,080	555,763,732	-6,126,373	-1.1%
All Providers	# Providers	7,856	8,418	8,918	9,405	10,112	10,875	11,390	11,701	11,876	11,764	330	3.1%
	Total Reimb	12,811,579,676	13,741,025,435	15,563,886,821	17,066,083,120	18,764,837,790	19,437,503,286	18,397,819,485	18,056,911,807	17,917,665,831	17,755,705,854	-201,826,387	-1.1%
	Avg Reimb/Prov	1,630,802	1,632,338	1,745,222	1,814,576	1,855,700	1,787,357	1,615,261	1,543,194	1,508,729	1,509,326	-69,275	-4.0%
	Episodes	5,188,341	5,360,578	5,687,512	6,121,980	6,505,359	6,838,385	6,822,473	6,737,788	6,681,860	6,579,440	14,816	0.2%
	Undup Benes	2,965,051	2,981,069	2,931,652	3,153,243	3,302,515	3,416,779	3,448,866	3,497,411	3,592,806	3,498,030	39,103	1.2%
	Traditional Enrollees	36,204,964	35,291,924	35,346,059	35,004,234	34,968,097	35,290,166	36,361,748	36,944,218	37,253,278	37,349,239	476,228	1.3%
	Reimb/Episode	2,469	2,563	2,737	2,788	2,885	2,842	2,697	2,680	2,682	2,699	-37	-1.3%
	Episodes/Bene	1.75	1.80	1.94	1.94	1.97	2.00	1.98	1.93	1.86	1.88	-0.02	-0.9%
	Avg Length of Stay	101.35	104.39	112.64	114.00	117.14	117.57	116.84	115.38	113.82	112.85	-0.86	-0.7%
	Outlier Reimb	527,005,012	689,841,459	1,095,947,206	1,153,655,369	1,228,277,867	369,646,124	286,228,984	319,898,059	342,843,843	316,457,219	-182,364,130	-23.8%
	Outlier %	4.1%	5.0%	7.0%	6.8%	6.5%	1.9%	1.6%	1.8%	1.9%	1.8%		
	Outlier Episodes	190,354	219,499	268,513	243,314	254,817	212,877	177,924	170,441	218,034	181,696	-14,624	-6.5%
	Non-OL Reimb	12,284,574,663	13,051,183,976	14,467,939,615	15,912,427,751	17,536,559,923	19,067,857,161	18,111,590,501	17,737,013,748	17,574,821,988	17,439,248,635	-19,462,258	-0.1%
	Regular Case Mix	1.2364	1.2503	1.2800	1.3128	1.3491	1.3626	1.3478	1.3733	1.3923	1.0471	-0.0210	-1.8%
	Reg Visits/Epi	17.8	17.8	17.6	17.7	17.9	17.6	17.5	16.9	16.9	17.6	-0.06	-0.3%
	Reg SN Visits/Epi	8.2	8.2	8.3	8.3	8.4	8.3	8.2	8.1	8.2	8.6	0.04	0.5%
	Reg TH Visits/Epi	5.7	5.7	5.8	5.9	6.2	6.4	6.5	6.3	6.5	6.9	0.13	2.0%
	Outcomes - Hospital (2)	28	28	28	29	29	29	27	17	16	16	-2.60	-11.2%
	Outcomes - Walk	37	39	41	44	45	47	55	55	57	63	3.60	7.0%
	Outcomes - Transfer	51	52	53	53	54	54	53	52	52	58	0.80	1.4%
	Outcomes - Pain	61	62	63	64	64	64	66	65	65	68	0.80	1.2%
	Outcomes - Bath	61	62	63	64	64	65	64	63	63	68	0.80	1.2%
	Outcomes - Meds	39	40	41	43	43	43	46	45	46	52	1.80	3.9%
	Outlier Savings	274,846,606	409,781,371	777,252,200	851,199,265	897,056,261	18,774,629	1,661,851	268,794	505,956	622,682	-179,286,716	-76.6%
	LUPA Savings	33,062,096	54,107,558	84,528,223	93,515,041	107,946,798	94,411,020	88,288,688	85,314,365	84,659,347	80,922,666	-5,404,826	-5.6%
	Episode Savings	281,159,907	383,418,890	709,535,103	798,703,233	926,159,535	954,836,224	875,328,007	715,045,522	588,394,979	555,763,732	-74,079,160	-9.7%
National Payment Rate (1)		2,264.28	2,327.68	2,339.00	2,270.32	2,324.31	2,366.28	2,249.28	2,191.80	2,153.82	2,921.88	119.51	4.7%
Avg Reimb Regular Ep		2,799.56	2,910.30	2,993.92	2,980.48	3,135.73	3,224.29	3,031.58	3,010.00	2,998.76	3,059.50	28.88	1.0%

(1) CMS recalibrated the case mix model by a factor of 1.3464 in 2014

(2) CMS recalibrated its hospitalization measure in 2012

CBO: Home Health Spending Growing Slower Than Other Venues

Medicare Spending -- Historical and Projected by CBO

	Compound Annual Growth Rates		Beneficiaries and Spending In $B except Per Bene amounts		
	2012-2017	2018-2022			
	Last Five Years	Next Five Years	2012	2017	2022
Beneficiaries	0.4%	1.0%	34.1	34.8	36.6
Total Spend ($B)	1.4%	4.9%	$ 358.0	$ 384.0	$ 488.0
Per Beneficiary	1.0%	3.9%	$ 10,502	$ 11,033	$ 13,341
Hospital Spend	1.8%	4.8%	$ 174.0	$ 190.0	$ 240.0
Per Beneficiary	1.4%	3.7%	$ 5,104	$ 5,459	$ 6,561
Physicians	0.6%	4.9%	$ 68.0	$ 70.0	$ 89.0
Per Beneficiary	0.2%	3.9%	$ 1,995	$ 2,011	$ 2,433
SNF	0.7%	5.4%	$ 29.0	$ 30.0	$ 39.0
Per Beneficiary	0.3%	4.3%	$ 851	$ 862	$ 1,066
Home Health	**0.0%**	**3.9%**	**$ 19.0**	**$ 19.0**	**$ 23.0**
Per Beneficiary	**-0.4%**	**2.9%**	**$ 557**	**$ 546**	**$ 629**
Home Health % of Total			**5.3%**	**4.9%**	**4.7%**

Home health has been the slowest growing element and is projected to remain the slowest growing element over the next five years.

Home health is projected to shrink as a percent of total Medicare spending.

Source: Bank of America Merrill Lynch Equity Research Report on Home Health Care

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EBITDA margins

EBITDA is the most common profitability metric used in the home health industry. Given that companies form joint ventures (JVs) with health systems, the EBITDA metric is adjusted for minority interest.

Below we show Adjusted EBITDA margins (adjusted for one-time items and minority interest) for publicly traded home care companies in 2002-2016.

The companies reported elevated margins in the 10-15% range from 2005 to 2010 during the period of positive Medicare rate updates. Meanwhile, the average margin dropped to as low as 6% in 2013 due to the ongoing Medicare rate cuts. Margins rebounded since then are in the 8% range.

Table 40: Home Health historical Adjusted EBITDA margins, 2000-2016

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
AFAM	6.0%	6.6%	6.6%	7.2%	8.9%	11.2%	14.0%	15.0%	16.6%	11.7%	9.2%	6.2%	6.8%	7.6%	8.4%
AMED	3.0%	12.6%	16.5%	15.1%	14.0%	15.7%	15.3%	17.3%	14.8%	10.2%	7.1%	4.4%	6.2%	8.8%	7.6%
GTIV	3.0%	3.6%	4.3%	4.1%	6.8%	8.3%	9.0%	11.0%	13.8%	10.4%	10.5%	7.8%	NA	NA	NA
LHCG	13.3%	11.7%	13.0%	12.9%	14.6%	14.3%	13.7%	14.3%	13.7%	8.9%	8.9%	7.3%	7.4%	8.9%	8.4%
Average	**6.3%**	**8.6%**	**10.1%**	**9.8%**	**11.1%**	**12.4%**	**13.0%**	**14.4%**	**14.7%**	**10.3%**	**8.9%**	**6.4%**	**6.8%**	**8.4%**	**8.2%**

Adjusted EBITDA is adjusted for one-time items and minority interest.
GTIV was acquired by KND
Source: Company filings, BofA Merrill Lynch Global Research

Margins are heavily dependent on Medicare rates

Home health companies are heavily dependent on Medicare which accounts for about 80% of home health revenues on average for the publicly traded companies. Meanwhile, personal care business is more reliant on Medicaid and other government programs, which account for about 80% of revenues.

Home Health Subjected to Long and Severe Rate Cuts

Year	Description	% Cut
Prior to Rebasing		
2009-2013	Case mix creep adjustments -- These have all been proven to have resulted from increases in therapy visit utilization.	-14.4%
	The rates have been lowered but therapy utilization has normalized at the new higher level.	
2013	Sequestration -- 2% across the board	-2.0%
	Total prior to rebasing	**-16.4%**
Rebasing and SGR Fix		
2014-2017	Rebasing mandated by the ACA, calculated at the maximum allowable under the statute, phased in under four years.	-9.8%
2014-2017	Additional case mix creep adjustments -- again all related to increase in therapy visit utilization.	-2.9%
2018	Market basket reduction from MACRA SGR fix	-1.2%
	Total during period	**-13.9%**
	Subtotal BEFORE HHGM	**-30.3%**
Proposed in HHGM		
2019	**Rate cut from error/logic flaw in 60-30 day conversion**	**-14.2%**
	Total AFTER HHGM	**-44.5%**
	Average Cut PER YEAR, EVERY year for TEN Years	**-4.5%**

Even before HHGM, home health has sustained more rate cuts over a longer period than any other segment.

Unlike most sectors home health consists of entirely variable costs. Given clinical care giver wages and productivity, rate cuts to home health result directly in lower service levels to patients especially when rates are set BELOW costs as they are with the HHGM.

Background

CMS is required by statute to perform claims error rate testing by auditing large samples of providers' claims. A report of these error rates is published annually.

CMS implemented a physician face-to-face (F2F) encounter and documentation requirement for patients receiving home health services in mid-2011 (2012 being the first full year). At the time, CMS was advised strongly by home health providers and trade groups that the subjective nature of the documentation requirements was likely to lead to a dramatic increase in audit findings. Nonetheless the requirements were implemented. The 2013 CMS CERT report was the first time F2F requirements were mentioned as causing a problem with error rates. The reported error rate jumped from 6.1% in 2012 to 17.3% in 2013. In the 2013 report CMS noted the following:

> *"Insufficient documentation caused a large proportion of improper payments for home health service. Face-to-face encounter documentation that does not meet guidelines was the most common reason for insufficient documentation error."*

In its 2014 report CMS noted a dramatically increased 51.4% REPORTED home health error and stated the following:

> *"Since implementation of the face-to-face requirements in April 2011, CMS observed that the provider community had difficulty complying with the documentation requirements and these errors have increased the improper payment rate."*

In its 2015 report CMS noted that the REPORTED home health error rate increased to 59.0% and repeated the language from its 2013 reported shown above.

In 2016 CMS implemented the Pre-Claim Review process for home health service to attempt to address the high REPORTED home health error rates.

We say "REPORTED" in all capital letters because we believe the reported error rate is too high. It is, in fact, an erroneous error rate, dramatically overstated by the impact of CMS face-to-face document requirements as predicted by the home health provider industry. Industry efforts to convince CMS to make the face-to-face documentation standards clear and objective have improved matters, but have not been fully successful.

In September 2016, Almost Family President Steve Guenthner testified before the House Ways & Means Health Subcommittee with regard to the face-to-face documentation requirements, stating:

> *"CMS has fixed some of the problems, but we are left with an-over-reported error rate in home health payments. This now has CMS implementing a "pre-claim review" process that we expect to add significant burden and create unanticipated consequences. Not to actually reduce improper payments or improve quality, but rather to fix documentation issues caused by subjective regulations. CMS expects this to cost $300 million to implement."*

The table below shows the history of the error rates for total Medicare, Parts A & B and a selected group of provider types:

Overall Error Rates				Comparable Venues					
Year	Medicare	Part A	Part B	Hospital	Phys E&M	SNF	DMEPOS	Home Health	HH vs MCR
2010	10.5%	6.9%	12.5%	3.7%	12.3%	3.3%	73.8%	4.8%	-5.7%
2011	9.9%	7.4%	10.5%	9.6%	13.9%	4.7%	61.0%	7.0%	-2.9%
2012	8.5%	5.7%	9.9%	6.8%	14.0%	4.8%	66.0%	6.1%	-2.4%
2013*	10.7%	9.0%	10.5%	8.0%	13.4%	7.5%	58.2%	17.3%	6.6%
2014	12.7%	11.4%	12.1%	9.2%	14.6%	6.9%	53.1%	51.4%	38.7%
2015	12.1%	11.0%	12.7%	7.4%	14.6%	11.0%	39.9%	59.0%	46.9%
2016	11.0%	9.7%	11.7%	7.5%	14.3%	7.8%	46.3%	42.0%	31.0%

As shown in the highlighted GREEN area in the upper right of this table the error rates for home health were actually substantially *lower* than those for the Medicare program broadly. As the full impact of the face-to-face encounter requirement has come into the audit periods of 2013-2016 the REPORTED home health rates have steadily increased. As shown for 2016 further CMS changes to F2F requirements have caused a reduction in the reported error rate.

Not All Errors Are Created Equal

Importantly CMS states: "It is important to note that the improper payment rate does not measure fraud. It estimates the amount of payments that did not meet Medicare coverage, coding and billing rules"

In its CERT reports CMS groups error types into many different categories. The most common is "Insufficient Documentation". In its 2015 report CMS states:

*"As in previous years, during the 2015 report period the most common cause of improper payments (accounting for 65.4 percent of total improper payments) was a **lack** of documentation to support the services or supplies billed to Medicare. In other words, the CERT contractor reviewers **could not conclude** that the billed services were actually provided (not applicable to F2F), were provided at a level billed (also not applicable to F2F), and or were medically necessary (directly applicable to F2F)." [Emphasis and parenthetical comments added].*

The table below is a compilation from several years of CERT reports, of the impact of "Insufficient Documentation":

% of Errors Insufficient Documentation				Comparable Venues					
Year	Medicare	Part A	Part B	Hospital	Phys E&M	SNF	DMEPOS	Home Health	HH vs MCR
2010	44.1%	43.8%	62.0%	42.7%	62.7%	45.7%	61.5%	27.0%	-17.1%
2011	50.2%	50.5%	61.5%	52.4%	60.0%	43.3%	91.1%	45.7%	-4.5%
2012	53.9%	53.8%	64.0%	50.1%	59.4%	62.7%	94.2%	45.8%	-8.1%
2013*	56.8%	57.0%	63.0%	48.1%	63.1%	75.6%	94.9%	81.6%	24.8%
2014	60.1%	60.3%	67.7%	52.5%	65.9%	77.0%	92.5%	89.5%	29.4%
2015	65.4%	65.6%	68.8%	46.7%	62.4%	76.1%	77.8%	94.8%	29.4%
2016	65.5%	66.0%	68.2%	47.6%	63.5%	75.3%	80.4%	96.3%	30.8%

Again, as noted in the GREEN areas (2010-2012) home health results compared very favorably to the total Medicare program until the face-to-face encounter requirements started to take effect. Once face-to-face was fully in effect the error rate skyrocketed to now almost **ninety-second percent of all reported home health errors** in 2016. This means, NOT that payments were made in error, but rather the subjective and ill-defined CMS requirement for F2F have made it impossible to tell.

Converting "Percent of Errors" to the Resulting Error Rate

In the table shown below, we multiply the CMS REPORTED error rate times the CMS reported percentages "due to insufficient documentation" to arrive at the error rate due to insufficient documentation:

Error Rate -- Insufficient Documentation				Comparable Venues					
Year	Medicare	Part A	Part B	Hospital	Phys E&M	SNF	DMEPOS	Home Health	HH vs MCR
2010	4.6%	3.0%	7.8%	1.6%	7.7%	1.5%	45.4%	1.3%	-3.3%
2011	5.0%	3.7%	6.5%	5.0%	8.3%	2.0%	55.6%	3.2%	-1.8%
2012	4.6%	3.1%	6.3%	3.4%	8.3%	3.0%	62.2%	2.8%	-1.8%
2013*	6.1%	5.1%	6.6%	3.8%	8.5%	5.7%	55.2%	14.1%	8.0%
2014	7.6%	6.9%	8.2%	4.8%	9.6%	5.3%	49.1%	46.0%	38.4%
2015	7.9%	7.2%	8.7%	3.5%	9.1%	8.4%	31.0%	55.9%	48.0%
2016	7.2%	6.4%	8.0%	3.6%	9.1%	5.9%	37.2%	40.4%	33.2%

Again, note that the great disparity in home health REPORTED error rates is clearly coincident with the timing of the face-to-face encounter requirements. This creates an inappropriate distortion in the REPORTED error rates.

So What Do the Error Rates Look Like?

Next we subtracted the "insufficient documentation" error rate (the reviewer could not tell if the payment was inappropriate) from the total error rate. We have labeled the resulting table below the "Confirmed Error Rates":

Confirmed Error Rate				Comparable Venues					
Year	Medicare	Part A	Part B	Hospital	Phys E&M	SNF	DMEPOS	Home Health	HH vs MCR
2010	5.9%	3.9%	4.8%	2.1%	4.6%	1.8%	28.4%	3.5%	-2.4%
2011	4.9%	3.7%	4.0%	4.6%	5.6%	2.7%	5.4%	3.8%	-1.1%
2012	3.9%	2.6%	3.6%	3.4%	5.7%	1.8%	3.8%	3.3%	-0.6%
2013*	4.6%	3.9%	3.9%	4.2%	4.9%	1.8%	3.0%	3.2%	-1.4%
2014	5.1%	4.5%	3.9%	4.4%	5.0%	1.6%	4.0%	5.4%	0.3%
2015	4.2%	3.8%	4.0%	3.9%	5.5%	2.6%	8.9%	3.1%	-1.1%
2016	3.8%	3.3%	3.7%	3.9%	5.2%	1.9%	9.1%	1.6%	-2.2%
7-yr Avg	4.6%	3.7%	4.0%	3.8%	5.2%	2.0%	8.9%	3.4%	-1.2%

This brings great clarity and an entirely different perspective on the error rates across the board. For FIVE of the SIX years in the applicable period home health actually has substantially LOWER confirmed error rates than the Medicare program as a whole. Over the 7 year period home health's confirmed error rates are about 20% lower than the Medicare program overall and show very little variation over that time period. ***Based on 2016 report the confirmed error rate in Home Health is at an all-time low and lower than any other segment of Medicare.***

Excerpted from AFAM comment letter dated September 4, 2015 on CMS-1625-P
"Therapy Accounts for More than All the Increase in Case-Mix"

Exhibit #2 – Increases in Home Health Case-Mix

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implications of these Analyses

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

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

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

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

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