



August 24, 2020

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1730-P
Post Office Box 8013
Baltimore, MD 21244-8013

Re: File Code CMS-1730-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2021

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 175,000 Medicare home health beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the 2021 Medicare Home Health Prospective Payment System (HHPPS).

This letter will provide HCA's major comments on the 2021 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.

PDGM Kept Largely Intact in CY 2021 Proposed Rule: HCA Concerned with Maintaining Behavioral Adjustment Cut and RAP Proposal

HCA appreciates CMS issuing the proposed rule in late June which indicates that there were only modest changes proposed by CMS in CY 2021. We believe CMS recognized that any significant changes during the infancy of the Patient Driven Groupings Model (PDGM) would be premature given the limited data available from 2020, combined with the turmoil created by the COVID-19 pandemic. This is evident with CMS not making any structural changes to the PDGM system and maintaining the case mix weights and Low Utilization Payment Adjustment (LUPA) thresholds at the current 2020 levels.

However, the CY 2021 proposed rule continues to include the PDGM "behavioral-adjustment" cut that has been an ongoing concern of HCA and the entire home care industry. In last year's final rulemaking, CMS implemented **-4.36 percent** behavioral adjustment which CMS plans to keep in place for CY 2021.

Throughout the rulemaking process, CMS asserts that the 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 continues to strongly oppose 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 CY 2021 PDGM proposal:

- The assumed behavioral assumptions 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 behavioral adjustment for the clinical group coding and the LUPA avoidance are unrealistically high.
- HCA remains very concerned with CMS's decision to continue with the phase-out of the Requests for Anticipated Payment (RAP) process where a no-pay RAP is proposed to be implemented in CY 2021 and the implementation of a Notice of Admission (NOA) process beginning in CY 2022.

In its 2020 final rule, CMS finalized a payment reduction if the HHA does not submit the RAP for CY 2021 within 5 calendar days from the start of care. The reduction in payment amount would be equal to a one-thirtieth reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submits the RAP. The operational and financial strains that HHAs have experienced during the public health emergency (PHE) have impeded many HHAs ability to effectively operationalize the changes required to comply with the 5-day RAP submission time frame. Additionally, any payment reduction in 2021 to HHAs will be significantly more impactful than anticipated when CMS finalizes the provision.

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. Pre-COVID-19, many HCA provider members were already struggling to receive this information timely from the physician community. Now with many physician office buildings closed or operating remotely due to the pandemic, the phase-out of the RAP only exacerbates this problem for providers.

- HCA requests that in this year’s final rule CMS include some data analysis from the first 6 months of the CY 2020 PDGM that specifically looks at the percent of LUPAs experienced by HHAs nationally. We have heard from many of our HHA members in New York that experienced an increase in the number of their LUPAs, which were likely caused by dealing with the COVID-19 pandemic, especially in the first and second quarters of CY 2020.
- CMS’s decision to continue 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. **Many hospitals limited admissions during the COVID-19 pandemic and some patients had to access home health services in the community when before they may have entered the hospital. HHAs should not be reimbursed less for these patients who require intensive services.**
- The bundling of non-routine supplies (NRS) in the PDGM 30-day payment unit creates a 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 thresholds levels under the PDGM remains overly 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 as part of this year’s CY 2021 final rule. Last year’s rulemaking addressed only the calculation of the payment rates and the assumption-based behavior adjustment. Starting in 2021, CMS needs to take into account the impact the COVID-19 had on the PDGM in 2020 and 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

Due to the tremendous impact the COVID-19 has had on all healthcare providers including HHAs in 2020 and how it has impacted service delivery for one of Medicare’s most vulnerable beneficiary populations (home health), HCA offers the following recommendations:

1. CMS should withdraw or eliminate its ongoing **-4.36 behavioral adjustment for CY 2021**, until CMS has had an opportunity to review and analyze actual HHA behavior in CY 2020, especially when many HHAs have been dramatically impacted by the COVID, that has resulted in significant financial hardship as well as unprecedented operational challenges including the loss of staff due to actual death or concerns with simply working in a pandemic. In fact, one of our larger CHHA in the New York City (NYC) Metropolitan area is estimating decreased revenues between \$75-100 million in CY 2020 and has seen over 40 staff members lose their lives to COVID-19.
2. CMS should withdraw its continuation of the phase-out of the RAP process. If CMS intends to proceed with its proposal, CMS should continue with the current 20 percent RAP payment in CY 2021 and begin the no-pay RAP in CY 2022, and then implement the NOA process beginning in CY 2023, to allow HHAs additional time to adjust cash management, especially since many HHAs have seen significant reductions in revenue due to the pandemic.

At a minimum, CMS should delay the implementation of the RAP payment penalty in CY 2021, until the greater of 6 months after the implementation date or 3 months after the PHE.

Lastly, CMS should fully explore targeted approaches to managing the integrity of RAPs. Options to consider include focusing 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 an NOA 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 going back to a single LUPA threshold.
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-2021. 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.

Notice of Admission (NOA) Proposal for CY 2022

In last year's final rule CMS finalized a requirement that HHAs complete a Notice of Admission (NOA) form when the no-pay RAP process 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 will 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 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 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 last year's 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 and the POC is then developed. Therefore, not only are the NOA 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 2021 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) plan of care / 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 thirteen 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 2018 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 HHPS 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 Encourages Wage Index Refinements

CMS's CY 2021 proposed rule discusses a notification issued in September 2018 by the OMB that establishes revisions to the delineations of Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineations in these areas. While CMS believes that HHAs should be subject to the most current OMB delineations, CMS acknowledges that the revisions in several cases can be significant for some HHAs nationwide. These include changes in status from urban to rural, rural to urban, shifts of counties from one urban Core Based Statistical Area (CBSA) to another and CBSA name and number changes.

To mitigate the impact of these changes and address any short-term instability that may arise from these changes, CMS is proposing to apply a 5 percent cap on any decrease in a geographic area's wage index value from CY 2020 to 2021. No cap will be applied in CY 2022.

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.

This is particularly evident in CMS's proposed rule where we are very concerned for our HHAs in the following CBSAs who are proposed to see significant reductions from their current CY 2020 wage index to proposed CY 2021 wage index:

- 24020: Glen Falls: -4.01 reduction;
- 39100: Orange County: -5.00 reduction; and,
- 39100: Dutchess County: -3.70 reduction.

Based on the latest Cost Report data in New York, approximately two-thirds of HHAs operating in the state experienced negative operating margins in 2018. How can financially struggling HHAs in these CBSAs sustain these Medicare wage index reductions?

Also, we continue to believe that 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.

In addition, unlike the hospitals nationally, who are given the opportunity to appeal their annual wage index, HHAs do not have appeal rights with regards to its wage index. 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. Specifically, hospitals in the Albany-Schenectady-Troy CBSA have been working hard with Congress and CMS to appeal their wage index which is clearly needed, but any inroads or success they may reach, unfortunately, would not apply to HHAs in the same CBSA.

Recommendations

HCA appreciates CMS's willingness to consider major reform of the home health index in last year's rulemaking. This has been an ongoing concern of HCA throughout the years but unfortunately CMS has dismissed our calls for wholesale revision of the home health wage index. In this year's final rule, we recommend the following:

1. CMS should lower the percent cap on any decrease in a geographic area's wage index value from CY 2020 to 2021, from 5 percent to 3 percent. Having a Medicare wage index reduction of greater than 3 percent is unsustainable for most HHAs already operating at a loss.
2. CMS should develop and make public an impact analysis of applying the previous transition approach in implementing new wage areas in the wage index where a 50/50 blend of old and new indexes was used.

Use of Telehealth Under the Medicare Home Health Benefit

CMS is proposing to finalize the plan of care (POC) requirements within Section 409.43(a) related to telehealth as issued in the Coronavirus Aid, Relief, and Economic Security (CARES) Act interim final rule published on March 30.

The home health POC must include any provision of remote patient monitoring or other services furnished via a telecommunications system and describe how the use of such technology is tied to the patient-specific needs as identified in the comprehensive assessment and will help to achieve the goals outlined in the POC.

The amended POC requirements in Section 409.43(a) also state that these services cannot substitute for a home visit ordered as part of the POC and cannot be considered a home visit for the purposes of patient eligibility or home health payment. However, CMS is proposing to allow HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost report. Additionally, CMS is proposing to include not only remote patient monitoring but other communications or monitoring services, consistent with the POC for the individual.

HCA supports and appreciates CMS's efforts to promote the use of telecommunication technologies and the acknowledgment that technology has the potential to play a large role in enhancing the delivery of healthcare in the home. **During the COVID-19 pandemic, telehealth has been used to support Medicare beneficiaries when in-home services were not advisable or available.** However, our members have expressed concern over the requirements for the POC when telecommunication visits are ordered. Unless there is some flexibility in these requirements, HHAs are at risk for unreasonable claim denials.

The POC requirements coupled with CMS's position that visits conducted via telecommunication are not reimbursable are likely to serve as a deterrent to provide telecommunication technologies to Medicare home health beneficiaries.

Recommendations

CMS should provide flexibility regarding the documentation requirements on the POC and permit documentation throughout the medical record be used to support the use of telecommunication technology. Requirements for the POC should be limited to the practitioner's order that permits the HHA to use telecommunication technology in managing the patient's clinical condition. **Additionally, CMS should develop a model for claims reporting and payment for home health visits provided by telecommunication.**

Also, it is unclear whether audio only visits are included as telecommunications technologies for home health visits. Audio only visits have been permitted during the PHE, however, the amended language at § 409.46(e) to allow a broader use of telecommunications technology to be reported as an allowable administrative cost on the home health agency cost report does not appear to include audio only technology. **CMS should permit telecommunication technologies to include audio only (e.g. telephonic) technology.**

Medicare Coverage of Home Infusion Therapy Service: Provider Enrollment and Beneficiary Access to Home Health Concerns

Program Enrollment

In its proposed rule, CMS reiterates the coverage and payment requirements for home infusion therapy suppliers finalized in previous payment rules along with describing the

proposed Medicare enrollment requirements for accredited home infusion therapy suppliers.

It is HCA's understanding that the Medicare Administrative Contractors (MACs) will not accept Medicare enrollment applications for home infusion therapy suppliers until after the CY 2021 proposed rule has been finalized (usually end of October). HCA is very concerned that this would only allow two months for providers to complete the enrollment process prior to the permanent implementation of the new benefit that begins on January 1, 2021.

This narrow timeframe to enroll as a home infusion therapy supplier coupled with the interruptions in provider operations due to the PHE pose a high risk that a sufficient number of home infusion therapy supplies will not be available for beneficiaries receiving Part B infusion therapy beginning January 1, 2021.

Access concerns also revolve around the number of eligible entities that intend to enroll as home infusion therapy suppliers and whether there will be sufficient suppliers enrolled, particularly in rural areas.

A recent survey of home health and hospice providers conducted by our colleagues at the National Association for Home Care and Hospice (NAHC) revealed that 90% of respondents do not plan to enroll in Part B as a home infusion therapy supplier. Approximately 50% of the respondents indicated that they plan to subcontract with a home infusion therapy supplier to provide the professional services, but the availability of suppliers that HHAs and hospice providers can subcontract with is unknown. This is of particular concern for beneficiaries receiving services associated with Part B drug infusions by an HHA when the benefit transitions to the permanent home infusion program in January. If these patients cannot be transferred to a home infusion therapy supplier, HHAs may be forced to provide unreimbursed care. Or worse, the HHA may not be eligible to provide any service associated with the infusion if they are not a home infusion therapy supplier. This places patients at risk for service disruptions that could lead to serious harm.

Beneficiary Access to Home Health Concerns

Beginning January 1, 2021 HHAs will not be able to bill for the professional services associated with Part B home infusion drugs under the home health benefit. Rather, these services will need to be provided and billed by a home infusion therapy supplier under Medicare Part B, whether or not the home infusion therapy supplier is also the Medicare certified HHA. This benefit structure disadvantages beneficiaries in terms of cost to the beneficiary, restricting entitled benefits, and fragmenting care. 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 beneficiary co-pay of 20 percent 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 needs

skilled nursing for infusion therapy, but also needs a dependent home health services (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 HHA as required by the home health conditions of participation.

Recommendations

HCA requests that CMS delay the implementation of the permanent home infusion therapy supplier benefit by the greater of six months from the scheduled implementation date or three months after the COVID-19 PHE ends.

If a delay is not possible, CMS should use its authority to not enforce the prohibition for HHAs to provide the professional services associated with Part B infusion drugs under the home health benefit.

Finally, CMS should work with home health stakeholders and Congressional members to develop a revised and comprehensive home infusion therapy supplier benefit that serves the needs of beneficiaries and providers/suppliers.

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

In 2018, 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 CY 2021 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
Vice President, Finance & Management
Home Care Association of New York State, Inc.