Optional Points to use in 2020 HH Proposed Rule

OVERALL: Will cause instability to all home health care providers, threaten access to care, and harm the Medicare home health program for seniors.

IMPORTANT - Be sure to add how these proposed changes will negatively impact your agency and the patients you serve.

Behavioral Assumption - CMS is proposing an 8.01% reduction in the base rate to account for projected behavioral changes equivalent to a **$1.3 billion cut to home health care**.

- Without any data or evidence, CMS makes assumptions or guesses about provider behavior in a new payment system. Simply, CMS assumes that providers systemically will change their coding to maximize payment in a new model.
- There is no evidence to support this assumption. In fact, CMS' own analysis of home health payments (CMS' 2017 Fee-for-Serve Supplemental Improper Payment Data Report) indicates that improper payments due to incorrect coding was zero dollars. This is in direct contrast to CMS' assumptions about provider behavior in the new payment system.
- No data or evidence warrants a 8.01% ($1.298 billion) cut to home health providers.
- A behavioral assumption cut without data is not sound payment policy. CMS, in issuing the Skilled Nursing Facility (SNF) model, refused to make assumptions about provider behavior, stating that it would "not make any attempt to anticipate or predict provider reactions to the implementation of the proposed [payment model]." CMS declined to make assumptions about such behavior in the SNF system because it "lack[ed] an appropriate basis to forecast behavioral responses."

Requests for Anticipated Payments (RAPs) - CMS is proposing a reduction in RAP payments from 60/50% to 20% in 2020 and in 2021 total elimination of a near 20-year payment process, that was instituted to address cash flow needs. These needs continue in PDGM.

- Along with the additional financial impacts this will add to the extreme financial hardships home health agencies will face
- Because of the change from 60-day billing periods to 30-day billing periods under PDGM, agencies were already preparing for a significantly reduced cash flow in Q1 2020 until the accumulation of 30-day billing periods provided a cash flow "catch-up" with the 60%/50% RAPs. With the introduction of a reduction of RAPs to only 20% for 2020 and complete elimination of RAPs in 2021, the negative financial impact could have devastating results for many home health agencies, especially the smaller free-standing agencies typically located in the under-served rural markets. This will likely result in a dramatic number of closures impacting access to care for many Medicare participants.

Elimination of RAPs and use of a Notice of Admission (NOA) – CMS is proposing to eliminate RAP payments and replace them with a NOA which must be accepted with 5 days of the admission date, or result in financial penalties to the agency.

- Since the NOA does not generate a payment it is baffling why CMS would require agencies to have the same requirements for the NOA submission as for the RAP submission.
- Obtaining a signed physician order within days of admission will be nearly impossible as home health agencies deal with hundreds of physicians and timeliness of obtaining signatures on

orders is already a problem. This seems to again, punish home health agencies for something they have little control over.

- Home Health agencies may begin services based on a verbal order as long as the order contains the services required for the initial visit. Therefore, not only are the proposed requirements overly burdensome, they are unnecessary, and do not fall within the current Administration's "patients over paperwork" initiative. All Medicare home health agencies will need to submit a new Notice of Admission on 3.5 million patients.

Home Infusion Therapy Services and Interaction with Home Health – Beginning in 2021, home health agencies will not be able to provide Part B home infusion therapy to beneficiate under the home health benefit.

- The proposed benefit structure disadvantages beneficiaries in terms of cost to the beneficiary, restricting entitled benefits, and fragments 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 20% beneficiary co-pay for the professional services that are otherwise covered in full under the home health benefit.
- Some beneficiaries could see limitations in eligibility for home health services, be forced to go without the needed support or pay for care privately. If the only needed skilled service is nursing for infusion therapy, but the beneficiary also needs support services (occupational therapy, home care aide, etc.) they will be precluded from receiving those other support services under the home health benefit as the home infusion therapy supplier will not be eligible to provide such services.
- Could require two distinct service providers in the home under separate plans of care. This fragmentation of care poses a clear risk to the quality of care provided to the beneficiary.
- Creates additional burden of coordinating care to assure beneficiary safety will be the responsibly of the home health agency since the home health COPs hold agencies accountable for the coordination of all services the beneficiary receives while under a home health plan of care.

Admission Source - CMS proposes a financial impact on the admission source. Will be classified into one of two admission source categories —community or institutional

- Does this seem to incentivize HHAs to give priority to post-acute patients over those who are admitted from the community? Incentivizing discriminatory action should not be built into any Medicare payment model. CMS should guard against substituting one bad incentive in the payment model with another.
- 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 – will CMS closely monitor this?

Therapy – PDGM will eliminate therapy thresholds as a means of determining payment and base payment on patient characteristics instead of therapy needs.

- Concerned that the PDGM design will have a negative impact on patients who need therapy services and the HHAs that provide it. Therapy services are extraordinarily valuable in the care of Medicare home health beneficiaries and should be supported to the greatest degree possible.
- The outcome of the disincentives in PDGM in the provision of therapy services is an arbitrary one, not one related to patient characteristics and needs.