September 9, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1711-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Comments on Proposed Rule: CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements

Dear Ms. Verma:

LeadingAge, ElevatingHome and the Visiting Nurse Association of America (VNAA) appreciate the opportunity to provide feedback regarding the Calendar Year (CY) 2020 Home Health Prospective Payment System proposed rule. We offer these comments in the spirit of collaboration and look forward to working with the Centers for Medicare & Medicaid Services (CMS) as it strives to modernize the payment system to more closely align reimbursement to the clinical needs of Medicare beneficiaries.

The mission of LeadingAge is to be the trusted voice for aging. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

ElevatingHOME and its subsidiary VNAA, share the mission of advancing high-quality, patient-centered health care that starts in the home. ElevatingHOME members are mission-driven home health and hospice providers serving rural, urban and underserved communities across the nation. ElevatingHOME members provide cost-effective and compassionate care to the most vulnerable individuals, including older people and persons with disabilities.

Our comments cover several sections of the proposed rule. For ease of interpretation, we have provided the name of the heading or sub-heading most closely related to the specific element on which we wish to comment.

Proposed Provisions for Payment Under the Home Health Prospective Payment System (HH PPS)

Behavior Assumption Adjustment: *We strongly oppose the prospective application of behavior assumptions on CY 2020 payment rates*

Notwithstanding the requirement from the Bipartisan Budget Act of 2018 (BBA) to make assumptions about behavior changes that could occur as a result of the implementation of the Patient-Driven Groupings Model (PDGM) and the requirement for a description of such assumptions, we strongly oppose the prospective application of behavior assumptions on CY 2020 payment rates. The degree to which CMS is assuming the three behavioral changes by providers due to the PDGM proposal takes an

unnecessarily cynical view of home health agencies. According to the proposed rule, if no behavioral assumptions were made the 30-day payment amount, to achieve budget neutrality would be $1,907.11. With all three assumptions, clinical coding, increased comorbidity diagnoses, and low utilization payment adjustment (LUPA) avoidance, that amount drops over 8% to $1,754.37. The degree of downward shift through these assumptions goes too far and has the potential to create negative consequences for providers who are already following appropriate clinical practices. We recommend that CMS monitor these assumptions but base payment adjustments on observed behavior as adjust accordingly for CY 2021.

To the extent that CMS developed the rate of $1907.11 to reach budget neutrality in absence of behavior assumptions indicates that a rate above the $1,754.37 figure has validity. Given the BBA also grants authority to make temporary or permanent payment adjustments to offset increases or decreases in aggregate spending, we support and recommend the application of actual behavior from the first year of the PDGM implementation to drive payment rates. With the scale of the changes that home health agencies are preparing for with the implementation of PDGM and uncertainty that comes with the difference between policy design and implementation, it might prove prudent to allow the implementation of the new payment system to be evaluated without prospective behavior assumptions.

Phase out of Requests for Anticipated Payment (RAP): *We are concerned with the phase out and elimination of RAPs and the impact particularly on nonprofit and smaller organizations*

Our members are not in favor of phasing out the RAP payments even with the move to 30-day units of service. Within nonprofit providers, particularly smaller organizations, cash flow can still be an issue if RAP payments were to go away. While we are supportive of measures to ensure program integrity broadly, not all organizations that request RAP payments are fraudulent. We recommend continuing the practice of RAP payments for existing home health agencies as well as considering the cash flow requirements of new home health agencies who also have capitalization needs.

Allow Therapist Assistants to Perform Maintenance Therapy: *We support this proposal and encourage CMS to continue to identify barriers to patient care created by artificial limits on the scope of practice of all home care professionals*

Currently therapy assistants can perform only restorative therapy according to the care plan developed and supervised by a licensed therapist. Only licensed therapists can provide maintenance therapy in the home. This standard is inconsistent with other post-acute care settings. The proposal would allow therapy assistants to perform maintenance therapy services under a program established by a qualified therapist. To the extent that CMS is continuing to explore cross-setting commonalities for post-acute care and the concept of a unified post-acute care prospective payment system according to the IMPACT Act, proposals that create more uniform policies across settings is largely a positive direction. We support this proposal and encourages CMS to continue to identify barriers to patient care created by artificial limits on the scope of practice of all home care professionals.

Proposed Provisions of the Home Health Value-Based Purchasing (HHVBP) Model: *We encourage CMS to continue to develop and share quality data*

CMS proposes to publicly report the total performance score and the percentile ranking for home health agencies involved in the HHVBP from the final year (year 5, calendar year 2020) of the pilot. The data would be available on CMS operated websites after December 1, 2021. As a general principle, we support

transparency efforts across the spectrum of health care services. Transparency is key to the transfer and adaption of knowledge, the critical step in all quality improvement efforts. We encourage CMS to continue to develop and share quality data in partnership with organizations providing services and beneficiaries who rely on those services. HHVBP is a major multi-year model expected to influence home health services well into the future. The sooner data from the model is available, the sooner patient care can benefit from the lessons.

However, we heard from members some concerns with public reporting, particularly for providers who are not participating in the HHVBP but are in markets that overlap with HHVBP states. We want to ensure that the variation of participation by geography does not give advantages or disadvantages to providers based purely on state lines. Members in non-participating states will not have the same quality information publicly available as the participating providers, which could be confusing to consumers and referral sources when selecting an agency. CMS should ensure all agencies providing services in selected areas are represented and clearly define the differences in the quality information reported. Additionally, we ask for information about CMS' intention to expand the number of states that are included in the HHVBP model. Our members are interested to know if CMS has a timeline for model expansion.

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

Removal of Pain Measure and Question: *We strongly oppose removal of pain measures from HH QRP and HHCAHPS*

Citing the removal factor for measures that can lead to negative unintended consequences other than patient harm, the proposal seeks to remove the "Improvement of Pain Interfering with Activity" Measure starting in 2022 as an effort to "mitigate any potential unintended, over-prescription of opioid medications inadvertently driven by these measures". CMS reports the elimination of the measure is in line with the agency's broader efforts to address the opioid epidemic.

Additionally, the proposal removes Question 10 from the Home Health Care Consumer Assessment of Health care Providers and Systems Survey (HHCAHPS). This question asks, "In the last 2 months of care, did you and a home health provider form this agency talk about pain?" The justification aligns with the removal of the pain measure from the HH QRP as well as the hospital CHAPS survey. Pain is a valid issue and pain management is essential to quality of life. The goal of optimal functioning to attain and maintain the highest practicable quality of life is embedded in post-acute care policies. We appreciate CMS' recognition that pain management is a vital part of achieving that optimal functioning.

We strongly oppose these proposals. The measure reflects the dominate and detrimental impact pain can have on activity which in turn, is the root cause of a complex cascade of declining health and well-being. As stated in the proposed rule, there is no evidence to suggest that the use of these measure or any other pain measures is linked to opioid misuse. The rationale for eliminating the measure suggests a causal link, which is even a more difficult relationship to demonstrate. Measures of pain management do not inherently connect to the use of opioids, or even pharmaceuticals. The assumption of this linkage dismisses the complex, professional efforts to support people experiencing pain. This assumption is an overly simplified solution to a highly nuanced problem. Measures of pain management are more important in relation to the opioid misuse epidemic than ever before. Providers of all disciplines and roles must continuously develop knowledge about techniques and interventions to reduce, control and manage pain. Eliminating quality measures about pain as a method to reduce opioid addition is only going to reduce efforts to manage pain, push the issue of pain off the priority list and result in greater human suffering. Greater emphasis on measures of pain management and impact are needed in response to opioid

misuse. More attention on the issue will provide more solutions. Measures that offer greater detail about how pain is managed are critical to understanding what interventions are effective.

Addition of Health Information Measures: *We support the proposed measures and recommend that CMS continue to strive for more outcome and fewer process measures*

Two measures, "Transfer of Health Information to Providers of Post-Acute Care" and "Transfer of Health Information to Patient Post-Acute Care", are proposed to promote effective communication and coordination of care, specifically in the area of the transfer of health information and interoperability. Both measures will monitor the transfer of reconciled medication lists at the discharge from home health. Recognizing the importance of the communication between different care settings and with families is vital particularly related to medications. We are supportive of the proposal for the two new measures. Furthermore, we encourage CMS to continue to strive for more outcome measures and fewer process measures. We recognize and applaud the commitment to an organized process, grounded in scientific inquiry, and the use of evidence to guide implementation.

We are pleased to continue the conversation around home health services and how federal payment and regulations effect nonprofit providers. Please do not hesitate to contact us (Aaron Tripp, atripp@leadingage.org) if you have any questions or would like further discussion. We look forward to our continued work with you on this and related issues.

Sincerely,

Katie Smith Sloan
President & CEO
LeadingAge

Kate Rolf
Board Chair
VNAA