

August 24, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

***CMS–1730–P: 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:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 900 hospital-based home health (HH) agencies, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2021 proposed rule for the HH prospective payment system (PPS). Specifically, this letter focuses on the projected and actual behavioral response by the field during the CY 2020 implementation of the new HH PPS case-mix system, the Patient Driven Grouping Model (PDGM), as well as the proposed provisions for the home infusion benefit.

While we continue to support the PDGM objective of increasing HH PPS payment accuracy, we remain concerned that CY 2020's large behavioral offset, 4.36%, was implemented on a prospective basis. This concern remains based on the historic difficulty CMS has had in aligning prospective adjustments with actual provider behavior. Indeed, initial data from the beginning of 2020 show that most of CMS' assumptions were not accurate. The COVID-19 public health emergency (PHE) has certainly had an impact on this; however, while policymakers could not have anticipated an event with the scope and impact of the PHE, its existence only underscores the risks inherent in making prospective behavioral offsets. As such, we urge CMS to reverse its 4.36% behavioral offset, for the remainder of CY 2020 and beyond, until all CY 2020 data are available for analysis.



Improbable Accuracy of CY 2020 Behavioral Offset

When commenting on CMS' plan to implement PDGM in CY 2020, instead of a prospective behavioral offset, the AHA and other stakeholders [strongly urged](#) the agency to implement a retrospective adjustment based on actual payment data. The advantage of a retrospective approach is that it eliminates the often inaccurate assumptions used to project future provider behavior.

While we currently lack a full set of CY 2020 data, some stakeholders in the field have evaluated January through April 2020 data under the PDGM system. The service utilization and coding patterns they found do not align with CMS' behavioral assumptions. That said, we recognize that a comprehensive analysis of CY 2020 cannot be carried out at this time; ultimately, that will require 12 months of data as well as a targeted effort to disentangle the concurrent and material impacts of PDGM rollout versus the PHE.

Regardless, however, it is clear that the disruptions caused by the COVID-19 pandemic virtually eliminate the possibility that CMS' CY 2020 behavioral offset was accurate. Therefore, CMS should reverse its 4.36% behavioral offset until a full year of data are available to analyze actual provider behavior.

CMS is required by law to implement the PDGM in a budget-neutral manner. As such, the agency noted in last year's rulemaking its plans to fulfill this mandate by monitoring provider behavior to determine if the 4.36% offset actually achieves budget neutrality in CY 2020. The agency also stated that if it underestimated or overestimated this offset, relative to the three behavioral offset elements below, it would adjust the CY 2021 30-day payment amount through another behavioral offset, and would do so through the rulemaking process.

Unfortunately, beyond stating that the agency may act when, in the future, additional data become available, this proposed rule did not comprehensively discuss the agency's plan by, for example, explaining how the agency is likely to evaluate and attempt to isolate the intertwined impacts of PDGM rollout and COVID-19. The proposed rule also did not elaborate on how the agency might consider PHE data in their assessment of CY 2020 budget neutrality.

CY 2020 PDGM Behavioral Assumptions. The CY 2020 final rule based the current PDGM behavioral offset on the three projected behavioral responses below. **Based on HH stakeholders' close analysis of the first four months under PDGM, January through April 2020, it appears that providers' behavior does not closely align with CMS projections.**

- **Clinical Group Coding:** CMS assumed that in CY 2020, HH agencies would change their documentation and coding practices to choose the highest-paying

diagnosis as the principal diagnosis code. However, it appears that average case payment amounts for the first four months of 2020 fall short of CMS' projected amount. In fact, as an example, April 2020 claims data indicate that actual payments were at least 15% below CMS' projected average. In addition, the actual distribution of cases across PDGM clinical groups varies from the distribution projected by CMS. Further, as noted in our [CY 2020 comment letter](#), AHA analysis found that substantial portions of patients transferring from hospitals to HH already fall in highest-acuity clinical categories, as indicated by the rates of patients with major (43%) and extreme (11%) severity levels.^[1] In other words, because of higher medical necessity among this large subgroup, many cases likely already are coded to a principal diagnosis eligible for a high payment.¹

- **Comorbidity Coding:** CMS assumed that by accounting for additional diagnoses codes, more 30-day episodes would qualify for a PDGM comorbidity adjustment. However, analysis of the first four months of 2020 show that of PDGM's three comorbidity tiers, only one (for cases with one qualifying comorbidity) matches projected case rates as a percent of total. **In other words, for two out of three tiers of this case-mix element, CMS' projection was not accurate for the first four months of PDGM implementation.**
- **LUPA Threshold:** **The agency's assumption that the volume and rate of LUPA episodes would fall has been proven false.** Rather, as has been widely reported and is supported by initial claims analysis, LUPA case volume and percent of all cases have both increased, with some members reporting an increase from 7% to 14% of all cases. **If currently available national data also indicate an overall trend of this or similar scale, this misalignment alone warrants a pause in continued application of the current behavioral offset, at least for the remainder of 2020.** This national trend, at least in part, reflects beneficiary concerns with having health care practitioners enter their homes.

Collectively, these findings call into question the continued application of the CY 2020 behavioral offset, as its projected provider responses to PDGM initially appear to be inaccurate. Further, the drop in HH case volume during these months makes it likely that total HH spending for CY 2020 will fall short of what Medicare spending would have been under the prior case-mix system.

Given these trends, AHA calls on CMS to reverse its 4.36% behavioral offset, for the remainder of CY 2020 and beyond, until a full year of data are available to analyze actual provider behavior. In addition, in its rulemaking for CY 2021, CMS should take steps to reconcile any gap in projected versus actual Medicare spending in CY 2020. Further, we continue to support an annual cap

^[1] Analysis of FY 2018 Medicare Provider Analysis and Review (MedPAR) data and major and extreme severity levels under 3M's All Patients Refined (APR)-DRG Severity of Illness (SOI) ranking.

¹ Analysis of FY 2018 Medicare Provider Analysis and Review (MedPAR) data and major and extreme severity levels under 3M's All Patients Refined (APR)-DRG Severity of Illness (SOI) ranking.

of 2.0 percentage points on any future, negative behavioral offsets for PDGM, with any additional amount applied in increments in future years.

To keep the field informed of the quickly changing situation, we also ask CMS to use the final rule to update and discuss the utilization and outcome findings from CY 2020 claims data available at that time. In addition, given the dynamic nature of this situation, the agency should consider a mid-year CY 2021 adjustment, as warranted by claims data available in early 2021.

Home Infusion Therapy Provisions. In this rule, CMS proposes to implement revisions of the home infusion therapy benefit established in previous rulemaking, specifically related to the permanent payment system for these services that will come into effect Jan. 1, 2021. These provisions are similar to the temporary transitional payment system that was in place for the first two years of the benefit, and as such carry similar disadvantages to those AHA has [commented on](#) in the past. Namely, the permanent payment system continues to bundle professional services into a single unit of payment payable only on an “administration day.” This methodology leaves out many of the professional services that go into preparing infusion drugs.

In addition, we urge CMS to provide further clarity on certain enrollment requirements, such as what supplier type to select on enrollment form CMS-855B and licensure requirements for suppliers that operate in multiple jurisdictions or who work with subcontractors.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact me, or have a member of your team contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org regarding the payment provisions, or Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org regarding the home infusion therapy provisions.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy