JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

August 31, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1689-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

**Submitted electronically** www.regulations.gov

**Re: CMS-1689-P: Home Health Prospective Payment System Rate Update**

Justice in Aging appreciates the opportunity to comment on the above referenced Notice of Proposed Rulemaking.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

## I. Patient Driven Groupings Model (PDGM)

Justice in Aging urges CMS to put the PDGM payment rules on hold. We believe that the proposed home health payment methodology as written is flawed and will not achieve its stated purpose "to better align payment with patient care needs and better ensure that clinically complex and ill beneficiaries have adequate access to home health care."[1] Instead, the proposed payment methodology will have the effect of limiting access to home health care for those who need it most, beneficiaries with complex, longer-term and chronic conditions. It is inconsistent with *Olmstead* principles and with the broader goals of CMS to provide person-centered care and prevent unnecessary institutional placement of people who can live safely in the community.

The PDGM Proposal Will Hurt Beneficiaries Living with Chronic Conditions or Functional impairments.

It is incontrovertible that Medicare payment incentives drive the delivery of care. Therefore, it is critical that those payment incentives be based on actual beneficiary needs. Unfortunately the proposed methodology builds on a system that has rewarded serving beneficiaries whose conditions will improve, and making it less profitable to serve patients with longer-term and chronic conditions. The proposed rules would make these perverse incentives worse and create additional incentives to provide care to beneficiaries with short-term, improvement goals. As co-counsel in *Jimmo v. Sebelius*, the case that

[11] 83 Fed. Reg. 32340 at 32380-81 (July 12, 2018).

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confirmed that Medicare determinations should turn on the need for skilled care, not on an individual's ability to improve, we strenuously object to the PDGM.

Our concerns are that beneficiaries who were not recent inpatients or need more than 30 days of home health care will experience even greater problems accessing care than they currently experience, and that those with longer-term and chronic conditions who are unlikely to improve will continue to experience a decline in the availability of Medicare home care services. Further, beneficiaries with hospital observation stays or emergency room visits will experience a decline in access to home health care. Beneficiaries who need and qualify for Medicare-covered therapy will receive less therapy. We also expect that beneficiaries with severe functional impairments and comorbidities will have greater problems accessing care, as agencies will not receive a high enough payment boost to provide this care. Access to home health aide care will continue an already precipitous decline.

The PDGM Would Work Against Congressional Intent

Medicare law does not cap reasonable and necessary home care, except for a weekly limit of up to 35 hours a week of skilled nursing and home health aide, combined. The law does not limit the duration of time a beneficiary can receive home health care, a fact affirmed by Congress since at least 1980 when it repealed caps on visits and prior hospitalization requirements.

CMS interim payment system (IPS) and prospective payment system (PPS) policies, however, have tilted payment incentives to disproportionately discourage provision of services to beneficiaries with complex needs who have managed to avoid acute care. The PDGM payment scheme would exacerbate the current imbalance.

Instead, CMS should design payment and quality rules that effectuate Medicare coverage laws and encourage providers to serve all patients. The proposed rule, with its 216 categories heavily weighted towards providing care for the short term, creates strong incentives to serve post-hospital and short-term patients and is bound to further limit home care access problems for individuals with longer-term and debilitating conditions. It will inevitably hamper implementation of the *Jimmo* Settlement, which reaffirmed Medicare coverage for skilled maintenance care, and will lead to discrimination against people with disabilities in violation of *Olmstead*.

Throughout the agency, CMS is designing incentives and developing programs to promote community living, enhance person-centered planning and care, keep beneficiaries out of hospitals, and provide alternatives to institutional placement. The proposed home health payment rule is not in alignment with these many important efforts and would in fact work against them.

To be consistent with Congressional intent and *Olmstead* principles, CMS should rescind this proposed rule and develop person-centered systems based on individual functional status and care needs so that providers are encouraged to serve all beneficiaries who qualify for coverage under the law.

## II. Request for Information on Price Transparency

The Notice includes a request for comments on how to provide better price transparency in home health for beneficiaries. It discusses the issue in the context of broader efforts by the agency to use transparency and consumer-friendly communications to address rising concerns about "surprise billing" faced by beneficiaries.

Justice in Aging supports price transparency in health care. Transparency alone, however, does not fully address surprise billing. Without other protections, attempts to address surprise billing or other issues with health care access and costs through price transparency alone puts additional and unfair burdens on consumers to navigate even more information in an already complex system.

The Medicare "limiting charge" policy is one critical piece of surprise billing protection for Medicare beneficiaries and we urge CMS to maintain this important safeguard.[2] In Medicare Advantage, the requirement that plans only charge in-network co-insurance for emergency services,[3] even if providers are out-of-network, also provides some important, though limited protection.

Particularly for Medicare Advantage plan members, however, much more is needed to address the underlying cause of surprise billing, a delivery system design in which services embedded in in-network facilities are provided by out-of-network providers not chosen by or even known to the beneficiary. When beneficiaries visit in-network facilities, it is impossible and unworkable for them to navigate the labyrinth of contracted doctors, radiologists, anesthesiologists and other providers to determine which specific providers who serve patients in the in-network facilities are themselves out-of-network. Further, the pharmacy section of facilities that are otherwise in-network may not be considered in-network for purposes of Part D drugs that an individual may need during an out-patient or observation visit. These issues exist whether or not a situation meets the definition of an "emergency." This situation is simply irrational, and providing a beneficiary, who likely is sick and under stress, with a piece of paper describing the situation and predicting the charges that may ensue, does not provide sufficient billing protections for the older adults and people with disabilities who rely on Medicare.

It is imperative that CMS impose order on this situation so that Medicare Advantage beneficiaries may always be confident that when they follow the rules and choose an in-network facility and in-network treating provider, there will be no surprise bills and all the "behind the scenes" providers whom they had no role in choosing will be treated as in-network. There are different ways to achieve this result by placing the responsibility on the facility, the plan or some combination. But CMS needs to address the issue head-on and ensure that the responsibility lies with the facility/provider/health plan and not the beneficiary. Merely being transparent about a hopelessly confusing and unfair situation is insufficient. With a third of Medicare beneficiaries in Medicare Advantage plans and that number growing, it is imperative that CMS ensure that the operation of the Medicare Advantage program is coherent and fair to beneficiaries.

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[2] Proposals to broaden the conditions under which providers can privately contract with Medicare beneficiaries about the price of services would erode these critical protections. See discussion at Medicare Rights Center, Paying More for Less: Private Contracting (2018), available at 42 www.medicarerights.org/pdf/paying-more-for-less-private-contracting.pdf.

[3] See, e.g., 42 C.F.R. § 422.113.

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
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