September 9, 2019

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

Submitted electronically to http://www.regulations.gov

Re: 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; CMS-1711-P

Dear Administrator Verma:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on this proposed rule for Medicare payment to home health agencies (HHAs) under the home health prospective payment system (PPS). Our comments focus on understanding the impact of the new Patient-Driven Grouping Model (PDGM) that will be implemented in 2020; new measures and standardized patient assessment data elements (SPADEs) for the home health quality reporting program (HH QRP); the home health value-based purchasing (HHVBP) model; and the home infusion therapy benefit.

Understanding the Impact of the Patient Driven Grouping Model (PDGM)

PDGM implementation introduces significant changes to the Medicare home health payment system, including moving to a 30-day unit of service (episode), revisions to case-mix methodology and payment categories, and varying payments based on admission source and episode of care. AARP urges that CMS establish a system of early warning/near real-time data collection and reporting to assess the impact of the PDGM on Medicare beneficiaries’ access to home health services and to make this information publicly available. We continue to believe that one helpful tool may be surveys of Medicare beneficiaries using home health services and their family caregivers, as appropriate.
As expressed in past comments, we remain concerned that the PDGM, which begins in 2020, could create financial incentives for home health agencies to under-supply needed care through inappropriate early discharge, improperly limiting the number of visits or types of services provided, or discouraging serving individuals with longer-term needs and people without a prior institutional stay. We believe it is particularly important to monitor these issues and quality of care during initial implementation of the PDGM in ways that will allow CMS to quickly understand and address emerging problems affecting the provision of home health services.

All the changes associated with PDGM implementation also require CMS to educate home health agencies as well as beneficiaries and their family caregivers about the need for beneficiaries to receive high-quality home health care that meets each Medicare beneficiary’s unique needs. This holds whether those needs arise from a short-term or chronic condition, an institutional or community admission, or require a type of therapy, or skilled nursing care, or other services. Medicare beneficiaries and their family caregivers need to be provided clear, accurate information by agencies about what Medicare covers and their appeal rights. CMS educational materials for beneficiaries should be updated to assist in this effort, but ensuring that agencies understand how to communicate to beneficiaries about decisions regarding the amount and type of services they will be provided is essential. Given the importance of education during the PDGM implementation, we urge CMS to be transparent about its education budget and include information about the different mechanisms it will use for the education of providers, beneficiaries, and their family caregivers (as appropriate).

Regulatory Change to Allow Therapist Assistants to Perform Maintenance

AARP remains concerned that under the PDGM a home health agency will not have a financial incentive to provide necessary therapy services, which could have a negative impact on the ability of beneficiaries who need ongoing therapy services to obtain needed care. AARP understands that if the Medicare regulations allow a therapist assistant to perform restorative therapy, they should also be able to perform maintenance therapy, if acting within the therapy scope of practice defined by state licensure laws, as CMS proposes. If CMS moves forward with this proposal in the final rule, given all the changes with the implementation of the PDGM in 2020 and the need for CMS to closely monitor any possible effects of the PDGM on the quality of therapy care provided to beneficiaries, we recommend that CMS take into account this change in the provision of care when evaluating the impacts of the PDGM.

Public Reporting of HHVBP Model Performance

AARP supports the proposed public reporting of HHVBP performance data. Although limited to performance during the final year of the model, it would be beneficial for members of the public in the nine states in which the HHVBP model is in effect to have access to information on each HHA’s total performance score and percentile ranking. We support CMS’ proposal in this regard, and also encourage that the payment adjustment and components of the total score be made public. As CMS proposes that the HHVBP data be posted on the CMS Innovation website,
it would be helpful to provide a link on the Home Health Compare website alerting consumers that this supplemental information is available for HHAs in the nine states.

**Removal of Pain Question from the Home Health Quality Reporting Program (HH QRP)**

AARP is concerned about the proposed removal of the National Quality Forum-endorsed measure on Improvement in Pain Interfering with Activity from the HH QRP beginning in 2022. (The related Outcome and Assessment Information Set (OASIS) item would no longer be reported beginning in January 2021.) We understand and share CMS’ concern about the role that over-prescribing plays in the opioid epidemic. However, pain management is an important part of quality care in the home health setting as elsewhere, and removing this measure would limit CMS’ ability to assess how well HHAs manage patient pain.

Notably, CMS is not aware of any studies that link this measure to opioid prescribing practices. Moreover, CMS recently finalized for other post-acute providers the addition of the standardized patient assessment data element on Pain Interference, which assesses pain effect on sleep, therapy activities and day-to-day activities. In supporting that decision, CMS noted the value of measuring pain interference with activities as compared with self-reported measures of pain intensity.

If removal of this measure is finalized, it is critical that CMS work to quickly adopt alternative metrics for assessing successful pain management in the home health setting.

For similar reasons to those outlined above, AARP is also concerned about the proposed removal of Question 10 regarding communication about pain from the Home Health Consumer Assessment of Providers and Systems (HHCAHPS) Survey beginning July 1, 2020. This question asks “In the last 2 months of care, did you and a home health provider from this agency talk about your pain.” This question provides an important opportunity for assessing whether agencies ask patients about pain and presumably take steps to address it. We urge CMS to retain this question.

**Addition of Transfer of Health Information Quality Measures for the HH QRP**

AARP supports the proposed addition of two transfer of health information measures to the HH QRP and other post-acute care provider quality reporting programs and encourages CMS to further strengthen one of these measures. The PAC measures “Transfer of Health Information to the Provider” and “Transfer of Health Information to the Patient” would assess the frequency with which the HHA provides a current reconciled medication list when an individual is discharged to another provider setting (and the information transferred to the provider) or home (information transferred to the individual, family or caregiver). As the review of the literature in the proposed rule indicates, proper transfer of health information and patient care preferences is critical to ensuring safe and effective transitions from one health care setting to another.

In particular, with respect to the Transfer of Information to the Patient measure, AARP notes the importance of providing the reconciled medication list to the family caregiver (broadly defined), as appropriate. Very often, smooth care transitions and successful discharge
planning depends on the active involvement of family caregivers who voluntarily provide support and assistance to their loved ones before, during, and after discharge. When a patient’s home health episode is ending and they remain at home, the family caregiver(s) may be implementing a discharge plan or care plan so that the individual can avoid an unnecessary hospital visit. For this reason, giving the caregiver accurate and up-to-date information about the beneficiary’s medication list can help ensure compliance with needed prescriptions and serve as a patient safety measure, as patients are vulnerable to avoidable adverse drug events during care transitions resulting in unnecessary health care utilization and costs. The data element for this measure should be clear that if a Medicare beneficiary has a family caregiver that individual should receive the list if the beneficiary and family caregiver consent, even if it is also provided to the patient.

We also urge CMS to further strengthen the Transfer of Information to the Patient measure. While it is very important for the individual, family or caregiver to have the reconciled medication list, in some cases, simply providing the list may not be sufficient. We urge CMS to strengthen this measure to also include that the patient, family, or caregiver be given a chance to ask questions about the medication list to ensure they understand it. Importantly, this could also help ensure that individuals correctly take their medications and avoid adverse events.

Request for Information on HH QRP Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs)

Caregiver Status is identified as a possible standardized patient assessment data element (SPADE) for addition to the program in future years, and CMS seeks comment on its importance, relevance, appropriateness and applicability. AARP strongly supports adding a SPADE to the patient assessment instruments in all the post-acute settings that would identify whether the patient has a family caregiver and to identify that individual to the facility or provider including contact information (with consent of the beneficiary and the family caregiver). This would ensure that the provider is aware when a beneficiary has a caregiver, who may or may not be the next of kin. The caregiver may have information that is helpful to the provider in caring for the individual, and involving the caregiver during the discharge planning process can help the beneficiary make a smooth transition home or to the next provider setting. In addition, family caregivers can also be vital to ensuring that the individual’s care preferences are communicated and carried out. Creating a Caregiver Status SPADE would also allow for future development of one or more quality measures regarding HHA interaction with and support of family caregivers.

Standardized Patient Assessment Data Reporting Beginning with 2022

AARP supports the greater use of SPADEs to enable creation of quality measures that can be used across all the post-acute care settings, consistent with the IMPACT Act requirements. We are particularly pleased to see the proposal for a new category of SPADEs that would collect data on social determinants of health, including race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation. In addition to potentially adding to the provider’s knowledge of the individual, when aggregated, this information will allow for greater understanding of the needs of vulnerable populations as
well as permit the creation of tools to assess provider performance on quality metrics among different populations. CMS may also want to consider adding level of education to the data collected regarding social determinants of health.

**All-Payer Data Reporting for the HH QRP**

AARP supports the expansion of HH QRP OASIS data reporting to include data on all patients regardless of payer, which CMS intends to propose in future rulemaking. We agree that this policy would allow for comparisons between care provided to Medicare beneficiaries and other patients. It is also appropriate to align home health data reporting with that of other PAC providers, where all-payer data reporting is already in place or under development.

**Payment of Home Infusion Therapy Services**

CMS seeks comment on the statutory requirement that prior to furnishing home infusion therapy, the physician establishing the plan of care must notify the beneficiary of the options available for infusion therapy, such as treatment at home, in the physician’s office, or in the hospital outpatient department.

AARP believes that decisions about patient care, such as where to receive infusion therapy, should be the result of a dialogue between the physician, patient, and any family caregiver chosen by the patient. In this way the patient (and family caregiver) can have immediate answers to questions that may not be addressed in written materials. Written materials may be a helpful supplement but should not be the sole means of beneficiary notification.

As part of the notification, beneficiaries should be informed about differences in out-of-pocket costs. Beginning in 2021, home infusion therapy is a new Medicare Part B benefit that has the standard 20 percent Part B coinsurance. The dollar amount of beneficiary out-of-pocket costs can vary based on the site of care chosen for treatment due to Medicare payment policy differences. The ordering physician should be aware of the beneficiary’s status with respect to supplemental coverage and therefore able to assist the beneficiary in considering how out-of-pocket costs might be affected by the chosen site for home infusion therapy. It is important for beneficiaries to understand their potential out-of-pocket costs, so they can make informed decisions about their care.

AARP appreciates the opportunity to comment on this important proposed rule and urges CMS to address our comments to improve the final rule for beneficiaries and their family caregivers. If you have questions, please feel free to contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs