



August 24, 2020

Submitted via regulations.gov

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: CMS-1730-P: 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:

The Partnership for Quality Home Healthcare ("PQHH" or the "Partnership") appreciates the opportunity to submit comments on the CY 2021 Home Health Prospective Payment System ("HH PPS") Proposed Rule published at 85 *Federal Register* 39408 on June 30, 2020 (the "Proposed Rule"). We submit the following comments to offer constructive feedback and recommendations that we believe will help avoid disruptions in patient care so that Medicare beneficiaries will continue to have access to skilled home health services. In addition, we offer comments regarding the impact that COVID-19 has had on patient care and needs in the home.

As a national coalition of skilled home healthcare providers, we appreciate the fact that the Centers for Medicare & Medicaid Services ("CMS") has consistently recognized the value and quality that the Medicare home health benefit provides to patients, as well as the value it creates for the Medicare program as a lower cost setting for patients to receive high quality skilled care. As professionals dedicated to ensuring the quality, efficiency, and integrity of the Medicare home health benefit for homebound seniors and disabled Americans, we want to offer our expertise in ways to improve the implementation of CMS's significant new payment reform, the Patient Driven Groupings Model. As you know, the Partnership spent considerable time analyzing and seeking policy improvements to PDGM to ensure that it would prove to be successful. It is important that any improvements to PDGM ensure continued access to the highly valued home health benefit through continued refinement and growth that allows more patients to be cared for in their home as an alternative to institutional services, which in turn results in savings to the Medicare program.

In particular, COVID-19 has changed the delivery of services, highlighted that home health is a preferred site of services for post-acute care, as well as yielded certain changes to regulatory and legal requirements which are showing successes in addressing the needs of vulnerable Medicare patients. We appreciate CMS's leadership in reducing certain burdens, such as the homebound requirement and face-to-face requirements, while enhancing efforts with telemedicine and telecommunication issues. We encourage CMS to consider the value of these changes for the future, as well as the present.

In addition, we urge CMS to evaluate the impact COVID-19 has had on the new home health payment system and the system at large, particularly with respect to changes in utilization, volume and services provided to patients. We urge CMS to carefully examine the analysis that we have presented regarding the original behavioral assumptions of provider behaviors in the new payment system. The data we have included in our comments indicates that in large part, these behaviors have in fact, not occurred. As a result, we encourage CMS to thoughtfully reassess issues, such as budget neutrality, behavioral assumptions, and quality, until we all better understand what the present and future holds in delivery of care to Medicare beneficiaries.

We are commenting on several important provisions in this Proposed Rule. We urge CMS to review and incorporate these important recommendations before finalizing the rule.

Our primary concerns relate to the Patient Driven Groupings Model ("PDGM"), including assumptions (actuarial and behavioral) used in developing the payment rate. In addition, we have expressed support for continuing regulatory changes, including telehealth, that have been implemented during the Public Health Emergency ("PHE").

## **I. Budget Neutrality/Patient Driven Groupings Implementation/Rates/Behavioral Assumptions**

### **A. Patient Driven Groupings Model - Behavioral Adjustments/Budget Neutrality**

In the CY 2019 HH PPS final rule, CMS finalized the PDGM, which shifts the focus of payments away from the volume of services provided toward patients' clinical characteristics. The new payment system requires that the system be developed to be budget neutral, taking into account updated rates and growth in anticipated utilization. Budget neutrality has been supposedly achieved by offsetting the anticipated spending increases with rate reductions based on "presumed behavioral assumptions" related to PDGM and case-mix. Based on current Medicare 2020 claims data where 2.6 million 30-day PDGM episodes<sup>1</sup> were evaluated, it is clear that these assumptions are not actually what has occurred.

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<sup>1</sup> Similar to the attached report, we refer to the terms "30-day PDGM episode" and "case" interchangeably.

Over the past several rulemaking cycles, the Partnership has provided comments and recommendations to improve the model and raised concerns regarding the behavioral adjustments that CMS has applied in establishing payments under the system. While recognizing that assumptions are not based on actual data, we appreciate the modification of the reduction in the CY 2020 final rule. However, we continue to have concerns about transparency and the need for continued assumption-based rate reductions at a time when home health providers are facing challenges and the data from the first four months of 2020 clearly does not support the underlying assumptions used by CMS and the Office of the Actuary in attempting to establish budget neutral rates.

In establishing new payment rates under the HH PPS for CY 2020, CMS made three major behavioral assumptions in predicting how home health agencies (“HHAs”) would respond to the new PDGM framework. As noted in our comments to last year’s CY 2020 proposed HH PPS rule, these behavioral assumptions lack evidence and justification, remove too much funding from the payment system, and therefore, do not result in budget neutral payments.

In the final CY 2020 rule, CMS indicated that it planned to review data from CY 2020 to inform the CY 2021 rulemaking to determine if any change to the behavior assumption adjustment percentage should be proposed. In the proposed CY 2021 rule, CMS has proposed to maintain the 4.36 percent reduction, but has not provided any evidence that the reductions are in fact necessary to achieve budget neutrality. Instead, the proposal indicates it would be premature to release any information related to these issues based on the amount of data currently available and in light of the current PHE and the COVID-19 pandemic outbreak.

As a result, the proposed rule continues the assumptions and is proposing no additional changes to the national, standardized 30-day payment rate other than the routine rate updates. CMS indicates its intent to determine in future rulemaking whether any changes need to be made to the national, standardized 30-day payment rate based on the analysis of the actual versus assumed behavior change.

However, given home health providers’ significant concerns with this adjustment, PQHH has commissioned Dobson | DaVanzo & Associates to examine 2020 Medicare claims data that included 2.6 million 30-day PDGM episodes. Their analysis and findings from the first half of 2020 cast significant doubt regarding the accuracy of these behavioral adjustments being applied going forward, as discussed in detail below and in the attached report.<sup>2</sup> The Partnership believes these findings, which are based on actual Medicare claims data from the first four months of CY 2020, provide justification for CMS to discard any previous CMS theoretical assumptions and projections of providers’ behavioral response to PDGM, and provide more than a sufficient basis to remove the -4.36 percent behavioral adjustment for CY 2021. CMS can then collect the information and data it needs to determine an empirically based adjustment, if appropriate.

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<sup>2</sup> See Exhibit A

## **B. CMS Behavioral Assumptions**

CMS identified three behavioral assumptions that could occur as a result of the implementation of PDGM in CY 2020: (1) clinical group coding – HHAs will change their documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code; (2) comorbidity coding – HHAs will further adjust payments based on patients' secondary diagnoses; and (3) low-utilization payment adjustment ("LUPA") threshold – HHAs will provide additional visits in order to meet the LUPA threshold and obtain a full episode payment. Applying the aforementioned behavioral assumptions, CMS proposed a behavioral adjustment of -8.01 percent for CY 2020 payments. However, in the final rule for CY 2020, CMS applied a lower adjustment of -4.36 percent.

On clinical group coding, CMS had previously asserted in the CY 2020 proposed rule that HHAs would likely change their documentation and coding practices in 100 percent of the cases where opportunities are present, and put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group. CMS assumed that when there are available secondary diagnoses that would produce a higher reimbursement if placed in the primary diagnosis field under the PDGM, home health providers would choose the higher-paying code, 100 percent of the time, an assumption we completely disagreed with and commented on previously. As the Partnership has noted in past comments, CMS has still not provided any evidence or the actuarial data to support this coding behavior in the context of PDGM, and has said that in some instances, it is appropriate to bill the secondary coding as primary. In addition, this practice runs counter to clinical coding guidelines and common practice of coding, which are to ensure that the documentation contained in the patient's record supports the coding. While not transparent, CMS appears to have somewhat modified this assumption in the CY 2020 Final rule, however, it continues to have a significant and unjustified downward impact on payments.

On the behavioral assumption related to LUPAs, CMS assumes that in one-third of instances when a case is one or two visits away from the LUPA threshold, HHAs will provide an additional extra visit(s) solely in order to receive a full 30-day episode payment. CMS has not provided support for this assumption with any solid data or evidence. LUPAs are not a new feature of the payment system under PDGM. Prior to CY 2020, the HH PPS had a single LUPA threshold for all cases. However, under the PDGM, the LUPA threshold ranges from 2–6 visits depending on the case-mix group assignment for a particular period of care, and the LUPA thresholds correspond to the 432 case-mix groups under the PDGM. It remains unclear why CMS believes provider behavior with respect to LUPAs will be so different under PDGM.

As explained above, CMS' behavioral assumptions are based on "assumed" provider behavior under PDGM without any empirical or actuarial information to support them. Now that actual data exists for CY 2020 under PDGM those assumptions must be evaluated against that data. The analysis conducted by Dobson | DaVanzo provides critical information on the operation of PDGM and calls into question key assumptions made by CMS.

### **C. Analysis of Behavioral Assumptions under PDGM**

In order to understand whether the behavioral assumptions made by CMS were evidenced by CY 2020 data, Dobson | DaVanzo compared outputs from CY 2020 claims and the rate setting files issued by CMS with the CY 2020 HH PPS Final Rule. The CY 2020 data presented in this analysis covers January 1 through April 30 of 2020. While including only four months of data in CY 2020, the data comprises over 2.6 million cases and thus serves as a statistically representative sample; payment levels have been adjusted for claims run-out. The rulemaking files used 2018 claims and OASIS data and included both unadjusted and ‘behaviorally adjusted’ estimates for case-mix groups, payments, and LUPAs.

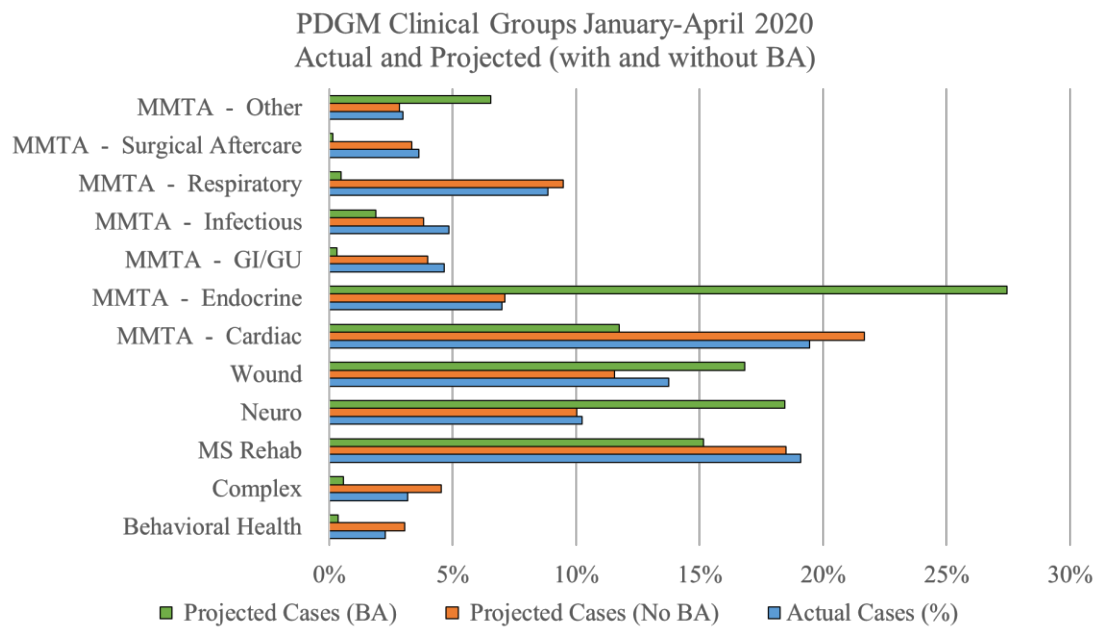
As noted above, the CY 2020 Final Rule described three behavioral assumptions as the basis for prospectively reducing the HH PPS payments. These are that: (1) in a significant portion of the cases where a higher paying secondary code exists, providers would submit claims such that the highest paying clinical group diagnostic code reported anywhere on the claim would be chosen for the primary diagnosis code; (2) In one-third of cases within 1-2 visits of the LUPA threshold, providers would deliver enough additional visits to become fully paid episodes, and (3) A portion of cases would have additional comorbidities reported that were also reported elsewhere in that beneficiary’s HH claims or OASIS data.

Based on an analysis of the available and actual CY 2020 claims data, home health provider’s actual behaviors are inconsistent with two of the three behavioral assumptions described by CMS in the CY 2020 HH PPS final rule as the basis for their estimate and justification for the prospective reduction to home health payments to ensure budget neutrality. To amplify this point, 2020 actual data confirms that the bulk of assumptions that were the basis of the 4.36 percent rate reduction were wrong. Specifically, the two areas where the CY 2020 actual data did not align with CMS’ assumptions (Clinical Group Coding and LUPAs) comprise most of the downward adjustment that CMS applied. Highlights of this analysis are summarized below and, as noted above, a complete report is attached to our comment letter.

As shown in Figure 1 below, case-mix groupings reflect historical trends of primary diagnoses from prior to the implementation of PDGM and not payment-optimized groupings as CMS had assumed in making downward adjustments to HH payments. This behavioral assumption resulted in the largest portion of the base reduction applied to HH payments by far.

**FIGURE 1**

*2020 Clinical Groups are Much More Similar to Unadjusted Projections than Behaviorally Adjusted Ones; This Suggests Clinical Category Behavioral Assumption Largely Has not Happened*



**Dobson | DaVanzo**  
HEALTH ECONOMICS CONSULTING

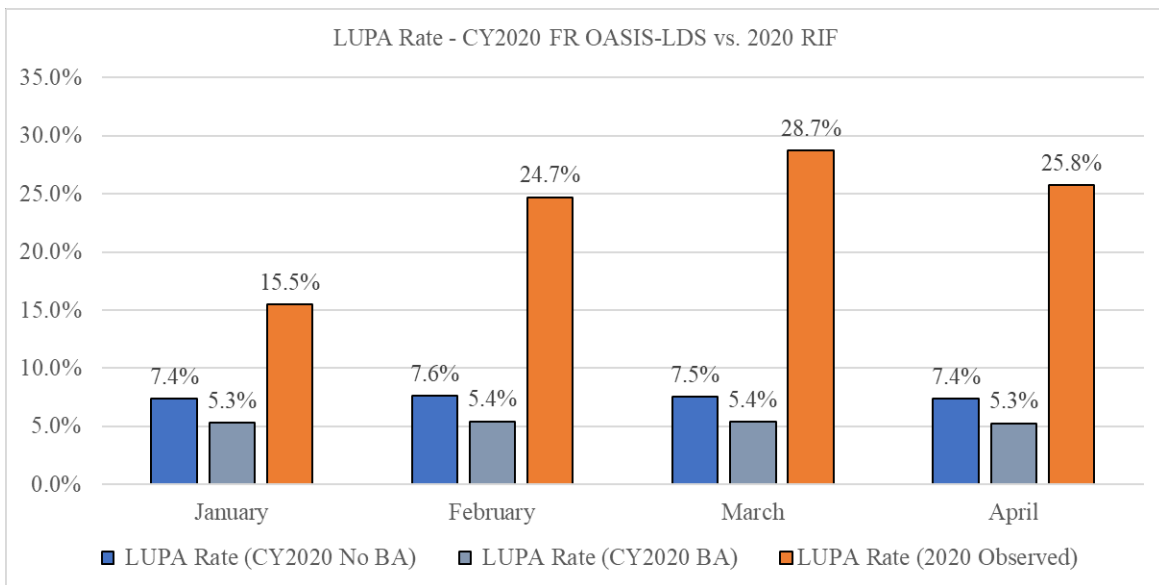
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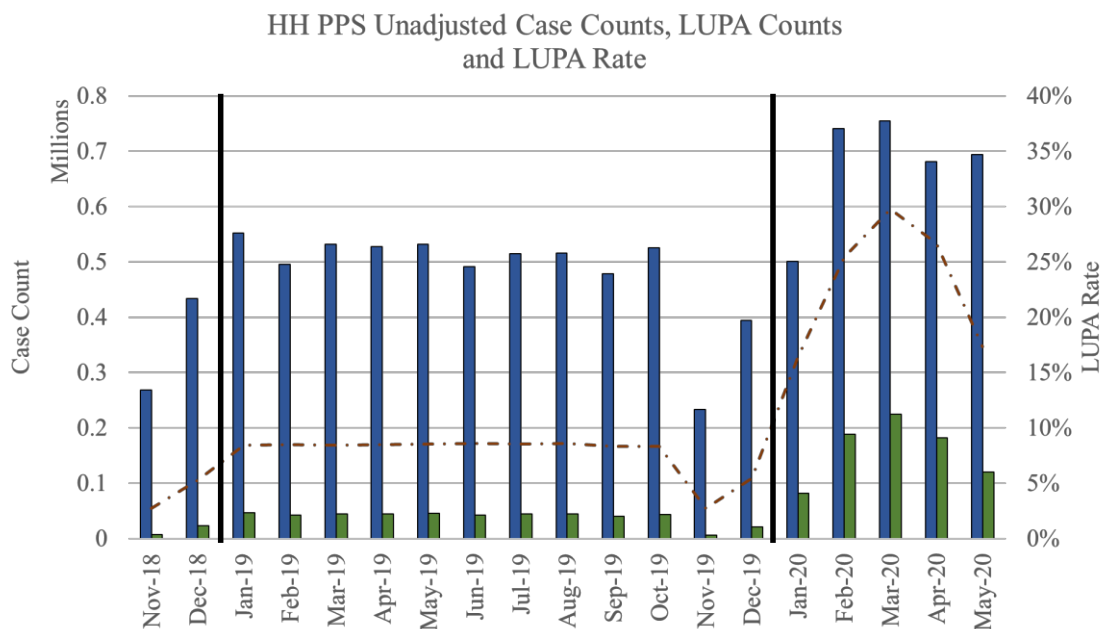
Source: Dobson DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

In addition, the overall number of LUPAs is much higher under PDGM, rather than lower as CMS had assumed. As shown in Figure 2 below, the number of LUPAs actually increased upon implementation of PDGM for several months before moderating in April and May. This assumption represented the second most significant reduction to HH payments.

**FIGURE 2**



## Unadjusted Case Counts and LUPAs, November 2018 – May 2020

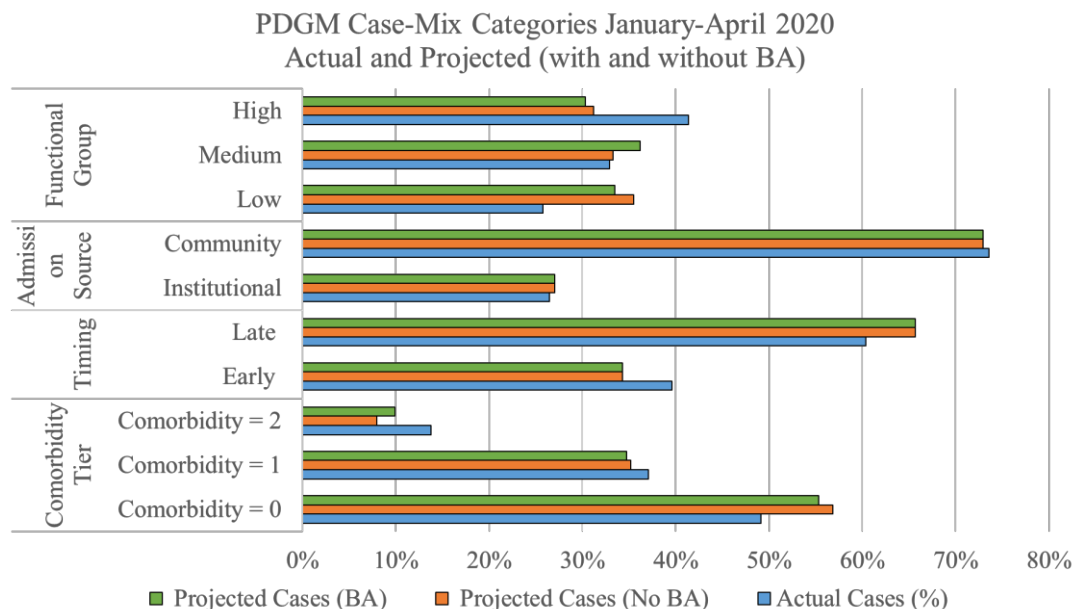
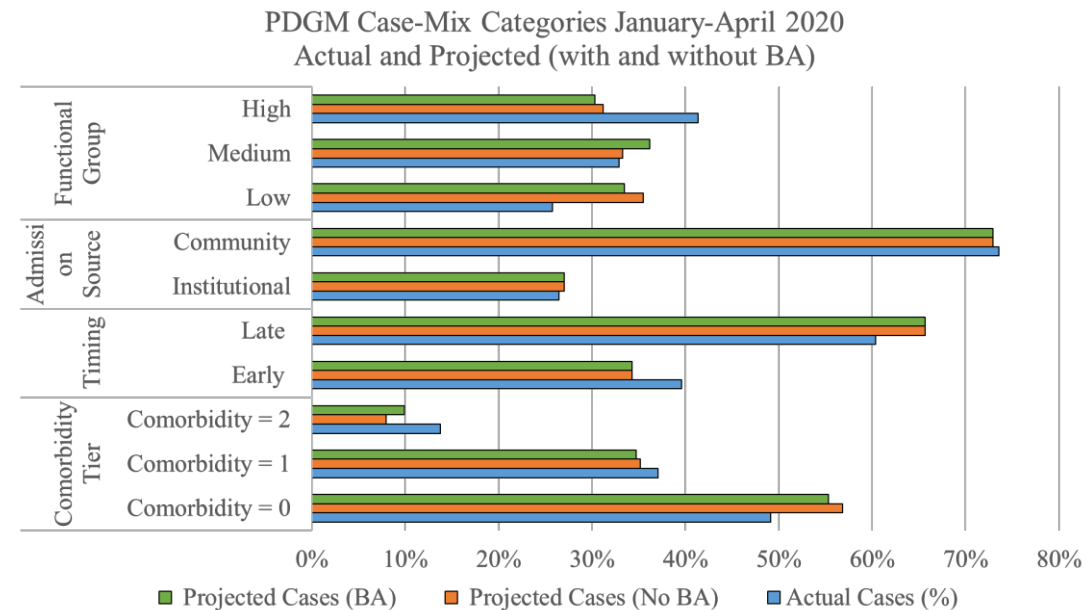


While by far the smallest of the three behavioral adjustments in terms of effect on HH payments, comorbidity and functional group scores are somewhat higher than anticipated, as shown in Figure 3 below. This may, in part relate to CMS assumptions regarding improved coding under PDGM but the apparent increase in case-mix severity shown in the data could also relate to the overall reduction in volume of home health services that accompanied the onset of the COVID-19 pandemic. That is, some beneficiaries were unable to have elective surgeries or simply decided not to receive care in the home in order to self-isolate and thus did not receive home health care, however, more severe cases could not avoid such care. The analysis (Table 1) shows that total volume of high comorbidity and functional need patients is relatively consistent indicating that demand for HH services may be more stable among this group.



**FIGURE 3**

*2020 Case-Mix Indicates Higher Functional Group, Comorbidity Tiers than Projections; this Could Be Behavioral Adjustment or a Natural Response to COVID-19 (e.g. higher need cases may have less elastic care needs)*



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

**TABLE 1**

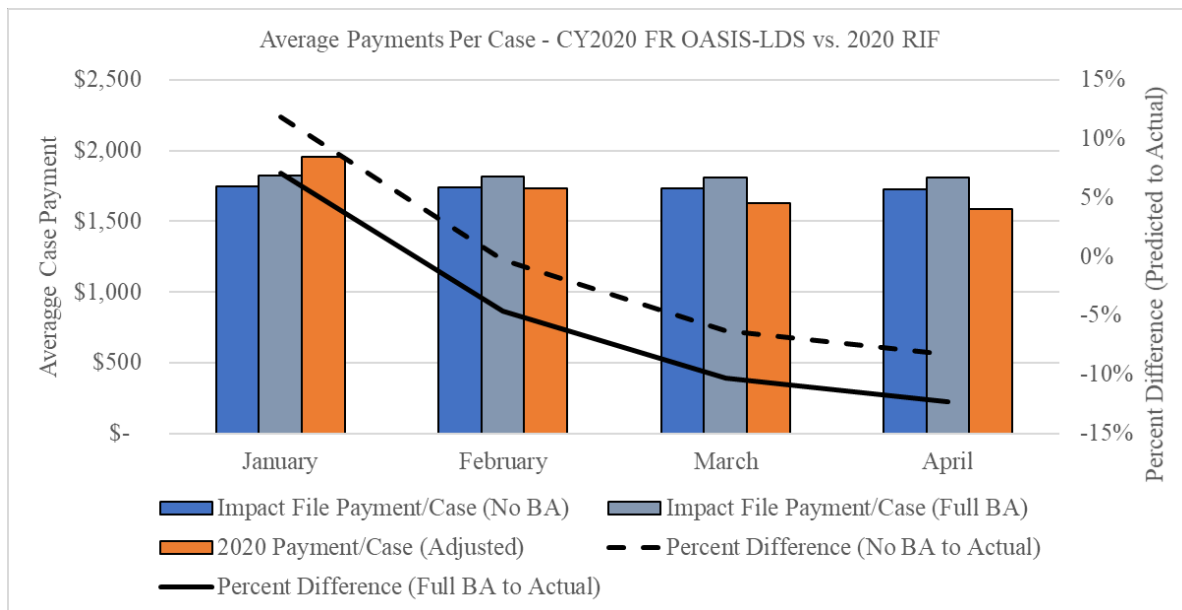
Category	Item	Case Count (Actual)	Case Count (CY20 Impact File, No BA)	Percent Change (Predicted to Actual)	Case Count (CY20 Impact File, BA)	Percent Change (Predicted to Actual)
PQGM	Grouped	2,661,190	4,058,066	-34%	4,058,066	-34%
Comorbidity Tier	Comorbidity = 0	1,307,741	2,306,130	-43%	2,244,762	-42%
	Comorbidity = 1	986,257	1,427,918	-31%	1,409,471	-30%
	Comorbidity = 2	367,192	324,018	13%	403,833	-9%
Timing	Early	1,054,050	1,392,738	-24%	1,392,738	-24%
	Late	1,607,140	2,665,328	-40%	2,665,328	-40%
Admission Source	Institutional	704,067	1,097,377	-36%	1,097,377	-36%
	Community	1,957,123	2,960,689	-34%	2,960,689	-34%
Functional Group	Low	685,887	1,440,013	-52%	1,358,355	-50%
	Medium	874,956	1,351,420	-35%	1,469,379	-40%
	High	1,100,347	1,266,633	-13%	1,230,332	-11%

Source: Dobson / DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

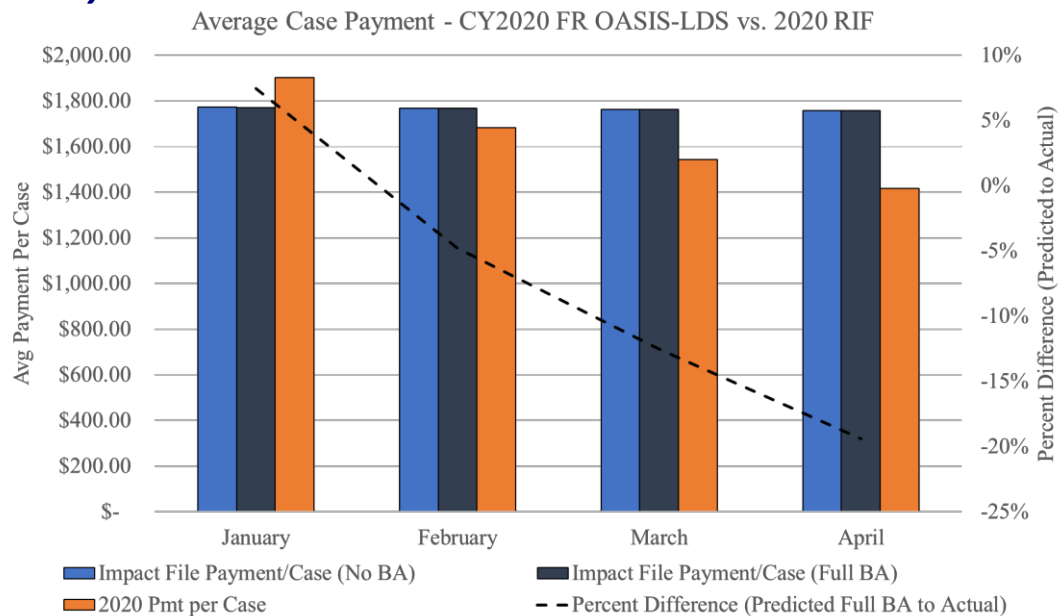
#### **D. Impact of Behavioral Adjustments on Providers and Patients**

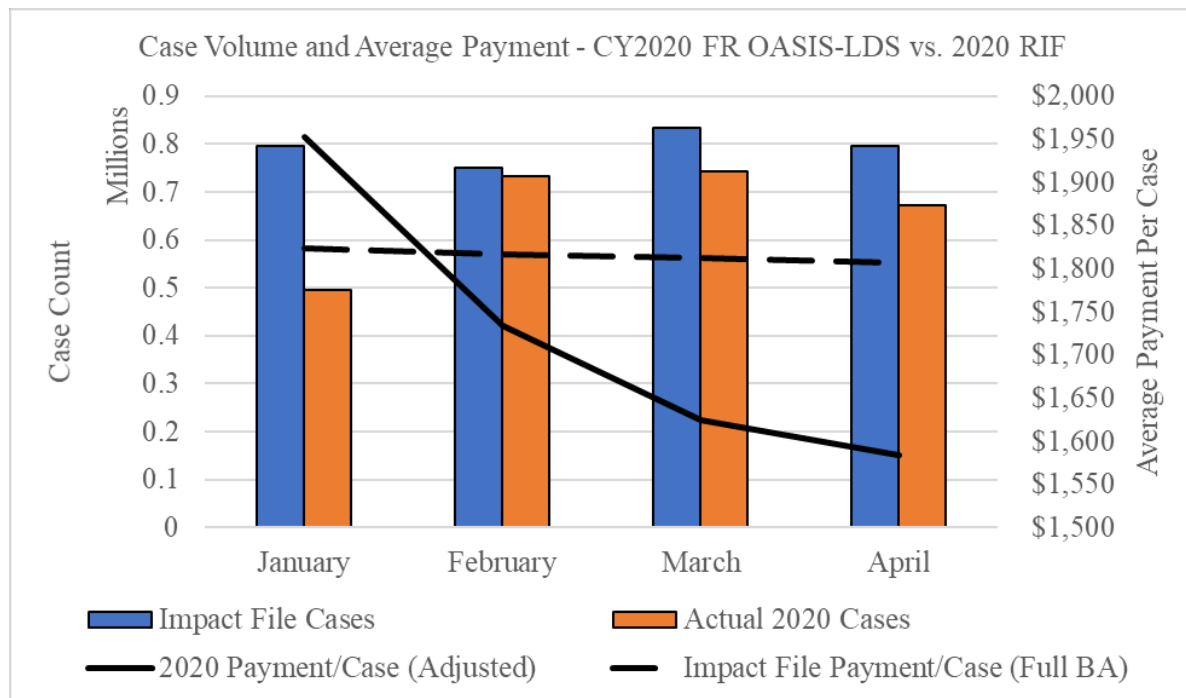
The proposed -4.36 behavioral adjustment to HH payments for CY 2021 is excessive. Home health providers already face enormous challenges in delivering care to patients as the significant financial and clinical impact of the COVID-19 pandemic continues to affect our nation and health system. While we hope that as a nation, we will move past this public health crisis, the challenges for home health and other providers are likely to remain well into 2021.

Home health providers currently face higher costs related to personal protective equipment, infection control, staffing, training, and overall care delivery. As shown in Figure 4 below, average home health payments per case have gone down steadily in CY 2020 due to both the implementation of PDGM and the impact of COVID-19 pandemic. Volume has also decreased by 13% in March and April following state-level shutdowns, leading to fewer elective surgeries and some patients desiring to avoid interaction with the health system. These effects threaten both delivery of care in the short term, particularly in rural areas, and the long term sustainability of the home health benefit if providers are forced to close locations as in other sectors of the economy.

**FIGURE 4**

## Projected (CY2020 Rulemaking, with & without BA) vs. Observed Average Case Payments





Source: Dobson / DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

At a time of such enormous challenges, the Partnership and all of our state and national home health partners understand that this reduction will cause harm to Medicare beneficiaries and instability in the home health delivery system. Most importantly, these behavioral adjustments, which are not supported by data, deprive providers of the very resources needed to furnish high quality care and act to limit the provision of home health care at a time when patients need it the most and the Medicare program should be encouraging its use.

#### E. Establishing Home Health Payment Amounts for CY 2021

The CY 2021 proposed rule outlines various requirements in the law with respect to the establishment of HH payments under the PPS. Section 1895(b)(3)(A) of the Social Security Act (the Act) requires the Secretary to calculate a standard prospective payment amount (or amounts) for the 12-month period beginning January 1, 2020, in a budget neutral manner. The law also requires that in calculating these amounts, the Secretary must make assumptions about behavior changes that could occur as a result of the 30 day unit of payment and case-mix adjustment factors associated with PDGM (1895(b)(4)(B) of the Act). Finally, Section 1895(b)(3)(D)(i) of the Act requires the Secretary to annually determine the impact of differences between assumed behavior changes as described in section 1895(b)(3)(A)(iv) of the Act, and actual behavior changes on estimated aggregate expenditures under the HH PPS with respect to years beginning with 2020 and ending with 2026.

The Partnership continues to be concerned that CMS has failed to provide any data or evidence to support these behavioral assumptions and has chosen not to consider the available data for CY 2020 which, as demonstrated above, raises significant concerns regarding the accuracy of the assumptions that CMS has made. In the CY 2020 HH PPS Final Rule, CMS committed to doing such an evaluation, saying “we will review data from CY 2020 to inform next year’s rulemaking to determine if any change to the behavior assumption adjustment percentage should be proposed in CY 2021”. However, in the proposed rule for CY 2021, CMS has offered no real explanation for not evaluating the data and making the determination required by law other than to say “it would be premature to release any information related to these issues based on the amount of data currently available and in light of the current public health emergency resulting from the COVID–19 pandemic outbreak.” CMS indicates it will continue to monitor this area and expects to address the issue in future rulemaking.

CMS’ position in the proposed rule also raises several policy concerns for the Partnership and its members. First, CMS and its Office of the Actuary have chosen to continue to rely on pre-PDGM theoretical assumptions rather than actual data and evidence from CY 2020 and the PDGM implementation period before applying a behavioral adjustment, as the law permits. It is not logical for CMS to require a robust data base to modify or eliminate the current adjustment when it applied the reduction based on scant information in the first place. Now we have partial 2020 actual data, which raises significant questions regarding the accuracy of the behavioral assumptions.

In addition, CMS’ position suggests that the continuing existence of the public health emergency and COVID-19 pandemic provides a basis for CMS to not re-examine its determination of the behavioral adjustments and budget neutrality, again, despite evidence which calls into question their accuracy. The Partnership believes the opposite is true, particularly given the COVID-19 related challenges faced by providers that are expected to continue well into CY 2021. While it is clear that COVID-19 has had an impact on the health system and the data, including for home health care, the data is still the data and nothing in the law directs CMS to continue to apply an adjustment that is not accurate for another full year. A better and more sound policy would be to eliminate downward adjustments that are not supported by data and have adverse consequences for patients and providers, particularly during the public health emergency.

CMS has the authority to eliminate the behavioral adjustments for CY 2021 and delay their future implementation until sufficient data justifying their application is compiled. The current reductions are excessive and do not support a budget neutral implementation of PDGM based on our analysis CY 2020 data to date. The Partnership acknowledges CMS’ responsibility under the law to evaluate of budget neutrality, however, the law does not require a 4.36 percent reduction that is based on theoretical assumptions. Furthermore, while the law does require budget neutrality, it also allows for achieving that over a longer period of time based on actual data in contrast to theoretical assumptions that appear to be questionable at best based on more recent information and data.

Partnership Recommendations: The 4.36 percent reduction in effect for CY 2020 and proposed for CY 2021 results in financial hardship for providers and has adverse consequences for patient access and quality of care. The Partnership encourages CMS to restore this reduction for CY 2021 and take the time to obtain actual evidence relating to what, if any, behavioral changes may be occurring that may lead to increased costs for the Medicare program. While budget neutrality is required under law, the law doesn't call for savings to come from behavioral changes. We urge CMS to increase the 2021 rate to reflect the restoration of the behavioral adjustment reduction.

Based on the data and analysis, discussed above and more fully in the attached report, the Partnership further recommends that CMS discontinue discontinuation of the Behavioral Adjustments for the rest of CY 2020.

## **II. Public Health Emergency Issues including Telecommunications Technology and Homebound Status**

### **A. Telecommunications Technologies in Home Health<sup>3</sup>**

Many HHAs have invested heavily in technologies that support remote care delivery, starting long before the current public health emergency. In 2020, HHAs worked quickly to expand their virtual care capabilities in order to continue to care for patients who suddenly could not receive in-person care and to reduce the risk of spreading COVID-19. The Partnership thanks CMS for acknowledging how technology can expand the reach of healthcare into the home, through consultation with specialized clinicians and critical care teams, as well as through the integration of devices designed to increase patient involvement and compliance. As CMS has noted, incorporating various forms of technology, in addition to remote patient monitoring, can be appropriate in furnishing home health services when used in conjunction with the provision of in-person visits.

The Partnership commends CMS for offering regulatory flexibilities to HHAs to help maintain the health and safety of patients and caregivers and facilitate care delivery during the current public health emergency and beyond. The clarifications and flexibilities offered related to use of telecommunications technologies have enabled providers to remotely monitor and care for patients while minimizing the patient and caregiver risk for COVID transmission and also serve to promote caregiver efficiency and cost-effectiveness.

HHAs, like other providers, should be able to readily access technologies to make care delivery more efficient and flexible to meet patients' care needs. Although HHAs currently have the flexibility to provide telecommunications visits and perform remote monitoring, CMS noted in the rule that payment for home health services remains contingent on the furnishing of an in-person visit. While the Partnership believes that CMS should revisit this restriction, particularly under a PHE, we nevertheless appreciate the Agency's strong support for the use of telecommunications technology in home health and its recognition of current policy. We

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<sup>3</sup> 42 C.F.R. §§ 409.43(a), 409.46(e)

encourage CMS to work with the Partnership to explore expanded use of telecommunications technologies to benefit patients in the home. This is a policy change that will create efficiencies in the home health system and benefit patients.

CMS solicits comments on its proposal to finalize the amendments outlined in the first COVID-19 PHE Interim Final Rule (“IFC”)<sup>4</sup> to: 1) allow the use of telecommunications technology to be included as part of the home health plan of care as long as the use of such technology does not substitute for ordered in-person visits; and 2) broader use of telecommunications technology to be reported as an allowable administrative cost on the home health agency cost report. We respond to these specific proposals below.

*a. Use of telecommunications technology as part of the home health plan of care*

CMS proposes to permanently finalize changes to “plan of care requirements”<sup>5</sup> that acknowledge the role of “remote patient monitoring or other services furnished via a telecommunications system” in the provision of home health care. The Partnership appreciates CMS’s effort to support home health agencies’ continued use of telecommunications technologies in providing care to beneficiaries under the Medicare home health benefit beyond the COVID-19 PHE. CMS’s proposed regulatory text specifies that the plan of care must include “[a]ny provision of remote patient monitoring or other services furnished via a telecommunications system.” We are concerned that the word “any” could place unnecessary limits on the availability of such services for patients. Absent reference to technology in an individual patient’s plan of care, it is possible that a monitoring service, for example, could improve quality of care for a specific patient. Amending a plan of care to require inclusion of “any” technology-based intervention would be more burdensome than what was required prior to the PHE. In attempting to clarify that technologies can be used by home health agencies to serve patients, CMS’s proposed regulatory text may make it harder for these services to be used for patients whose plan of care does not mention them specifically.

The Proposed Rule further specifies that remote patient monitoring or other services furnished via a telecommunications system 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. We acknowledge that virtual services cannot always substitute for in person care. We appreciate CMS’s acknowledgement that, while use of technology may not substitute for an in-person home visit that is ordered on the plan of care and cannot be considered a visit for the purpose of patient eligibility or payment, the use of technology may result in changes to the frequencies and types of in-person visits as ordered on the plan of care. During the PHE, we have seen a shift towards greater use of virtual care even as in-person visits continue to play a critical role in care delivery.

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<sup>4</sup> 85 Fed. Reg. 1923 (Apr. 6, 2020)

<sup>5</sup> 42 C.F.R. § 409.43(a)



*b. Reporting telecommunications technology costs on cost reports.*

CMS is also proposing to allow HHAs to continue to report the costs of telecommunications technology as allowable administrative costs on the home health agency cost report beyond the PHE for the COVID-19 pandemic. Specifically, CMS proposes to revise 42 C.F.R. § 409.46 to specify that “[t]he costs of any equipment, set-up, and service related to the technology are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the technology, without the provision of a skilled service, are not separately billable.” The proposed regulatory text at section 409.46 also describes “Telecommunications technology” as including “remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY) technology; and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician.”

This proposal clarifies that HHAs may only account for virtual care – including 2-way audio-video real-time interaction between the patient and clinician that would be separately billable as Medicare-covered telehealth services in other settings – as administrative costs.

The Partnership supports CMS’s proposal to modify instructions regarding line 5 on the cost report to reflect a broader use of telecommunications technology. However, characterizing the use of this technology as purely administrative discounts its significant value to patient care. CMS’s proposal will allow HHAs to invest in telecommunications systems and remote monitoring tools, and will allow CMS to track these investments as administrative costs. We note, however, that this proposal does not acknowledge the way in which HHAs deploy these technologies and interventions to deliver care.

As noted elsewhere in these comments, claims data do not capture the use of virtual care within home health. We have seen a significant rise in LUPA rates, which has a negative impact on HHA payments, but limited data is available to demonstrate HHAs’ corresponding increased use of virtual care to improve quality of care for patients. While the use of technology is not a substitute for the provision of in-person visits, the Partnership believes CMS should continue to consider options for acknowledging telecommunications technology use by HHAs as more than an administrative expense.

*c. Use of Telehealth for Face-to-Face Encounter*

To further leverage the rapid expansion of use of telecommunications technology during 2020, the Partnership recommends that CMS also permanently extend its policy to allow home health face-to-face encounters to be furnished via telehealth. Allowing physicians to complete the face-to-face visit required for home health certification has been extremely helpful in supporting patient access to skilled services in the home during the PHE, and we encourage CMS to continue the policy under the permanent benefit. Making this change permanent will increase provider efficiency and cost-effectiveness and patient access to physicians, which is especially needed in



rural areas. We further recommend that CMS allow the face-to-face visit to be provided via telephone-only communications.

**Partnership Recommendations: We encourage CMS to continue to look for opportunities to support the use of telecommunications technology as a part of the provision of home health services.** The Partnership recommends that CMS avoid unnecessarily restricting use of technology in ways not explicitly called for in the plan of care and find ways to recognize the expenses associated with virtual care beyond accounting for administrative costs. We also recommend that the face-to-face encounter be permitted to be furnished via telehealth on a permanent basis.

## **B. Homebound Eligibility**

During the PHE, CMS wisely implemented a “presumptive” definition that patients with COVID-19 or suspected of contracting COVID-19 are considered “homebound” – one of two tests to determine eligibility for the home health benefit. Homebound is defined as “is or was confined to the home.”<sup>6</sup>

In the IFC published in April 2020,<sup>7</sup> CMS acknowledged that physicians may make a determination that a patient be considered “homebound” either because the practitioner has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19, or because the practitioner has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19. While the homebound criteria are a key requirement for eligibility, the patient must also demonstrate a need for skilled services in order to be eligible for Medicare home health services.

The Partnership appreciates CMS’s statement in the interim final rule that this clarification related to the definition of homebound “is not limited to the PHE for the COVID–19 pandemic, but would also apply for other outbreaks of an infectious disease and instances where the condition of a patient is such that it is medically contraindicated for the patient to leave his or her home.”<sup>8</sup>

**Partnership Recommendation: We encourage CMS to evaluate whether this clarification can be expanded to other similar circumstances.** We believe that CMS could use presumptive eligibility and identify other similar circumstances where beneficiaries may meet the definition of homebound.

We believe that taking additional steps to find practical and objective standards to define scenarios or clinical conditions that meet the homebound definition would reduce some of the

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<sup>6</sup> 42 U.S.C. § 1395n(a)(2)(A)

<sup>7</sup> 85 Fed. Reg. 19230 (Apr. 6, 2020)

<sup>8</sup> 85 Fed. Reg. 19230, 19247 (Apr. 6, 2020)

unpredictability for patients who need and want skilled services in the home when such services can improve care and meet the needs of the patient in a way that is clinically appropriate.

There are significant benefits for patients, physicians, and providers to reduce the existing regulatory burdens of meeting the homebound definition for those instances when it is presumed or obvious that such a requirement is met. We applaud CMS in this effort and strongly recommend that further evaluation of other similar circumstances or diagnoses be included as “presumptive eligibility” in meeting the homebound standard.

### **III. Rural Add-on**

Medicare beneficiaries living in rural areas present distinct and unique challenges to home health agencies that serve them. The delivery of home health services in rural areas is substantially more challenging and costly than serving urban or suburban beneficiaries due to the additional travel times required to cover long distances between visits, higher transportation costs and still other factors that make rural service delivery distinctly different and more difficult than home health care delivered in metropolitan centers.

Historically, Congress has recognized these difficulties and additional costs associated with rural service delivery, and, over several decades, authorized CMS to make additional or “add-on” payments to the standard episode rate that have ranged from a high of ten percent in 2000 to one percent in 2021. While PQHH understands CMS is constrained by the current authorizing statute, the Bipartisan Budget Act of 2018, and supports the current proposed Rural Add-On Payment for CY 2021, we encourage the agency to continue to work with PQHH and with Congress on longer-term solutions that address the cost and population health differences in rural America that create challenges for the provision of high quality home health care.

As the President recognized in his Executive Order (EO) Improving Rural Health and Telehealth Access on August 3, 2020, the 57 millions Americans living in rural communities ... “face unique challenges when seeking healthcare services, such as limited transportation opportunities, shortages of healthcare workers, and an inability to fully benefit from technological and care-delivery innovations.”

“These factors,” the EO continues, “have contributed to financial insecurity and impaired health outcomes for rural Americans, who are more likely to die from five leading causes, many of which are preventable, than their urban counterparts.”<sup>9</sup>

The Partnership strongly views itself, its member organizations and their diversity of nurses, therapists and skilled clinicians as critical to reversing this trend, and to improving the overall health status of rural Americans through in-person and telemedicine encounters in the beneficiary’s home. We welcome the opportunity to engage with Congress, CMS and the White

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<sup>9</sup> <https://www.whitehouse.gov/presidential-actions/executive-order-improving-rural-health-telehealth-access/>

House on initiatives to improve rural health through an expanded deployment of home health agency personnel specifically trained in chronic disease management and in treating conditions like cancer, heart disease, and chronic lower respiratory disease – all from the safety and security of a beneficiary's home.

#### **IV. Quality Measures**

The Partnership appreciates that CMS did not include any changes to the Home Health Quality Reporting Program (HH QRP) for Calendar Year 2022.

However, we do understand that CMS granted exceptions for quality and outcome reporting. CMS has granted exceptions from reporting certain quality measures from the HH QRP for the Consumer Assessment of Healthcare Providers and Systems (CAHPS Home Health) submission from January 1, 2020 to June 30, 2020, as well as from the HH QRP for 2019 Q4, 2020 Q1, and 2020 Q2. It is unclear what impact this delay in assessment and submission will have on the Star Ratings for home health care providers.

#### **Partnership Recommendation:**

We encourage CMS to disclose, for comment, the path forward prior to implementing the Home Health Star Ratings, in order to provide consistent measures and adequate data for all home health agencies that receive Medicare payment.

#### **V. Additional Regulatory Issues**

##### **RAP Proposal for 2021:**

We are concerned that there will be payment reductions if the home health agency is unable to submit the RAP within a 5 calendar day period. We believe that this could cause many HHAs to have penalties imposed and cause a financial hardship. We recommend that this timeline be reconsidered to align with NOA which provides a simpler standard to meet. At a minimum, we ask that the timeframe be modestly extended to beyond 5 days. We appreciate your sensitivity of this timeline, which given the demands providers face currently with the ongoing challenges of COVID-19 and urge consideration of a more realistic and slightly extended time period that would allow providers enough time to complete RAP submissions.

## **VI. Conclusion**

We appreciate the opportunity to provide comments to this CY 2021 Proposed Rule. We encourage CMS to take the lessons learned through the first half of 2020 as information confirming the value and opportunity to ensure Medicare beneficiaries receive the skilled services they need within their home. We encourage CMS to step back on some of the analysis in implementing this new payment model and evaluate what improvements need to be made based on actual data. We look forward to continuing our efforts to provide quality health care services to Medicare beneficiaries in the future.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Keith Myers', is positioned above the printed name and title.

Keith Myers  
Chairman  
Partnership for Quality Home Healthcare

cc:

Demetrios Kouzoukas  
Principal Deputy Administrator & Director of the Center for Medicare

Ing-Jye Cheng  
Director, Chronic Care Policy Group

Brian Slater  
Director, Division of Home Health, Hospice and HCPCS, Chronic Care Policy Group

Enclosure



### **Exhibit List**

**Exhibit A** – Preliminary Evaluation of CY2020 Medicare Home Health Services, Dobson Davanzo,  
August 24, 2020

# **Preliminary Evaluation of CY2020 Medicare Home Health Services**

*Analysis of the Preliminary 2020 Medicare Claims to  
Assess the Early Impact of PDGM Implementation and  
COVID-19 Pandemic on Home Health Agencies*

Submitted to:

Partnership for Quality Home Healthcare (PQHH)

Submitted by:



Al Dobson, Ph.D.

Alex Hartzman, M.P.A., M.P.H.

Sandra Agik, Sc.M.

Sung Kim

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Monday, August 24, 2020

## Introduction

Dobson DaVanzo & Associates (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to analyze available Medicare home health claims data reflecting the initial implementation of the Patient-Driven Groupings Model (PDGM). Dobson | DaVanzo previously supported PQHH in the review of PDGM as included in the Calendar Year (CY)2018, CY2019, and CY2020 Home Health Prospective Payment System (HH PPS) proposed and final rules, as well as accompanying technical reports. To inform our analyses and conclusions, we draw on this prior work along with other responses to the prior comment periods, the Abt Technical Expert Panel report, as well as early 2020 claims data, published CY2020 PDGM case-mix weights, and CY2020 rate-setting and impact files.

Effective January 1, 2020, the PDGM overhauled the HH PPS episode and case-mix group definitions, payment weights and base rate. PDGM is a revision of the Home Health Resource Group (HHRG) case-mix group definitions initially proposed in the CY2018 HH PPS administrative rulemaking cycle that was refined and finalized in the CY2019 and CY2020 HH PPS rulemaking cycles. The CY2021 HH PPS rule proposes limited changes to PDGM. Complicating the preliminary evaluation of PDGM implementation is the ongoing novel coronavirus (COVID-19) public health emergency (PHE).

Comparison of preliminarily available 2020 Medicare claims to projections used in rate setting indicates that home health case volume, total payments, and average payments have declined in 2020, and that Low-Utilization Payment Adjustment (LUPA) case rates have increased. While it is difficult to parse what effects are due to the PDGM implementation itself and what is due to the ongoing COVID-19 PHE, the outcome is that it appears so far the CY2020 HH PPS is not budget neutral to prior years. Using available data from January-April 2020 we estimate the system to be 6-22% below budget neutral payment levels, depending on the exact method chosen to make the calculation. Agency adjustments made in the remainder of the year appear unlikely to make up for the payment system shortfall in part due to prospective reductions to the base payment rate for assumed provider behavioral changes enacted by CMS.

When implementing PDGM in the CY2020 Final Rule (FR), CMS prospectively reduced the HH PPS base rate from the budget neutral calculated level by 4.36%. This prospective base rate reduction is inherently a significant contributor to the observed payment shortfall – even without this reduction, payments would still be at below budget neutral levels. The level of rate reduction was justified by analytic assumptions on how providers might change their behavior once PDGM was implemented. In the CY2020 FR, CMS described three underlying assumptions to determine the behavioral adjustment:

- For one-third of LUPAs that are one to two visits away from the LUPA threshold, HHAs will provide one to two extra visits to receive a full 30-day payment.
- HHAs will change documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code (payment optimized clinical coding). This allows a 30-day period of care to be placed into a higher-paying clinical group.
- By taking into account additional ICD-10-CM diagnosis codes listed on the HHA claim (that exceed the six allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment than periods otherwise would have received if CMS had only used the OASIS diagnosis codes for payment.

CMS based its projections and assumptions in the CY2020 FR using 2018 claims data (paid through July 31, 2019), to inform its calculations. Now eight months into the implementation of the new payment system, there is preliminary data to evaluate whether these assumptions have held true. However, it is important to note that home health providers have also been grappling with the ongoing COVID-19 PHE and widespread state-level public policy actions beginning in March of 2020.

Using preliminary 2020 Medicare claims, we find that the behavioral assumptions for PDGM implementation have not held true with implications for home health market stability and subsequently beneficiary access to home health services. We find evidence that neither the LUPA assumption nor the payment optimization of clinical coding assumption have occurred through April 2020. Analyses of preliminarily available data suggest that the COVID-19 PHE may have led to an apparent increase in case-mix severity for the high comorbidity and high functional need groups; utilization decreased overall and LUPA rates increased, but less so among cases with high comorbidity and functional need scores, suggesting patients with the most severe needs were more likely than others to receive full episodes.

We commend CMS for making extensive case data available and showing transparency to enable robust and productive commentary by the public. In the CY2020 FR CMS OASIS-LDS PDGM rate-setting and impact files, CMS provided payment estimates which included case-level estimated behavioral responses, as well as data usable for reproducing PDGM payments without behavioral responses.

## Summary Findings

We find that the CY2020 HH PPS so far appears to have been implemented at a below budget neutral level. Further, anticipated behavioral changes, case shortfalls and volume reductions deviate from the trends CMS predicted in its initial projections.

1. *Budget Neutrality*: PDGM does not appear to be budget neutral compared to prior years measured either by average or total aggregate payments.
  - a. Over the first four months of PDGM implementation observed average case payments were 6% lower than projected (average case payment of \$1,706 January-April 2020 compared to projected \$1,815 from January-April of the FY2020 CR file).
  - b. After accounting for case-volume reductions, total aggregate payments are about 21.6% lower than projected (\$4.5B observed compared to \$5.8B expected for the period).
  - c. We are confident that findings are representative given the sample of over 2.6M home health episodes during the period. We anticipate further changes as providers continue to adapt to PDGM and navigate the unfolding COVID-19 PHE, however preliminary data provides evidence that corrective action may be warranted to appropriately pay home health providers in CY2021.
2. *Case Volume Shortfall*: We find a 16.6% reduction in home health episode volume from PDGM and the COVID-19 PHE January-April 2020 compared to the rate-setting file:
  - a. PDGM case utilization decreased due to the shift from 60-day episodes to 30-day cases and the timing of visits within an episode of care.
    - i. Projections used in rate-setting also had inherently reduced volume due to data cleaning procedures which removed paid cases; the comparison to historical projections does not fully capture the complete decline in case volume.



- b. Additionally, the decline in home health volumes can be largely attributed to the COVID-19 PHE as states enacted restrictions to control the spread of the virus. These policy actions enacted mandated lockdowns that halted elective procedures, delayed other procedures, and did not designate therapists as essential workers during the initial onset of the pandemic. Patients were and remain wary of allowing healthcare workers into their homes to some extent during the pandemic.
    - i. Some portion of home health visits were shifted to telehealth during this time however, this is not captured in the claims data, per CMS pandemic flexibilities guidance.<sup>1</sup> HHAs can report costs of telehealth on the HHA cost report, but incompletely. Lack of data on telehealth services has implications for future HH PPS rate-setting and rebasing.
3. *Behavioral Assumptions:* In HH PPS rulemaking, CMS assumed that agencies would automatically and instantaneously change their coding and visit allocation behavior to maximize reimbursement under the novel payment system. Our results show that home health agencies thus far have not followed these behavioral assumptions described by CMS in the CY2020 HH PPS final rule to justify the prospective base rate reduction of 4.36%.
  - a. *LUPA rates in 2020 so far are much higher than anticipated, which has contributed to a low measured per-case payment rate as well as low total aggregate case payments.* In the first four months of the year when home health agencies were adjusting to PDGM, the national LUPA rate was 24.4% with an all-time high of 28.7% in March. While the pandemic dramatically impacted home health activities, we observed a spike in LUPA rates even prior to the onset of pandemic responses in March. This suggests that agencies were struggling with the new PDGM LUPA threshold requirements before the pandemic.
  - b. *Case-mix groups reflect historical trends of primary diagnoses rather than payment-optimized groupings.* While CMS assumed that some portion of cases would have their claims submitted such that the highest paying clinical group diagnostic code reported anywhere on the claim would be chosen for the primary diagnosis code, our results show that this has, by in large, not happened. Clinical case-mix groups observed are much more like historical trends from the rate-setting file without the behavioral adjustment.
  - c. *Comorbidity and functional group scores are higher than anticipated which may be some part behavioral adjustment but also a relative increase in case-mix severity from historical trend.* CMS assumed that some cases would have additional comorbidities reported that were also reported elsewhere in that beneficiary's home health claims or assessment data. While preliminary 2020 claims data shows that providers have an increased rate of high comorbidity and functional need cases, total volume of high comorbidity and functional need patients remained relatively consistent to projections from historical trends. Providers are increasingly supplying care to patients of higher complexity, despite or perhaps because of the overall reduction in volume accompanying the COVID-19 PHE.
4. *Case-Mix Severity:* Overall aggregate case-mix weights during the period were 1.066 and did not meet the level anticipated in behavioral adjusted projections of 1.082.

- a. Case-mix severity in general was higher than historical trends for PDGM (1.010). We further explored issues around case volume decline, LUPA rates, and PDGM case mix group categories and case-mix weights. This provided additional evidence suggesting that increases in case-mix severity are more due more to volume declines (where higher need cases are more likely to receive visits) rather than coding changes.
5. Policy Implications: Findings have implications for rate-setting in CY2021.
  - a. The lack of observed provider behavioral responses so far suggests CMS assumptions may not come to pass; some part of the occurrence of increased case-mix severity may be a response to the COVID-19 PHE. CMS is explicitly authorized under the Bipartisan Budget Act of 2018 to adjust HH PPS base rate the CY2021 temporarily or permanently to achieve budget neutrality.<sup>2</sup>
  - b. COVID-19 PHE response activities among states, CMS, and providers all serve to make data from this time less reliable and representative than the typical data used for rate-setting, rebasing, and payment reform.
    - i. This has implications from everything from future rebasing of the HH PPS to the IMPACT Act timeline.

## Detailed Findings

The Bipartisan Budget Act of 2018 mandated CMS to develop a new payment model for the Medicare home health program with a number of requirements, namely that: 1) HH PPS cases<sup>3</sup> are shortened from 60 days to 30 days, 2) cases are no longer paid based on volume of therapy services and 3) changes are implemented in a budget neutral manner. We examined the actual changes in coding under PDGM in comparison to CMS projections using data from early 2020 claims files and the CY 2020 CMS OASIS-LDS PDGM rate-setting file.

- Preliminary 2020 claims are available under CMS Research Identifiable File (RIF) Data Use Agreement (DUA) 54757. Data included in this report goes through April 2020, the most recent available month with sufficient claims run out.<sup>4</sup> Should subsequent data updates be made available during the comment period, we will include these in a brief update of analyses.
- Historical projections of PDGM using 2018 data and including both a regrouping of HH PPS cases to PDGM as well as the behavioral assumptions are available in the CY2020 OASIS-LDS file, Data Use Agreement 53367. This dataset was issued as a companion to the CY2020 Final Rule.

## Budget Neutrality

We find that PDGM does not appear to be budget neutral at its currently implemented payment levels, indicating higher base payments may be required to achieve budget neutrality. Over the first four months of implementation average case payments reduced by -6%, -9% since February. In Exhibit 1, we show the rate-

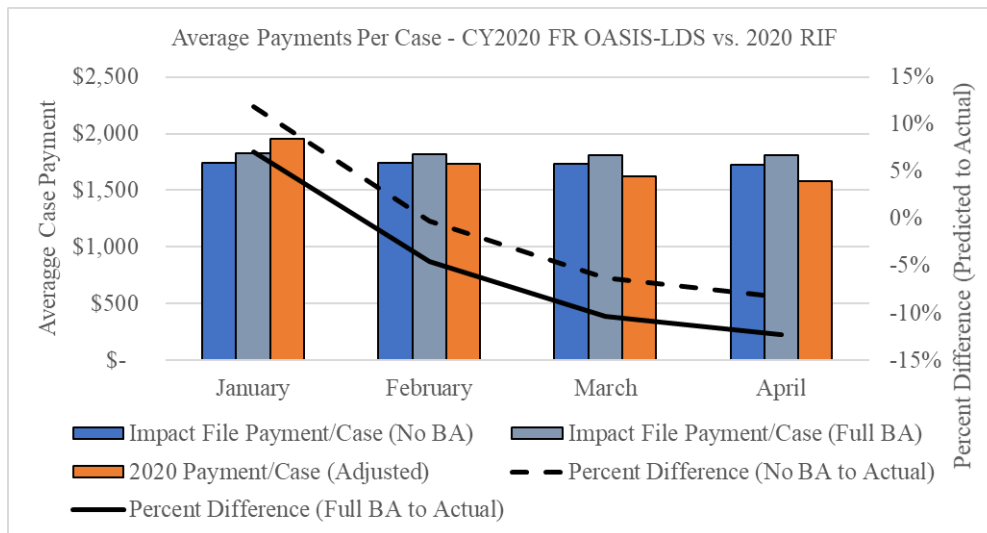
<sup>2</sup> <https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>

<sup>3</sup> Within the context of this report, we use “30-day PDGM episode” and “case” interchangeably.

<sup>4</sup> Claims data here are from the June 2020 update and results adjusted with completion factors. After comparing multiple files with varying run-out, we concluded that April 2020 is adequately complete for the purposes of this report. Completion factors were 1.015, 1.020, 1.036 and 1.095 to adjust observed payments January-April (respectively), based on investigation of claims run-out.

setting file outputs with CMS behavioral adjustment (Full BA) and without behavioral adjustments (No BA) compared to observed rates from preliminary 2020 RIF claims. Average case payments were likely inflated in January due to the transition to PDGM (more higher paying “early admission timing” cases because “late admission timing” cases could not occur, increasing average payment) which declined in subsequent months. Per-case payment rates dropped substantially further once COVID-19 PHE policy actions began to occur.

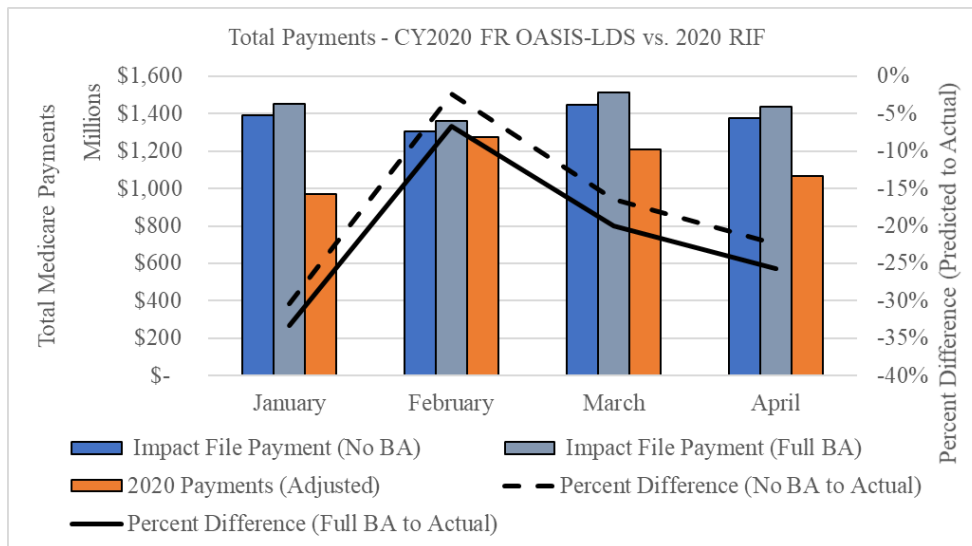
**Exhibit 1: Actual CY2020 Claims Average Case Payments vs. Projected Case Payments with and without Behavioral Adjustments**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

Total HH PPS payments have declined for this period as well. For the January-April period, we found that overall case payments declined by nearly 22%. Low total case payments in January are largely due to transition effects (we measure claims by admission date), and February may be similarly affected. However, we do find substantial decreases in March and April, most likely the primary contributor being reduced volume and increased LUPAs as a result of the COVID-19 PHE (Exhibit 2).

**Exhibit 2: Actual Total CY2020 Medicare HH Case Payments Compared to Projected Total Payments (with and without Behavioral Assumptions)**



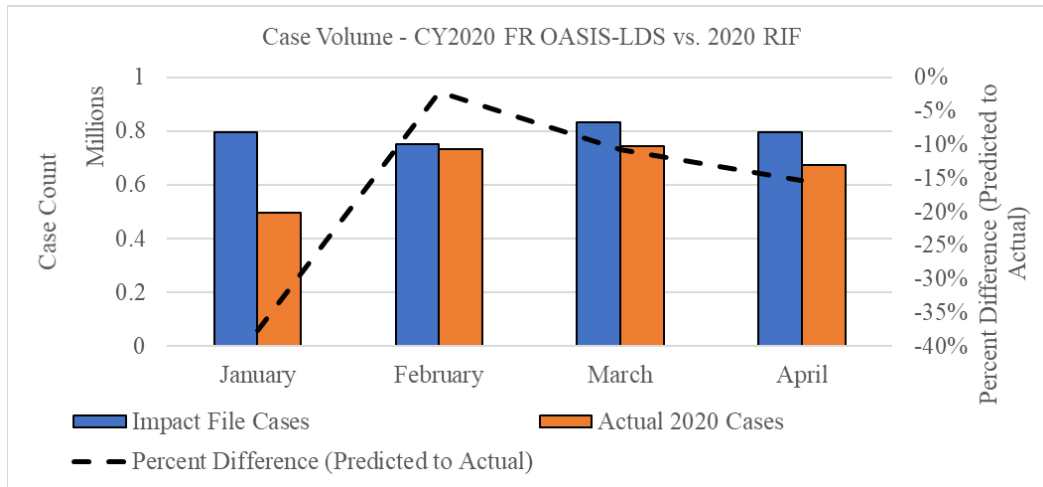
Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

### Case Volume Shortfall

We observe significant changes in home health volumes in the first third of 2020. This can in part be explained by the shift from 60-day to 30-day periods within an episode of care, but is largely due to the onset of the COVID-19 PHE.

Case volume has declined in this period as shown in Exhibit 3. January actual case counts are lower than anticipated largely due to the transition to PDGM (ongoing 153 group system 60-day cases complete rather than switch to 30-day cases). Case counts in February (when the transition to PDGM is mostly complete) were close to projected levels (2% lower than expected). Case volume is reduced in March and April, likely due to the COVID-19 PHE and widespread state-level countermeasures being enacted at the beginning of March. January-April volume is 16.6% lower than projected; March-April volume (isolating COVID-19 affected months and after the PDGM transition is completed) is down 13.0%. Note that estimates of the shortfall on case volume and total payments may be low because the rate-setting file included substantial (and not fully specified) cleaning procedures that exclude more cases than would be normally paid.

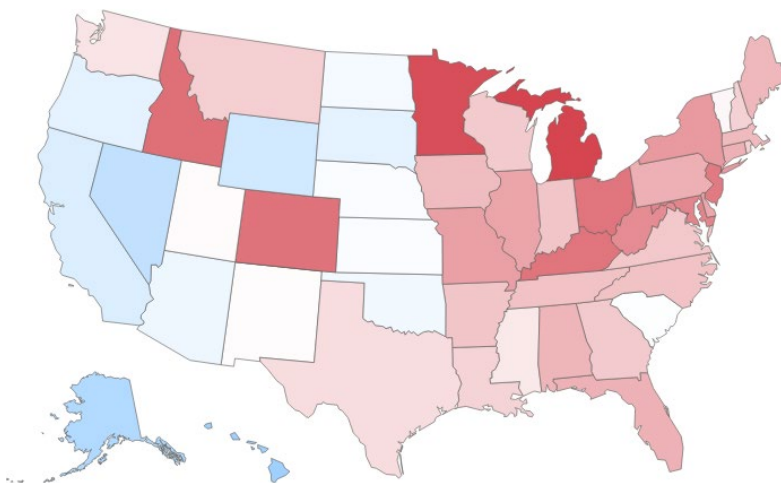
**Exhibit 3: Actual CY2020 Case Count vs. Projected Case Count (Behavioral Adjustments Not Applicable)**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

Though overall case counts were down, effects are not distributed evenly across providers or geographically. The map in Exhibit 4 shows the percent difference in projected to observed case counts (February-April to remove effects of the January transition). Red shading indicates observed case counts are lower than projected (darker shading represents a larger difference); blue shading indicated observed case counts are higher than projected. We find something of an east-west divide eastern and midwestern states were more likely to have an observed decline (MI -26%, FL -15%, PA -15%, KY -22%) compared to some western states that had an increase (AK +22%, NV +13%, CA +4%). States were more likely to have reductions than increases.

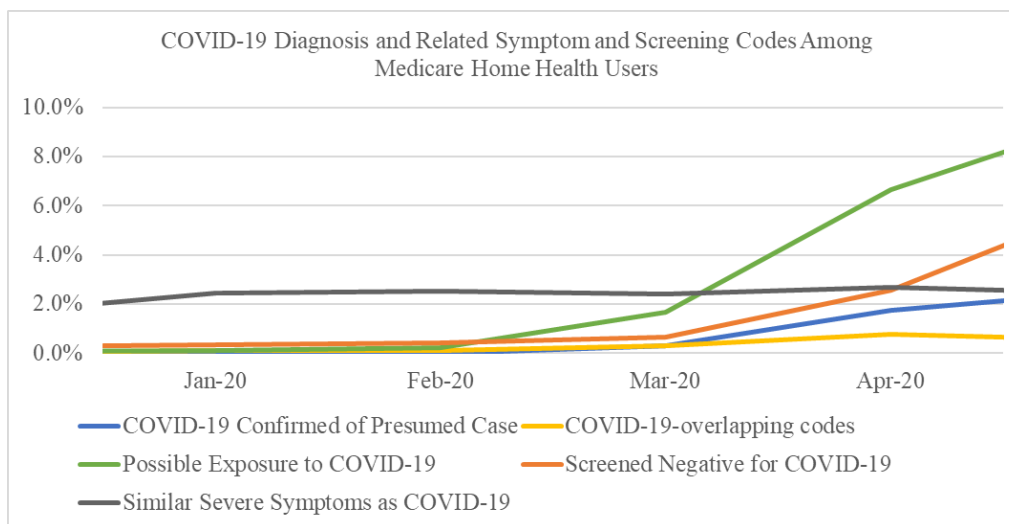
**Exhibit 4: Choropleth of Case Volume Percent Differences, from Projected to Actual CY2020**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

We examined COVID-19-related diagnostic codes for home health users in 2020. This includes coding for presumed or confirmed cases, possible exposure, negative screenings, historically used (and retired codes), and related severe symptoms (pneumonia or bronchitis due to viral or other cause). We examined inpatient, outpatient, physician office and home health claims during the home health episode and in the 30 days prior to home health admission to measure the direct service risk of home health providers in Exhibit 5. As anticipated, we find the COVID-19 case rate among home health users – as well as reports of possible exposure and negative screening – are increasing over the period. COVID-19 patients represent a very small portion of home health case load (~2% in April).

**Exhibit 5: COVID-19 Case Rates, Related Symptoms, and Related Codes, Among CY2020 Home Health Users**



Source: Dobson | DaVanzo Analysis of HH, IP, OP, and Carrier Claims, RIF 54757

**Behavioral Assumptions**

In the CY2020 HH PPS FR, calculated the 30-day payment rate in a budget-neutral manner for PDGM cases, then reduced that budget neutral base rate by -4.36% based on assumptions that providers would systemically change their visit volume and coding practices to maximize payment in the new model.

CMS cited three underlying assumptions to justify the payment reduction in the final rule:

- For one-third of LUPAs that are one to two visits away from the LUPA threshold, HHAs will provide one to two extra visits to receive a full 30-day payment.
- HHAs will change documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code. This allows a 30-day period of care to be placed into a higher-paying clinical group.
- By taking into account additional ICD-10-CM diagnosis codes listed on the HH claim (that exceed the six allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment than periods otherwise would have received if CMS had only used the OASIS diagnosis codes for payment.

Combined, the agency indicated in the CY2020 HH PPS proposed rule that these three assumptions (which are interactive) would lead to 8.01% overrun; in the final rule, CMS reduced this to 4.36%. As described above, we find that the HH PPS is underpaying relative to budget neutral levels; below we address each behavioral assumption in greater detail. Ultimately, we find the behavioral assumptions have largely not come to pass:

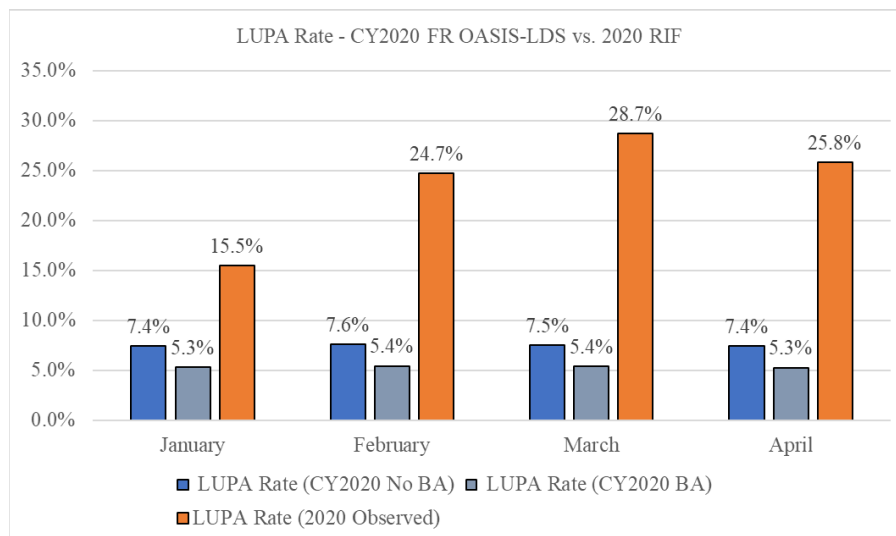
- Observed LUPA rates greatly exceed predicted rates.
- Payment optimization of primary diagnostic coding has largely not occurred (clinical case-mix groups represent historical rather than optimized groupings).
- High comorbidity and functional need groups are bigger than expected, but this is tempered by increased relative case-mix severity with reduced volume.

### LUPA RATES

During this period, LUPA rates were much higher than historically or in the rate-setting file (with or without behavioral adjustment). LUPAs are cases that do not meet the full payment visit threshold and are paid on a per-visit basis; the large portion of LUPA cases serves to reduce average case payments. We find a 24.4% LUPA rate in January-April 2020 compared to the predicted 5.3% (with behavioral assumptions) or 7.5% (historical trend without behavioral assumptions). LUPA rates were very high and increasing in the PDGM case mix groups in January and February, prior to widespread state responses to the COVID-19 PHE, as shown in Exhibit 6. This suggests that providers were struggling with the new PDGM LUPA rules.

LUPA rates began trending back down in April; however, LUPA rates would have to be consistently below 5% for the remainder of the year to come back to the CMS behavioral assumption.

**Exhibit 6: Actual CY2020 LUPA Rate vs. Projected LUPA Rate (Behavioral Adjustments Not Applicable)**

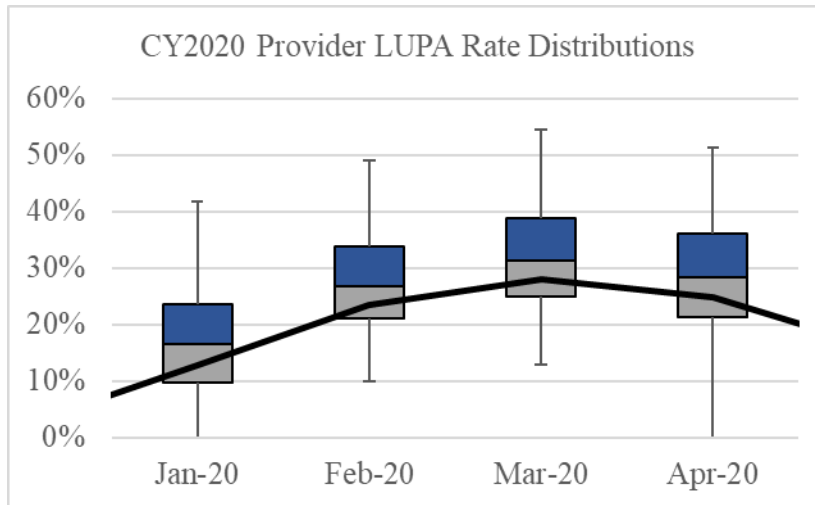


Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757



We also examined LUPA rates across providers. Exhibit 7 shows the distribution of LUPA rates across agencies by month. This box plot shows the 25<sup>th</sup>, 50<sup>th</sup> and 75<sup>th</sup> percentiles (bottom of gray box, middle of box, top of blue box, respectively), whiskers demonstrate 5<sup>th</sup> and 95<sup>th</sup> percentiles, and the line represents the mean. The ranges are broad, with some providers achieving semi-normal LUPA rates where others experience abnormally high rates. While we also observe what appears to be a peak of LUPAs in March with a subsequent decline, individual providers may still be experiencing very high LUPA rates.

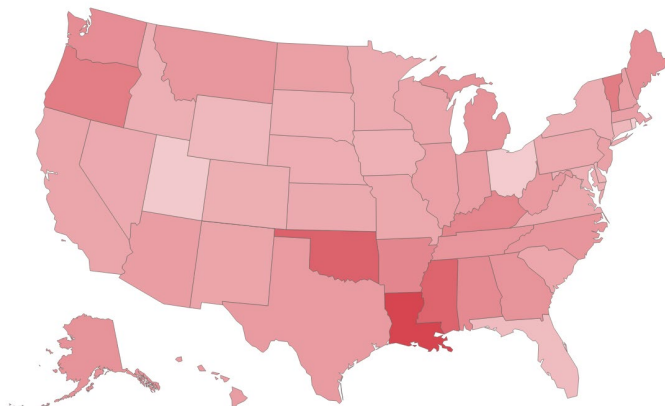
**Exhibit 7: CY2020 Observed Distribution of Provider Level LUPA Rate**



Source: Dobson | DaVanzo Analysis of HH Claims in RIF 54757

LUPA rates for the period (January-April 2020) are consistently very high across the country. In the map in Exhibit 8, darker shades of red indicate higher LUPA rates. This ranges from UT and OH with LUPA rates around 18% up to LA, OK and MS with aggregate LUPA rates exceeding 34%.

**Exhibit 8: Choropleth of CY2020 LUPA Rates, January-April 2020**



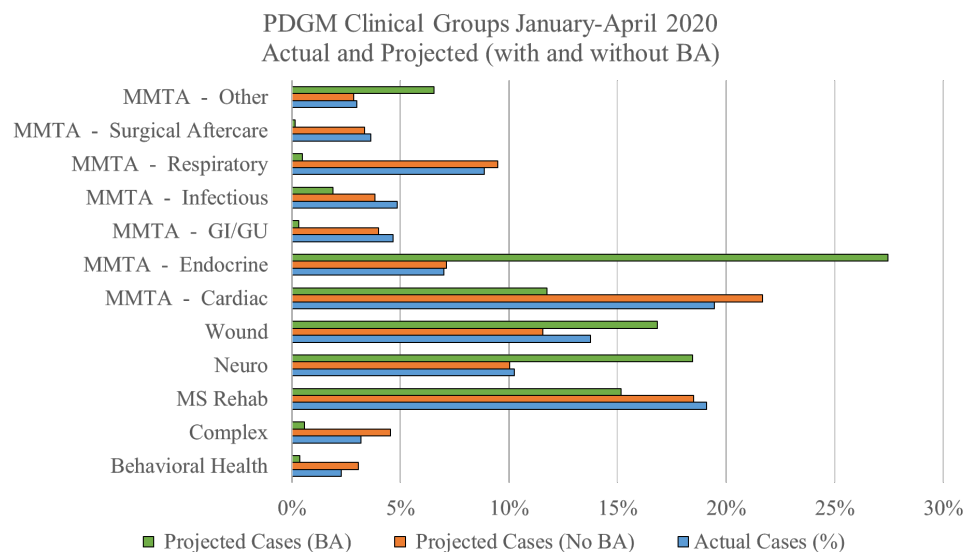
Source: Dobson | DaVanzo Analysis of HH Claims in RIF 54757



### CLINICAL GROUP CODING

We find that case-mix groups are more similar to historical trends of primary diagnoses rather than payment-optimized groupings as projected by CMS in the behavioral assumptions, as shown in Exhibit 9. The agency assumed home health agencies would change their documentation and coding practices to assign the highest-paying diagnosis code as the principal code for the 30-day period of care, which has largely not occurred. Certain groups stand out for their departure in the behavioral assumption group from historical trend – especially clinical groups MMTA-Endocrine and Neuro groups – where actual 2020 case-mix results hewed close to historical levels. This behavioral assumption would require agencies to substantially disregard international agreed coding schemas, so it is unsurprising shifts did not occur to the extent predicted in the behavioral assumption.

**Exhibit 9: Observed Clinical Groups January-April 2020 Compared to Projected Clinical Groups (with and without Behavioral Adjustments)**

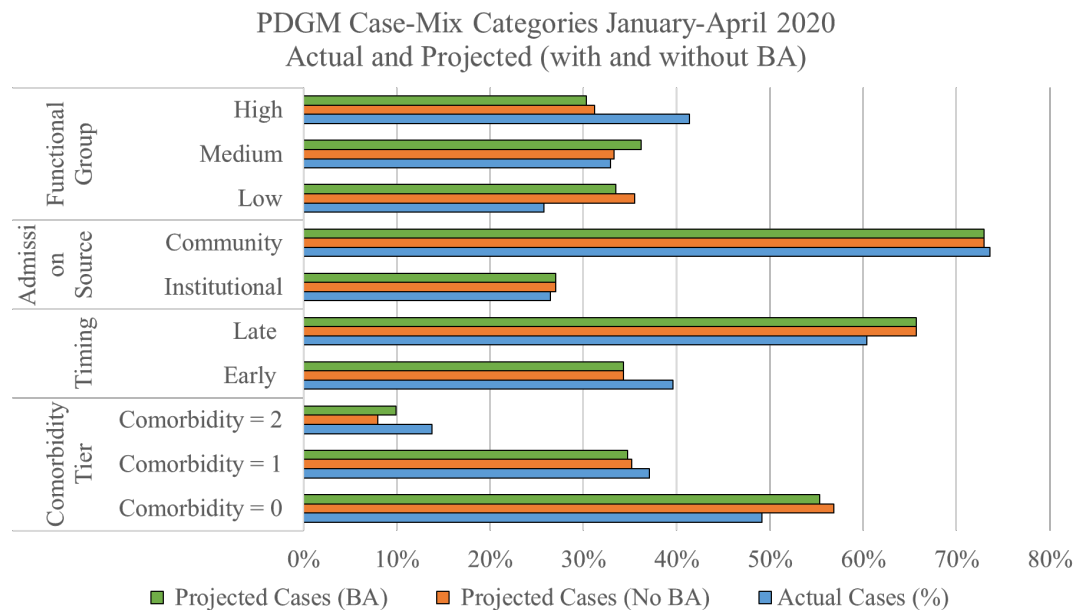


Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

### IMPACT ON COMORBIDITY CODING

So far in 2020, agencies are reporting higher comorbidity and functional group scores, even much higher than scores projected from the rate-setting files with behavioral adjustment as seen in Exhibit 10. The increases in scores could be partially explained by the change in coding behavior as anticipated by CMS but also by the relative increase in case-mix severity due the ongoing coronavirus pandemic. However, it is difficult to determine by how much each factor contributed to the observed comorbidity coding changes.

**Exhibit 10: PDGM Case-Mix Categories January-April 2020, Actual and Projected (with and without BA)**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

While the above data in Exhibit 10 shows that providers coded for high comorbidity and functional status more frequently, total volume of high comorbidity and functional need patients remained relatively consistent as shown in Exhibit 11. This suggests that observed shifts are more likely due to the COVID-19 PHE – as overall case volume drops, cases that still occur are likely to serve higher need patients.

**Exhibit 11: High Functional Group and Comorbidity Tier Total Volumes vs. Projections with and without Behavioral Adjustment**

Category	Item	Case Count (Actual)	Case Count (CY20 Impact File, No BA)	Percent Change (Predicted to Actual)	Case Count (CY20 Impact File, BA)	Percent Change (Predicted to Actual)
PQGM	Grouped	2,661,190	4,058,066	-34%	4,058,066	-34%
Comorbidity Tier	Comorbidity = 0	1,307,741	2,306,130	-43%	2,244,762	-42%
	Comorbidity = 1	986,257	1,427,918	-31%	1,409,471	-30%
	Comorbidity = 2	367,192	324,018	13%	403,833	-9%
Timing	Early	1,054,050	1,392,738	-24%	1,392,738	-24%
	Late	1,607,140	2,665,328	-40%	2,665,328	-40%
Admission Source	Institutional	704,067	1,097,377	-36%	1,097,377	-36%
	Community	1,957,123	2,960,689	-34%	2,960,689	-34%
Functional Group	Low	685,887	1,440,013	-52%	1,358,355	-50%
	Medium	874,956	1,351,420	-35%	1,469,379	-40%
	High	1,100,347	1,266,633	-13%	1,230,332	-11%

Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

These issues tie into overall case-mix severity observations, below.

### CASE-MIX SEVERITY

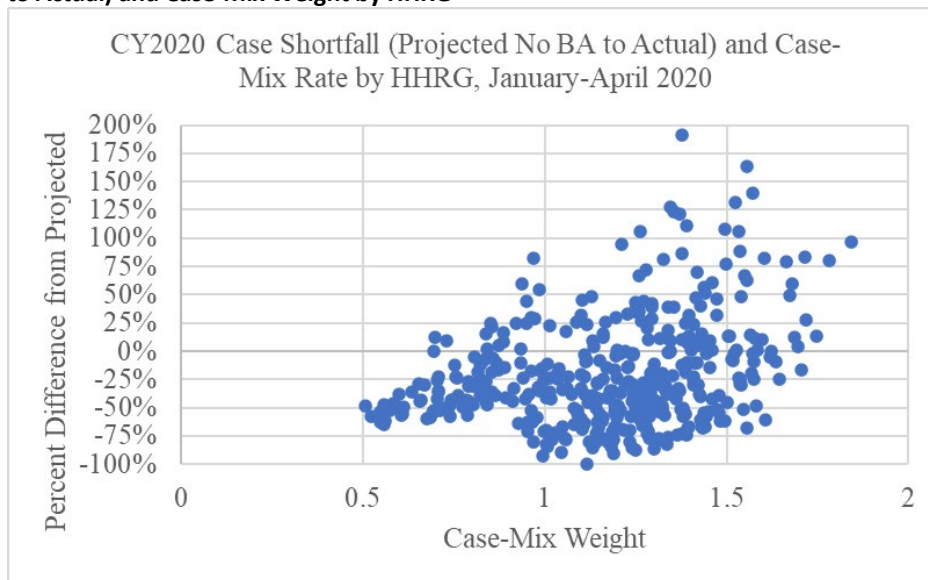
A key issue in both the transition to PDGM and the ongoing COVID-19 PHE is the overall severity or patient service need of home health users. We apply the aggregate case-mix weight as a numerical signifier of case-mix severity (or patient service needs) as it denotes the expected relative case resource use. As the pandemic has led to major volume declines, the apparent case-mix severity has increased. From our observations, it appears that the volume decline and LUPA rate increases affect lower severity cases. In other words, patients who needed greater service use were more likely to get home health care and have a fully paid episode than otherwise.

For January-April 2020, we compare the aggregate case-mix weights across cases:

- Projected without Behavioral Assumption: 1.010
- Projected with Behavioral Assumption: 1.082
- Observed claims: 1.066

However, as described above in Exhibit 11, the relative increase in case-mix weights may be driven by fall-off in low-severity cases more than changes in coding. Indeed, clinical groups coding remained close to historical case-mix while overall severity increased. We demonstrate the case shortfall relative to case-mix weight by PDGM HHRG for data January-April 2020 in Exhibit 12 – cases with a lower case-mix weight (case severity proxy) were more likely to show substantial reductions in case volume.

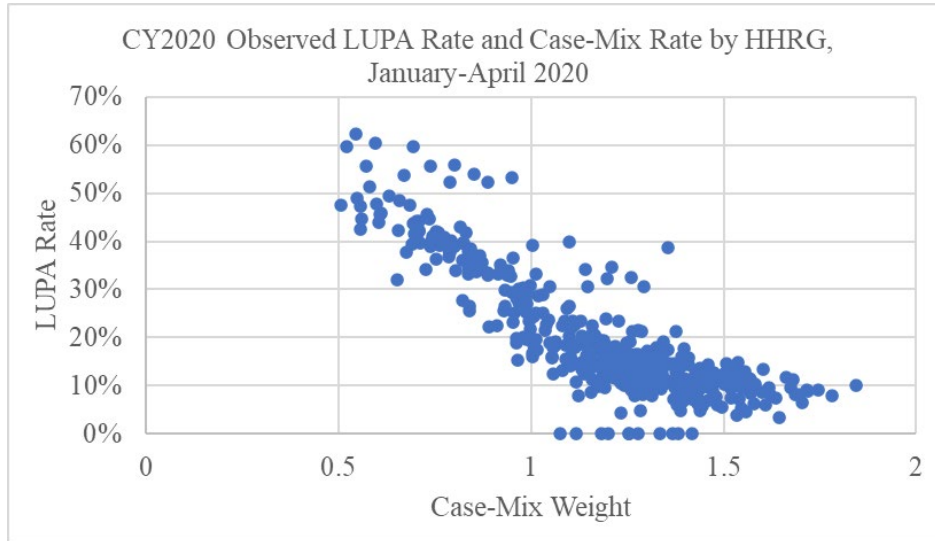
**Exhibit 12: CY2020 Case Shortfall (Percent Difference from Projected without Behavioral Adjustment to Actual) and Case-Mix Weight by HHRG**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

This relationship between case-mix severity and utilization reduction is demonstrated in the LUPA rate in Exhibit 13. Here, an increased LUPA rate goes with lower severity (case-mix weight) cases, indicating cases with more severe clinical needs are more likely to become a fully paid episode.

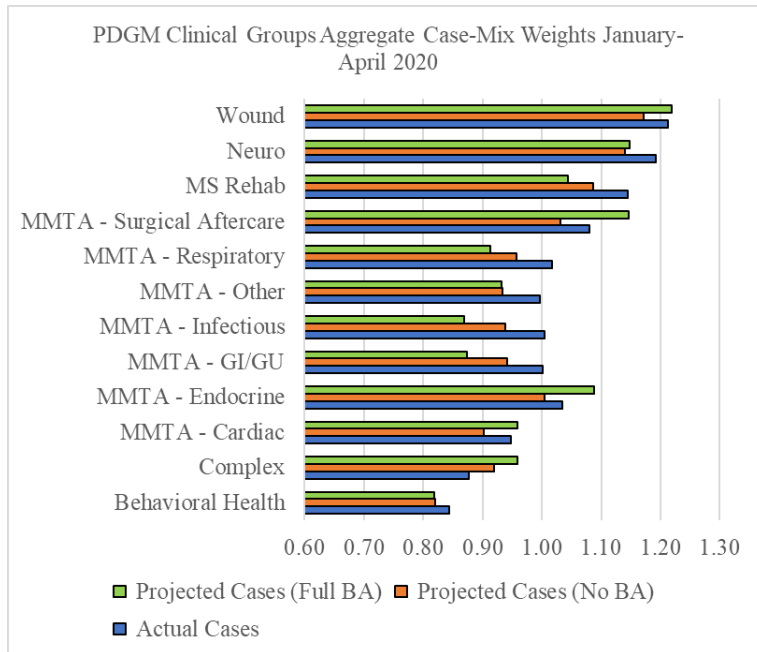
**Exhibit 13: CY2020 Observed LUPA Rate and Case-Mix Weight by HHRG**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs RIF 54757

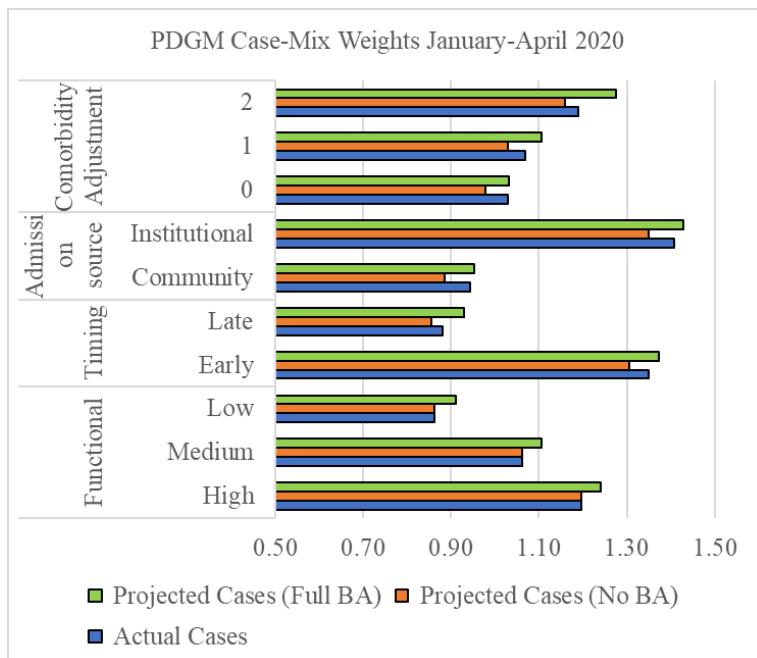
This results in apparent shifts in aggregate case-mix weight across payment categories in Exhibit 14 and Exhibit 15. Case-mix severity increases appear to be largely due to the distribution of cases across the functional groups in Exhibit 15. While all other case-mix variables show some amount of shift from historical expected case-mix weights, the functional groups are very close to the historical weights. This indicates that holding the functional status constant, case-mix severity did not change substantially – in other words, increases in apparent severity appear largely driven by the distribution of cases across functional groups.

**Exhibit 14: Observed Average Clinical Group Case-Mix Weight January-April 2020 Compared to Projected Clinical Groups (with and without Behavioral Adjustments)**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

**Exhibit 15: PDGM Case-Mix Categories Average Case Weights, January-April 2020, Actual and Projected (with and without BA)**



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

## Conclusion and Policy Implications

CY2020 PDGM implementation has disrupted home health operations which were then coincidentally impacted by the COVID-19 PHE. Regardless of the root cause, two of the three anticipated behavioral changes that CMS used to justify prospective payment rate reductions have not occurred as of April – overall payments and case volume are down with very high LUPA rates. This affects case-mix severity in complex ways; the PHE may be the predominant cause of the observed increase in case-mix severity rather than provider adjustments.

In the near-term, CMS may consider taking corrective action to increase the base rate so the HH PPS will be more likely to achieve budget neutrality in the CY2021, as authorized by the Bipartisan Budget Act of 2018. Looking ahead, PDGM implementation and regulatory changes enacted (temporarily or permanently) to support beneficiary access and health during the COVID-19 PHE will leave a lasting imprint on the data used to rebase, set payment weights, and eventually transition to new payment systems.

The allowance of telehealth visits for home health services after the LUPA threshold is reached is potentially helpful in assuring continuous beneficiary access during the COVID-19 PHE, particularly for some monitoring and teaching services (among others) which may reasonably shift from in-person care to telehealth. However, there is no requirement to capture these services in the claims and telehealth costs are not well-reported in Medicare Cost Reports. As such, the service shift towards telehealth must be accounted for outside of the traditional rate setting and rebasing model at the risk of decreasing the payment accuracy and adequacy of the HH PPS.

Atypical volume and case-mix severity is occurring across all healthcare providers during the COVID-19 pandemic. Other COVID-19 PHE responses also affect payment system data in ways which may impact future payment system reform. For instance, post-acute care providers are not required to collect complete Standardized Patient Assessment Data Elements, which were designated as a key input to the timeline of payment reform proposals in the IMPACT Act of 2014.

Ultimately the COVID-19 PHE will affect future rate setting, rebasing and payment system overhauls across all Medicare payment systems. The data that is normally relied upon to conduct these activities will represent a strange time and be less complete than previously (e.g. telehealth and SPADES under-reporting). The agency will need to carefully consider how it addresses and corrects for these issues. The COVID-19 PHE is changing the shape of healthcare across the country – how CMS incorporates this into rate setting (future incentives) will help determine to what extent these changes are permanently ingrained in the payment systems.