August 24, 2020

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; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services 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; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements ("Proposed Rule")**[i]. The Alliance appreciates the opportunity to provide comments as always.

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 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) telehealth; (III) home infusion changes, (IV) rate adjustments; and (V) negative pressure wound therapy (NPWT).

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

Data from the Alliance's 2019 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, and more racially diverse than their peers. The home is an especially critical location of care in light of the current COVID-19 pandemic, and patients seen in the home are often already more vulnerable than their peers.

Demographics of Home Health Users

Table 1.9: Selected Characteristics of Medicare Home Health Users and All Medicare Beneficiaries, 2016

	All Medicare Home Health Users	All Medicare Beneficiaries
Age 85+	25.6%	11.0%
Live alone	37.8%	29.0%
Have 3 or more chronic conditions	80.5%	58.9%
Have 2 or more ADL limitations*	27.8%	10.4%
Report fair or poor health	46.2%	24.6%
Are in somewhat or much worse health than last year	38.4%	19.4%
Have incomes at or under 200% of the Federal Poverty Level (FPL)**	64.0%	46.8%
Have incomes under 100% of the Federal Poverty Level (FPL)**	27.5%	19.2%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2016.
*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 2016, 100 percent of FPL for a household of 1 was $11,880, a household of 2 was $16.020, a household of 3 was $20,160, and household of 4 was $24,300. 200 percent of FPL was double each amount.

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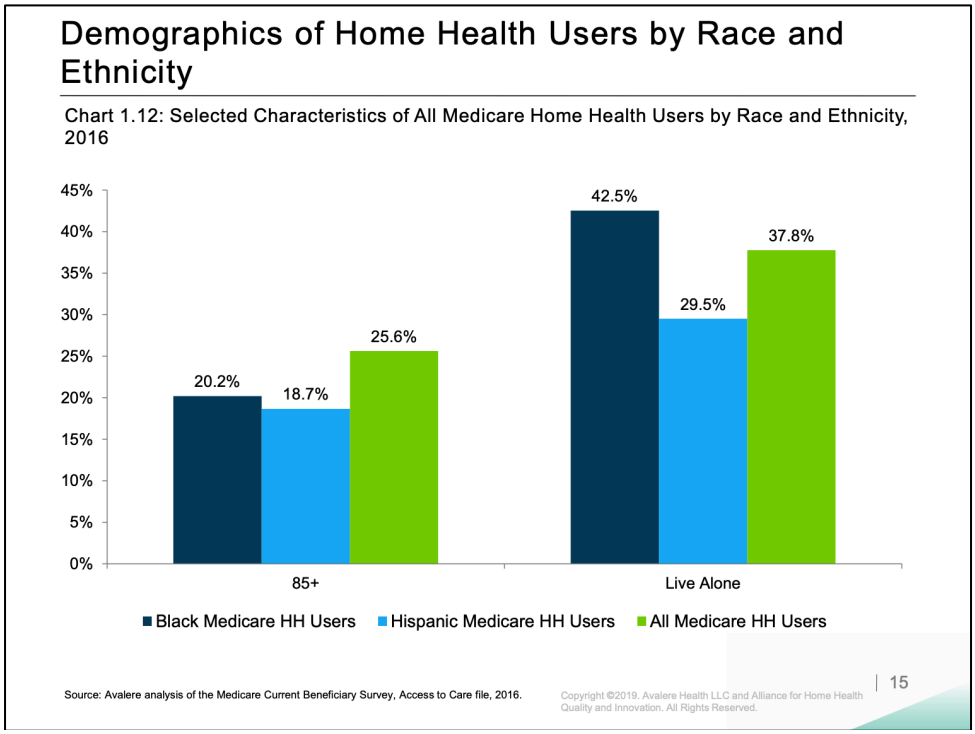
More than a quarter of home health care users are 85 years or older, over twice as many as the Medicare population at large, and nearly one in three has an income at or under 200 percent of the Federal Poverty Level (FPL), significantly higher than their peers. Medicare home health patients are also 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.

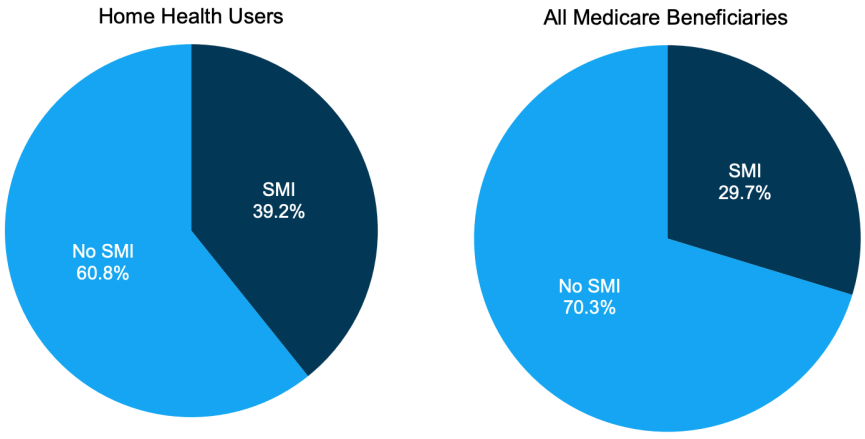
Additionally, home health patients are more racially and ethnically diverse, with a higher portion of racial minority patients receiving home health as compared to those served by skilled nursing facilities (SNFs). Black home health users are significantly more likely than their peers receiving home health care to live alone, as demonstrated in the graph below.



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)*

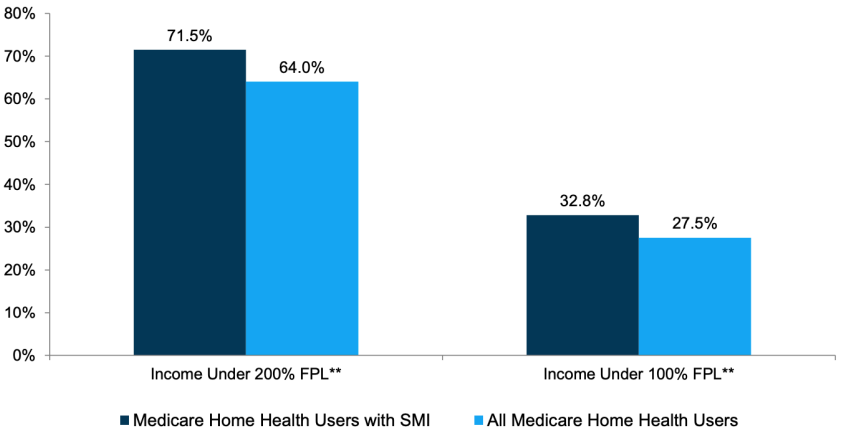
Chart 1.25: Percentage of Medicare Home Health Users with SMI Compared to the Percentage of Medicare Beneficiaries with SMI, 2016



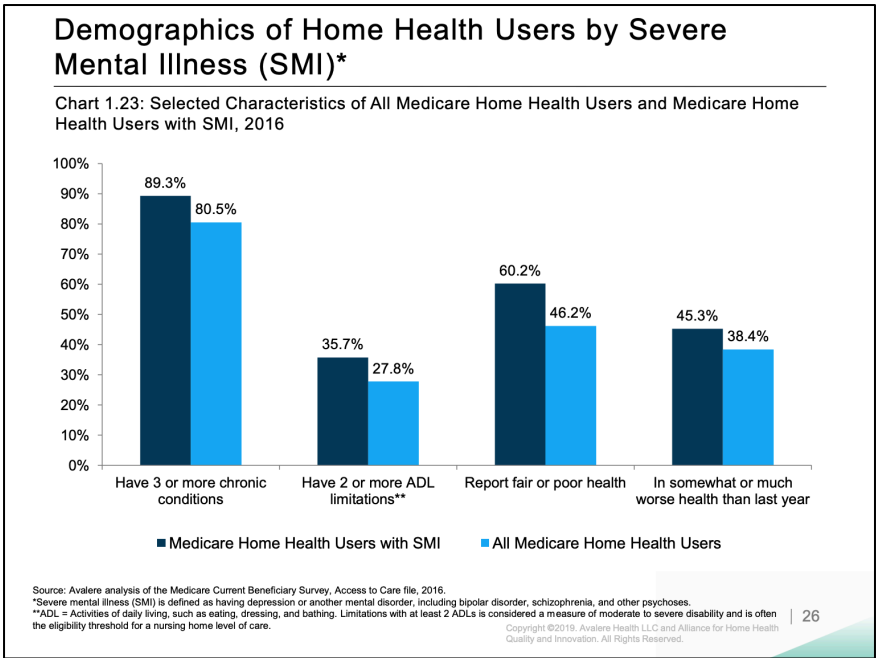
Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2016.
*Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

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

Chart 1.24: Selected Characteristics of Medicare Home Health Users with SMI and All Medicare Home Health Users, 2016



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2016.
*Severe mental illness (SMI) is defined as having depression or another mental disorder, including bipolar disorder, schizophrenia, and other psychoses.
**In 2016, 100 percent of FPL for a household of 1 was $11,880, a household of 2 was $16.020, a household of 3 was $20,160, and household of 4 was $24,300. 200 percent of FPL was double each amount.



In light of the current public health crisis, and the expanded need to treat vulnerable patients in their homes, the Alliance would like to reiterate previous comments regarding the need for greater flexibility in the homebound and face-to-face requirements. There exists a real opportunity to treat patients safely in their homes while helping to prevent the spread of COVID-19. We appreciate CMS's efforts to embrace home health and telehealth in the current pandemic, and look forward to continuing to work with CMS on ways to deliver high quality care to patients in the home both during the current public health crisis and in the future.

II. Telehealth

Firstly, the Alliance would like to thank CMS for their recognition of the need for greater access to telehealth services, both during the current public health crisis, and in order to treat patients moving forward as well.

The Alliance requests further clarification from CMS on whether telephonics are included in the updated regulations. There is a disconnect between the language in the preamble versus the text, and the Alliance would ask that CMS not only clarify the discrepancy but allow for the use of telephonics and any and all audio-based visits, as per the allowances in the CARES Act. This is a critical distinction and allows for patients who may not have internet access, or stable access, or other obstacles to video-based care, to be able to continue to receive the healthcare they need. We would also ask CMS to consider extending the face-to-face flexibilities allowing for a face-to-face encounter to be completed via telehealth, as this has shown to be vitally important in the CARES Act implementation and allows patients greater access to physicians, particularly in rural areas.

Further, the Alliance would ask CMS to reconsider the current requirement that reimbursement for a telehealth visit require an in-home visit as well. As the current public health crisis

highlights, telehealth visits provide critical care for patients. While the Alliance appreciates CMS's recognition of telehealth, the benefit goes beyond the bounds of what is administrative. The current lack of reimbursement, coupled with the strain on providers who are trying to navigate the safety of their patients and staff, requires greater consideration of the critical care being provided to some of the most vulnerable patients, particularly given the current risks of unnecessary exposure. Coupled with the fact that telehealth visits do not show up in claims data, and may be one of several factors in the increase of low-utilization payment adjustment (LUPA) rates, the Alliance requests CMS consider recognizing the use of telehealth for the purposes of claims and reimbursement.

Overall, the Alliance greatly appreciates CMS's acknowledgement of the critical usage of telehealth in treating patients both during the public health crisis and moving forward in the future of care delivery.

III. Home Infusion Therapy

Reiterating our comments from the last two previous proposed rules[iii], the Alliance again believes further clarification on the changes to home infusion therapy are required.

Especially in light of the COVID-19 crisis, 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. The home is a vital node of care, and even more so as hospitals become overrun. Further, without any analysis or further information from CMS, it remains unclear how many suppliers will be providing accredited home infusion therapy. We remain concerned about the unintended access issues patients will face, especially in areas hit hard by COVID and those facing other critical access issues currently.

Furthermore, the Alliance requests clarification on patients receiving home infusion therapy prior to January 1, 2021 by a provider who will not be accredited. The proposed rule is unclear on whether agencies can continue providing the care already initiated in order to create a consistent care continuum or whether patients would need to be treated by an accredited provider beginning January 1, 2021, potentially disrupting the patient's care.

IV. Rate Adjustments

The Alliance would also like to offer our support for the comments submitted by our colleagues at PQHH and NAHC regarding the rate adjustments for CY2020 and CY2021. Their comments provide significant in-depth analysis regarding the impact of the rate setting and adjustments, and the Alliance would like to echo PQHH, NAHC, and our colleagues across the home health care space in asking CMS to eliminate the 4.36 percent reduction for CY2021 as it continues to evaluate any possible behavioral changes.

V. Negative Pressure Wound Therapy (NPWT)

Finally, consistent with our comments submitted on the CY2017 prospective payment system proposed rule[iv], and in keeping with comments submitted by our colleagues at NAHC, we would ask CMS to consider the following regarding negative pressure wound therapy (NPWT): (1) streamline billing for HHAs by allowing them to file a claim for disposable NPWT on TOB 32x, which may require a national payment rate (with an area wage index of 1.0); (2) remove an unnecessary burden on home health nurses by ending the requirement that they separately account for their time providing disposable NPWT; and (3) allow HHAs to receive credit for a home health visit in cases where its application is the only service provided.

* * *

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
Executive Director

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[i] Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements ("Proposed Rule") https://bit.ly/2YwRMV9

[ii] 2019 Home Health Chartbook https://bit.ly/31qsuK4

[iii] Alliance Comments on "CY2019 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

[iv] Alliance Comments on "Medicare and Medicaid Programs; CY 2017 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies (CMS-1611-P)" https://bit.ly/2QibaRr