September 9, 2019

Via Regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
PO Box 8013
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements

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' request for comment on proposed rule **Medicare and Medicaid Programs; CY2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements ("Proposed Rule")**[i]. 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 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 (PQHH), and the National Association for Home Care and Hospice

(NAHC). In addition to supporting these organizations' comments, the Alliance appreciates the opportunity to provide comments in the following topic areas: (I) home health's value proposition and the impact on vulnerable communities; (II) finalizing the patient driven groupings model (PDGM); (III) elimination of RAP payments; (IV) changes to therapy; (V) home infusion changes; and (VI) changes to the Home Health Quality Reporting Program (HHQRP).

I. Home Health's Value Proposition and Impact on Vulnerable Communities

Data from the Alliance's 2018 Home Health Chartbook[ii], 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, and other data from the Centers for Medicare and Medicaid Services, 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 defined 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.

Demographics of Home Health Users

Table 1.9: Selected Characteristics of Medicare Home Health Users and All Medicare Beneficiaries, 2015

	All Medicare Home Health Users	All Medicare Beneficiaries
Age 85+	24.5%	11.2%
Live alone	36.4%	30.0%
Have 3 or more chronic conditions	85.9%	63.0%
Have 2 or more ADL limitations*	32.9%	11.7%
Report fair or poor health	46.2%	25.6%
Are in somewhat or much worse health than last year	41.7%	20.3%
Have incomes at or under 200% of the Federal Poverty Level (FPL)**	62.5%	48.2%
Have incomes under 100% of the Federal Poverty Level (FPL)**	28.7%	19.2%

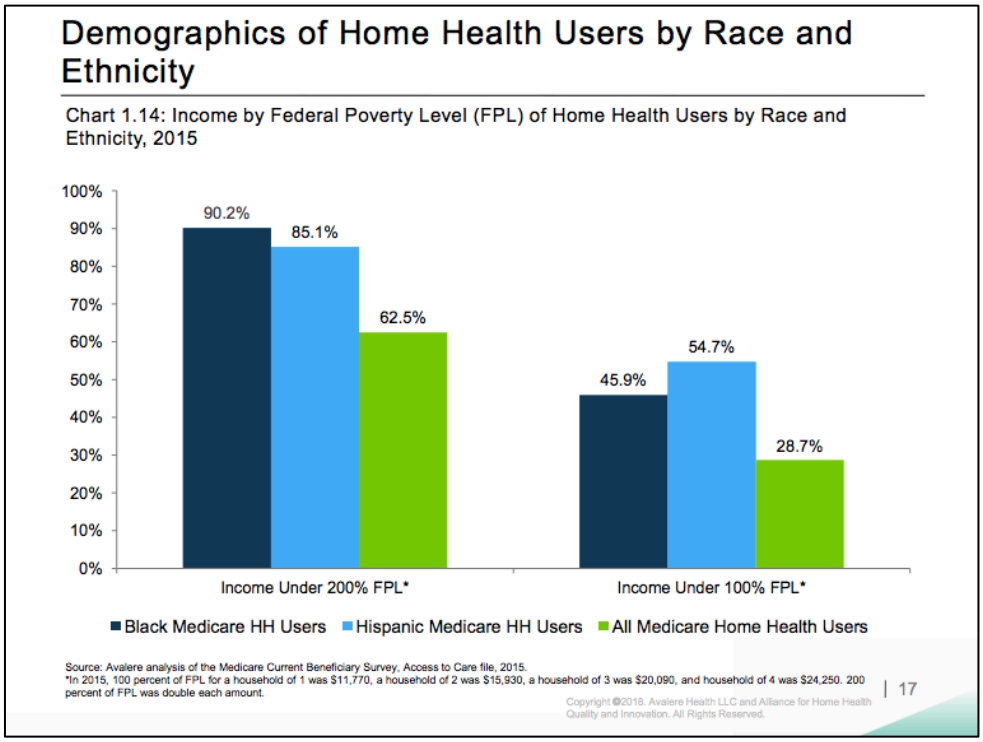
Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2015.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
**In 2015, 100 percent of FPL for a household of 1 was $11,770, a household of 2 was $15,930, a household of 3 was $20,090, and household of 4 was $24,250. 200 percent of FPL was double each amount.

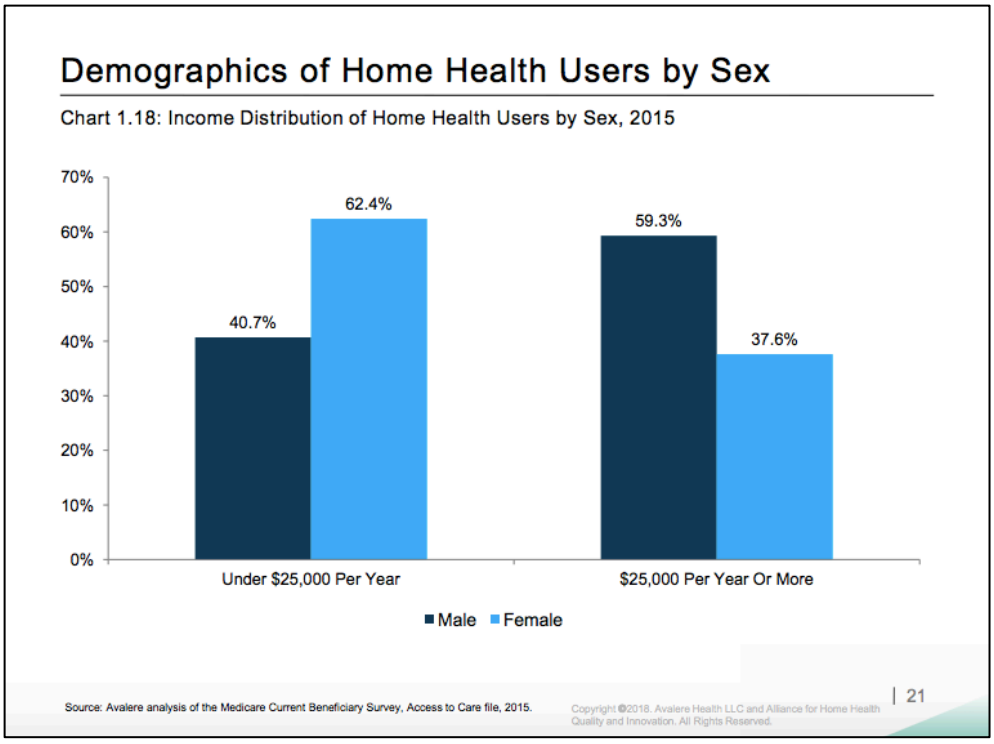
As demonstrated in the aforementioned graphic, nearly one in four home health care users is 85 years or older, twice as many as the Medicare population at large, and nearly one in three has an income at or under 200 percent of the Federal Poverty Level (FPL), higher, again, than their peers. Medicare 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. 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.

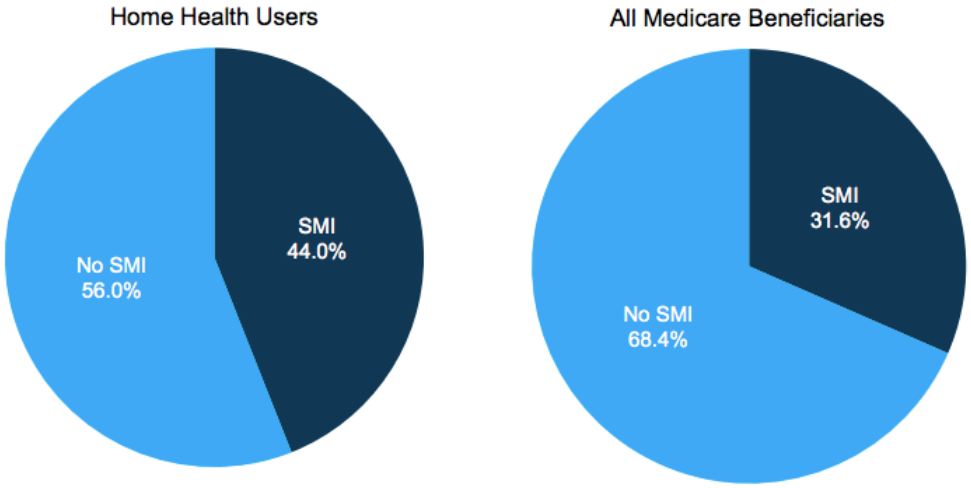




Finally, home health patients are more likely to suffer from severe mental illnesses (SMI). As demonstrated by the following graphs, home health patients are significantly more likely to be diagnosed with SMI than the general Medicare population. These patients require additional considerations and are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

Demographics of Home Health Users by Severe Mental Illness (SMI)*

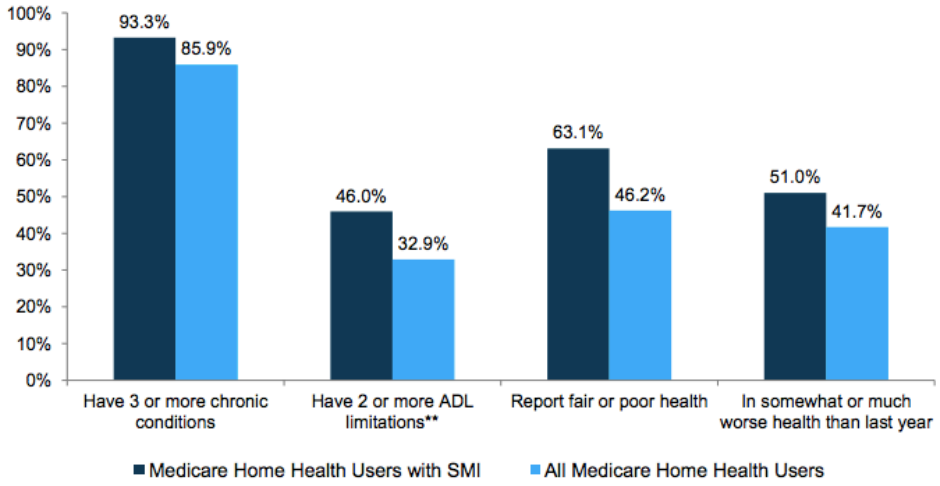
Chart 1.25: Percentage of Medicare Home Health Users with SMI Compared to the Percentage of Medicare Beneficiaries with SMI, 2015



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2015.
*Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Demographics of Home Health Users by Severe Mental Illness (SMI)*

Chart 1.23: Selected Characteristics of All Medicare Home Health Users and Medicare Home Health Users with SMI, 2015



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2015.
*Severe mental illness (SMI) is defined as having depression or another mental disorder, including bipolar disorder, schizophrenia, and other psychoses.
**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.

As always, the Alliance urges CMS to consider the impacts of proposed changes on a vulnerable patient population, especially large-scale models such as PDGM which drastically alter the delivery of care, including access for a number of different patient populations.

II. Finalizing the Patient Driven Groupings Model (PDGM)

As the Alliance has stated in the past, and in support of comments made by our peers at NAHC and PQHH, we continue to have serious concerns with regards to PDGM and urges CMS to considerable the sizable impact the implementation of this model will have on patients and access to care.

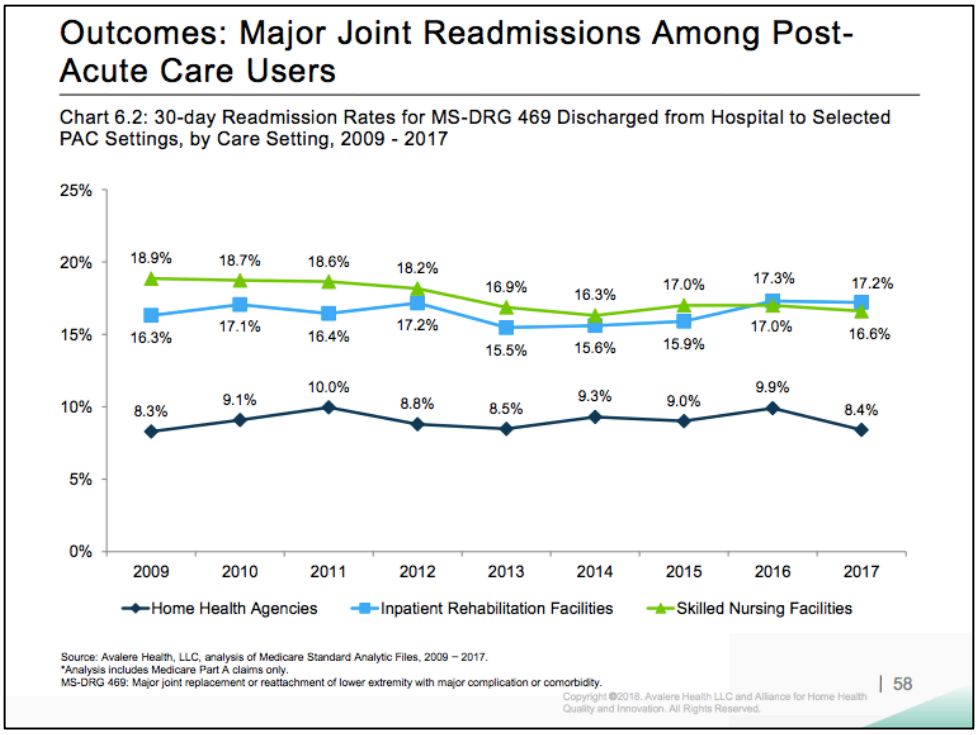
a. Behavior Adjustment

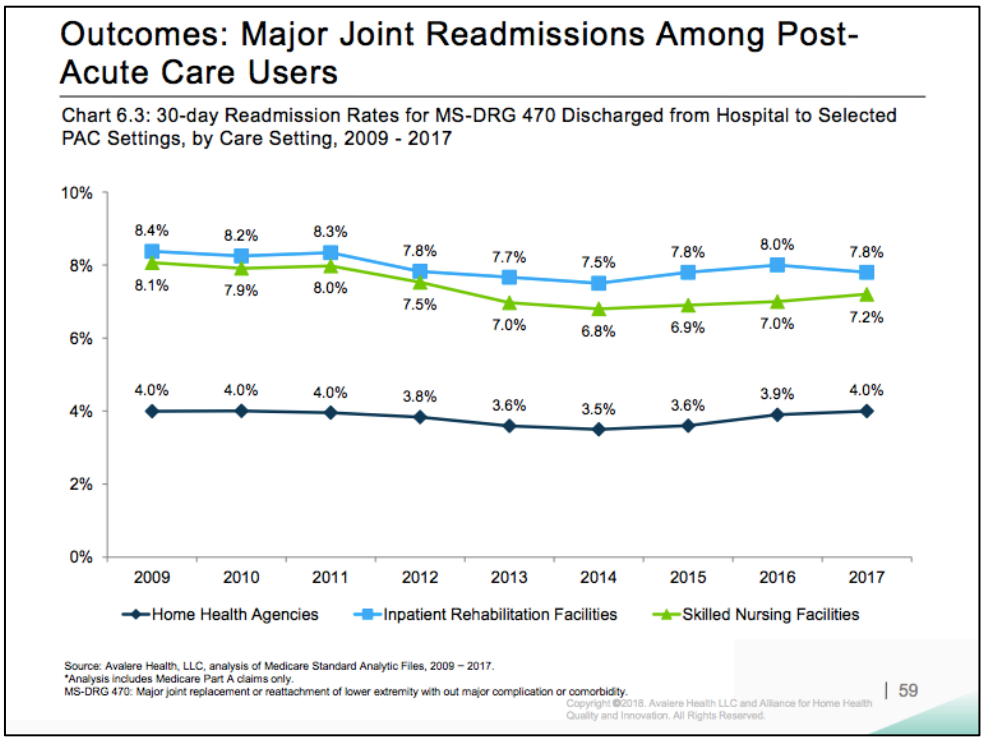
Consistent with comments submitted by our peers in home health care, the Alliance remains concerned with the behavior adjustment implemented by CMS within PDGM. For more detailed analysis of the behavior adjustment and the potential impacts on patient access and quality of care, we ask CMS to consider the comments and analyses complied by NAHC and PQHH in their respective comment letters on this year's Proposed Rule. However, we reiterate here their comments that the 8.01 percent reduced base rate, a comparatively large reduction within the standards of previous CMS imposed behavior adjustments, will likely have a considerable impact on home health agencies and the patients they serve. These impacts include major cash flow changes that may force the closure of some agencies, once again impacting access to care for vulnerable patients.

Given the near impossibility of predicting how behaviors will actually change within PDGM before the actual start of the model in CY2020, the Alliance urges CMS to reconsider and withdraw any implementation of such a considerable behavioral adjustment, at the very least until the model is tested and the impacts to access and patient care are assessed properly.

b. Implications on Therapy Services

We therefore support our colleagues at both NAHC and PQHH and their recommendations on ensuring patient care is not diminished or denied due to the expected decreases in therapy services as part of the implementation of PDGM.





Finally, the Alliance would also like to suggest to CMS the need to invest in an evaluation of the model once implemented, including answering specific research questions posed by the community. The Alliance would like to offer help and guidance in any research evaluations, and asks CMS to reconsider implementation of the model until further analysis is conducted which more fully defines the impact of the model,

including the impacts of an any behavior adjustment, as well as much more comprehensive communication and information provided to agencies whom are expected to implement such a drastic change so quickly.

III. Elimination of RAP Payments

The Alliance has serious concerns about the proposed phasing out and eventual complete elimination of RAP payments as proposed in the Proposed Rule.

While the Alliance understands CMS's rationale as stated in the Proposed Rule, the Alliance urges CMS to re-consider the elimination of RAP payments, especially in conjunction with the early days of PDGM implementation. Given the many changes required by the new model, and the burden already being placed on providers to adapt to the new model, the Alliance believes that a delay in payment may result in serious consequences for agencies already attempting to adapt to the new payment model.

Additionally, as noted by our colleagues at both NAHC and PQHH, the Alliance is concerned agencies will be unable to meet the short timeline for the Notice of Admission (NOA) given the complexity of the form and the current structure of the home health plan of care. Inability to meet the five-day deadline, despite the current average length of time for submission of a RAP being 12-13 days, may cause a reduction in the episode payment and further increased burden on providers.

IV. Changes to Therapy

The Alliance appreciates CMS's proposed changes to allow therapy assistants to perform maintenance therapy.

However, the Alliance echoes the statements made by our colleagues at NAHC to clarify the intent of the Proposed Rule to extend beyond physical therapy assistants and to include occupational therapists as well. Further, the Alliance reiterates that availability of therapy to patients who need it will ultimately be most hindered by PDGM, and addressing the anticipated utilization of therapy in that model is of much more pressing concern.

V. Home Infusion Therapy

Reiterating our comments to last year's proposed rule[iii], the Alliance believes further clarification on the changes to home infusion therapy are required.

Additionally, the Alliance remains concerned about access issues impacted by the changes. Given the already increasing burden on providers, agencies, especially smaller agencies serving underserved communities, may be reluctant to apply for accreditation. This runs the risk of an already vulnerable patient population being left with few or no options for home infusion therapy.

Further hindering access issues are cases, such as those cited in the comments made to this year's Proposed Rule, of home health eligible patients whose only skilled need is infusion therapy, but who need supplemental aide or therapy care. These patients may be forced to either go without or pay out of pocket expenses for critical care due to the proposed changes. For an already poorer and sicker community, these changes may be catastrophic for patients dependent on infusion care. Even those who are able to receive home health care, but whom may need to find a separate entity for infusion care, are at risk of receiving overall poorer care due to a siloed system that hinders care coordination.

The Alliance would ask CMS for the following clarifications, in addition to addressing the concerns listed above via appropriate legislative action in conjunction with Congress: 1) will there be a grace period for accreditation; 2) will more accrediting bodies be added; and 3) further clarification on medication included within the parameters of the new proposal.

VI. Changes to the Home Health Quality Reporting Program (HHQRP)

The Alliance recognizes the changes implemented in the Proposed Rule are a mandatory part of the IMPACT Act and are overall supportive of the new measures and standardized patient assessment data elements (SPADEs). However, the Alliance urges CMS to work with our colleagues in home health care to reduce strain of implementation on home health providers in order to ensure the focus remains on delivering high quality clinical care rather than battling administrative burden.

* * *

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

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[i] Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health

Quality Reporting Requirements; and Home Infusion Therapy Requirements https://bit.ly/2lM9XFH

[ii] 2018 Home Health Chartbook https://bit.ly/2zzuUbA

[iii] Alliance Comments on "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" https://bit.ly/2kBeQ4o