September 9, 2019

U.S. Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1711-P  
Post Office Box 8013  
Baltimore, MD 21244-8013

Re: File Code CMS-1711-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2020

To Whom It May Concern:

The Home Care Association of New York State (HCA), Inc., on behalf of its 200 plus member home health agencies (HHAs) serving approximately 171,000 Medicare home health beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the 2020 Medicare Home Health Prospective Payment System (HHPPS).

This letter will provide HCA’s major comments on the 2020 HHPPS proposed rule, addressing elements of the rule that are a major concern for home care and should be revised, as well as those proposals which we believe to be positive steps for the system.

Proposed 2020 Home Health Rule with PDGM Largely Intact: HCA Concerned with Increased Behavioral Adjustment Cut and RAP Proposal

The rule, if adopted, leaves the Patient Driven Groupings Model (PDGM) substantially intact, once more proposing a significant change in the unit of payment from a 60-day episode of care to a 30-day unit of care, beginning on or after January 1, 2020.

The proposed rule also continues to include a so-called "behavioral-adjustment" cut that has been an ongoing concern of HCA and the entire home care industry. In previous rulemaking, CMS had suggested a possible -6.42 percent behavioral-adjustment but in its latest proposed rule CMS goes even further with an alarming -8.01 percent adjustment.

While CMS maintains that the proposed PDGM aligns with the Bipartisan Budget Act (BBA) of 2018 which required budget neutrality for any new home health payment methodology, HCA strongly believes there is no reasonable statistical justification for this cut. HCA supports true budget neutrality as a precondition for any payment changes and strongly opposes this adjustment.
While HCA and our provider members along with the other state and national associations all support efforts to better align Medicare payments with patient characteristics, we nevertheless still have the following ongoing concerns with CMS’s PDGM proposal:

- The proposed behavioral assumptions and increased negative adjustment are troubling in several ways. We are concerned that the adjustment will effectively establish a target for gaming behavior that represents what CMS expects of agencies, as codified in the payment system itself. Further, we find the methodology, assumptions, analytic documentation, and underlying data supporting these behavioral assumptions troubling, especially considering CMS did not apply the same type of adjustment to the PDGM methodology for the nursing home industry. We also maintain that the -5.91 behavioral adjustment for the clinical group coding and one-third of agencies engaging in Low Utilization Payment Adjustment (LUPA) avoidance is unrealistically high.

The BBA of 2018 amended Medicare law so that in any rulemaking regarding behavioral adjustments to the rate of payment, CMS “shall provide a description of such assumptions in the notice and comment rulemaking used to implement this clause.” 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 proposed rule contains a summary description with the needed details absent both in terms of the rational 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.

- HCA strongly rejects CMS’s proposal to implement a very damaging measure (ostensibly for integrity purposes) that would eliminate Requests for Anticipated Payments (RAPs), which agencies rely on for cash flow. Under the proposal, RAP payments for existing providers would be phased out over the next year and eliminated completely for 2021; new providers would receive no RAP payments. For existing providers, CMS would reduce the RAP payments to 20 percent in 2020.

RAPs are vital to an agency’s cash-flow and the changes in the episode units do not substantially alter the need for RAPs as a mechanism for covering services in advance of a final claim. Also, providers can not submit their final claims until they have received signed physician orders/plans of care as well as the signed documentation involving the home health face-to-face (F2F) requirement. Many HCA provider members struggle to receive this information timely from the physician community, hence delaying final claim billing and this change to 30-day payment units will only exacerbate this problem.

- CMS’s decision to base case-mix adjustment measures on admission source creates a poor substitute for measures based on patient characteristics even if there is a greater resource use by post-institutional care patients. The admission source measure also creates an undesirable incentive for HHAs to prioritize post-institutional care patients over community admissions.

- The bundling of non-routine supplies (NRS) in the new PDGM 30-day payment unit creates risk that high-cost NRS patients (e.g., wound care) may face obstacles to care access. The
original HHPPS started in 2000 with NRS bundled and later went to a specific NRS payment because of the same concerns we have under PDGM.

- CMS’s change in LUPAs under the PDGM is over complicated.

- CMS is required to engage in a reconciliation process to “true up” payment rates to achieve budget neutrality in comparison to the current HHPPS-HHRG payment model through 2026. HCA recommends that CMS establish the standards and process for future behavior adjustments and payment reconciliation at the outset of PDGM. 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 and other factors that may contribute to Medicare spending changes not specifically related to PDGM.

Recommendations

Certain baseline considerations in any payment overhaul must be made in order to ensure that access to care is maintained for one of Medicare’s most vulnerable beneficiary populations while also giving HHAs sufficient time to properly prepare for such a significant undertaking. HCA’s recommendations are:

1. CMS should publish for public notice and comment (in its final rule) a full description of its behavior adjustment calculation, including all the specific data used in the assessment along with the complete calculation methodology. All existing work papers 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.

   In lieu of that, 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 adjustments should be based on the behavior changes in other health care sectors.

2. CMS should withdraw its proposed modification and termination of RAPs. 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.
3. HCA 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. HCA also 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.

4. CMS should design and evaluate a reimbursement model that accurately pays for NRS separately within the home health benefit. CMS should also include NRS costs in any outlier payment model used in home health services.

5. CMS should consider maintaining a single LUPA threshold in the initial stages of payment model reform. Such is more likely to bring an outcome consistent with the current model thereby minimizing any impact risks.

6. HCA 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 – especially as it relates to the reconciliation process. The resulting proposed standards and process should be presented through a formal rulemaking, including public notice and opportunity to comment, by mid-2020. HCA 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.

7. PDGM preparedness of the Medicare Administrative Contractors (MACs) is also a concern. We request information on the readiness of all MACs to accept and process claims in accordance with PDGM requirements. This 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.

**Notice of Admission (NOA) Proposal for CY 2021**

CMS is proposing to require a Notice of Admission (NOA) when the RAP is eliminated in CY 2021. The NOA will be required to update the common working file (CWF) in order to enforce consolidated billing rules for HHAs. CMS proposes 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’s proposed requirements for submitting NOA would mirror the requirements at §409.43(c) for the RAP. Since the NOA does not generate a payment and only serves to update the CWF, it is inexplicable why CMS would require agencies to have the same requirements for the NOA submission as for the RAP submission.

Agencies 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. 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 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.

Furthermore, HHAs may begin services based on a verbal order as long as the order contains the services required for the initial visit; the POC is developed as outlined above. Therefore, not only are the proposed requirements overly burdensome, they are unnecessary, and do not comport with this 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. Information from beneficiaries is often unreliable and the plans have varying policies related to authorization procedures and how they relate to providers. Some plans will not provide authorization until the agency evaluates the patient. Several days can pass before the plan provides any eligibility and/or authorization information on the beneficiary. Therefore, there is concern that agencies could be at risk for missing the 5-day window while seeking to confirm a beneficiary’s insurance coverage.

Recommendations:

CMS should:

- Require only what is necessary to begin home health services in order to submit the NOA, which would 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.

- Provide an explicit exception to the timely submission requirement for the NOA when the CWF is not updated timely.

Make the Face-to-Face Requirement Practical, Remove Undue Burdens

The current face-to-face (F2F) regulation remains an undue burden for HHAs and physicians alike, with little justification in terms of payment integrity or effective eligibility oversight.

CMS’s CY 2019 final rule made a nominal change in the physician certification process, acting on a provision of the BBA of 2018. As finalized, CMS now allows for the home health record to be used along with the physician record when determining a patient’s eligibility for the Medicare home health
benefit. In places where the physician’s record may be insufficient to determine eligibility, the HHA’s record may be used as supporting material to attest eligibility for home health services.

At a time when CMS and the U.S. Department of Health and Human Services (HHS) are separately inviting recommendations on regulatory or sub-regulatory changes as well as proposed administrative paperwork reductions, HCA again stresses the fact that F2F relief has long been a point of recommendation for bureaucratic and regulatory relief that could — and should — be addressed immediately in the 2020 final rulemaking process.

As HCA has repeatedly stressed, CMS’s implementation of the F2F rule is confusing to all involved, including physicians, HHAs and hospitals. CMS has tried to mitigate the confusion in various ways, but those solutions fail to provide basic clarity, ease of application or sensible application of the F2F standards. As a result, the requirement continues to be an access-to-care barrier, and practitioners find that it is easier to care for patients in alternative settings to home health care.

HCA believes CMS made the home health F2F physician encounter requirement much more burdensome than the Affordable Care Act (ACA) ever intended and that physicians conducting the F2F encounter should be able to simply sign and date the beneficiary’s plan of care which would serve as an attestation that the F2F encounter has been met.

**Recommendations**

A F2F solution needs to be workable and amenable to home care providers and physicians alike. We urge CMS to do the following:

- Eliminate or significantly modify the physician documentation requirements so that physicians no longer must explain why the patient’s clinical condition requires Medicare-covered home health services, nor require such an insurmountable level of documentation in their own files.

- Modify the F2F mandate so it can be met through the completion and collection of the separately signed and modified (if necessary) 485 form.

- Establish F2F exceptions for patients who have been recently discharged from an inpatient setting, individuals in rural areas where access to a physician or non-physician practitioner is limited, and individuals unable to leave home or have a physician perform a home visit.

- Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

- At a very minimum, HCA encourages CMS to go further in its revised language for physician certification documentation by requiring that home health documentation be included in the full physician record for determining a patient’s qualification for home care services, rather than merely allowing it.
HCA Urges Extension, Examination of Adequacy and Corresponding Refinements to Rural Add-On Tiers

Contrary to the perception that New York is largely urban/metropolitan, nearly 40 percent (24) of the state’s counties meet the latest rural designation established by CMS and many of the remaining geographic areas are essentially rural in character.

Furthermore, over the last twelve years, most of the county-sponsored Certified Home Health Agencies (CHHAs) in New York’s rural counties have either closed or sold their agency.

A 2017 cost report analysis by HCA found that approximately 67 percent of all Medicare-certified agencies operating in New York’s rural counties had negative operating margins, which is a contributing factor in the overall diminution of rural home health services; indeed, more than half of New York’s rural communities have only two or fewer providers of skilled care for Medicare and Medicaid home health services. If any more of these agencies close, access to skilled home care will be seriously threatened for residents in rural areas of New York.

Recommendations

Because of these facts, HCA is very concerned with the phase-out of the rural add-on from 2019 through 2022. While we understand that CMS is compelled to follow the tiered rates mandated by Congress, we urge CMS to closely monitor the adequacy of the Medicare HHPPS payment so that agencies can continue to provide important care to Medicare beneficiaries in rural areas, and we urge CMS to seek Congressional authority, if necessary, to extend and modify the rural add-on as necessary to appropriately reflect access-to-care and labor conditions.

HCA Urges Wage Index Refinements to More Accurately Reflect Local Market Conditions

CMS’s decision fourteen years ago to switch from Metropolitan Statistical Areas (MSAs) to the Core Based Statistical Areas (CBSAs) for the wage index calculation has had serious financial ramifications for New York HHAs. Unlike past MSA designations – where all of the counties in the New York City (NYC) designation were from New York State – the 2006 CBSA wage index designation added Bergen, Hudson and Passaic counties from New Jersey into the NYC wage index area. In 2015, CMS added three more New Jersey counties (Middlesex, Monmouth and Ocean) to the NYC area wage index. The New Jersey and NYC counties are very different labor markets with very different wage profiles that must be more precisely accounted for in the designations.

HCA has also consistently raised issues with CMS’s decision to maintain the current policy of using the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next.

Other specific wage index case examples raise questions about the validity of CMS’s data – for instance, CMS’s analysis of the Albany-Schenectady-Troy (aka, the Capital District) CBSA. In the past six years, this CBSA has seen its wage index reduced 5.17 percent, going from 0.8647 in 2013 to a proposed CY 2020 wage index of 0.820. Anyone who is familiar with the upstate New York labor
market and general cost of living would recognize that the Capital District CBSA should not be lower than any of the following other upstate New York CBSAs: Binghamton, Elmira, Glen Falls, Rochester, Syracuse, Watertown-Fort Drum and, most significantly, the “New York Rural Areas CBSA,” which is proposed to be 0.8431.

In addition, unlike the hospitals in the Albany-Schenectady-Troy CBSA, who are given the opportunity to appeal their annual wage index, HHAs in this CBSA don’t have appeal rights. This lack of parity between different health care sectors further exemplifies the inadequacy of CMS’s decision to continue to use the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates.

Lastly, the provision of home health care is a local endeavor; thus, the decision to view the current CBSA area designation in the “aggregate” for a large geographic region like NYC fails to represent the actual impact of the change. CMS’s shift to the CBSA wage index designation has resulted in below trend reimbursement for NYC agencies since 2007.

**Recommendations**

HCA appreciates CMS’s willingness to consider major reform of the home health index in this year’s proposed rule. This has been an ongoing concern of HCA throughout the years but unfortunately CMS has repeatedly dismissed our calls for wholesale revision of the home health wage index, even with the compelling examples given above.

We believe the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting home health costs, particularly in states like New York, which has among the nation’s highest labor costs, now greatly exacerbated by our state’s implementation of a phased-in $15 per-hour minimum wage hike, the balance of which is unfunded by Medicare. This mandate, when fully phased-in, will cost over a stunning $2 billion for New York HHAs across all payors (Medicaid, Medicare, managed care, commercial insurance and private-pay) and will never be adequately addressed due to CMS’s ongoing disposition to continue using the pre-floor, pre-reclassified hospital wage index to adjust home health costs.

CMS has also stated in previous final rules that the MSA delineations, as well as the CBSA delineations, are determined by OMB. OMB reviews its Metropolitan Area definitions preceding each decennial census to reflect recent population changes.

HCA disagrees with CMS’s assertion that the OMB’s CBSA designations are reasonable and appropriate, reflecting the most recent available geographic classifications, and we urge refinements to more accurately reflect local market conditions.

**Outlier Policy: HCA Appreciates CMS’s Ongoing Monitoring of the Fixed Dollar Loss Ratio in Recognition of Financial Losses on Outlier Episodes for High-Need Patients**

HCA welcomes CMS’s ongoing analysis of its outlier policy. HCA **supported** CMS’s decision last year to lower the Fixed Dollar Loss (FDL) ratio from 0.55 to 0.51 to better approximate the 2.5
percent statutory maximum. By doing so, this increases the number of episodes that would qualify for outlier payment as HHAs in New York serve a disproportionately high number of patients who are dually eligible beneficiaries (Medicare and Medicaid) and tend to have extensive and clinically complex care needs.

However, for this CY 2020 proposed rule, simulating payments using preliminary CY 2018 claims data (as of January 2019) and the CY 2019 HHPPS payment rates, CMS estimates that outlier payments in CY 2019 would comprise 2.42 percent of total payments for those 60-day episodes that span into 2020 and are paid under the national, standardized 60-day payment rate (with an FDL of 0.51) and 2.5 percent of total payments for PDGM 30-day periods using the 30-day budget-neutral payment amount as detailed in this proposed rule (with an FDL of 0.63). Given the statutory requirement that total outlier payments not exceed 2.5 percent of the total payments estimated to be made under the HHPPS, CMS is proposing that the FDL ratio for 30-day periods of care in CY 2020 would need to be set at 0.63 for 30-day periods of care based on CMS’s simulations looking at both the 60-day episodes that would span into CY 2020 and the 30-day periods.

CMS indicates that its CY 2020 final rule will update the estimates of outlier payments as a percent of total HHPPS payments using the most current and complete year of HHPPS data (CY 2018 claims data as of June 30, 2019 or later). At that time, CMS may adjust the final FDL ratio accordingly.

HCA appreciates CMS’s continuing analysis of its outlier policy. Even though CMS is proposing to increase the FDL ratio in its CY 2020 final rule to assure that outlier payments are as close to 2.5 percent of the total payments to be made under the PDGM as possible, we recognize this is being analyzed closely and may be adjusted in the final rule.

**HCA Supports Proposed Regulatory Change to Allow Therapy Assistants to Perform Maintenance Therapy**

In its proposed rule, CMS indicates that it would be appropriate to allow therapy assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the home health benefit, if acting within the therapy scope of practice defined by state licensure laws. The qualified therapist would still be responsible for the initial assessment; plan of care; maintenance program development and modifications; and reassessment every 30 days, in addition to supervising the services provided by the therapist assistant.

CMS believes this would allow HHAs more latitude in resource utilization. Furthermore, allowing assistants to perform maintenance therapy would be consistent with other post-acute care settings, including SNFs. Thus, CMS is proposing to modify the regulations in Section 409.44 to allow therapist assistants (rather than only therapists) to perform maintenance therapy under the Medicare home health benefit.

**HCA Comments and Recommendations**

HCA **strongly supports** this proposed change by CMS to allow therapy assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the home health benefit, if acting within the therapy scope of practice defined by state licensure laws.
HCA also agrees with CMS that this would allow HHA more latitude in resource utilization of its employees.

HCA’s only concern with this proposal is that CMS’s proposed regulatory language only addresses Physical Therapy (PT) Assistants. We would appreciate if CMS would confirm in its final rule that this helpful proposal also includes Occupational Therapy (OT) Assistants as well as Speech-Language Pathology (SLP) Assistants as well.

Proposed Updates to the Home Health Care Quality Reporting Program (HHQRP)

CMS proposes to require agencies to 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 that 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 increase resource use for agencies in terms of staff training and altered productivity associated with the learning curve required for collecting new material.

HCA and our colleagues at the National Association for Home Care and Hospice (NAHC) believe 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, we are 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, HCA 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’s 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.

HCA Supports CMS’s Proposal to Remove Question # 10 but CMS Should Eliminate HHA Requirement to Monitor HHCAHPS Vendor Compliance and Provide Administrative Reimbursement Mechanism for HHCAHPS Activities

HCA supports CMS’s proposal to remove Question 10 from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) tool which asks beneficiaries “In the last two months of care, did you and home health provider from this agency talk about pain?” CMS’s proposal to remove questions or items involving pain is sensible, especially when many individuals today are really struggling with this national opioid epidemic.

HCA understands the rationale for the HHCAHPS tool to measure the experiences of home health beneficiaries, but we continue to be most concerned that the HHCAHPS survey places another unfunded administrative burden on HHAs – a mandate that requires significant time and resources.

Also, while HHAs can certainly monitor survey vendors’ activities through reviews of their survey data submissions, HCA believes CMS’s 2013 decision to codify requirements for HHA verification of vendor compliance is problematic since vendor operations, activities and processes are not within the total control of the HHA.

Recommendations
HCA requests that CMS eliminate the survey requirement in the home health CoPs, in Section 484.250(c). In addition, we request that CMS consider including an administrative reimbursement mechanism in its final rule to help cover these costs.

Home Infusion Therapy Proposal and the Interaction with Home Health

HCA 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, HHAs 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 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 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 services 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. Such legislation 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.

**Billing Procedures for CY 2021 Home Infusion Services**

CMS requires that all home infusion therapy suppliers be enrolled in Medicare as Part B suppliers 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 HHAs that are accredited home infusion therapy suppliers to bill for the home infusion services under the home health provider number on a TOB 34x

**Concerns with Software Vendor Readiness**

A large number of HCA members depend on software vendors to help them operate their agencies. These solutions typically cover all aspects of agency financial and clinical operations. As such, our member’s vendors enhance and modify their health information technology (HIT) solutions in accordance with proposed and final rules.

We urge CMS to consider the need for software 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 software vendor has delivered appropriate updates. It is expected most HIT solution updates will not be delivered until late 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 a software vendor update are the interpretive guidelines. Frequently, the interpretive guidelines require software 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 software vendors as well.
Finally, PDGM 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.

**HHAs Need Financial Assistance on Achieving Interoperability and Electronic Healthcare Information Exchange**

Last year, we welcomed CMS’s plan to release a Request for Information (RFI) on interoperability and/or the sharing of health care data between providers.

CMS has stated that Medicare- and Medicaid-participating providers and suppliers are currently at varying stages of adoption of HIT. Many hospitals have adopted electronic health records (EHRs) because CMS has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology (CEHRT) under the Medicare EHR Incentive Program.

HIT and clinical technology are at the core of every aspect of health facility/agency operation; they are integral to service delivery, quality evaluations and outcomes, cost-effectiveness and administration. **However, federal, state and private payors have long overlooked home care in the health IT development area,** even though virtually every new state and federal care model or demonstration project — including value based payments — requires this kind of technology infrastructure and interoperability to succeed.

Furthermore, HHS and CMS have stated in the past that all individuals, their families, their health care and social service providers, and payors should have consistent and timely access to health information in a standardized format that can be securely exchanged between the patient, providers, and others involved in the individual’s care. The secure, efficient and effective sharing and use of health-related IT information, when and where it is needed, is an important tool for settings across the continuum of care, including home health.

HCA agrees that these are laudable principles; however, we are disappointed that HHAs remain ineligible for monies through the Medicare and Medicaid EHR Incentive Programs.

**Recommendations**

HCA asks that CMS and/or HHS incorporate funding in the 2020 final rule to invest in HIT and integrated clinical technology for home care. Such technology investments should be targeted to promote health care quality, cost-effectiveness, care management and integration of home care within provider systems and between sectors.

**Conclusion**

HCA appreciates this opportunity to submit comments and respectfully requests CMS’s consideration of our concerns and recommendations.
I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or (518) 810-0661.

Sincerely,

Patrick Conole, MHA
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