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The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1711-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, Maryland 21244-8013

Submitted via: [regulations.gov](https://www.regulations.gov).

Re: CMS-1711-P: Medicare and Medicaid Programs: CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements

Dear Administrator Verma:

The Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services have proposed a number of reforms in the Medicare home health benefit along with setting out CY 2020 payment rates in the Notice of Proposed Rulemaking (NPRM). 84 Fed. Reg. 34598 (July 18, 2019). The changes include updates and refinements to the Patient Driven Groupings Model (PDGM), a new payment model that takes effect in CY 2020 and much more.

The National Association for Home Care & Hospice (NAHC) respectfully submits these comments regarding the proposals contained within the NPRM. NAHC is the largest trade association representing the interests of Medicare home health agencies (HHAs) nationwide including nonprofit, proprietary, urban and rural based, hospital affiliated, public and private corporate entities, and government run providers of home health care since 1982. NAHC members provide the majority of Medicare home health services throughout the U.S.

NAHC is also an original provider-member of the Leadership Council of Aging Organizations (LCAO) as it has put patients first in its health policy and advocacy positions since its inception. Each year, NAHC members serve millions of patients of all ages, infirmities, and disabilities, providing an opportunity for individuals to be cared for in their own homes, the care setting preferred by virtually all people.

These comments are also supported by our Forum of State Associations, an affiliate organization made up of all of the state associations that represent the interests of home health agencies in each state. We are specifically joined on this letter by several state home care associations listed on the final page. Many others are filing their own comments too. State associations are an important voice in understanding impact of the proposed rules in their local settings. Their “on the ground” perspective deserves special attention.

Payment Reform: Patient Driven Groupings Model (PDGM)

We greatly appreciate the efforts that CMS has employed to modernize the Medicare home health payment model. Further, the degree of transparency provided regarding the development of the Patient Driven Groupings Model (PDGM) has been crucial in permitting stakeholders to evaluate it and the potential impacts on patients and home health agencies. We look forward to working with CMS on the implementation of these very important changes. While transparency has improved, the below comments note certain areas of the PDGM development that need further illumination.

NAHC maintains the following guiding principles for establishing and operating an acceptable payment model:

1. Budget neutral transition to any new payment model.
2. No incentives that trigger undesirable behavioral changes

3. Sufficient reimbursement to cover the entire scope of the home health benefit
4. Payment amounts should be based on patient characteristics and clinical needs
5. The payment model should operate consistently with other aspects in service delivery.
6. All stakeholders should be given sufficient time to implement any changes in operations
7. Significant changes in payment models should be fully tested and validated

Overall, while PDGM presents significant improvements over the 2017 proposed Home Health Groupings Model (HHGM), it falls somewhat short of meeting the guiding principles. We remain concerned that, as with HHGM, the PDGM does not achieve the goals set out in in principles 2, 3, 4, and 6. Each of these areas of weakness is discussed below. Also, it is very apparent that PDGM will not be tested or validated as a reliable payment model at all prior to its nationwide implementation. This means that CMS must be vigilant in monitoring the effects of PDGM as it is implemented and that CMS be prepared to consider early modifications to eliminate or mitigate any unintended consequences. NAHC is ready to work in partnership with CMS throughout the transition to PDGM to achieve this end.

Risks to Monitor and Address

1. Therapy

One of the most significant changes in the payment model is the elimination of the Utilization Domain measure that is part of the current HPPS HHRG model. NAHC fully supports such a change and has consistently advocated against that measure beginning with the early unveiling of the proposed model in 1999. Most recently, NAHC strongly supported Medicare amendments in the Bipartisan Budget Act of 2018 that mandated the development of a new home health payment model that did not include the volume of therapy services as a measure for the payment level. While we are very encouraged by CMS's efforts to develop a valid and reliable case mix adjustment model that relies on patient characteristics rather than resource use to determine the amount of payment in individual service claims, we remain concerned that the PDGM design will have a negative impact on patients who need therapy services and the HHAs that provide it. Therapy services are extraordinarily valuable in the care of Medicare home

health beneficiaries and should be supported to the greatest degree possible. At the same time, we agree that, a prospective payment system should not be relegated to rely upon the volume of services utilized to determine payment amounts. Patient characteristics, not resource use should be the core focus of any prospective payment model.

NAHC recently conducted a nationwide survey regarding HHAs planned and/or anticipated changes in the provision of therapy services given the elimination of the Utilization Domain in the payment model. The results were disturbing, but not surprising. One-third of the respondents indicated that they expect to reduce the volume of therapy services under PDGM. That is disturbing because those respondents had not given such a response after evaluating any patients' needs for care. Instead, it was a clear reaction to the payment model changes alone that generally reduce the amount that will be payable for patients receiving therapy in comparison to the current payment model. While CMS might welcome such a reduction in therapy volume, PDGM does not discriminate between an appropriate care volume reduction and an inappropriate one. The outcome of the disincentives in PDGM in the provision of therapy services is an arbitrary one, not one related to patient characteristics and needs.

NAHC strongly encourages CMS to closely monitor clinical behavior changes that are driven by PDGM. Further, NAHC recommends that CMS join forces with NAHC to help educate HHAs regarding Medicare coverage of therapy under the home health benefit and that PDGM is not intended to drive clinical practice instead of setting reimbursement consistent with best practices.

Finally, NAHC wishes to repeat comments it has made throughout the development of PDGM. While we recognize that a regression analysis is an important component to payment model reform. We remain concerned that using such is an impediment to full correction of the longstanding barriers to skilled maintenance therapy. If patients who need and receive skilled maintenance therapy are not fully within the database used in the regression analysis, such patients may not be adequately recognized in the payment model. PDGM is based on a period of time when skilled maintenance therapy was not readily provided as a result misunderstandings regarding coverage of maintenance therapy by CMS contractors and HHAs. CMS needs to monitor the implementation of PDGM to ensure that it does not create new barriers to the full application of Medicare benefit standards. Further, CMS should rectify the shortcomings of a regression analysis methodology by updating PDGM in the future to fully respect the coverage of skilled maintenance therapy.

2. Admission Source Measure

Throughout the development of PDGM, NAHC has expressed concerns that the existence of and weight given to the admission source measure demonstrates a significant weakness in the strength of PDGM as a case mix adjustment model for the distribution of payments. To date, CMS has not responded to these concerns.

With PDGM, CMS uses certain clinical and functional measures reflecting individual patient characteristics. However, significant weight is given to the admission source at a level that easily overwhelms the impact of all other measures.

While data demonstrates that patients discharged to home health services from an inpatient setting utilize higher levels of services than patients admitted from the community, the level of impact from that measure in PDGM indicates that the remaining measures have extremely limited explanatory power on resource needs. Where patients are identical in all PDGM measures other than admission source, the reimbursements rates are generally \$200-\$350 per 30 day unit higher for patients coming from an institutional setting. That means that the resource use explanatory power of the clinical and functional measures is extremely weak.

NAHC has previously expressed with comments on HHGM that the application of an admission source measure may seem warranted given data demonstrating different resource use, but that doing so raises the specter of incentivizing HHAs to give priority to post-acute patients over those who are admitted from the community. Incentivizing discriminatory action should not be built into any Medicare payment model.

However, the financial impact of the PDGM admission source measure also highlights the inherent weaknesses with all the other PDGM measures. If the admission source measure is withdrawn from PDGM, the use of the remaining measures certainly results in an unacceptably weak case mix adjustment model. CMS must rely on true patient characteristics that reliably explain resource use rather than a combination of weak measures and a proxy for patient characteristics. With the HHRG model, CMS relied too much on therapy utilization. With PDGM, admission source has replaced therapy volume as a measure to support an otherwise weak case mix adjuster.

The weight given to the admission source measures is comparable to the weight given to the Utilization Domain measure of therapy visit volume in the current HHRG model that has been criticized for creating the risk of abusive utilization incentives and application of a fairly weak case mix adjustment model relative to all other patient characteristics. As conveyed uniformly by participants at the Technical

Expert Panel discussion, CMS should guard against substituting one bad incentive in the payment model with another.

RECOMMENDATIONS: NAHC strongly recommends that CMS closely monitor changes in practice that can be correlated with the impact of the admission source measure. For example, any downturn in the volume of community admissions may be a sign that the measure is creating a barrier to full access to the benefit. Further, NAHC recommends that CMS re-evaluate PDGM as a reliable case mix adjustment model and explore alternatives to the application of an admission source measure that involve clinical and functional patient characteristics rather than what appears to be an artificial explanation for differences in resource use. Correlation does not always equal causation.

3. Payment Distribution Fairness

CMS has proclaimed that among its goals with a reformed payment model is to achieve fair compensation and increased accuracy of reimbursement for the resources employed in caring for the variety of patients served in Medicare home health. NAHC fully supports these goals as central tenets of any reimbursement model. As we recommended in our 2018 comments, we once again recommend that CMS provide a full public evaluation as to whether the proposal meets these goals as part of the rulemaking process. NAHC conducted such of an evaluation in 2018 and concluded that PDGM results in little or no improvement in reimbursement fairness or payment accuracy. Given that the PDGM as proposed in the current rulemaking is not significantly different than that set out in the 2018 rulemaking, we believe that a comparable finding would be expected.

NAHC analyzed the Medicare margins of HHAs in 2016 (most recent data available) in comparison to the CMS impact analysis that is part of the tools CMS has made available for review of the proposed rule. In theory, improved payment accuracy and fairness would redistribute payments such that low-reimbursed HHAs would receive increased payment and high-reimbursed HHAs would receive lower payments. However, that does not occur with PDGM. The payment redistribution does little to improve fairness and makes matters worse in terms of accuracy.

Of the HHAs displayed in the 2018 CMS HHA-specific impact estimates, the CMS cost report database provides 8442 HHAs with usable reports. These data, in combination with the CMS impact estimates, show that nearly one-half of HHAs have the reverse impact from what should occur through payment model reforms that are intended to improve payment accuracy and fairness of compensation.

As noted in TABLE 1, 41% of HHAs with below average Medicare margins (<15%) will be paid less under PDGM than under the current payment model.¹ Likewise, a significant number of HHAs with above average Medicare margins, 49.87%, will receive increased Medicare revenues under CMS estimates.¹ If the CMS goals of improving payment accuracy and providing fair compensation are met, such an outcome would not occur. Generally, below average Medicare margin HHAs would receive increased payments while those with above average margins would receive decreased payments. NAHC recognizes that many factors, especially efficiencies, affect the level of Medicare margins. However, improved payment accuracy and fairer payment distribution is not achieved when nearly half of the HHAs experience the reverse of expected outcomes under a new payment model.

TABLE 1

Medicare Margin/PDGM Outcome	Number of HHAs	% of Below Average	% of Above Average	% of all HHAs
Below Average Medicare Margin with Increased Revenue in PDGM	2626	58.94%		31.11%
Below Average Medicare Margin with Decreased Revenue in PDGM	1830	41.06%		21.68%
Above Average Medicare Margin with Increased Revenue in PDGM	1988		49.87%	23.55%
Above Average Medicare Margin with Decreased Revenue in PDGM	1998		50.13%	23.67%

TABLE 2 further highlights the inequities of PDGM. At all segments of HHAs with Medicare margins lower than the average, over 40% of the HHAs are estimated to receive less Medicare reimbursement under PDGM than under the current HHPPS. Correspondingly, virtually 50% of HHAs with Medicare margins higher than the average receive more Medicare reimbursement under PDGM.

¹ It should be noted that the overall margin for these HHAs is less than 1.95% with resources applied to Medicare Advantage and Medicaid patient reimbursement shortfalls. This also reflects the Medicare margin resulting from traditional Medicare Fee-For-Service (FFS) payment in 2016 that preceded rate cuts in 2017, 2018, and scheduled for 2020. Under PDGM, nearly half of those HHAs with lower than average Medicare FFS margins are increasingly in financial jeopardy.

TABLE 2

Medicare Margin 2016	HHAs w/ Increased Revenue in PDGM	HHAs w/ Decreased Revenue in PDGM
< 0%	1371	859
0-5%	356	275
5-10%	413	334
10-15%	450	326
15-20%	459	401
>20%	1565	1633

CMS must move forward with a responsible payment model reform that does not increase risks of care access by financially destabilizing the home health agency infrastructure. The analyses presented in Tables 1 and 2 demonstrate that PDGM triggers such a risk at a high level.

RECOMMENDATION: CMS should develop focused monitoring program in concert with the home health community intended to ensure that PDGM does not affect care access, quality, and proper service levels while maintaining the full breadth of the Medicare home health benefit. NAHC further recommends that CMS should eliminate any PDGM measures that can lead to unintended behavior changes.

Transparency

NAHC recognizes that CMS has significantly improved the transparency of PDGM and the proposed payment rates. However, there remains one very important area that still falls short. The calculation of the behavior adjustment to the 30-day unit rate is not supported in a necessary and fully transparent manner. What appears to be the case is that CMS calculated the proposed 8.01% adjustment based on up-coding the primary diagnosis in 100% of the claims in the database and assuming that 1/3 of LUPAs that would otherwise occur are instead paid at the full unit level as a result of added visits. In addition, it appears that CMS assumes that there would be added diagnoses that affect the comorbidity measure scoring. Still, such information lacks the detail and explanation of the analytics employed not only in the mathematical calculations, but also in the rationale supporting the calculation.

With respect to the analytics, CMS simply displays the outcome and claims that it is justified because home health and other health care sectors historically have instituted behavior changes in reaction to new payment models. However, none of these references are tied to an assumption justifying a 100% up-coding impact or a 1/3 LUPA avoidance change in behavior in the first year of a new payment model alone. The closest offering connecting the analysis to the calculation is a reference to a finding in the current payment model of a behavior change that accounted for a 2% nominal case mix growth annually from 2000 to 2007. 84 Fed. Reg. at 34615, citing 82 FR 35274. It is difficult to understand how a historical 2% annual actual change could support a first year 8.01% assumed change. Transparency improvement would help perhaps. Likewise, it is reasonable to expect that an adequate level of transparency would expose the assumptions as without proper justification.

The Bipartisan Budget Act of 2018 amended Medicare law to authorize the establishment of a new payment model for home health services. That change in the law, codified at 42 U.S.C. 1395fff, provides in part that in the rulemaking regarding any behavioral adjustment to the rate of payment, CMS “shall provide a description of such assumptions in the notice and comment rulemaking used to implement this clause.” The purpose and intent of notice and comment rulemaking is to provide the interested public with the essential information necessary to provide an adequate understanding of any proposed action such that a party can effectively comment. NAHC is clearly an interested party with respect to this proposed rule. We do not believe we have been afforded an adequate “description” of the behavior adjustment to fully comment on the assumptions made to support the proposed adjustment. Instead, the NPRM contains a summary description with the needed details absent both in terms of the rationale for the assumptions made and the calculations made using those assumptions. A cursory description fails to meet the required standard of a “description” sufficient to provide comment on the proposed rule. What is sufficient is not based on CMS’s perspective, but on that of stakeholders such as NAHC.

RECOMMENDATION: CMS should publish for public notice and comment a full description of its behavior adjustment calculation, including all the specific data used in the assessment along with the complete calculation methodology prior to applying any adjustment. All existing workpapers on the PDGM behavior adjustment by any party within CMS, including the Office of the Actuary, should be made readily available to the public through the CMS website.

CMS Behavior Change Assumptions Significantly Overstate Risk of Actual Change

CMS assumes that home health agencies (HHAs) will modify their diagnosis coding and service utilization behavior in the aggregate by 8.01% in the first year of the new Patient Driven Groupings Model, PDGM. Of that amount 5.91% is assumed to be change in diagnosis coding alone.

The proposed behavior change adjustment is based purely on assumptions. CMS defends its assumptions with generalized references to past behavior changes by HHAs and other provider sectors. However, CMS has no reason to rely on experiences of other provider sectors to assess the potential for change by HHAs. Notably though, the actual behavior changes in coding in those other sectors never came close to the level predicted by CMS for HHAs. The actual behavior change by HHAs in response to the initiation of a new payment model is better represented in two instances in the past: 1998-1999 Interim Payment System (IPS) and 2000-present Home Health Prospective Payment System (HHPPS). Given the nature of the changes triggered by PDGM, both instances are instructive.

With IPS, HHAs shifted from a “per visit” and “reasonable cost” reimbursement model to one that limited the annual reimbursement through a “per beneficiary limit” applied in the aggregate. The Congressional Budget Office estimated the impact of that change to reduce Medicare spending by \$16.7B based on the application of a behavior change adjustment that discounted calculated spending reduction by two-thirds. However, the actual affect of IPS was a reduction in spending of over \$70B as Medicare beneficiaries serviced dropped from 3.5 million annually in 1997 to 2.1 million along with the closure of nearly 40% of HHAs. Report to Congress, March 2019, Medicare Payment Advisory Commission, Ch. 9, Table 9-1, http://medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec_rev.pdf?sfvrsn=0 This example clearly shows that behavior changes by HHAs in response to a new payment model are far from predictable.

HHPPS is especially instructive as the experience virtually mirrors the type of payment model changes planned with the transition to PDGM. The behavior change triggers in HHPPS primarily involved clinical diagnosis and utilization of therapy services. With PDGM, CMS expects changes in clinical diagnosis and visit volume utilization to surpass the LUPA thresholds. However, the rate of behavior change that actually occurred under HHPPS is in stark contrast to the assumed change under PDGM. With HHPPS, the actual change in coding and utilization that affected payment rates was less than 2% on average over seven (7) years. That is a rate far different than the one (1) year projection in PDGM of 8.01%. It is highly notable also that the HHPPS actual change includes the significant spending

impact of increased therapy visits that is incentivized in HHPPS, a spending factor that is wholly eliminated in PDGM without a replacement counterpart creating an alternative change risk.

The actual behavior change in HHPPS was as follows:

Time Period	Behavior Change	Average Annual Change Rate
2000-2003	8.7%	2.9%
2000-2005	10.71%	2.14%
2000-2007	12.46%	1.9%

Source: Analysis of 2006-2007 Home Health Case Mix Change, Final Report, April 2009 Abt Associates; Refinement of Medicare’s Home Health Prospective Payment System: Final Report, August 2008

It is entirely unreasonable for CMS to assume over four (4) times the average annual change actually experienced in the current home health services payment model in the new model, PDGM. In fact, PDGM has fewer meaningful areas of behavior change risk than existed in the HHPPS model when it was initiated in 2000.

Notably, CMS references the rate of change with HHPPS in the proposed rule. 84 Fed. Reg. at 34615, citing 82 FR 35274. However, CMS makes no further attempt to provide an analysis that would explain how a 2% annual nominal case mix growth can translate to an assumed one year behavior change spending impact of 8.01%. Virtually the same areas of change existed in HHPPS as are involved in the 2020 assumption-based behavior adjustment. However, HHPPS had the added high risk factor of therapy visit volume that is wholly absent from PDGM primarily because it is a risk factor for unnecessary spending increases in Medicare. As such, the most relevant behavior change history in home health services does not come close to justifying the proposed 2020 adjustment.

To somehow assume an adjustment in one year that is 4 times the level previously experienced in the home health level when the areas that pose risk for change are also reduced in number challenges logic to a breaking point. It also is counter CMS’s own logic whereby the increase in the number of diagnosis categories in PDGM through the addition of subcategories under the MMTA category justified the proposed increase of the adjustment from 6.42% to 8.01%. If an increase in change risk factors justifies an increase in an adjustment, so does a decrease in such factors justify a decrease in the

adjustment. Accordingly, the historical annual actual change in coding in HHPPS should translate to a first year adjustment of less than 2% at most.

The application of assumption-based adjustments to payment rates significantly increases the likelihood of patient-impacting disruptions in home health services beyond those that would normally occur in any transition to a new payment model. Those disruptions are greatly enhanced when the assumption-based adjustments have no foundational support in the levels proposed. Where there are historical experiences in circumstances comparable to the new payment model changes, CMS must rely on them as a starting point for any behavioral adjustments. Here, that experience is clear and applicable. In addition, that experience is one that presented a higher risk of behavior change than exists under PDGM and displays a rate of change dramatically lower than that projected by CMS with PDGM. Accordingly, CMS's proposed behavior adjustment should be withdrawn and replaced with one that has a reasonable basis in fact or a related experience to support any assumptions and predictions.

RECOMMENDATION: CMS should withdraw the proposed behavior adjustment. Any replacement should be based on the most relevant and reliable historical data that ties previous behavior changes to facts similar to the change risks in PDGM. No home health adjustments should be based on the behavior changes in other health care sectors.

CMS Has Flexibility in the Application of a Behavior Adjustment

While CMS is authorized to make an assumption-based behavior adjustment to achieve budget neutrality, Medicare law does not dictate how CMS must implement that authority. In particular, 42 USC 1395fff does not mandate any particular level of adjustment, up or down. CMS maintains significant flexibility relative to any adjustment. The specific provision states:

With respect to payments for home health units of service furnished that end during the 12-month period beginning January 1, 2020, the Secretary shall calculate a standard prospective payment amount (or amounts) for 30-day units of service (as described in paragraph (2)(B)) for the prospective payment system under this subsection. Such standard prospective payment amount (or amounts) shall be calculated in a manner such that the estimated aggregate amount of expenditures under the system during such period with application of paragraph (2)(B) is equal to the estimated aggregate amount of expenditures that otherwise would have been made under the

system during such period if paragraph (2)(B) had not been enacted. The previous sentence shall be applied before (and not affect the application of) paragraph (3)(B). In calculating such amount (or amounts), the Secretary shall make assumptions about behavior changes that could occur as a result of the implementation of paragraph (2)(B) and the case-mix adjustment factors established under paragraph (4)(B) and shall provide a description of such assumptions in the notice and comment rulemaking used to implement this clause.

42 USC 135fff(b)(3)(A)(iv)

With such flexibility, CMS could conclude that no adjustment is needed, that any adjustment should not be greater than a certain level so as to not trigger undesirable behavior, or that an adjustment can be made in steps over several years to reduce the risk of unintended consequences. There are likely many more options open to CMS to ensure continued access to high quality home health services.

NAHC notes that HHAs and Medicare beneficiaries will remain at risk due to the behavior adjustment proposed by CMS even in circumstances where any adjustment is implemented in a series of steps rather than wholesale in 2020. However, a stepped adjustment will certainly mitigate risk.

CMS should consider the consequences and risks associated with applying the proposed behavior adjustment in combination with the initiation of a radically different payment model along with all the other changes occurring in health care such as ACOs, expanded Medicare Advantage enrollment, PAC bundling, and other payment innovations. In doing so, CMS can take into consideration that a combination of changes all at the same time can be intensely disruptive and end with direct and negative impact on those intended to be protected through home health services. CMS can still achieve full budget neutrality overall in doing so too.

Congress is weighing in on the matter with bicameral, bipartisan legislative proposals to modify the Bipartisan Budget Act, specifically the behavior adjustment under 42 USC 1395fff. The two bills, S.433 and HR 2573, would cap any single year adjustment at 2 points until 2025 when CMS can make further adjustments to ensure budget neutrality over the period of 2020 through 2029. NAHC believes that the process and schedule of behavior adjustments set out in these bills is the best way to ensure operational stability in HHAs and continued access to care. Nevertheless, even without this legislative change, CMS can rely on its existing reconciliation power as it provides a fail-safe for budget neutrality over a full term, obviating any reason to apply significant rate adjustments in just the first year of PDGM.

RECOMMENDATION: CMS should consider the impact of any behavior adjustment applied to the first year rates in PDGM to ensure that the transition to the new payment model fully limits the risk of disruptions in full access to the Medicare home health benefit. In doing so, CMS should apply any adjustment in a flexible manner to secure both continued access to care and budget neutrality under PDGM by 2029.

Concerns Regarding Behavior Adjustment Impact and Options to Consider

CMS is required under the Regulatory Flexibility Act and the Small Business Regulatory Enforcement Fairness Act to consider all available options in its regulatory actions to limit the impact on small businesses. As CMS is well aware, most HHAs qualify as “small business” under these laws as the vast majority of HHAs have under \$16 billion in revenue.

The most significant alternative that CMS has not considered is utilizing targeted oversight instead of instituting an across-the-board behavior adjustment to payment rates. CMS is well equipped to use its oversight powers and systems to stop HHAs from diagnosis upcoding to increase reimbursement. Even when considering the CMS assumption that all claims will be upcoded, CMS can easily address this action with targeted claim edits and predictive analytics. However, given that assuming that 100% of claims will be upcoded strains credulity, using claim edits to detect those HHAs engaged in upcoding is also a fairer approach as it affects only upcoders and not those HHAs that do not adopt the coding practice assumed by CMS. There is no doubt that a targeted approach to upcoding not only makes sense, it achieves compliance with the RFA and SBREFA.

It is also necessary that CMS recognize that a behavior adjustment to payment rates in advance of any actual changes in behavior is likely to **cause** behavior changes rather than simply predict them.. CMS has experience with behavior adjustments that trigger behavior changes. A specific example is the behavior changes that occurred with the transition to a new payment model in the inpatient hospital benefit.

Similar to the experience with MS-DRGs, the assumptions of PDGM-related behavior changes in coding a service utilization are likely to morph into an expectation of change and then transform into encouragement of such change as it is necessary for HHAs to engage in that behavior to maintain financial stability. The dynamic of assumed behavior change in the context of a Medicare payment model

is one where, out of necessity, the providers of service must actually engage in the assumed behavior changes in order to survive under the new payment model. If the providers do not do so, they are assured of losing revenue. As such, it is a natural and foreseeable risk that HHAs will change behaviors consistent with the CMS projections as CMS has provided a roadmap as to the changes HHAs should make. However, CMS must recognize that its assumptions are the cause of change not the predictor of it.

With hospital payment reform, CMS effectively sanctioned and encouraged hospitals to engage in upcoding to a degree. Recently, a federal court dismissed a whistleblower case under the federal False Claims Act based on a finding that a hospital did exactly what CMS expected it to do with coding and that CMS itself recognized that it was a necessary business practice to code at the highest reasonable level available to maximize Medicare reimbursement. *USA ex rel Integra Med Analytics, LLC v. Baylor Scott & White Health, et al*, Order Granting Defendants Motion to Dismiss (DKT. #21), No. 5:17-CV-886-DAE, (W.D. TX 8/5/19).

With the transition to the new hospital payment model, CMS indicated in its rulemaking that it “reaffirm[ed] its view that hospitals focus their documentation and coding efforts to maximize reimbursement.” 72 F.R. 47130, 47181. CMS further indicated that hospitals “utilize[e] clinical documentation specialists that work on the hospital treatment floors to encourage clinical documentation” to “improve coding and increase payment.” *Id.* at 47182.

Similarly, CMS assumes that HHAs will choose the highest paying diagnostic code and include full listings of comorbidities to achieve the highest reimbursement level possible based on the expectation of 100% of all claims coding at the highest ICD-10 code for the patient’s documented condition. As with the hospitals, CMS is encouraging and sanctioning such behavior. This does not mean that HHAs will be doing anything fraudulent or abusive. Instead, they are expected to choose the highest code that can be justified under the available patient documentation.

If CMS considers the assumed upcoding to be “misbehaving,” CMS has an arsenal of oversight tools available to address such with claim down-coding or prosecution of those who might engage in fraudulent upcoding.

RECOMMENDATIONS:

1. CMS must comply with the Regulatory Flexibility Act and the Small Business Regulatory Enforcement Fairness Act. To do so, CMS must consider the alternative to the behavior adjustment of relying on its oversight capabilities and powers to address any unwarranted changes in behavior rather than apply the proposed adjustments in an untargeted manner.

CMS should factor into any assumptions an offsetting consideration as to what it can achieve through targeted oversight to prevent upcoding or unnecessary utilization increases.

Oversight can significantly reduce any level of change from the current assumption that 100% of all claims will be upcoded. If CMS oversight can reduce such by 50%, the adjustment would be significantly less.

2. CMS must acknowledge that its proposed rate reduction based on assumed behavior changes sanctions and encourages the behavior changes through the adjustment. CMS must clearly state, as it did with inpatient hospital services, that any reasonable upcoding is expected and accepted as compliant behavior.
3. CMS should recalculate its assumptions to recognize that its behavior change assumptions can actually trigger change. Reducing or eliminating the proposed adjustment should reduce or elimination the assumed behavior changes.

Standards and Process for Budget Neutrality Reconciliation

Under 42 USC 1395fff, CMS is required to engage in a reconciliation process to “true up” payment rates to achieve budget neutrality through 2026. NAHC recommends that CMS establish the standards and process for future behavior adjustments and payment reconciliation at the outset of PDGM rather than at some later date.

The proposed rule addresses only the calculation of the 2020 payment rates and the assumption-based behavior adjustment. Starting in 2021, CMS needs to take into account the impact of its 2020 rule and PDGM to determine what actions are needed to achieve budget neutrality. In doing so, CMS must establish standards for determining nominal versus real change in case mix as well as changes that affect other aspects of Medicare home health spending such as Medicare enrollment, increased/decreased utilization of home health services, modification/improvement of enforcement of coverage standards (e.g. maintenance therapy; home infusion therapy), 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.

Overall, the standards and process should recognize that many factors beyond PDGM can contribute to changes in Medicare spending. CMS must take all reasonable steps to ensure that it does not modify payment rates under its ongoing behavior adjustment and reconciliation authority based on any factor other than those directly triggered by the transition from HHPPs-HHRG to PDGM.

RECOMMENDATION: NAHC recommends that CMS convene a Technical Expert Panel (TEP) to develop the necessary standards and processes on an expedited basis as new data may be needed that currently is not collected. The resulting proposed standards and process should be presented through a formal rulemaking, including public notice and opportunity to comment, by mid 2020. NAHC recognizes that the matter involved is very complex. Such necessitates the input of a broad spectrum of stakeholders with the expertise to ensure that all relevant factors are properly considered.

CMS Must Consider the Readiness of Multiple Stakeholders

It is very apparent that the payment model reforms proposed by CMS are extensive. All stakeholders will need to undertake unprecedented actions for successful implementation by January 1, 2020. While some elements can be addressed prior to the final rule issuance, most actions are fully dependent on the specific standards that will be revealed only 60 days or so prior to the implementation date.

Historically, the CMS MACs have experienced serious implementation difficulties in dealing with minor system updates. PDGM reforms are a wholesale replacement of the claim submission and processing system. If history is any guide, the implementation problems are likely to be at-levels never experienced before.

The readiness of HHA Information Technology and billing partners is also doubtful as they are unable to finalize and test new systems until after the final rule is issued. Similarly, other payers, particularly MA plans, TRICARE, and the VA Health program, will have very little time to modify their systems to accommodate PDGM reforms. While MA plans are not required to utilize the PDGM system, many have expressed an interest and intention to do so.

A large number of NAHC members depend on Health Information Technology (HIT) to operate their agencies. These solutions typically cover all aspects of agency financial and clinical operations. As such, our member's HIT vendors enhance and modify their HIT solutions in accordance with proposed and final rules.

We urge CMS to consider the need for HIT vendors to interpret proposed and final rules, design, code and test solutions, and deliver updates to providers. The magnitude of changes to support PDGM requires multiple calendar quarters of the "interpret, design, code, test, deliver" cycle. Once delivered, providers must test the changes, review impacted workflows and procedures, and train staff in new or

enhanced capabilities. These burdens are in addition to the policy and procedure changes required by the rule itself.

It is important to note that the time period providers have to fully prepare does not begin with the proposed rule, or even the final rule. Providers may not fully operationalize PDGM until their HIT vendor has delivered appropriate updates. It is expected most HIT solution updates will not be delivered until late summer 2019 or early fall 2019. This leaves little time for providers to fully internalize HIT update impacts.

Related to the delay between the posting of a final rule and delivery of an HIT vendor update are the interpretive guidelines. Frequently, the interpretive guidelines require HIT vendor solution changes. Like the final rule, these interpretive guidelines also require design, coding, testing, and delivery to providers. We urge CMS to consider the impact of providing interpretive guidelines close to established effective dates. It is quite possible that a provider may not be able to comply with interpretive guidelines, unless effective dates consider the time required by HIT vendors as well.

Preparedness of the MACs are also a concern. We request clear and frequent visibility into the readiness of all MACs to accept and process claims in accordance with PDGM requirements. This visibility is critical not only for provider financial planning. HIT vendors also need time to test their solutions in advance of effective dates to assure minimal or no disruption to provider financial operations.

NAHC recommends that CMS make available all specifications of the PDGM pricer module as soon as possible to allow these stakeholders the opportunity to prepare for PDGM on a timely basis. In addition, CMS should establish an efficient accelerated payment program to protect HHA from third-party implementation problems that could jeopardize continued operations. The existing program has routinely fall short of the protections needed.

Medicare Home Health Services Proposed Rule: RAP Phase-Out

The Centers for Medicare and Medicaid Services (CMS) has proposed that the split payments made to home health agencies under the Request for Anticipated Payment (RAP) process will end in 2021. As an interim step, no “new” HHAs will receive RAPs in 2020 and HHAs that have been in operation prior to 2019 will receive 20% of the expected final payment amount in contrast to the 60% initial episode/50% later episode levels that have been in place since 2000.

The origin of the RAP dates back to the start of the Home Health Prospective Payment System (HHPPS) in October 2000. NAHC advocated for payers, in particular the application of an advance payment component to HHPPS to accommodate the cash flow needs of HHAs that would otherwise incur significant costs for care over a 60-day episode, yet receive no payment on a claim until some extended period thereafter. The earliest a final claim can be paid would be on the 15th day following receipt of the claim given the statutory 14 day floor for issuing payments in Medicare. If one assumes that a claim is filed 5 days after the end of the episode, the HHA would not receive payments until no earlier than the 80th day following the start of the episode under the HHPPS model.

In the 2019 home health rulemaking, CMS terminated RAP eligibility for any HHA that became Medicare certified as a participating HHA on January 1, 2019 or later. CMS hinted at ending RAPs for all HHAs in the future. However, CMS did indicate that it intended to maintain the RAP at a 60/50% level with the onset of PDGM in 2020. It appears that CMS's support for continuing RAPs was very short-lived.

CMS now explains that there are two reasons for the elimination of RAPs. First, with the shift from a 60-day episodic reimbursement to a 30-day payment unit, CMS expects that the cash flow needs of HHAs will be limited. CMS attempts to support that rationale with data indicating that 5% of RAPs are not submitted until the end of the episode, 10% are not submitted until 36 days after the start of the episode, and the median date of submission is 12 days from the episode start. CMS believes that HHAs will not have a cash flow problem because the loss of the RAP split payment will be offset by the ability to submit a final claim for a full 30-day unit payment much sooner than occurring in a 60-day episode model.

The second reason for eliminating RAPs is CMS's concern with fraudulent RAP submissions. CMS references some instances where an HHA submitted large numbers of RAPs, but never submitted any final claims. CMS explains that while RAP payments are quick, the ability to determine whether there is a fraud involved is complicated by the length of time it takes to conclude that no final claim is billed given the 12-month billing window. In further discussions with CMS officials, the fraud extends to situations where an HHA has changed ownership, but that change has not been properly reported to CMS. In doing so, the fraudster avoids a RAP roadblock that would potentially come through a noticed change of ownership.

The reduction in the split payment amount to 20% in 2020 and the elimination of RAPs in 2021 present serious cash flow challenges for HHAs. While the application of a 30 day payment unit reduces the length of time that HHAs incur costs prior to receiving payment on a claim, an extended period of

time still remains. Typically, a final claim can be expected to be paid around 50-60 days following the start of care at best.

At the close of a 30-day payment period, it is necessary for an HHA to secure all the necessary paperwork from physicians and subcontractors before submitting a claim for payment. In addition, most HHAs engage in some form of quality control on the completeness and appropriateness of each claim. All told, these processes can take a minimum of two to three weeks. With the complications of a new payment model added to the mix, further delays are likely. It is not expected that PDGM will provide any opportunity to accelerate obtaining the needed paperwork from physicians or the quality assurance measures employed prior to claim submission. HHAs have worked to secure the highest degree efficiency and timing for nearly 20 years with limited success in affecting the actions of third-party physicians. PDGM cannot be expected to change that outcome, especially since it will lead to two periods of physician documentation for every one period under the 60-day episode system in place today.

When a claim is submitted to Medicare, the Medicare Administrative Contractor (MAC) can begin processing it immediately. However, the MAC cannot issue payment any earlier than the 15th day following receipt of a “clean claim” under Medicare law that sets a “14-day floor” on payment release. Together, these process steps and payment restrictions are likely to lead to a normal payment receipt cycle of 50-60 days from the start of the period.

For nearly 20 years, HHAs have managed their finances consistent with a Medicare payment model that provides 60% or 50% of the anticipated episodic payment within a matter of days of the start of the episode. While CMS reports the median RAP submission date at 12 days, it can be expected that the elimination of RAPs will still leave those HHAs at the median submission timeframe with an additional payment delay of 40-45 days depending on the time it takes to secure complete paperwork from outside parties.

The first cash flow difficulty facing HHAs with the elimination of the RAP is the reduction of the split payment from 60% to 20% in 2020. That will require costly bridge financing either by way of tapping any existing reserves or borrowing in order to meet payroll obligations that do not get suspended while waiting for Medicare to pay its bills.

In 2021, HHAs' cash flow is impacted again as the 20% split payment disappears. That will mean increased reliance on borrowing or further depletion of liquid reserves that might have been used for instituting care and operational innovations or simply updating systems to better manage within a constantly changing health care environment.

Home health financial experts appear to be a bit divided on the expected impact of the RAP reduction and eventual elimination. Some indicate that it could cause the closure of numerous home health agencies. Others see it as disruptive, but not the death knell of HHAs. Still others contend that HHAs can manage the change if they have sufficient time to build capital or establish lines of credit.

No matter which viewpoint is most accurate, it is very apparent that the elimination of RAPs will mean an end to business as usual with respect to cash flow. Based on all of these inputs, NAHC does not support the proposal. With respect to the fraud risks, NAHC recommends that CMS explore a targeted approach to RAP suppression or termination. It is patently unfair to cause operational disruption to thousands of HHAs that do not pose a risk to the Medicare program to address important concerns triggered by a very small minority of HHAs.

A national consulting group that represents HHAs from across the country has assessed the cash flow problems that will occur in 2020 with the proposed RAP changes. Blacktree Healthcare Consulting prepared the attached spreadsheet showing the ups and downs of affected cash flow demonstrating a need for RAP continuation through all of 2020.

This detailed analysis looks at cash flow impact simply using industry standards for days to bill RAP and Final Claim (7 days for final claims and 14 days for final claims), looking at normal Medicare processing times to pay each (5 days for RAPs, 14 days for final claims) and assuming no revenue change from PPS to PDGM, here is what the cash flow impact in 2020 (compared to December cash numbers) looks like with the RAP payments at 60%:

January	February	March	April
-15%	-17%	+16%	-8%

This table illustrates the negative cash flow impact simply from the change from PPS and higher dollar claims to PDGM.

Now if RAP payments were to be reduced to 20%, the cash flow impact is much greater which is illustrated in the table below:

January	February	March	April
-27%	-44%	+2%	-8%

While most HHAs may eventually be able deal with phase out, the timing of doing that along with instituting a dramatically changed payment model could be crippling for many HHAs. The attached spreadsheet provides a more detailed analysis on likely impacts for a typical HHA..

RECOMMENDATION: CMS should withdraw its proposed modification and termination of the RAP model. Should CMS intend to proceed with its proposal, CMS should delay its application an additional 12 months to allow HHAs sufficient time to adjust cash management. In addition, CMS should fully explore targeted approaches to managing the integrity of RAPs. Options to consider include focus on anomalous volume and timing changes that may be a “red flag” of abusive behavior. Predictive analytics should be employed to determine characteristics of fraudulent RAP submitters. Note that acceptance of this recommendation obviates the need for a Notice of Admission from most HHAs as the RAP can continue to serve that purpose.

In the event that CMS continues to phase out the RAP, NAHC recommends that it maintain the current RAP framework through 2020 and drop the RAP system in 2021 instead of reducing the RAP amount o 20% in 2020. Further, CMS should clarify whether new owners in a CHOW are subject to the proposed immediate RAP elimination.

III.G, Proposed Changes to the Split-Percentage Payment Approach for HHAs in CY 2020 and Subsequent Years

Notice of admission (NOA)

CMS proposes to require an NOA when the request for anticipated payment (RAP) is eliminated. The NOA will be required to update the common working file (CWF) in order to enforce consolidated billing rules for home health agencies. CMS proposes to use the RAP submission requirements and to mirror the process for the notice of election (NOE) submission that is currently in place for hospice providers. HHAs will be required to submit the NOA within 5 days of the start of care date. Failure to submit the NOA timely will result in a payment reduction for each day the NOA is submitted late.

CMS proposes to require the following before an NOA can be submitted.

For periods of care beginning on and after January 1, 2021, all HHAs must submit a Notice of Admission (NOA) when either of the following conditions are met:

(i)(A) The plan of care has been signed by the certifying physician. B) If the physician-signed plan of care is not available at the time of submission of the NOA, then the submission must be based on either of the following:

(1) A physician's verbal order that—

(i) Is recorded in the plan of care;

(ii) Includes a description of the patient's condition and the services to be provided by the home health agency;

(iii) Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in § 484.115) responsible for furnishing or supervising the ordered service in the plan of care; and

(iv) Is copied into the plan of care and the plan of care is immediately submitted to the physician.

(2) A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician

These requirements also mirror the requirements at §409.43(c) for the Request for Anticipated Payment.

Physician signature—(1) Request for Anticipated payment signature requirements. If the physician signed plan of care is not available at the time the HHA requests an anticipated payment of the initial percentage prospective payment in accordance with §484.205, the request for the anticipated payment must be based on—

(i) A physician's verbal order that—

(A) Is recorded in the plan of care;

(B) Includes a description of the patient's condition and the services to be provided by the home health agency;

(C) Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.115) responsible for furnishing or supervising the ordered service in the plan of care; and

(D) Is copied into the plan of care and the plan of care is immediately submitted to the physician

(ii) A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician

Since the NOA does not generate a payment and only serves to update the CWF it is unnecessary for CMS to require agencies to have the same requirements for the NOA submission as for the RAP submission. Further, experiences with RAP submissions indicate that HHAs will not likely be able to meet the 5 day time frame for submission of the NOA if agencies must comply with all of the proposed requirements.

An HHA can start care for Medicare beneficiaries with far less paperwork than that required under the NOA proposed rule. Home health agencies may begin services based on a verbal order as long the order contains the services required for the initial visit; the POC comes later.

The start of care standards recognize that the extensive paperwork required to support payments would be a roadblock to timely care. However, the proposed NOA standards erect a roadblock simply to serve the interests of other providers that would be affected by the home health consolidated billing requirements. Those provider interests should not create barriers to timely patient care. A modification of the NOA proposed standards to mirror the home health patient admission/start of care standards would remove those barriers and still fulfill the intended purpose of the NOA..

A home health plan of care (POC) is based on the findings from the clinician's comprehensive assessment in consultation with the physician. Agencies have 5 days from the start of care (SOC) date to complete the comprehensive assessment and from that time point develop the POC. Before the POC is sent to the physician agencies will conduct quality reviews and any other administrative actions required to ensure the POC is complete and ready for the physician's signature. This process may explain why the median number of days for a RAP submission is twelve, as noted by CMS in the proposed rule. This extensive process should not be needed to trigger an NOA submission. The proposed requirements are unnecessarily burdensome, are not consistent with start of care standards, and do not comport with the Administration's "Patients Over Paperwork" initiative.

We also urge CMS to consider that, unlike hospice providers, HHAs also bill for services provided to beneficiaries under Medicare Advantage plans. Agencies continue to struggle with ascertaining beneficiary

eligibility against inaccurate information in the CWF. Even with specified open enrollment periods for MA plans, there can be significant lag time between a beneficiary's enrollment/disenrollment date and CWF update. Therefore, there is concern that agencies could be at risk for missing the 5 day window while seeking to confirm a beneficiary's MA enrollment.

RECOMMENDATIONS: CMS should:

- 1) Require only what is necessary to begin home health services in order to submit the NOA, to include:
 - A verbal order to begin care that is signed and dated by the registered nurse or qualified therapist (as defined in § 484.115) responsible for furnishing or supervising the ordered service in the plan of care signed by the clinician.
 - Conduct the SOC visit

Or, allow a least 14 days for the agency to submit the NOA before any penalty is imposed

- 2) Provide an explicit exception to the timely submission requirement for the NOA when the CWF is not updated timely to show MA enrollment status.

III.H. Proposal Changes to Therapist Assistants to Perform Maintenance Therapy

CMS proposed to modify the regulation to permit therapy assistants to perform maintenance therapy. However, the proposed regulation at §409.44(C) only addresses physical therapy assistants. NAHC believe CMS intends to also permit occupational therapy assistants to perform maintenance therapy.

RECOMMENDATIONS: Revise the regulation to clarify that occupational therapy assistants may also perform maintenance therapy.

V. Proposed Updates to the Home Health Care Quality Reporting Program (HH QRP)

CMS proposes to require agencies adopt two new quality measures:

- (1) Transfer of Health Information to Provider–Post-Acute Care; and
- (2) Transfer of Health Information to Patient–Post-Acute Care

Agencies would be required to document that a medication list was sent on transfer to a subsequent provider and to a patient or caregiver upon discharge to the community.

In addition, CMS proposes to require agencies collect standardized patient assessment data elements (SPADES) that address the following four domains:

- cognitive function;
- special services, treatments, and interventions;
- medical conditions and comorbidities, impairments; and
- social determinants of health

Under the cognitive domain CMS proposes three screening tools that assess for mental status, confusion/delirium, and mood. The special service, treatments, and intervention assessment items asks the agency to select services and treatment the patient is receiving, along with identifying any high risk drugs the patient is taking. The assessment item for medical conditions and comorbidities addresses whether the patient has pain during several activities, and impairments are assessed through items for hearing and vision.

CMS also proposes a domain that addresses social determinants of health and includes items for race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation.

The proposed new measure and SPADEs would significantly increase the number of assessment items to the Outcome and Assessment Information Set (OASIS) instrument, resulting in a very different data set in 2021 than what agencies are currently using. Any changes in the OASIS assessment data set increases resource use for agencies in terms of staff training and altered productivity associated with the learning curve required for collecting new material.

NAHC believes these changes will initially be quite burdensome for agencies to implement due to the number of new items and the fatigue agencies are experiencing related to having to accommodate multiple alterations to the OASIS assessment over the past several years. Adding to the burden is the time it takes for CMS to receive final approval from the Office of Management and Budget for the modified data set.

However, NAHC is reluctant to recommend delaying the implementation of the new measures or any of the proposed SPADEs since that would require additional iterations of the OASIS instrument; leading to continued costs and burdens. Therefore, assuming that CMS has completed its work for assessment

modifications related to the IMPACT act, NAHC supports the proposed changes to the OASIS data set for CY 2021 with the following recommendations.

RECOMMENDATIONS: CMS should:

- 1) Issue a draft of the assessment tool no later than 6 months prior to the implementation date to allow for staff training and other necessary preparations required for agency implementation
- 2) Use the authority permitted by the IMPACT Act to waive the Paperwork Reduction Act (PRA) requirements related to modification of the assessment tools for providers subject to the IMPACT Act. Waiving the PRA may expedite CMS' ability to issue a final version of the revised OASIS instrument in a timely manner.
- 3) Refrain from issuing any revisions to the OASIS instrument for at least 5 years after the 2021 implementation of the proposed changes.

I.4. Input Sought To Expand the Reporting of OASIS Data Used for the HHQRP To Include Data on all Patients Regardless of Their Payer

CMS is seeking input on its proposal to collect and report OASIS data on all patients served by the home health agency regardless of payer. Specifically, CMS is interested in information regarding the following five questions. NAHC conducted a survey of the home health community that included these same questions. 199 respondents, both members and non-members of NAHC, completed the survey. Below is a summary of the results of that survey.

- Do you agree there is a need to collect OASIS data for the HH QRP on all patients regardless of payer?
 - *Slightly more than 75% of respondents disagreed that there is need to collect OASIS data on all patients regardless of payer, while slightly less than 25% agreed.*
- What percentage of your HHA's patients are you not currently reporting OASIS data for the HH QRP?
 - *Responses ranged from 0-100%, which suggests the question may have been confusing for some of the respondents.*

- Are there burden issues that need to be considered specific to the reporting of OASIS data on all HH patients, regardless of their payer?
 - *The majority of respondents affirmed that there are burdens associated with collecting OASIS on all payers. The burden is associated with both financial and opportunity costs for agencies, with no additional reimbursement from payers.*
 - *Additionally, several of the respondents that were in support of collecting the OASIS on all patients also agreed that there is increased burden with such a collection.*

- What differences, if any, do you notice in patient mix or in outcomes between those patients that you currently report OASIS data, and those patients that you do not report data for the HH QRP?
 - *Respondents stated that patients where OASIS collection is not required are usually younger with shorter lengths of stay, have a healthier baseline and have more acute care needs than the population for which the OASIS collection and reporting currently applies.*
 - *Agencies with a large amount of VA referral impacts the patient mix served by the agency. Many patients have chronic conditions and behavioral health needs*
 - *Agencies that serve private pay patients provide a variety of health care and non-healthcare related services.*
 - *Agencies reported no difference in care delivery between the patients where OASIS collection and reporting applies and those where the OASIS is not required.*

- Are there other factors that should be considered prior to proposing to expand the reporting of OASIS data used for the HH QRP to include data on all patients, regardless of their payer?
 - *Respondents expressed concern with collecting OASIS data on patients that have different demographics, health care needs, insurance coverage policies, and differing expected outcomes than the Medicare and Medicaid population, and the ability to fairly compare outcomes.*
 - *Concerns with how CMS intends to use the information.*
 - *The quality of care provided to all patients served by home health agencies is more appropriately measured through Medicare certification/recertification surveys*

RECOMMENDATIONS: CMS should not require the OASIS data set be collected on all patients served by the agency regardless of payer. In the event that CMS decides to collect OASIS data on all patients,

CMS must modify its Home Health Compare and Star ratings system to reflect the impact of that increased patient population on outcomes. Just as patients with different diagnoses or functional status can have different outcomes, patients of non-Medicare payers can be affected by the payer's scope of benefits, benefit administration, and care management.

VI. C.1. Home Infusion Therapy and the Interaction With Home Health

NAHC continues to have concerns regarding the negative impact the home infusion therapy supplier benefit as structured will have on beneficiaries when it becomes a permanent program in 2021. Beginning in 2021, home health agencies will not be able to provide Part B home infusion therapy to beneficiaries under the home health benefit. This benefit structure disadvantages beneficiaries in terms of cost to the beneficiary, restricting entitled benefits, and fragmenting care.

Currently eligible beneficiaries are able to receive the professional services associated with infusion therapy under the home health benefit without incurring out of pocket costs. The new Part B home infusion therapy benefit will require a 20 % beneficiary co-pay for the professional services that are otherwise covered in full under the home health benefit.

Additionally, some beneficiaries could see limitations in eligibility for home health services. For example, if a beneficiary is otherwise eligible for home health services and the only needed skilled service is nursing for infusion therapy, but the beneficiary also needs a dependent home health service(s)(occupational therapy, home care aide, social worker), the beneficiary will be precluded from receiving the other support services under the home health benefit. The qualifying service for Medicare home health services will be shifted to the home infusion therapy supplier. The home infusion therapy supplier will not be eligible to provide the support services nor will the beneficiary be eligible to receive the services under the home health benefit. Therefore, the beneficiary will be forced to go without the needed support services or pay for the care privately.

Furthermore, the proposal for the home infusion therapy benefit and the home health benefit to run concurrently could require two distinct service providers in the home under separate plans of care during the same spell of illness. For example, a beneficiary that requires skilled nursing for wound care and infusion services could potentially be required to receive skilled nursing for the wound care from the home health agency and receive skilled nursing for the infusion from the home infusion therapy supplier.

This fragmentation of care poses a clear risk to the quality of care provided to the beneficiary. Additionally, the burden of coordinating care to assure beneficiary safety will be the responsibility of the home health agency since the home health conditions of participation hold agencies accountable for the coordination of all services the beneficiary receives while under a home health plan of care.

Unfortunately, the statute requires that beneficiaries will not be able to receive professional service related to Part B infusion drugs under the home health benefit when the program becomes a permanent program in 2021. Therefore, any resolution to these concerns will require legislative action.

RECOMMENDATION: CMS should work with Congress to promote legislation that would enable beneficiaries to continue to receive the professional services associated with Part B home infusion drugs under the home health benefit. A legislated change should either limit the home infusion therapy supplier benefit to beneficiaries not eligible for the home health benefit, or provide beneficiaries with a choice of receiving the benefit from a home infusion therapy supplier or a home health agency under a home health plan of care.

If the fragmentation of home infusion therapy and home health services is continued, CMS should revise the regulations to permit beneficiaries to meet the qualifying skilled services condition under the home health benefit to be met through any skilled nursing services provide through the home infusion therapy supplier. Further, CMS should waive any copayment or coinsurance for any services provided under the home infusion benefit that would not be subject to such if those services could previously have been provided under the home health benefit.

G. Billing Procedures for CY 2021 Home Infusion Services

CMS requires that all home infusion therapy suppliers be enrolled in Medicare as Part B supplier and bill the home infusion therapy services on a supplier and professional claim 837P/CMS-1500. Home health agencies are eligible to enroll as home infusion therapy suppliers beginning 2021 when the benefit becomes permanent.

Home health agencies may currently bill for select Part B items and services under the agency's provider number using a Type of Bill (TOB) 34x. For example, HHAs may bill for outpatient Part B therapy and DME without enrolling as Medicare Part B supplier.

RECOMMENDATION: CMS should permit home health agencies that are accredited home infusion therapy suppliers to bill for the home infusion services under the home health provider number on a TOB 34x.

CONCLUSION

NAHC appreciates the opportunity to submit these comments. We intend to act as a constructive partner with CMS throughout the transition to PDGM and other reforms set out in the proposed rule.

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Forum of State Associations

Arizona Association for Home Care

Connecticut Association for Health Care at Home

Home Care Association of Florida

Georgia Association for Home Health Agencies

Kansas Home Care & Hospice Association

Minnesota HomeCare Association

Missouri Alliance for Home Care

Oklahoma Association for Home Care & Hospice

Oregon Association for Home Care

Rhode Island Partnership for Home Care
