September 4, 2012

Ms. Marilyn Tavenner
Acting Administrator, Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1358-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies

Dear Ms. Tavenner:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") to provide comments on the **Proposed Rule on the Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies.**[1] The Alliance appreciates the opportunity to provide comments on the proposed rule and has comments on the Home Health Care Quality Reporting Update.

About the Alliance for Home Health Quality & Innovation

The Alliance is a non-profit organization committed to research and education focused on the value that home-based care provides to patients in the U.S. health care system. Founded in 2008 by some of the largest home health providers in the United States, the Alliance is a membership organization comprised of home health care providers and organizations dedicated to improving individual patient care and the nation's health care system. Our membership is noteworthy in that we are an organization with both for-profit and non-profit health care providers, brought together with a mission to support research and education on the value of home health in improving quality and efficiency of care. It is in this vein of thinking that the Alliance this year has been transitioning from a 501(c)(6) organization to a 501(c)(3) organization in order to focus more specifically on research and education for the public benefit.

As a quality organization, the Alliance participates in various quality initiatives to improve the quality and efficiency of home health care. We are currently members in the National Quality Forum and the

[1] Medicare Program; Home Health Prospective Payment System Rate Update for
Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies, 77 Fed. Reg. 41548, 41548 - 41600 (July 13, 2012).

National Priorities Partnership. Additionally, we have an active history of involvement in the Centers for Medicare & Medicaid Services' initiative and the Home Health Quality Improvement (HHQI) National Campaign.

The Alliance, and several of its members, served on the Steering Committee with West Virginia Medical Institute (WVMI) in preparation for the HHQI campaign. During the 2010-2011 HHQI campaign, the Alliance provided recommendations to the CMS Office of Clinical Standards and Quality and served as a Local Area Network for Excellence (LANE). LANEs served as hubs of HHQI campaign activity in local areas, with multiple opportunities to create awareness, provide encouragement and facilitate communication among agencies.

The Alliance will be participating in Phase III of the HHQI campaign, which will begin this fall.

Comments on Home Health Care Quality Reporting Program

The Alliance supports the use of the claims-based Acute Care Hospitalization and Emergency Care measures to replace the OASIS-based measures on Home Health Compare. It is our position that the claims-based measure will more accurately capture hospitalization rates and are a better measure of quality than the self-reported OASIS data. Additionally, this proposal will reduce the administrative costs and burden of data collection and allow home health care providers to harmonize this data with other Medicare providers such as acute care hospitals. We are optimistic that this proposal will enable home health care providers to form more meaningful partnerships with other providers and practitioners in the care continuum in order to track the quality of patient care.

We note, however, that there is still a discrepancy between the Acute Care Hospitalization measure for home health care agencies and that of acute care providers, such as hospitals. With respect to the Acute Care Hospitalization measure in particular, the Hospital Quality Reporting (QR) measures report hospital re-admissions over a 30-day period, not a 60-day period as is reported in the OASIS data set. Hospital readmission rates are also measured from the date of inpatient discharge whereas home health care providers measure admissions from Start of Care under OASIS-C. One of the most critical points of hand off and cross setting accountability is between the hospital and the home health agency and this difference in measures make shared accountability that much harder to achieve. As the measures are now being drawn from the same source, we believe that this is an important opportunity to harmonize and create a cross setting measure.

Measures vary dramatically across different care settings. In post-acute care alone, providers may use OASIS-C, MDS, IRF-PAI or others. This often creates a significant quality barrier for providers who wish to create longitudinal care plans across the spectrum of care. The discrepancy and variance in the data may affect quality reporting and the ability of home health care providers to build accountable partnerships with hospitals and physicians. **We are pleased that the home health quality reporting for this measure will be harmonized with the Quality Reporting of other providers such as hospitals, ambulatory surgery, and others, in that the measure as proposed covers Medicare fee-for-service beneficiaries only.**

Appropriately, the proposed calculation does not include the hospitalizations of Medicaid recipients who receive skilled care or that of beneficiaries enrolled in Medicare Advantage. These patients represent very different populations and their inclusion or exclusion can dramatically alter the resulting hospitalization rates. For example, it is the experience of our provider members that beneficiaries under

Medicare Advantage tend to have significantly fewer hospitalizations due to the payment structure. Medicare Advantage payments include a specific number of visits over a typical 10 – 21 day period, whereas Medicare home health beneficiaries receive episodic benefits over a 60-day payment period. This is just one example of a discrepancy between these three distinct beneficiary groups.

Finally, we would like to work with CMS to develop a long-term plan for quality measurement in home health care. Several final rules for health care providers have included a plan or map for measures that details which measures will be incorporated, which measures will be excluded and the like. For example, please see the following: Hospital Inpatient Prospective Payment System Final Rule for FY2013;[2] and the Hospital Outpatient Prospective and Ambulatory Surgical Center Proposed Rule on Quality Reporting Programs.[3] These CMS issuances provide a long-term, multi-year plan that comprehensively outlines measure development even when value-based purchasing is not included in the long-term plan. It is not apparent, however, that there has been a long-term plan developed for home health care despite the fact that home health care providers have submitted measurement data for twelve years for millions of beneficiaries across the United States. We would encourage that resources be devoted to providing a quality roadmap for this important setting for Medicare beneficiaries. If such a roadmap is developed, it is critical that the plan include a mechanism to review measures annually and remove measures that no longer support better patient care.

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Thank you again for the opportunity to provide comments on this proposed rule. Should you have any questions, please contact me at 202-239-3671 or tlee@ahhqi.org.

Sincerely,

Teresa L. Lee, JD, MPH
Executive Director

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[2] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers, 42 C.F.R. §§ 412, 413, 424, 476, *available online at:* http://www.ofr.gov/OFRUpload/OFRData/2012-19079_PI.pdf.

[3] *See* Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities
Quality Reporting Program; Quality Improvement Organization Regulations, 77 Fed. Reg. 45061, 45061 – 45233 (July 30, 2012).