Pennsylvania Homecare Association

August 27, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1747-P
P.O Box 8013
Baltimore, MD 21244-8013
Submitted via regulations.gov

Re: CMS-1747-P: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements, 86 Fed. Reg. 35874 (July 7, 2021)

Dear Administrator Brooks-LaSure:

The Pennsylvania Homecare Association (PHA) represents nearly 700 home-based care providers who bring skilled nursing, therapy, personal care, and end-of-life care into hundreds of thousands of individuals' homes across Pennsylvania. Thank you for the opportunity to provide comments on the CY 2022 Home Health Proposed Rule, which proposes reforms affecting the Medicare home health benefit, survey and enforcement requirements for hospices, and CY 2022 payment rates. As shared in more detail below, we urge CMS to reconsider a number of items in the proposed final rule, in order to ensure a stable, sustainable home health benefit for Medicare beneficiaries. We respectfully submit the following:

General Comments
As a general matter, we ask CMS to withdraw certain proposed changes to the PDGM model that are based on 2020 data, including those relating to recalibration of the case mix weights. 2020 was a year that no one could have predicted, as COVID-19 significantly impacted the provision of home health care, including changes to patient mix, patient census, workforce, practice and care-related challenges, and more.

We also believe that CMS should establish a process to allow expedited temporary adjustments when events such as national emergencies require payment and other changes or enhancements to ensure continued access to quality care. Home health providers treated many COVID-19 patients, played a critical role in keeping at-risk individuals out of institutional settings, and experienced significant

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increases in costs and expenses related to the pandemic, however reimbursement rates did not change. CMS should develop a process to make mid-year adjustments, when necessary.

Home Health Payment Rates

As a general matter, we are also concerned that annual increases to home health payments have not kept up with increases in labor costs and other resources necessary to deliver quality care. Recent market basket and annual update factors do not align with provider labor and other costs associated with delivering home health care services in today's environment. CMS should consider increased labor, PPE, infection control and other costs when finalizing CY 2022 rates, and we urge consideration of an add-on payment to cover pandemic-related costs.

CMS also outlines several payment proposals in the proposed rule that we ask it to modify, as they will result in unwarranted payment reductions. For the reasons set forth below, we ask CMS to:

- Eliminate the 4.36% behavior adjustment in the CY 2022 rates;
- Revise its methodology to evaluate budget neutrality and convene a TEP; and
- Withdraw the case-mix recalibration proposals, as they do not reasonably reflect care delivery expected for 2022.

<u>4.36% Behavioral Adjustment in CY 2022 Rates</u>

In establishing payments under the PDGM payment model, CMS made behavioral assumptions, including: 1) an anticipated inflation in the primary diagnosis measure that did not occur; 2) an anticipated reduction in LUPA, which actually increased; and 3) expectations regarding comorbidities, which scored slightly higher than anticipated. Because these assumed behavior changes did not occur, we urge CMS to eliminate the 4.36% rate reduction.

In fact, a study done by Dobson Davanzo & Associates[1] found that actual case payments for CY 2020 are 1.4% below what CMS projected, and as a result, payments made in CY 2020 were approximately 5.76% below the non-behaviorally adjusted payment rates.

<u>Methodology to achieve budget neutrality</u>

PHA appreciates the detail provided by CMS on its proposed methodology to achieve budget neutrality. At a minimum, we believe that the methodology must evaluate the accuracy of the behavior change assumptions and calculations that CMS relied on in its CY 2020 rulemaking, which CMS has not done. Any evaluation of PDGM's impact on Medicare spending must also include a PDGM 'neutral assessment' of what would have been spent under HHPPS-HHRG. CMS's estimates on home health payments that would have been made in the absence of the change to a 30-day unit of service and new case-mix system are flawed, given the significant differences in payment incentives that dramatically altered CY 2020 home health utilization.

We recommend that CMS convene a Technical Expert Panel (TEP) to develop and design a consensus-based methodology to evaluate PDGM budget neutrality. The need for accurate assessment methodology is critical to the future of the industry, given CMS's projection that HHAs have been overpaid by 6% in 2020, under the proposed assessment methodology.

[1] This analysis has been submitted by the Partnership for Quality Home Healthcare.

Recalibration of Case-Mix Weights

CMS proposes to recalibrate all 432 PDGM case mix weights for 2022. PHA understands and agrees that it is important that the case-mix weights reflect trends in utilization and resources. However, 2020 was an unprecedented year in the provision of home health services, and the COVID-19 Public Health Emergency (PHE) had a significant impact on usage and delivery of home health services. For example, elective surgeries were postponed in the early part of the PHE, dramatically lowering usage of home health services. Many services that were still being provided were delivered via telehealth, which did not count toward utilization numbers for payment. Finally, many patients were refusing services due to fears related to COVID-19.

PHA urges CMS to withdraw the case-mix recalibration using CY 2020 data, as they do not reasonably reflect care delivery expected for 2022 and are based on highly atypical circumstances.

Ceiling on negative changes in wage index values

CMS should extend the 5% ceiling on negative changes in wage index values to all provider types, including home health agencies, as it has done for inpatient hospitals. If it doesn't do so, it will advantage certain providers and provider types over others, create an unfair playing field relating to staff recruitment/retention and jeopardize access to home health services in some areas.

Home Health Value-Based Purchasing Model (HHVBP)

PHA supports a modified expansion of HHVBP. We recommend:

- Extension of the start date to avoid relying on an outdated benchmark year and allow HHAs sufficient time to implement operational changes that would support success;
- Reconsideration of the nationwide, volume-based cohorts;
- Reduction of the level of payment at risk to 3%, consistent with the start of the original demonstration; and
- Inclusion of a "shared savings" component to enhance incentives and lead to more Medicare savings.

PHA recommends that CMS delay the implantation of HHVBP until a time when a more typical benchmark year can be established and to allow providers sufficient time to implement necessary and appropriate operational changes.

The CY 2022 proposed rule suggests moving from a state-based cohort for setting benchmark and achievement standards to a nationwide volume-based cohort. Cohorts based on volume alone, without taking into consideration the significant regional differences in healthcare practice and utilization, presents a number of issues, including that it has the potential to deprive some regions of funding for critical home health services. Given regional differences in social determinants of health, as well as differences in state investments in community health, we believe that further analysis is necessary to avoid unintended consequences to equitable access to care.

We also recommend reducing the level of payment at risk to 3%, consistent with the start of the original demonstration, and including a "shared savings" component to enhance incentives and lead to more savings to Medicare.

Finally, we urge CMS to ensure that performance reporting is done in a timely manner, to support HHAs as they work to improve their performance.

Home Health HHVBP Quality Measures
PHA supports aligning the measures in the HHVBP program with measures reported in the HH QRP, however, CMS should allow time for HHAs to become familiar with the Home Health Within Stay Potentially Preventable Hospitalization measure before including it in the HHVBP program. We also ask CMS to exclude Observation Stays from this measure, for the reasons discussed in the proposed rule.

Changes to OASIS-E, new measurements, and related modifications to the risk adjustment model could potentially impact HHA performance in a manner that may not reflect a change in quality of care, but a change in statistical evaluation. We ask that CMS carefully evaluate these changes before applying them to HH VBP measurements.

Home Health Quality Reporting Program (HH QRP)
PHA supports the alignment of quality measures programs across home health quality measurement programs. Although we generally support the inclusion of standardized patient assessment data elements (SPADEs) categories, we are concerned about extensive reporting obligations relating to OASIS-E and ask CMS to consider the overall burden on providers relating to reporting.

Home Health Conditions of Participation (CoPs)
CMS proposes to give home health care providers limited flexibility to use remote technology for purposes of aide supervision. During the PHE, Providers found that when appropriate, remote visits worked well, met patients' needs, and created efficiencies in both staffing and patient care. We urge CMS to allow additional flexibility for agencies with respect to these visits and to allow expanded use of these interactive, two-way, audio-visual communications for purposes of aide supervision.

In 484.80(h)(3), CMS proposes to add "and all related skills" to training requirements. We ask for additional clarification on this phrase, so that providers and surveyors can interpret the requirement as consistently as possible.

Requests for Information and Equity
PHA supports the use of data and analytics for use in determining patient needs to ensure that health equity is aligned across all CMS programs. This can be used to highlight and identify barriers in accessing quality care.

Hospice Provisions
<u>General Provisions</u>
CMS proposes to require Accrediting Organizations (AOs) to submit a hospice's statement of deficiencies from health and safety surveys on Form CMS-2567 or a successor form in a manner specified by CMS, effective October 1, 2021. CMS has also indicated that in the future, major system changes will be necessary to migrate the CMS-2567 reporting system. We urge CMS to involve stakeholders in this process and allow for sufficient time for the transition.

<u>Posting Surveys/Need for TEP</u>
While PHA supports increased transparency relating to hospice surveys and reports, it is important that information be shared in a user-friendly, useful and informative way. Survey reports themselves are complex, voluminous and could be confusing. CMS suggests that some type of standard framework identifying key survey findings may be appropriate, and we support the establishment of a technical expert panel (TEP), including a wide variety of stakeholders, to ensure that this process is implemented

appropriately, in a way that identifies and emphasizes key quality indicators and the most effective way to share this information with the public.

Our expectation is that hospice survey findings will be linked from Care Compare, similar to nursing home surveys. We support posting survey summary information, along with a link to survey reports in a single, easily accessible location. Any posting indicating that provider has been cited must also note that the provider has corrected any deficiencies, is in full compliance with the CoPs, and the date of full compliance, as applicable. If a hospice is deemed by an AO, the notice should make clear that once compliance was achieved, the hospice was again accredited by the AO. Postings and any updates or corrections must be timely.

Hospice Surveys and Hotline

PHA supports the 36-month required minimum of frequency for hospice surveys and the establishment of a uniform requirement for toll-free hotlines.

Surveyor Education

PHA supports a minimum continuing education requirement for surveyors and the sharing of surveyors' performance on training/testing modules with survey entities. We further recommend that CMS communicate informal guidance relating to CoP interpretation of the survey process to SAs, AOs, hospice providers, and other stakeholders in a coordinated, consistent way.

Conflict of Interest

PHA supports the implementation of the conflict-of-interest provisions of CAA 2021 to support fairness in surveys and recommends that CMS develop materials for use in identifying potential conflicts of interest.

The CAA 2021 also requires the use of multidisciplinary teams in the use of surveys conducted by more than one surveyor. PHA recommends that CMS require all hospice surveyors to have experience in hospice care. Specialty surveyors should be used when appropriate.

Consistency in Survey Results

Consistency in survey findings is critically important, including that survey consistency reviews must include not only "disparity rates," but also a review of specific citations imposed, to ensure that they are appropriate. Validation surveys should be conducted, whenever possible, at the same time as other surveys. Finally, we recommend the development of protocols for deficiency citations for hospice surveyors.

Special Focus Program

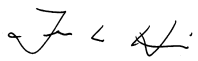
PHA supports additional, targeted oversight for hospices not delivering quality care and putting patients at risk. We believe that the TEP recommended above would play a critical role in the further development and implementation of this program.

Penalties and Enforcement

We ask CMS to include a dispute resolution process in the reforms, given the significant consequences for non-compliance. We also urge CMS to carefully consider any payment suspensions, limiting them to new admissions only, and to consider the potential impact on access to care when imposing penalties or other remedies.

Thank you in advance for your consideration of PHA's comments and recommendations. Please contact me if we can provide any additional information at thenning@pahomecare.org or (717) 649-6498.

Sincerely,



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