August 24, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-173-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, Maryland 21244-8013

Re: 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:

The Oregon Association for Home Care represents providers of skilled home health, hospice, in-home care, IV therapy, respiratory therapy and home medical equipment providers through the state of Oregon. Collectively, we provide high-quality, homebased services to Oregonians in our communities as a cost-effective alternative to institutional care.

On behalf of the Oregon providers we represent and the many patients they provide care for, we respectfully submit our comments to the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services regarding the proposed reforms in the Medicare home health benefit and the CY 2021 payment rates in the Notice of Proposed Rulemaking (NPRM) 85 Fed. Reg. 39408 (June 30, 2020).

These comments were developed while keeping in mind the unprecedented and unforeseen demands that have been put on the home health care provider model during the COVID-19 pandemic throughout 2020. We would hope that any proposed rules would take into account the lasting impact that COVID-19 will have on the home health care model.

Payment Reform: Patient Driven Groupings Model (PDGM)

CMS has made important progress in modernizing the Medicare home health payment model, while ensuring transparency and fair evaluation by stakeholders, including patients and home health agencies. When first proposed, the Patient Driven Groupings Model (PDGM) represented an opportunity to transition to a new and improved system.

However, COVID-19 has brought massive changes in patient mix, alterations of the patient census receiving home health services, significant changes in all health care delivery models and changing demand from patients in need of care. These changes were unprecedented and – we hope – are not indicative of an average year. Because of this, the first eight months of the PDGM

cannot be understood as an accurate representation of the success of the new model. As such, OAHC recommends maintaining the general structure of PDGM through 2021.

OAHC would, however, recommend that CMS restore the use of symptom codes as a patient diagnosis in 2021. These codes play an important role in patient referrals and planning of care for home health patients and should be incorporated into PDGM.

OAHC also recommends that CMS implement a systemic methodology that would allow expedited adjustments to be made as needed to accommodate unforeseen impacts to the home health care model (such as those caused by a pandemic) to ensure that home health patients will continue to access care, while also providing access to home health care patients that are new to the delivery system. Many patients who contracted COVID-19 received care from Medicare home health care agencies (HHAs). While hospitals and other providers saw significant reimbursement adjustments due to the pandemic, HHAs did not. Further, the cost of care for these new patients being seen by HHAs increased, due to increased costs and demand for PPE and other preventative measures. HHAs could have provided more access to home health care had CMS developed a process for mid-year adjustments for unexpected cost increases.

Recommendations:

1. Maintain the structure and design of PDGM for 2020, while adding symptom codes to the list of acceptable diagnoses.
2. CMS should implement a process and methodology to modify HHA payment systems and rates during the year as needed.

Achieving Budget Neutrality Through Rate Reduction Reversals

CMS's assumed behavior changes for 2020 were significantly overstated. CMS had assumed there would be an 8.01% change in the diagnosis coding and utilization behavior by HHAs in the first year of the PDGM, including a 5.91% change in just diagnosis coding. Even while CMS ultimately decided to reflect 4.36% of the overall assumed behavioral changes in the 2020 rates of payment, it is evident that none of those changes have occurred in the first part of 2020 and that CMS will not achieve budget neutrality on home health services.

The assumptions made by CMS regarding behavioral changes in response to the initiation of a new payment model – such as the PDGM – were not based on solid data. Using these unfounded assumptions as the basis for current race setting puts the neutrality of the budget at risk.

OAHC recommends CMS take steps to address the 4.36% behavior adjustment to reconcile budget neutrality shortfall.

Recommendations:

1. CMS should go back and review 2020 PDGM claim data to determine whether PDGM has been budget neutral and if adjustments need to be made going forward.
2. CMS should make the 2020 data available to the home health community for purposes of its analysis relative to 2021 rates of payment related to the budget neutrality requirements.

3. CMS should convene a Technical Expert Panel to evaluate the impacts of COVID-19 on the 2020 budget neutrality adjustment in 2020 and its continued application in 2021.
4. CMS should work to achieve budget neutrality under PDGM in 2021 and expedite any reconciliation required relative to 2020 payment rates.

Standards and Process for Achieving Budget Neutrality

Under 42 USC 1395fff, CMS is required to reconcile payment rates to achieve budget neutrality using the current HHPPS-HHRG payment model through 2026. To do this, OAHC recommends developing new standards and processes for behavior adjustments at the beginning of the implementation of PDGM. These standards must be established for determining nominal change compared to real change in case mix, as well as changes that affect other types of Medicare home health spending including Medicare enrollment, increase/decreased utilization of home health services, modification/improvement of enforceable coverage standards, behavior changes in other PAC services that affect home health utilization, technological advances and other factors that may contribute to Medicare spending changes not specifically related to PDGM. These standards must be addressed especially as we begin to see the drastic impacts that COVID-19 has had on the home health patient population. There are many factors, in addition to PDGM, that have the ability to impact Medicare spending. CMS should not modify payment rates under its ongoing behavior adjustment and reconciliation authority based on factors other than those directly triggered by the transition from HHPPS-HHRG to PDGM.

Recommendations

1. CMS should convene a Technical Expert Panel (TEP) to develop the necessary standards and processes for determining behavior adjustments related to the transition to PDGM and ensure that the TEP and CMS engage in a thorough public input process to ensure all stakeholder input is included in the development of any new standards and processes.

Accounting for COVID-19 Impacts When Rate-setting for 2021

CMS's rate adjustment modifications to the Market Based Index (MBI) and Productivity Adjustment (PA) in the final rules, nor the proposed 2021 rate adjustment adequately account for the increased costs of care in 2020 due to COVID-19 that are expected to continue through 2021. The National Association for Home Care (NAHC) has found that Personal Protective Equipment (PPE) alone has increased visit costs by $11.50 per visit. The MBI does not account for this increased cost of care.

Recommendations

1. CMS should account for the increased cost of care due to COVID-19 by adding a PPE cost add-on to the 2020 payment episodic and per visit payment rates.

Addressing the Proposed Wage Are Index Transition

The proposed 2021 wage area index includes a 5% cap on any reduction in the wage index, which will help with the wage index transition and help ensure financial stability for some providers. However, OAHC would like to better understand the impact of the transition approach, especially during this period of instability caused by COVID-19.

OAHC is also concerned by the use of the pre-floor, pre-classified hospital wage index for HHAs. Competing employers such as hospitals and other medical providers have district wage index adjustments intended to reflect wage variations across the country. As CMS continues to implement a rural floor and permit geographic reclassifications for hospitals under the wage index, CMS should allow the same for HHAs.

Recommendations:

1. CMS should conduct a public impact analysis of the proposed 5% transition approach, as compared to the 50/50 blend of old and new indexes previously used by CMS in addressing area wage index transitions.
2. CMS should employ a rural floor and permit geographic reclassifications for HHAs under the wage index or permit HHAs to assign the hospital wage index based on the primary hospital that serves the geographic area of the HHA patient.

Homebound Criteria During COVID-19

CMS has recognized that the homebound criteria for Medicare home health benefit during the COVID-19 pandemic is widely applied to vulnerable Medicate beneficiaries, especially as many Medicare beneficiaries will be required to receive care in their homes to prevent the spread of COVID-19.

Recommendations:

1. CMS should continue to recognize that COVID-19 and other situations that may prevent a Medicare beneficiary from leaving their home to receive medical care should be included in a categorical finding that an individual is homebound under existing law.

Delay Late RAP Submission Penalties in 2021

The 2020 HHPPS rate rule update includes a finalized payment reduction in an HHA does not submit the RAP for CY 2021 within 5 calendar days from the start of care. This reduction would equal one-thirtieth the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submits the RAP.

This 5-day RAP submission timeframe has become exceedingly difficult to meet during the COVID-19 crisis due to operational and financial challenges.

Recommendations:

1. CMS should delay the implementation of the payment penalty for late RAP submission in 2021 until 6 months after the implementation date or three months after the COVID-19 crisis has ended. Health care providers should remain focused on providing patient care during the pandemic throughout 2021.

Telecommunications and the Medicare Home Health Benefit

CMS proposes the adding to the home health plan of care (POC):

- Any provision of remote patient monitoring or other services furnished via a telecommunications system;
- Tying such services to the patient-specific needs as identified in the comprehensive assessment; and
- A description of how the use of such technology will help to achieve the goals outlined on the plan of care.

Visits conducted via telehealth cannot substitute for an ordered in-person home visit and cannot be considered a home visit for the purposes of patient eligibility or payment.

While OAHC is grateful for the steps taken by CMS to address the issue of telecommunications in the health care delivery model during the COVID-19 pandemic, our members are concerned by the POC requirements and their lack of flexibility, which could lead to increased risk for unreasonable claim denials. CMS' refusal to allow reimbursement for visits conducted via telecommunications will lead to a lack of access to telecommunications technologies and services for Medicare home health beneficiaries.

Recommendations:

1. CMS should allow for additional flexibility in the documentation requirements of the POC and allow documentation throughout the medical record to be used to support the use of telecommunications technology.
2. POC reporting requirements should be limited to the use of telecommunications technology in managing the patient's clinical condition
3. CMS should develop a model for claims reporting and payment for home health visits provided by telecommunication.
4. CMS should allow for the use of audio only telecommunications technology in home health care settings.

Home Infusion Therapy Services

CMS' proposed rule again mentions the coverage and payment requirements for home infusion therapy suppliers and outlines the proposed Medicare enrollment requirements for accredited home infusion therapy suppliers. However, Medicare contractors will not begin to accept enrollment applications for home infusion therapy suppliers until after the rule has been finalized, allowing only two months for providers to complete the enrollment process with suppliers prior to

the implementation of the new benefit. This narrow timeframe, in addition to the strains put on the home health system due to COVID-19, will make it impossible for many providers to serve beneficiaries receiving Part B infusion therapy beginning January 1, 2021.

In addition, OAHC and our members have concerns about access to home infusion therapy supplies and whether the number of enrolled suppliers will meet demand.

Recommendations:

1. CMS should delay the implementation of the permanent home infusion therapy supplier benefit at least six months beyond the scheduled implementation date or three months after the COVID-19 crisis ends. If this is not possible, CMS should not enforce the prohibition for HHAs to provide the professional services associated with Part B infusion drugs under the home health benefit.

Quality Reporting Program

CMS has not proposed any changes for the CY 2021 quality reporting program. However, many of the reporting mechanisms and programs that the quality reporting program are based off of have been delayed and adjusted due to the COVID-19 pandemic. It would be in the best interest of all HHAs and their patients were CMS to study and further consider other factors impacting the performance of all home health agencies on all quality measures during the pandemic and make appropriate changes to public reporting to reflect adjusted patient needs.

Recommendations:

1. CMS should further consider factors impacting HHAs during the COVID-19 pandemic and adjust public reporting as needed.
2. CMS should suspend the final year of the HHVBP demonstration, due to the wildly variant change in case mix and clinical practice throughout the COVID-19 pandemic.

Thank you for the opportunity to submit these comments on behalf of OAHC and the many Oregon-based providers we represent.

Sincerely,

Fawn Barrie
Executive Director