



9737 Washingtonian Blvd.
Ste. 502
Gaithersburg, MD 20878
August 24, 2020

Seema Verma, MPH 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

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 (CMS-1730-P)

Dear Administrator Verma,

The Association of Home Care Coding and Compliance (AHCC), the national membership organization for home health coding and compliance professionals, together with the Board of Medical Specialty Coding and Compliance (BMSC), the credentialing arm of AHCC, appreciate the opportunity to comment on changes to the Home Health Prospective Payment System as outlined by the Centers for Medicare and Medicaid Services Calendar Year 2021 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirement proposed rule.

COVID-19 Public Health Emergency

In light of COVID-19, it is critical that the federal government provide support to essential health care workers in the home health and community-based settings. This has been shown to reduce use of higher-cost centers of care and reduce hospital admissions and readmissions, which can be instrumental during public health events such as what we have experienced around the country during COVID-19. We urge the government to do more to facilitate the timely manufacturing and distribution of PPE through a process that is transparent, equitable, based on need, and noncompetitive. A streamlined and predictable supply chain must emerge that can last the duration of the pandemic and beyond. Whether that is through further use of the Defense Production Act to coordinate and set nationwide priorities and distribution chains, or enhancing and accelerating current work, action is needed now. Our nation is relying on

health care providers to carry us through this crisis, and they, in turn, are relying on the federal government to equip them to do so.

While we work to address the immediate needs of the health care community, we must also begin preparing for what lies ahead. Social distancing and shelter-in place orders are being lifted, and a wave of patients with deteriorating conditions is coming - due to both forgone care and COVID-related complications. Unfortunately, many health care provider organizations may not survive the crisis. CMS must take steps to ensure the health care workforce survives the crisis physically and financially so it may meet the coming demand. HHAs have been directly impacted by decisions to postpone or cancel elective surgeries, since many of the patients who undergo those surgeries go on to require home health care and/or rehabilitation. Similar to the wave of patients emerging from their homes, HHAs must prepare for the post-COVID-19 surge of postponed acute medical services. Moreover, HHAs are a critical component of the post-acute network of providers for persons most affected by the COVID-19 virus. Those affected are predicted to have a cascade of functional impairments, related both to pre-existing chronic comorbid conditions as well as those associated with the COVID-19 virus. CMS must ensure that enough providers remain solvent throughout the crisis so that they can adequately address the colossal demands facing the health care system once the public health emergency is over. These providers, both small and large, already operating on razor thin margins, are now facing financial ruin. We are concerned about the long-term survival of many of these health care providers and the impact this will have on access to care for the patients they serve.

The coronavirus pandemic highlighted barriers and gaps in the healthcare system. The result was that patients, health systems, payers, and providers had to rapidly adopt or expand models and modes of care delivery to minimize disruptions in care and the risks associated with those disruptions. The expansion of telehealth payment and practice policies during this Public Health Emergency (PHE) have demonstrated that many needs can be effectively met via the use of technology and that patients can have improved access to skilled care by leveraging these resources. Providers who had to rapidly deploy telehealth services in less than ideal situations were still able to support patients and positively impact outcomes. In addition, the HHS Office for Civil Rights (OCR) decision to modify HIPAA enforcement processes has been extremely beneficial mostly due to the flexibilities that permitted the use of more affordable, familiar, and available audio-visual technologies. The sudden termination of these options and resources would unnecessarily interrupt care. The safety of patients, especially older adults, to leave their homes for care is far from certain. It would not make sense, nor would it demonstrate a commitment to supporting patients when and where their needs exist.

The Interim Final Rule (CFS-1744-IFC) added language to 42 CFR §409.43(a)(3) that, during a public health emergency, the home health plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system and such services must be tied to the patient-specific needs as identified in the comprehensive assessment, cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment. While we

appreciate the spirit in which the language addition was made, use of telehealth and other remote services that can augment and improve patient care should not be limited to a public health emergency and should, instead, be viewed by CMS as a routine and often used tool for improving care outcomes during and beyond the public health emergency. Home health agencies should be encouraged to use these types of services to improve communication and interaction with each patient for his/her duration of services. Research has shown that patients are more satisfied with the care they receive when it is augmented in this way. Home health agencies will also be better poised to ensure that, with more communication between visits, patients will be able to stay at home and out of more intensive health settings such as hospitals.

The Association of Home Care Coding and Compliance (AHCC) strongly encourages HHS and CMS to work with Congress to amend the Social Security Act to provide CMS with the statutory authority to permanently extend the policy that allows telehealth services furnished by all clinical disciplines, including physical therapy, in HHAs to be reimbursed under Medicare, as well as make permanent the flexibilities associated with the originating site geography, authorized originating site, and audio-visual technology to allow all Medicare beneficiaries to receive telehealth services from their home, whether that home is in the community or part of an institutional setting. In the meantime, CMS should maintain these policies, which impact a particularly vulnerable population, until an effective COVID-19 vaccine is available and widely deployed in order for Congress to fully consider making such changes permanent.

Furthermore, AHCC is concerned that, despite the flexibilities outlined in the Interim Final Rule, agencies that choose to supplement patient care with technology such as Remote Patient Monitoring, two way audio-video communications and other telehealth solutions, may be at risk. This risk stems from the concern which CMS and OIG have both expressed that agencies will provide extra, medically unnecessary, visits to reach or exceed the LUPA threshold. This concern runs counter to both the guidance contained in the Interim Final Rule and the recognition that reducing patient exposure to staff is an important measure in responding to COVID-19.

In light of the COVID-19 Pandemic, CMS and OIG should expect more episodes to be near the LUPA threshold. This is not a factor of agencies performing unnecessary visits to meet or exceed the LUPA threshold, but rather it is the result of agencies reducing visits to keep patients safe from COVID-19 through the use of telehealth. Patients have, since March, expressed significant concern about the risks of COVID-19. This has led to many patients simply refusing care. It has also led many HHAs to utilize telehealth/technology to maintain patient care while reducing patient contact. The use of technology to reduce patient contact was specifically approved by CMS in the Interim Final Rule. CMS' and OIG failing to recognize the decline in visits resulting not only from COVID, but also from Medicare Beneficiaries' continuing concerns about their safety even after the PHE, is fundamentally unfair to home health agencies and put patients at risk, by undermining agencies ability to rely upon the Interim Final Rule's guidance regarding utilizing telehealth to reduce patient contact. AHCC strongly

encourages CMS to recognize the impact of COVID-19 on patient care, the resulting decline in visits and to revise its assumption about behaviors related to LUPAs.

The Use of Technology under the Medicare Home Health Benefit

The Association of Home Care Coding and Compliance (AHCC) supports CMS' proposal to make permanent the new flexibilities provided by the COVID-19 PHE Interim Final Rule with Comment Period (85 FR 19230), allowing the use of telecommunications technology included as part of the home health plan of care as long as the use of such technology does not substitute for in-person visits. The AHCC also supports CMS' proposal to allow a broader use of telecommunications technology to be reported as an allowable administrative cost on the cost report. However, because these services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment, the new flexibilities stop short of enabling HHAs to fully address the needs of the millions of Medicare beneficiaries they serve.

The COVID-19 pandemic has highlighted areas of the American health care system that clearly need modernization. Many services can be safely and effectively delivered remotely. Policy and payment systems should encourage their use. At the same time, enforcement and fraud prevention systems shouldn't discourage their use. When these services, and the technology being used to deliver them, are not reimbursed, providing them becomes administratively and financially infeasible. This forces providers to risk their own safety and the safety of their patients. While many services can and should only be delivered in person, AHCC strongly encourages CMS to work with Congress to amend Social Security Act Section 1895(e)(1)(A) to allow payment for services furnished via a telecommunications system when those services substitute for in-person home health services ordered as part of a plan of care.

CY 2021 Home Health PPS Rate Update

The Association of Home Care Coding and Compliance (AHCC) supports CMS' proposal to increase aggregate payments in CY 2021 but advises CMS to implement a greater increase than 2.6%. The COVID-19 pandemic has demonstrated the critical need for increased availability of quality medical care delivered in the patient's home. It has also greatly increased the demands on the home health industry, while simultaneously leading to a significant decline in agency revenue. This combination has placed a significant financial strain on the industry which may lead to a reduction in the availability home health services as agencies reach the breaking point. This strain is further exacerbated, by the fact that one of the key components of the industry's response to the Public Health Emergency, the use of technology to provide care, when appropriate, cannot be reimbursed due to the limits set forth in the SSA. This means that the industry will need a larger aggregate increase in payments or other financial support to survive.

Patients are safest at home during a pandemic, and home health providers risk their own safety to ensure that these patients continue to receive quality care with minimum exposure. HHAs and the providers they employ should be adequately reimbursed. AHCC is advocating that CMS consider additional financial relief for the HHA. AHCC understands the limits placed upon CMS

due to the requirements of rate setting. For that reason, AHCC requests that CMS consider another distribution of CARES Act funds that is focused on additional support for the home health industry.

Standardize Data Submission and Requirements for Medical Review

The Association of Home Care Coding and Compliance (AHCC) also encourages CMS to take action to relieve unnecessary administrative burden. Too often, CMS promulgates multiple systems, with varying billing, documentation, and other requirements, causing practitioners to spend as much time on compliance as they do on treating patients. For instance, there is significant inconsistency between CMS and Medicare Advantage (MA) plans' requirements when conducting medical review. When submitting documentation in response to an Additional Documentation Request (ADR), providers must use one process for Original Medicare, a different process for MA insurer #1, yet another process for MA insurer #2, and so forth. If the CMS contractor or MA insurer uses a website for electronic submission, the provider must log into a different portal for each payer. Making the process even more complex is the burden on the provider to locate the data submission location page for each MA insurer and CMS contractor. Even then, when on the submission page, the process is not consistent from one insurer to the next. In fact, we are aware of at least one MA insurer that refuses to allow electronic submission, requiring providers to fax the ADR. To decrease burden and substantially increase compliance and interoperability, The AHCC recommends that CMS recognize the value of standardizing the submission of data to all Medicare contractors, as well as to MA insurers. This feature alone would increase interoperability, allowing for data to be standardized, pulled, and submitted directly from the EHR, while also decreasing provider burden. At a minimum, there should be a ceiling on the number of varying data submission processes.

Again, we appreciate the opportunity to comment on the proposed rule. We hope you will consider our concerns before moving forward with plans to roll out the PDGM as currently proposed.

Sincerely,

The Association of Home Care Coding and Compliance



Jan Milliman, HCS-D

Chief Executive Officer

Association of Home Care Coding and Compliance

The Board of Medical Specialty Coding & Compliance (BMSC)