August 11, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1730-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

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

Re: Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements

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) in 2021.

Home health care provides critical skilled nursing care, physical and occupational therapy, speech-language pathology services, medical social services, part-time or intermittent home health aide services, and more for Medicare beneficiaries in their own homes rather than a facility setting. Our comments focus on monitoring the impact of the new Patient-Driven Groupings Model (PDGM) that was implemented in 2020; use of technology under the Medicare home health benefit; the home infusion therapy benefit; assessing pain management under the Home Health Quality Reporting Program; and COVID-19 reporting by HHAs.

Monitoring Implementation of the Patient-Driven Groupings Model

Beginning this year, the Centers for Medicare & Medicaid Services (CMS) implemented significant changes to the Medicare home health payment system, which moved to a 30-day unit of service (episode) and revised the case-mix methodology and payment categories by adopting the PDGM, which provides for differing payments based on admission source as well as clinical
characteristics of the patient. These changes have shifted the incentives faced by home health agencies in providing services to Medicare beneficiaries. Acknowledging the change, in the 2020 Home Health PPS final rule, CMS committed to closely monitoring patterns of home health utilization, including changes in the composition of patients receiving the home health benefit and the types and amounts of services they are receiving, as well as any changes in the settings of care.

Because it has the potential to affect whether Medicare beneficiaries receive the home health services they need, AARP continues to believe that it is critical for CMS to closely monitor the impact of Medicare’s changes to home health payment policy on the quality of and access to Medicare home health services in as close to real-time as possible. While we fully understand that the COVID-19 public health emergency has dominated CMS priorities in recent months, this issue should not be left unaddressed and access to these services at home is more important than ever. In particular, we are concerned that under the revised payment system, agencies will focus on serving post-hospital clients for short periods of time and may be discouraged from serving Medicare beneficiaries with longer-term conditions and those who do not have a prior institutional stay. Timely monitoring of the PDGM’s impact will also enable CMS to address any problems in home health access or quality more promptly.

We also urge that CMS should regularly report on utilization patterns and access to care under the PDGM, either as part of the payment rulemaking cycle or separately. Study of beneficiary appeals should also be considered as part of this assessment. Another helpful tool would be to survey Medicare beneficiaries who are using home health services and their family caregivers, as appropriate.

**Use of Technology under the Medicare Home Health Benefit**

The proposed rule would make permanent policies adopted for the COVID-19 public health emergency (85 FR 19247), which provide HHAs with the flexibility to use various types of telecommunications systems -- including remote patient monitoring -- in conjunction with the provision of in-person visits. Under the policy, the patient’s plan of care must include any provision of services furnished via a telecommunications system, the services cannot substitute for a home visit ordered as part of the plan of care, and they cannot be considered a home visit for the purposes of patient eligibility or payment. The use of the technology must be related to the skilled services being furnished by the nurse/therapist/therapy assistant to optimize the services furnished during the home visit. HHAs can report the cost of telecommunications technology as allowable administrative costs.

AARP believes that telecommunications systems can be useful to Medicare beneficiaries and family caregivers when they augment the care already provided by HHAs. We agree that when HHAs furnish services via a telecommunications system, they should not substitute for in-person home health services ordered by a physician under the plan of care and they should not be considered a home health visit for purpose of eligibility or payment. For example, remote patient monitoring should not substitute for appropriate face-to-face visits and is not appropriate for all patients in all situations. However, for home-based Medicare beneficiaries with chronic conditions, limited mobility, and lack of ability to accurately collect and communicate health-
related data, remote patient monitoring can be helpful. It is especially important that beneficiaries who can participate in remote monitoring do so only as a matter of consumer choice.

While we support continuation of these policies regarding the use of technology under the Medicare home health benefit for the duration of the public health emergency, AARP believes that CMS should study the effects of these policies on beneficiary care and program costs before making them permanent. The example offered in the proposed rule describes appropriate use of telecommunications for a patient with COVID-19. However, CMS has acknowledged that the use of telecommunications technology may result in changes to the frequency or types of visits outlined on the plan of care, and applications can extend beyond care of patients with COVID-19.

**Home Infusion Therapy**

Prior to furnishing home infusion therapy to a Medicare beneficiary, the physician who establishes the plan of care must notify the beneficiary of available options for infusion therapy (such as home, physician’s office, hospital outpatient department). The law provides flexibility in determining the form, manner, and frequency for the notification, and CMS previously solicited comments on this issue. Based on those comments, beginning in 2021, CMS is requiring that physicians continue with the current practice of discussing options available for furnishing infusion therapy under Part B and annotating these discussions in their patients’ medical records prior to establishing a home infusion therapy plan of care.

AARP supports this requirement. We believe 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. As part of the required notification regarding home infusion therapy options, beneficiaries should be informed about differences in the amount of out-of-pocket costs, which 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 site chosen 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.

**Home Health Quality Reporting Program: Assessing Pain Management**

In the 2020 Home Health Prospective Payment System final rule, CMS removed the National Quality Forum-endorsed measure on Improvement in Pain Interfering with Activity from the Home Health Quality Reporting Program (HH QRP) beginning in 2022. The related Outcome and Assessment Information Set (OASIS) item will no longer be reported beginning in January 2021. The decision was made out of an abundance of caution to avoid any potential for the measure to inadvertently lead to over-prescribing of opioids. No other current HH QRP measures address pain management.
AARP urges that CMS engage in timely development of new measures for assessing successful pain management as part of the HH QRP. Pain management is an important part of quality care in the home health setting, including for patients with COVID-19 as well as many other conditions. The 2020 final rule requires agencies (aligned with other post-acute care providers) to report on several new OASIS items related to assessment of Pain Interference beginning in 2021. These items assess pain effect on sleep, therapy activities, and day-to-day activities, and are one avenue that could be explored for their potential to form the basis of a new pain management quality measure for the HH QRP.

COVID-19 Reporting

AARP supports increased transparency of COVID-19 cases and deaths in long-term care facilities, and we believe it would serve Medicare beneficiaries and their family caregivers during the public health emergency to provide similar transparency with respect to home health agencies. In the Interim Final Rule issued on May 8, 2020 (85 FR 27601), CMS required that nursing homes must report electronically in a standardized form suspected and confirmed COVID-19 infections and deaths and total deaths to the Centers for Disease Control and Prevention (CDC), at least every week. That information is provided to and made public by CMS.

Home health agency staff make visits to the homes of multiple patients in a day, and it would be reasonable to expect agencies to report to CDC information on COVID-19 cases and deaths among agency patients and staff, similar to nursing homes. These data should be reported electronically in a standardized format and made publicly available in an easy to understand format to assist Medicare beneficiaries and their families in making decisions about their care.

As we have stated with respect to long-term care facilities, we believe that demographic data should be included when reporting COVID-19 cases and deaths, including race and ethnicity. These data provide a clearer picture to help effectively minimize the spread of the virus and to help address the racial and ethnic disparities affecting COVID-19 outcomes for communities of color across the country.

AARP appreciates the opportunity to comment on this important home health services proposed rule and CMS’ consideration of our comments. 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