August 31, 2018

Via Regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations

Dear Administrator Verma:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") in response to the Centers for Medicare and Medicaid Services' (CMS) request for comment on proposed rule **Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations ("Proposed Rule")**. The Alliance appreciates the opportunity to provide comments.

About the Alliance for Home Health Quality and Innovation

The Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions and incubate research that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation's healthcare system. For more information about our organization, please visit: http://ahhqi.org/.

The Alliance is supportive of comments submitted by our colleagues at the Visiting Nurse Associations of America and ElevatingHOME, the Partnership for Quality Home Healthcare, and the National Association for Home Care and Hospice. In addition to supporting these organizations' comments, the Alliance appreciates the opportunity to provide comments in the following topic areas: (I) 2019 rate update; (II) the patient driven groupings model (PDGM); (III) remote patient monitoring; (IV) home infusion therapy; and (V) interoperability.

I. 2019 Rate Updates

The Alliance would like to commend CMS on the considerations made to the proposed national, standard 60-day episode payment amount. We appreciate CMS's recognition of the need for an increase in payment of 2.1 percent. Pursuant to our comments in section II.a of this letter, home health care patients are, on average, poorer, sicker, and more vulnerable than their peers and many require complex plans of care and care coordination.

II. Patient-Driven Groupings Model

Pursuant with the Alliance's comments on last year's proposed "Home Health Groupings Model", the Alliance continues to be concerned about the impact of the newly proposed Patient Driven Groupings Model ("PDGM") for reasons outlined in the sub-sections below.

a. Impact on patients whom are poorer, sicker, and more vulnerable

Data from the Alliance's 2015 and 2017 versions of a the Home Health Chartbook[1], a compilation of descriptive statistics from government data sources that includes the Medicare Current Beneficiary Survey, the Bureau of Labor Statistics, the U.S. Department of Commerce, Medicare Cost Reports, Home Health Compare, Medicare fee-for-service claims, along with additional data from CMS, provides a high-level look at patients being served by home health care agencies across the country.

Patients who receive home health care services are on average poorer, sicker, older, more racially diverse, and overall more vulnerable than their peers. Therefore it is imperative that any large-scale changes to the Medicare benefit, such as those proposed within PDGM, are cognizant of, and structured to accommodate, the unique patient population and setting in which home care is provided. Given the changes impacting community referrals, patients who may be able to avoid acute care may be missed, or see access threatened, and may end up costing the system significantly more.

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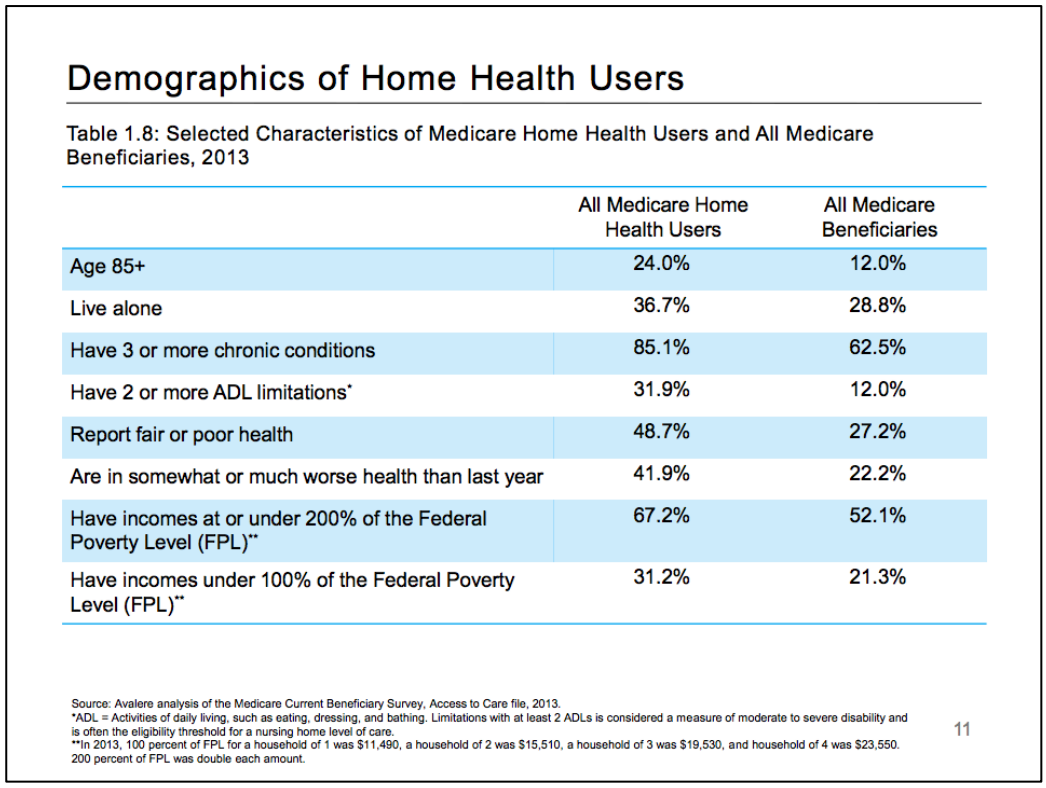
[1] Home Health Chartbook https://bit.ly/2wquF0z

[2] Alliance Comments to ONC on Shared Nationwide Interoperability Roadmap Draft 1.0 (April 2015)



Demographics of Home Health Users

Table 1.8: Selected Characteristics of Medicare Home Health Users and All Medicare Beneficiaries, 2013

	All Medicare Home Health Users	All Medicare Beneficiaries
Age 85+	24.0%	12.0%
Live alone	36.7%	28.8%
Have 3 or more chronic conditions	85.1%	62.5%
Have 2 or more ADL limitations*	31.9%	12.0%
Report fair or poor health	48.7%	27.2%
Are in somewhat or much worse health than last year	41.9%	22.2%
Have incomes at or under 200% of the Federal Poverty Level (FPL)**	67.2%	52.1%
Have incomes under 100% of the Federal Poverty Level (FPL)**	31.2%	21.3%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
**In 2013, 100 percent of FPL for a household of 1 was $11,490, a household of 2 was $15,510, a household of 3 was $19,530, and household of 4 was $23,550. 200 percent of FPL was double each amount.

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As demonstrated in the above graphic, nearly one in four home health care users is 85 years or older, twice as many as the Medicare population at large, and over one in three has an income at or under 200 percent of the Federal Poverty Level (FPL), higher, again, than their peers. Medicare home health patients are also nearly three times as likely as the population as a whole to have two more activities of daily living limitations (ADLs). These patients come from a variety of referral sources and rely on home health care to remain in their homes, a lower-cost option where clinically appropriate.

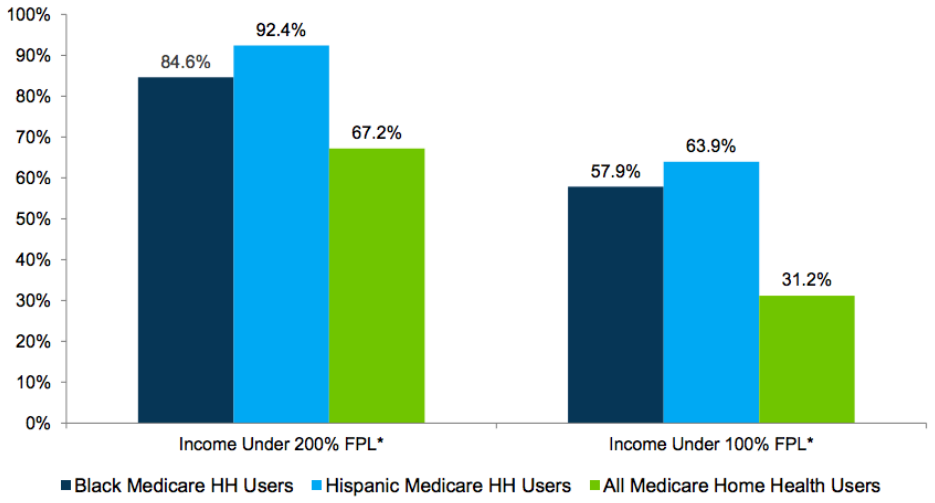
Additionally, home health patients are more racially and ethnically diverse, with a higher portion of racial minority patients receiving home health as compared to those served by skilled nursing facilities (SNFs).

Black and Hispanic home health users are significantly more likely than their peers in the general Medicare population to live at 100 or 200 percent of the FPL, as demonstrated in the graphic below.

Female home health users, as well, tend to be more vulnerable than their male peers, and are more likely to live alone, be widowed, over 85 years old, and have an income under $25,000 per year.

Demographics of Home Health Users by Race and Ethnicity

Chart 1.13: Income by Federal Poverty Level (FPL)* of Home Health Users by Race and Ethnicity, 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.
*In 2013, FPL for a household of 1 was $11,490, a household of 2 was $15,510, a household of 3 was $19,530, and household of 4 was $23,550. 200 percent of FPL is double those amounts.

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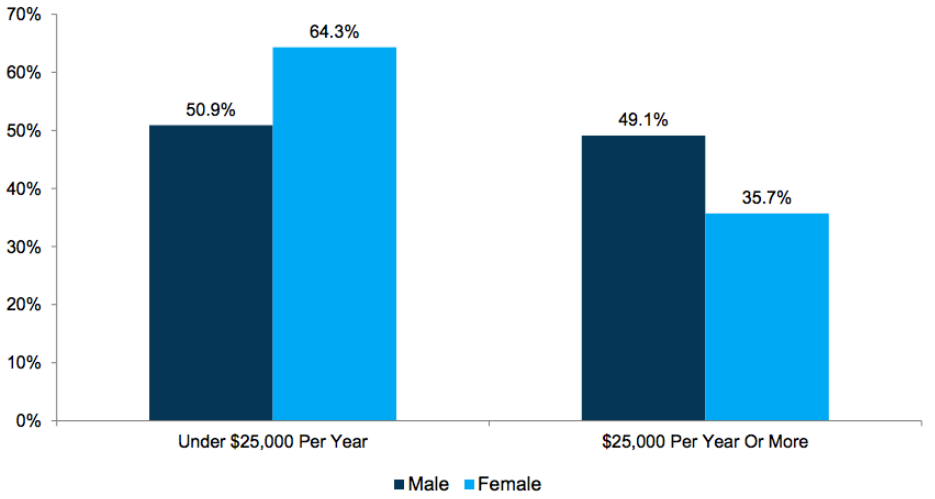
Demographics of Home Health Users by Sex

Chart 1.17: Income Distribution of Home Health Users by Sex, 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.

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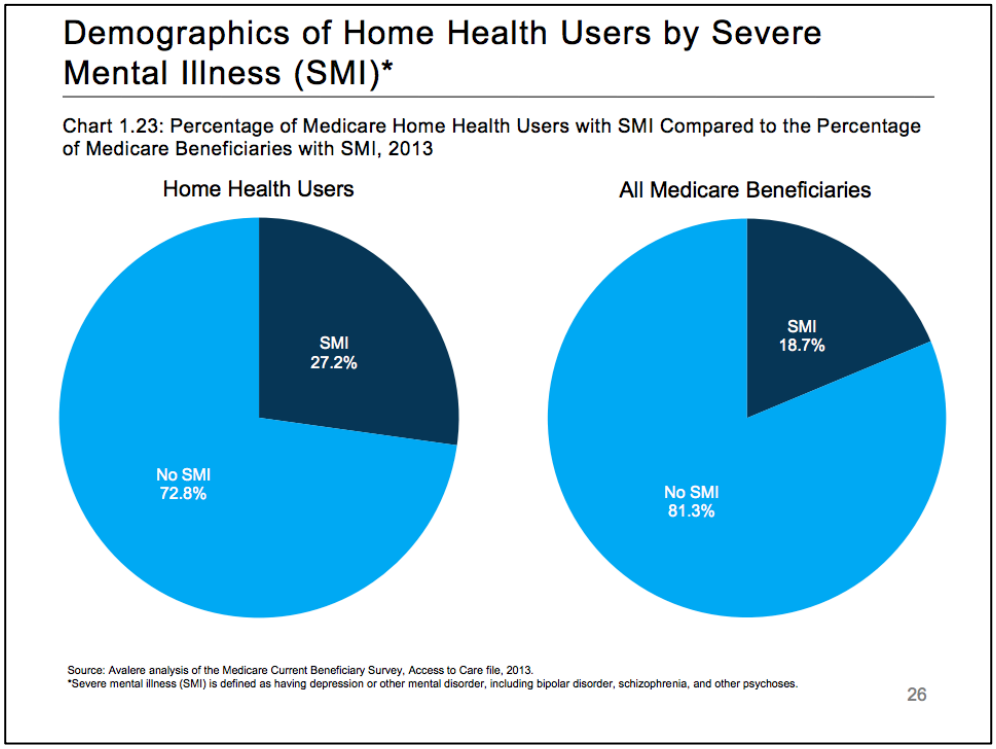
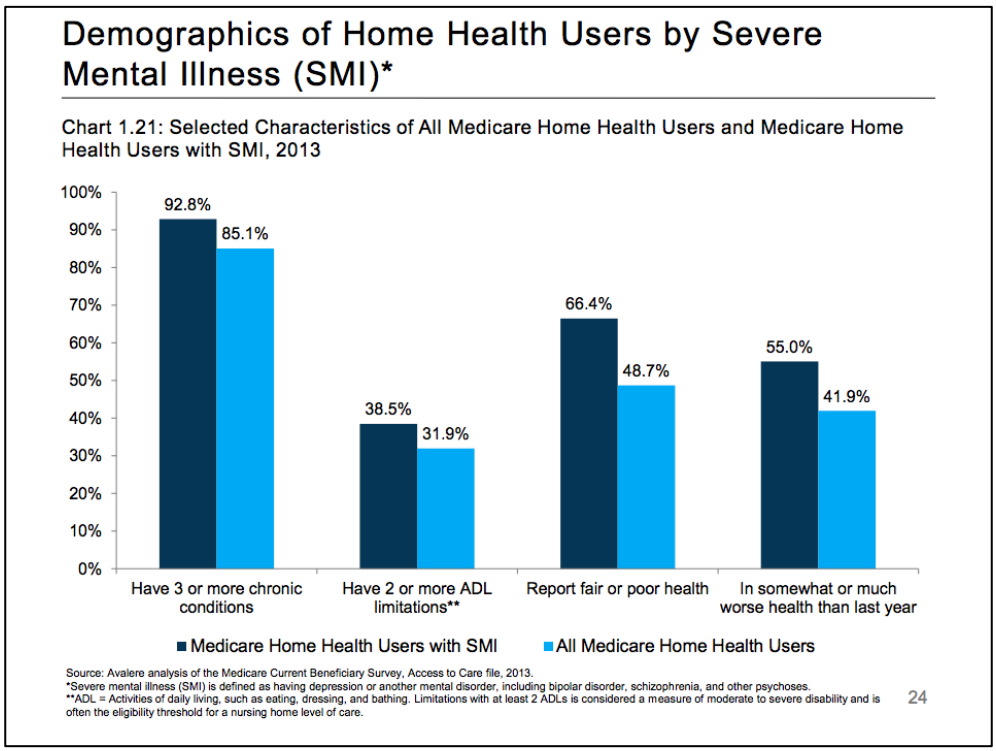
Finally, home health patients are more likely to suffer from severe mental illnesses (SMI). As demonstrated by the following graphs, home health patients are significantly more likely to be diagnosed with SMI than the general Medicare population. These patients require additional considerations and are more susceptible to major changes than their peers.





As referenced above, home health users with SMI struggle with more chronic conditions, ADL limitations, and overall health than their peers. These patients require multi-faceted care coordination plans and many involve coordination with community-based service providers.

Again, the Alliance urges CMS to consider the impact of such an extensive new model on an already vulnerable patient population, and weigh the considerable impact PDGM may have on these groups.

b. Integration with existing alternative payment models (APMs)

The Alliance remains concerned about the impact of PDGM on existing APMs and the newly proposed Pre-Claim Review Demonstration. Greater clarification is needed on how PDGM will be integrated with pre-existing models which operate under different payment structures. Even within the confines of the proposed rule there is confusion about how PDGM fits within the Home Health Value Based Purchasing Model, and the Alliance asks CMS to provide further guidance on integration within these models.

c. Questionable encounters coding

Within regard to PDGM, the Alliance would like to see greater clarification from CMS regarding the coding of questionable encounters. Consistent with questions surrounding the previous HHGM, even with an expanded number of different episode types, there are concerns that some episodes may not be accurately represented and may lead to confusion over coding and diagnosis. We urge CMS to continue working to add diagnoses in order to eliminate confusion, working with agencies to identify episode types needed for inclusion.

The Alliance refers CMS to the comments submitted by ElevatingHOME and the VNAA regarding specific concerns.

d. Functional assessment

Finally, the Alliance would like to echo the concerns of our colleagues at the American Occupational Therapy Association (AOTA) with regards to functional measurement. The Alliance agrees that adding an OASIS item in the functional level, such as light meal prep, which addresses cognition, is critical to best assess patient resource usage. The Alliance refers CMS to AOTA's comments regarding the proposed rule, along with previously submitted comments in March of 2018 on HHGM, and in September of 2017 on the CY2018 Home Health Prospective Payment System proposed rule, for more specifics on adding a functional measurement.

Recommendation: Overall, the Alliance believes there are significant questions related to PDGM and its implementation still unanswered, and

urges CMS to consider delaying any implementation until sufficient clarification is provided. We would encourage CMS to continue working with the Alliance and our peers on identifying areas for adjustment and proper training for agencies to implement such a drastic change.

III. Remote Patient Monitoring

Within the proposed rule, the Alliance appreciates CMS's recognition of the need for remote patient monitoring in the care of many home health patients. It is a critical tool for care delivery in the home now, and will continue to be so in the future.

The Alliance urges CMS to continue considering the impact of remote patient monitoring, as well as the need for greater payment consideration for home health agencies utilizing the technology in order to incentivize increased adoption and lessen the cost burden on agencies already adopting the technology.

IV. Home infusion therapy

The Alliance has a few concerns regarding the language and implementation of the home infusion therapy section of the proposed rule. First, the Alliance is slightly confused by the use of the proposed rule as the appropriate forum for these significant changes.

However, given the language in the text, the Alliance does feel further clarification is still needed with regard to coordination with home health agencies. Currently as the text stands it is unclear what will be needed for home health agencies and their role working with infusion therapy providers if they themselves are not certified. In speaking with Alliance members we are concerned about the efficiency of the proposed system and potential coordination issues, especially considering the expedient proposed implementation date. We ask CMS to provide further guidance on the integration of the new requirements for home infusion therapy certification with regard to coordinating supplemental and complimentary care provided by home health agencies.

V. Interoperability

Consistent with the Alliance's comments to the Office of the National Coordinator for Health Information Technology (ONC) on their Shared Nationwide Interoperability Roadmap Draft 1.0[2], the Alliance is supportive of efforts to increase interoperability across the healthcare system and appreciative of CMS's interest in exploring interoperability with the inclusion of home health care further. Interoperability is

[2] Alliance Comments to ONC on Shared Nationwide Interoperability Roadmap Draft 1.0 (April 2015) https://bit.ly/1WYkpBU

crucial to the success of care coordination, and the Alliance is happy to see a continued focus from CMS on interoperability as a benchmark of healthcare delivery.

The Alliance appreciates the opportunity to provide comments on the request for information on interoperability in the proposed rule. While strides have been made in increasing interoperability, and further integrating home health and long-term and post-acute settings into the health information technology space, more is needed to create fully interoperable healthcare.

First, the Alliance continues to believe further discussions on standards are required to create interoperability across settings.

Additionally, the Alliance recommends continued discussion and consideration of incentives for adoption of interoperable systems. New models of care and payment are one way to incentivize adoption of interoperable systems, and the Alliance continues to believe that providers within the meaningful use program should be required to exchange information with long-term and post-acute care providers.

Finally, the Alliance urges CMS to consider burden on home health providers when pushing for increased interoperability, and recommends discussion and deliberation with providers in order to best assess how to increase interoperability and work with companies to create systems that are interoperable across referral sources.

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Thank you for the opportunity to comment on the proposed rule and included request for information notices. Should you have any questions, please contact me at jschiller@ahhqi.org.

Sincerely,
/s/
Jennifer Schiller
Director, Policy Communications & Research