November 20, 2017

Via email at CMMI_NewDirection@cms.hhs.gov

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

RE: Centers for Medicare & Medicaid Services: Innovation Center New Direction Request for Information

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') and the **Centers for Medicare & Medicaid Services: Innovation Center New Direction Request for Information ("RFI").** [1] Thank you for the opportunity to provide comments on the RFI.

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/.

We appreciate the opportunity to provide comments on the RFI, and offer recommendations and considerations to CMMI on the following topics outlined in the RFI: (1) Advanced Alternative Payment Models (APMs); (2) State-Based and Local

[1] Centers for Medicare & Medicaid Services: Innovation Center New Direction (herein after "RFI"), https://innovation.cms.gov/initiatives/direction?utm_source=Global+%2B+Members&utm_campaign=ac5f9a22cc-AHHQI_Monthly_e_News_Template5_10_2012&utm_medium=email&utm_term=0_a57c50e6f8-ac5f9a22cc-72151561

Innovation, including Medicaid-focused Models; (3) Mental and Behavioral Health Models; and (4) Program Integrity.

I. Advanced Alternative Payment Models (APMs)

The Alliance is supportive of the greater inclusion of home health care in APMs, and would welcome a chance to work with CMS and CMMI on appropriate inclusion of home health care in new and existing APMs.

Home health care is already serving as a valuable partner in some APMs, including the Comprehensive Care for Joint Replacement (CJR) model. MS-DRG 470 is the most common diagnosis code in home health care. Based on data analysis conducted by Dobson | DaVanzo, when home health care is the first setting post acute the average Medicare episode payment is $5,000 less than the average across all settings, while the average readmissions rate for home health care was also below the average across all settings.[2]

In the same vein, home health has shown an ability to be an important partner in the care of patients with cardiovascular disease. A number of pilots and studies have shown that home health care interventions for patients with acute myocardial infarction (AMI), coronary artery bypass grafting (CABG), and heart failure (HF) may lead to lower 30-day readmission rates and improved outcomes.[3]

Additionally, home health has also shown to be an valuable partner in other existing APMs, such as Bundled Payment for Care Improvement (BPCI) and accountable care organizations (ACOs). While these models are still ongoing and have not been fully evaluated yet, they offer a chance for home health to be a vested partner in the care continuum. Within these existing and potential models, the Alliance asks for continued stakeholder engagement with CMS in order to ensure that do not have unintended consequences. The Alliance would also echo calls for models which allow for shared incentives, not just shared risk, and allow providers to access feedback in a timely manner so as to address any issues or raise any concerns.

As a lower cost alternative when clinically appropriate, home health care can and should be a greater partner in models going forward. However, within the aforementioned and potential and existing other APMs and models, the Alliance stresses the importance of regulatory flexibility. Based on stakeholder interviews done as part of the research paper, "The Future of Home Health Care: A Strategic Framework for Optimizing Value" one of the biggest regulatory constraints facing home health agencies is the requirement a patient be homebound in order to receive

[2] "Distribution of Post-Acute Care under CJR Model of Lower Extremity Joint Replacements for MS-DRG 470" June 2016. http://ahhqi.org/research/joint-replacement-data
[3] "Untapped Potential of Home Health Care Innovations to Improve Outcomes With Bundled Payment Initiatives" Dec. 2016. http://journals.sagepub.com/doi/abs/10.1177/1084822316679935

care in the home. Selectively waiving this requirement as a means of regulatory relief in new and innovative models of care would allow patients the ability to receive optimal care in the home and may lead to savings in the long term. The Alliance provided more in-depth comments regarding selective waiver of the homebound requirement in our comments to CMS on the proposed Medicare Shared Saving Program proposed rule, which we would refer to for a fuller analysis of waiving homebound in APMs.[4]

II. State-Based and Local Innovation, including Medicaid-focused Models

Home health patients are generally poorer, sicker, and frailer than their peers. Per data from the Home Health Chartbook[5], nearly one in every three home health patients has a an income at or below 100 percent of the Federal Poverty Level (FPL), and two in three have incomes at or below 200 percent of the FPL. More than 50 percent of dual eligible home health care patients require assistance with at least one activity of daily living (ADL), and over half also suffer from five or more chronic conditions.

The Alliance is supportive of further state-based and Medicaid-focused models that can help provide supports to home health care patients and may improve care in the home. For example, Sarah Szanton and her colleagues at Johns Hopkins School of Nursing designed a program called, "Community Aging in Place, Advancing Better Living for Elders," or CAPABLE. The program brings together a nurse, an occupational therapist, and a handyman to address the environmental and physical limitations of patients in order to improve outcomes, safety, and ultimately hopefully independence.

Opening up state models to better include Medicaid-focused and community-based supports, such as the CAPABLE program, is critical to the continued care for older and disabled Americans. Given the number of dual eligibles receiving home health care, and the number of those users who require assistance with at least one ADL, programs like CAPABLE are necessary for being able to keep patients at home, where we know people would prefer to live as long as possible, and that when clinically appropriate is the most cost-effective post-acute care setting[6]. As such, the Alliance would ask CMS to consider expansion of Medicaid services and to look at programming that supports the ability to patients to stay in the home and community.

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[4] Alliance Comments to CMS on Medicare Shared Saving Program. Feb. 2015. http://ahhqi.org/images/uploads/Alliance_ACO_Comments_20615_FINAL_WEB.pdf

[5] "Home Health Chartbook Preview, 2017" http://ahhqi.org/images/uploads/AHHQI_2017_Chartbook_PREVIEW.pdf

[6] "The Future of Home Health Care: A Strategic Framework for Optimizing Value" Oct. 2016. http://journals.sagepub.com/doi/full/10.1177/1084822316666368

III. Mental and Behavioral Health Models

More than even the general Medicare home health population, home health users with severe mental illness (SMI) are more likely to have three or more chronic conditions, need help with two or more activities of daily living, and report fair or poor health. More than 25 percent of Medicare home health users have SMI, a figure which trended upward each year from 2011 – 2013.[7]

The Alliance is supportive of models that better integrate mental and behavioral health with the rest of the health care system, including primary care and home health care, and looks forward to working with CMS and CMMI on models that address the specific needs of home health care patients with SMI.

IV. Program Integrity

The Alliance recognizes the need for robust program integrity programming and would like to continue to engage with CMS and CMMI on programs and levers that will target offenders without imposing unnecessary burden on compliant agencies that are simply trying to care for patients. CMS already lists certain areas of emphasis in targeting actors committing fraud, including timely licensure and accreditation, transparency, and auditing. This should be done in a purposeful manner directed at "hot spot" areas identified through patterns in claims data.

In addressing program integrity and fraud, home health can play an even greater role in the delivery of safe, patient-centered care, and the Alliance looks forward to engaging CMS in ways to reduce fraud and abuse without creating undue burden on agencies.

V. Additional Comments

Finally, the Alliance would like to reiterate a commitment to working with CMS on the priority areas addressed in the RFI and beyond.

Several existing barriers for home health agencies remain unaddressed, including but not limited to the face-to-face requirement and the previously mentioned homebound requirement. These significant issues, addressed in previous comment letters and communications with CMS, continue to present challenges to optimizing care for a growing and vulnerable patient population.

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[7] "Home Health Chartbook Preview, 2017"
http://ahhqi.org/images/uploads/AHHQI_2017_Chartbook_PREVIEW.pdf

The Alliance greatly appreciates the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at (571) 527-1532 or jschiller@ahhqi.org.

Sincerely,

/s/

Jennifer Schiller
Director, Policy Communications & Research