CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 24, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G z
Washington, D.C., 20201

SUBJECT: CMS-1730-P, Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Update: Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, Federal Register (Vol. 85, No.126), June 30, 2020

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including home health agencies (HHAs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) Home Health (HH) Prospective Payment System (PPS) proposed rule for calendar year (CY) 2021.

The current calendar year (2020) represents the first year of the Patient-Driven Grouping Model (PDGM), which includes wide-ranging changes to case-mix methodology and HHA payment policies. The simultaneous implementation of a new benefit for infusion therapy services has required additional changes in documentation, billing, and care coordination for home health beneficiaries receiving infusion therapy. The scope and pace of these changes has challenged HHAs to not only develop and implement significant changes in operations and workflow, but also to provide additional education and training to staff — all while continuing to deliver timely home health care services in their communities.

Additionally, the COVID-19 public health emergency further disrupted our health care system. Care providers at all levels are experiencing major changes in the types of patients they are seeing, care needs, and how and where care is delivered. Adjusting to these changes requires significant investment of time and resources.

Another consequence of the COVID-19 public health emergency is the recognition of the unique value and role of home health care, and how improving access to effective home health services can improve outcomes and control costs for Medicare beneficiaries. Our review of this proposed policy must consider these unique circumstances and incorporate the lessons we have learned during this difficult time.

CHA supports and appreciates CMS' proposals to:

- Maintain for 2021 current case-mix weights in the PDGM as well as low-utilization payment adjustment (LUPA) thresholds
- Amend allowable administrative costs to include additional telecommunication and remote patient monitoring services. We urge CMS to consider additional policy adjustments that

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recognize and utilize the full potential of telehealth services. CMS should also consider providing adequate reimbursement and financial incentives to encourage and support the significant financial investment required to effectively utilize these new technologies.

CHA continues to be concerned about CMS' behavioral offsets, especially in the context of the current COVID-19 public health emergency. We continue to believe that additional information and analysis, including consideration of the impact on hospital-based HHAs, is needed to support the change.

PAYMENT AND CASE-MIX UPDATES

The current CY 2020 represents the first full calendar year of implementation of the PDGM, which includes significant changes to case-mix methodology as well as changes to documentation and billing requirements. We appreciate and support CMS' decision to defer adjustments to PDGM case-mix weights and LUPA thresholds, recognizing that HHAs and software vendors are still adjusting to the new case-mix methodology.

BEHAVIORAL OFFSETS

The Balanced Budget Act of 2018 required the Secretary to make certain assumptions about changes in patterns of service delivery that might occur due to the change in the unit of payment from a 60-day episode of care to a 30-day period of care. Beginning in 2020 and ending in 2026, the Secretary must determine for each year the difference between the estimated impact of the behavior changes it assumed and make offsetting adjustments as indicated. In the CY 2020 final rule, CMS finalized the application of a behavioral offset; in the current rule, CMS proposes to maintain the adjustment implemented last year.

CHA recognizes and appreciates that, in the final rule for CY 2020, CMS lowered its proposed rate reduction in response to stakeholder comments. However, CHA continues to believe that CMS has not provided sufficient evidence to support its specific assumptions and its associated financial impact. Moreover, assessment of provider behavior changes and their financial impact will be limited by the significant impact of the COVID-19 public health emergency on HHAs and their patient care operations.

Moreover, hospital-based HHAs are disproportionately impacted by the application of the behavioral offsets, which are applied on an aggregate basis. As compared with free-standing HHAs, agencies operated by hospitals and health systems care for a wider range of medically complex patients and often operate at minimal, or even negative, Medicare margins. A "one-size-fits-all" reduction to the standard payment rate, as proposed, unfairly penalizes those agencies. Moreover, the many changes to the PPS in recent years — including rebasing, legislative cuts, and limitations to home health payments — have disproportionately affected HHAs that care for the most medically complex and frail patients.

We reiterate our previous requests that CMS provide additional information and data to support its current assumptions about the impact of provider behavior changes on payment, including an analysis of the projected impact on different types of HHAs, including hospital-based HHAs.

POST-ACUTE CARE PAYMENT REFORM

CHA supports CMS' efforts to improve the accuracy of post-acute care payment, including the development of standardized patient assessment items and the design and implementation of the PDGM case-mix methodology. **CHA reiterates our prior request that CMS assess the reliability and**

validity of the data collection efforts and related case-mix changes, including additional provider engagement, education, and training.

The COVID-19 public health emergency has severely impacted our health care system. CHA supports and appreciates CMS' rapid response, as evidenced by the implementation of multiple waivers to provide flexibility and to assist hospitals and other health care providers to respond to the needs of their communities.

The resulting disruption to the health care system will impact the mix of patients seen in various settings, as well as associated data collection and reporting and patient outcomes. These factors underscore the need to allow additional time for data collection and analysis and to slow down the process of post-acute care payment reform.

TECHNOLOGY USE

We applaud CMS' position that telecommunications technology — when deployed as part of the home health plan of care — is an effective complement to in-person visits. CMS now proposes to finalize provisions that would allow HHAs to use various types of telecommunications systems in addition to remote patient monitoring. Additionally, CMS proposes to amend the allowable administrative costs to include not only the costs of telehealth/telemedicine, but also other communication or monitoring services, consistent with the individual's plan of care. **CHA strongly supports this proposal. In addition, we encourage CMS to consider additional changes** to support HHAs' ability to improve care and care access through telehealth and remote patient monitoring.

Under current proposals, telecommunications systems and remote patient monitoring are included as allowable administrative costs, but a clinical telehealth visit may not be counted as a qualifying visit under the HH PPS. While CHA agrees with CMS' position that telehealth visits cannot fully substitute for in-home, face-to-face visits, the current approach limits the potential use and benefit of telehealth in home health. CMS should consider policy changes that would allow for HH visits to be conducted virtually, subject to certain limitations.

Incorporating telehealth as an integral modality for care delivery in home health is critical to ensuring access to care and timely service delivery, particularly at time when we must meet increased demand, conserve resources, and limit unnecessary visits and potential for exposure. CHA member hospitals are making significant investments to develop the infrastructure necessary to meet the needs of Medicare beneficiaries both now and in the years to come. It is critical that future policy provide adequate reimbursement and regulatory support to allow providers at all levels of the care continuum to develop the health care system of the future.

CHA appreciates the opportunity to comment on the HH PPS proposed rule for CY 2021. If you have any questions, please do not hesitate to contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Pat Blaisdell, vice president, continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,
/s/
Megan Howard