October 3, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445—G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)

To whom it may concern:

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 comments on the proposed rule on Advancing Care Coordination Through Episode Payment Models ("proposed EPM rule"), 81 Fed. Reg. 50794 (Aug. 2, 2016).[1] 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/.

[1] Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR), 81 Fed. Reg. 50794 (Aug. 2, 2016) (herein after "proposed EPM rule"), https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf

As referenced in the Alliance's comments to CMS on the Comprehensive Care for Joint Replacement (CJR) rule,[2] when home health care is used as the first post-acute care setting in major joint replacement episodes, the care is on average more cost-effective for the Medicare program and produces lower readmission rates, compared to such episodes overall. Expanding on those comments, the Alliance appreciates the opportunity to provide specific comments on the proposed EPM rule in the following topic areas: (I) timeline for implementation; (II) home health's role in orthopedic post-acute care and the potential for home health's use to provide cardiac rehabilitation; and (III) waiver of the homebound requirement in limited circumstances.

I. Timeline for Implementation

The Alliance urges CMS to consider altering its timeline for implementation of any additional EPMs, such as those proposed within the rule. The Alliance supports the movement toward new and alternative payment models, including episode payment models (i.e., bundled payment approaches), accountable care organizations, and the Independence at Home model. However, regarding the EPMs proposed, the Alliance is concerned that evidence has not yet been collected on the impact on patients and the healthcare system of mandatory bundled payment initiatives. The Alliance urges CMS to ensure adequate evaluation of mandatory EPM programs such as CJR, before expanding EPMs to additional MS-DRGs. The Alliance strongly supports the concepts of advancing care coordination in patient care for the conditions set forth in the proposed rule, but recommends that CMS complete some evaluation of mandatory bundled payment models such as CJR before expanding such programs. Although BPCI has been evaluated through its second year of implementation, and the results to date have shown some significant areas of success in terms of cost savings and quality, the results of that evaluation may not necessarily be more broadly applicable. BPCI is a voluntary program, whereas CJR and the EPMs described in the proposed rule would be mandatory programs for hospitals in the identified metropolitan statistical areas.

Furthermore, in the context of evaluating these episode payment models, we urge CMS and its evaluation contractor to scrutinize the impact on quality of care and access to care. The Alliance is concerned that the quality measures built in to the payment model may not be sufficient to assess and evaluate access to care and quality of care. While those measures may be sufficient for payment purposes, it may be difficult to glean whether access and quality are affected based on those specified measures alone.

Recommendation: The Alliance recommends that CMS reconsider its timeline for implementation of the proposed rule to enable adequate evaluation of the impact on patients and the health system of mandatory bundled payment models (i.e., the CJR

[2] Alliance Comments to CMS on Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services, Sept. 8, 2014 http://ahhqi.org/images/uploads/AHHQI_CCJR_Comments_90815.pdf

model) and to identify ways to appropriately safeguard patient access and quality of care.

II. Home Health's Role in Orthopedic Post-Acute Care and Potential for Increased Home Health Usage in Cardiac Rehabilitation

Home health care has played a significant role in offering a cost effective means of providing post-acute care, as evidenced to date in the Bundled Payments for Care Improvement Initiative (BPCI). The value proposition borne out in BPCI is also borne out in claims data for major joint replacement episodes. For example, for MS-DRG 470 (major joint replacement without major complication or comorbidity), in the 67 participating CJR MSAs, average episode cost drops nearly $5,000 when home health is the first setting of post acute care. MS-DRG 481 (hip and femur procedures except major joint replacement) is one of the proposed diagnosis related groups for CJR model expansion and is the fifth most common MS-DRG that precedes Home Health Part A episodes, accounting for nearly 35,000 Part A claims in 2013.[3] Patients who receive home health care as the first setting post-discharge for MS-DRG 481 are also less likely to have a hospital readmission within 30 days (8.03 percent) compared to those that are sent to skilled nursing facilities as the first post-acute care setting (11.64 percent). There may be many factors influencing these readmission rates, including patient severity, however the data on both readmissions and Medicare episode expenditures suggest that home health care offers a strong value proposition in post-acute care.

[3] Chartbook Id at 2.1

Clinical Profile of Home Health Users

Table 2.1: Top 20 Most Common Diagnosis Related Groups (MS-DRGs) for Beneficiaries Discharged from Hospital to Part A Home Health Episodes, 2013

MS-DRG	Number of Home Health Part A Claims, 2013	Percent of Total Home Health Part A Claims, 2013
Major joint replacement or reattachment of lower extremity w/o mcc	190,046	9.98%
Septicemia or severe sepsis w/o mv 96+ hours w mcc	61,440	3.23%
Heart failure & shock w cc	42,687	2.24%
Heart failure & shock w mcc	39,931	2.10%
Hip & femur procedures except major joint w cc	34,074	1.79%
Simple pneumonia & pleurisy w cc	32,256	1.69%
Intracranial hemorrhage or cerebral infarction w cc	30,319	1.59%
Kidney & urinary tract infections w/o mcc	29,592	1.55%
Chronic obstructive pulmonary disease w mcc	28,843	1.52%
Simple pneumonia & pleurisy w mcc	27,974	1.47%
Cellulitis w/o mcc	27,451	1.44%
Renal failure w cc	27,332	1.44%
Septicemia or severe sepsis w/o mv 96+ hours w/o mcc	23,212	1.22%
Chronic obstructive pulmonary disease w cc	22,555	1.18%
Spinal fusion except cervical w/o mcc	19,947	1.05%
Esophagitis, gastroent & misc digest disorders w/o mcc	19,876	1.04%
Pulmonary edema & respiratory failure	19,237	1.01%
Renal failure w mcc	18,293	0.96%
G.I. Hemorrhage w cc	18,143	0.95%
Major small & large bowel procedures w cc	17,919	0.94%
Total for Top 20 MS-DRGs	731,127	38.41%

Source: Avalere Health, LLC analysis of Medicare Standard Analytic Files, 2013.
Data for beneficiaries with a Part A home health episode and a prior short-term acute care hospital stay in 2013.
Note: CC is complication or comorbidity. MCC is major complication or comorbidity.

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Outcomes: Readmissions Among Post-Acute Care Users

Table 7.1: 30-day Readmission Rates for Top 20 Most Common MS-DRGs Discharged from Hospital to Selected Post-Acute Care (PAC) Settings, by Setting, 2013

MS-DRG	% of Home Health Users Readmitted Within 30 Days	% of SNF Users Readmitted Within 30 Days
Major joint replacement or reattachment of lower extremity w/o mcc	3.59%	6.97%
Septicemia or severe sepsis w/o mv 96+ hours w mcc	21.37%	22.74%
Heart failure & shock w mcc	24.77%	25.66%
Heart failure & shock w cc	23.86%	23.28%
Kidney & urinary tract infections w/o mcc	18.51%	14.21%
Hip & femur procedures except major joint w cc	8.03%	11.64%
Intracranial hemorrhage or cerebral infarction w cc	12.39%	14.64%
Simple pneumonia & pleurisy w cc	16.93%	16.42%
Renal failure w cc	22.78%	19.47%
Simple pneumonia & pleurisy w mcc	20.40%	21.88%
Septicemia or severe sepsis w/o mv 96+ hours w/o mcc	16.21%	16.77%
Chronic obstructive pulmonary disease w mcc	22.30%	23.77%
Cellulitis w/o mcc	14.00%	13.88%
Renal failure w mcc	25.19%	24.02%
Misc disorders of nutrition, metabolism, fluids/electrolytes w/o mcc	21.16%	15.67%
Kidney & urinary tract infections w mcc	21.10%	17.66%
Pulmonary edema & respiratory failure	22.26%	25.75%
Chronic obstructive pulmonary disease w cc	22.20%	20.83%
Esophagitis, gastroent & misc digest disorders w/o mcc	19.71%	16.68%
G.I. hemorrhage w cc	18.58%	17.99%
Average Rate Across All MS-DRGs	16.92%	17.49%

Source: Avalere Health, LLC, analysis of Medicare Standard Analytic Files, 2013.
*Analysis includes Medicare Part A claims only.
Note: CC is complication or comorbidity. MCC is major complication or comorbidity.
SNF: Skilled Nursing Facilities

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Furthermore, CMS's own analysis that it commissioned from the Lewin Group shows significant savings for CMS when orthopedic surgery episodes were initiated at Bundled Payment for Care Improvement (BPCI) participating hospitals (Model 2). This $864 estimated cost savings "was because of reduced use of institutional PAC following the hospitalization."[4] The report goes on to say specifically:

> For Model 2 orthopedic and cardiovascular surgery episodes participants' efforts to reduce episode spending are achieving expected results. For these episodes, which account for a large share of Model 2 episodes, we saw a statistically significant shift from more expensive institutional PAC to less expensive home health care among beneficiaries discharged to any PAC setting. This shift was the major contributor to the larger relative decline in total payments during the anchor stay and the 90-day PDP for orthopedic surgery episodes.

Home health care is already playing a critical role in enabling savings for CMS in BPCI, and the figures above from the Home Health Chartbook establish the outcomes-related benefits of utilizing home health care when clinically appropriate. Home health care already plays a critical role in orthopedic post-acute care for many major joint replacement patients, and has great potential to provide cost-effective, high-quality care when used for hip/femur procedures. Thus, an opportunity for optimizing home health utilization within new and alternative payment models of care exists as a means of providing clinically appropriate care and great savings for the Medicare program.

In addition to the demonstrated benefit of home health care for patients recovering from orthopedic procedures, home health care can also play a critical role in caring for patients in cardiac rehabilitation (CR), specifically following acute myocardial infarction (AMI) and cardiac bypass grafting surgery (CABG).

The American Heart Association (AHA) published literature citing the importance of home health in CR, especially as an intermediary between acute and outpatient treatment. According to an article, endorsed by both the Preventative Cardiovascular Nurses Association and the American Association of Cardiovascular and Pulmonary Rehabilitation, "In instances when there is an anticipated gap between inpatient discharge and initiation of the outpatient CR program, a home health therapy referral in the interim should be strongly considered."[5]

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[4] Lewin Group "CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report" Aug. 2016 https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf

[5] American Heart Association Science Advisory, "Increasing Referral and Participation Rates to Outpatient Cardiac Rehabilitation: The Valuable Role of Healthcare Professionals in the Inpatient and Home Health Settings" March 13, 2012 http://circ.ahajournals.org/content/125/10/1321.long

While there was no significant cost savings shown related to post-acute care (PAC) costs in the Lewin Group's aforementioned BPCI second year evaluation report for cardiovascular surgery episodes, there is reason to believe that home health was not optimized in these episodes. In fact, the report asserts that the reason for the drastic savings in orthopedic episodes was achieved by changing the type and use of PAC, something not focused on in cardiac episodes. Greater education on PAC options, specifically home health care, is needed to better prepare patients following discharge, which may lead to savings as it did for orthopedic episodes.

Additionally, telehealth has shown to be an integral component in successful home health CR programs, and the Alliance appreciates CMS's proposal to waive telehealth originating site and geographic site requirements for all three EPMs. A case study of the Visiting Nurse Association of Western New York's telehealth care transitions program, utilized for at-risk patients with a number of cardiac conditions including CABG, demonstrated marked reductions in readmissions rates upon implementation of the program. After just three years of implementation, rehospitalization rates fell from 29 percent to 18 percent, and fell to 16 percent between October 2011 and September 2012, below both the national and New York state averages.[6] Such cases show that successful telehealth implementation, hand-in-hand with home health care, have the potential to play a vital role in reducing readmissions after cardiovascular surgery.

III. Waiver of the Homebound Requirement in Limited Circumstances

In the context of various new and alternative payment models, CMS has allowed select waivers to enable appropriate use of services that would otherwise not be permitted by law or regulation. Examples built into the EPM proposed rule are the waiver of the three-day requirement for a skilled nursing facility stay and waiver of the direct supervision requirement for post-discharge home visits. The Alliance appreciates CMS's recognition of the role of home health care in the context of the proposed EPMs, but urges CMS to reconsider its analysis of the need for a waiver of the homebound requirement.

In previous comments to CMS, the Alliance has urged CMS to allow a waiver of the homebound requirement in the context of new models of care such as the Medicare shared savings program[7] and the comprehensive care for joint replacement program.[8]

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[6] AHHQI "Home Health Initiatives Reduce Avoidable Readmissions by Leveraging Innovation" http://ahhqi.org/images/uploads/Innovations@Home_131024.pdf

[7] Alliance Comments to CMS on Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services, Sept. 8, 2014http://ahhqi.org/images/uploads/Alliance_ACO_Comments_20615_FINAL_WEB.pdf

[8] Alliance Comments to CMS on Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services, Sept. 8, 2014 http://ahhqi.org/images/uploads/AHHQI_CCJR_Comments_90815.pdf

The Alliance continues to support the concept of a homebound waiver in the programs and initiatives that CMMI has been testing.

Notwithstanding, the Alliance recommends that CMS incrementally test waiver of the homebound requirement for the home health benefit by using a limited waiver. The Alliance recommends that such a limited waiver would apply only in the CJR model, EPM tracks or BPCI models when the episode initiator has downside risk, and where the home health agency has 3 stars or greater on Home Health Compare.

Furthermore, the Alliance suggests testing waiver in certain limited circumstances. Two specific circumstances for waiver of homebound that the Alliance offers for consideration are highlighted below:

1. A beneficiary meets all eligibility requirements at the beginning of a 60-day home health episode, but during the course of the episode experiences improvement and evolves to no longer being homebound at some point during the 60 days. In such cases, the homebound requirement would be waived to enable the beneficiary to continue receiving care during the remainder of the episode, rather than being discharged from the home health agency's care. For beneficiaries who have already received at least 5 episodes, if a patient is discharged prior to the 60 days, Medicare pays the full 60-day episode rate. This waiver would simply enable the HHA to continue to provide services during the remainder of the 60-day episode to non-homebound beneficiaries so that care is not interrupted.

2. A beneficiary meets all eligibility requirements throughout an initial 60-day home health episode of care, but after receiving the full 60-day episode of home health care, the beneficiary's condition has improved and he or she is no longer homebound. The improvement occurred because of the home health care interventions provided during the first episode. Waiver of the homebound requirement for a second episode of care would enable the HHA to continue to provide support to the beneficiary in the context of the two-sided risk EPM bundled payment episode and support avoidance of unnecessary readmission after the first episode and overall achievement of improved or maintained outcomes. By way of example, some home health beneficiaries use telehealth during a first episode of care as part of the plan of care, and benefit from the improvement in patient engagement that results from remote patient monitoring and associated interactions with home health nurses and therapists. Patients that improve during the home health episode and are no longer homebound after the first episode would benefit from continued use of telehealth that could be provided by the home health agency if a second episode were permitted.

These are only two examples of the types of patients who would benefit from continued support from home health agencies if a limited waiver of the homebound

requirement were used in EPMs. As with the waiver of the 3-day rule for SNF care, all other Medicare rules for coverage and payment of home health care would continue to apply.

In addition, the Alliance recommends that the waiver of the direct supervision requirement for post-discharge home visits (up to 9) be structured to enable home health agencies to bill for such visits. Home health nurses and therapists are specifically trained to serve patients in home visits. Allowing home health agencies to bill the Medicare program directly for appropriately supervised post-discharge home visits would leverage the trained workforce that has already been cultivated within home health agencies.

The Alliance would welcome the opportunity to have a conversation with CMS regarding appropriate regulatory waivers and safeguards to serve the best interests of both Medicare patients and the program. The Alliance looks forward to discussing with CMS appropriate ways to optimize the valuable role that home health agencies can play in CMS's efforts toward achieving the Triple Aim.

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Thank you for the opportunity to comment on this notice. Should you have any questions, please contact me at 571-527-1530 or tlee@ahhqi.org.

Sincerely,

/s/

Teresa L. Lee, JD, MPH
Executive Director