September 9, 2019

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

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; Proposed Rule (Federal Register, Vol. 84, No. 138, July 18, 2019)

Dear Ms. Verma:

On behalf of our 37 member hospital-based home health agencies, the Illinois Health and Hospital Association (IHA) takes this opportunity to formally comment on the proposed rule establishing new policies and payment rates for Medicare home health service for calendar year (CY) 2020. The proposed rule contains four policies that raise concerns and for which we are presenting comments: (1) the CY 2020 proposed budget neutrality adjustment for 30-day episodes; (2) rural add-on payments and classifications; (3) proposed elimination of split percentage billing; and (4) proposed changes to the home health quality reporting program (HH QRP). We also provide feedback, as requested, on proposed expansion of Outcome and Assessment Information Set (OASIS) data reporting and future changes to the HH QRP.

Proposed Budget Neutrality Adjustment for 30-Day Episodes: In accordance with Section 1895(b)(3)(A)(iv) of the Social Security Act, CMS outlined the impact of assumptions regarding behavior changes that may occur as the result of implementing the 30-day unit of payment in CY 2020. These assumptions were also outlined in the CY 2019 home health prospective payment system (HH PPS) proposed rule and include: (1) the assumption that home health agencies (HHAs) will put the highest paying diagnosis code as the principal diagnosis code in order to maximize payment; (2) more specificity in comorbidity coding that will increase the number of documented secondary diagnoses and, in turn, increase payment amounts by up to 20% and (3) a low-utilization payment adjustment (LUPA) threshold that may result in more HHAs providing extra visits in order to receive a full 30-day payment, as opposed to per-visit payments.
In the CY 2019 HH PPS proposed rule, CMS estimated that behavior adjustments based on these three assumptions would result in a budget neutrality cut of 6.42%. However, in the CY 2020 HH PPS proposed rule CMS updated the proposed budget neutrality cut to 8.01%. IHA echoes the sentiments of others that the value placed on these assumptions seem arbitrary when uniformly applied to all HHAs. Therefore, IHA strongly urges CMS to closely monitor the actual data regarding HHA behavior, as required, and to make such analysis publicly available. We also urge CMS to re-evaluate its decision to apply this behavior adjustment industry-wide rather than targeting specific HHAs through program integrity initiatives. Should the data indicate these assumptions are inappropriate for industry-wide application, we urge CMS to revisit this decision and make the appropriate changes so that these behavior adjustments are not applied prospectively, but rather retrospectively based on actual HHA data and behavior.

**Rural Add-On Payments for CY 2019-CY2022:** In our comments on the CY 2019 HH PPS proposed rule, we expressed strong concern that over time, our rural HHA members would incur significant losses as the rural add-on percentage decreases and is eventually eliminated. In response, CMS stated in the CY 2019 final rule that they would provide the industry with periodic updates on the impact of this policy, including the costs associated with providing home health care in rural versus urban areas. We remain concerned that rural HHAs will be significantly negatively impacted by the decrease and eventual elimination of the rural add-on percentage. By extension, we are concerned about the impact this policy change will have on Medicare beneficiaries’ ability to access home health services in rural areas. We urge CMS to closely monitor the impact of the declining rural add-on percentage on rural HHAs and their Medicare-enrolled patients, and to make such analysis public.

Additionally, while we recognize that CMS does not have the statutory authority to allow for rural county reclassifications within the four-year period (CY 2019-CY 2022) as stipulated by Section 421(b)(2)(a) of the Medicare Modernization Act (MMA), we urge the agency to include analysis of the impact of this decision on rural HHAs in Illinois and across the country. As indicated in comments to the CY 2019 proposed rule, counties may experience demographic changes within this four-year period that would normally allow for reclassification. We urge CMS to monitor the impact of this inflexibility on HHAs and their ability to serve Medicare-enrolled individuals.

**Elimination of Split Percentage Billing:** In response to the CY 2019 HH PPS proposed rule, we expressed concern about the implementation the Patient-Driven Groups Model (PDGM) and, in particular, the potential for confusion and increased burden on agencies regarding changes to “split percentage” payments. In the CY 2020 proposed rule, CMS reiterates the new split percentage payment at a rate of 20%/80% for all 30-day episodes, and proposes eliminating split percentage payments altogether for CY 2021 and beyond. Additionally, CMS proposes a new requirement for HHAs to electronically submit a notice of admission (NOA) within five
calendar days of the start of a new episode, assessing financial penalties on providers that fail to submit a timely NOA and LUPAs for qualifying cases until the NOA is received.

While CMS identifies “exceptional circumstances” which would result in penalties being waived for failure to submit a timely NOA, the proposed changes present substantial process changes that could significantly impact payment to HHAs. Further, the financial ramifications of these proposed changes could be substantial, particularly as they coincide with the implementation of the PDGM. Therefore, **IHA recommends CMS postpone the phase-out of split percentage payments and NOA requirements, allowing HHAs time to adjust to the new PDGM 30-day payment episodes. Additionally, IHA recommends CMS provide education and resources in the final rule to assist HH providers with adapting to the new model, and specifically, that CMS provide additional information on payment and process changes.**

**Home Health Quality Reporting Program Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs):** In the CY 2020 proposed rule, CMS proposes to modify one measure in the HH QRP for CY 2021, adopt two new measures and remove one measure for CY 2022 and remove one question from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. CMS also proposes adopting several SPADEs in the OASIS.

CMS proposes modifying the Discharge to Community measure beginning in CY 2021, excluding patients who had a long-term nursing facility stay in the 180 days preceding their hospitalization and HH episode with no intervening community discharge between the nursing facility stay and hospitalization. **IHA supports this change.**

CMS also proposes adopting two new measures for CY 2022. They are: (1) Transfer of Health Information to the Provider – Post Acute Care; and (2) Transfer of Health Information to the Patient – Post Acute Care. Both measures are process measures meant to satisfy requirements outlined in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. Both measures were proposed to the National Quality Forum’s (NQF’s) Measure Applications Partnership (MAP) in December 2019, and MAP conditionally supported both measures pending NQF endorsement. **IHA recognizes these measures address important aspects of patient care, however, we encourage CMS to only propose and/or require measures that have received NQF endorsement.**

CMS proposes removing the HH QRP measure “Improvement in Pain Interfering with Activity.” This proposal coincides with a proposal to remove question 10 from the HHCAHPS survey which says “In the last 2 months of care, did you and a home health provider from this agency talk about pain?” Both proposals are meant to assist providers in avoiding any potential unintended over-prescription of opioid medications. **IHA supports these changes.**
Finally, CMS proposes adding several SPADEs, including data elements within a sixth domain: Social Determinants of Health (SDOH). Overall, CMS proposed adding 25 new items to the OASIS, which are associated with the need to potentially complete more than 60 new data elements, depending on the patient. IHA recognizes the need for comprehensive, standardized and accurate data for both treatment and payment purposes. However, IHA strongly encourages CMS to rigorously evaluate the appropriateness of these proposed data elements for the HH setting, as well as the frequency with which they should be captured. Specifically, most of the data elements proposed in the Special Services, Treatments and Interventions category do not appear to be widely applicable to the HH setting based on the results of the national beta test and stakeholder feedback. Additionally, we question whether some of the proposed SDOH data elements need to be collected at both admission and discharge, as the answers for data elements such as “health literacy” may be unlikely to change.

Collecting OASIS Data on All Patients, Regardless of Payer: CMS plans to propose the expansion of OASIS reporting to all patients, regardless of payer, in future rulemaking. Some of our members indicate this would not be overly burdensome, while other say this would require significant administrative changes. IHA strongly encourages CMS to survey a nationally-representative sample of HHAs in order to better understand the potential burden on providers before proceeding with a proposal to expand OASIS reporting to all patients.

Request for Information on Future HH QRP Measures, Measure Concepts, and SPADEs: CMS requested information on the importance, relevance, appropriateness, and applicability of several concepts for potential inclusion in future iterations of the HH QRP. IHA supports the inclusion of additional measures and data elements so long as they contribute to the plan of care. Any additions that do not meet this criterion should be avoided on the OASIS assessment tool. Additionally, we urge CMS to consider data elements that may no longer be necessary in tandem with consideration of additional data elements.

Ms. Verma, thank you again for the opportunity to comment.

Sincerely,

A.J. Wilhelmi
President & CEO