



August 16, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

SUBJECT: CMS-1766-P Medicare Program; Calendar Year 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirement; Federal Register (Vol. 87, No. 120) June 23, 2022

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including numerous home health agencies (HHAs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services' (CMS) home health prospective payment system (PPS) proposed rule for calendar year (CY) 2023.

Our comments are made in the context of the ongoing COVID-19 public health emergency (PHE), which continues to challenge providers at all levels of the care continuum. Given the unique role of home health in the care continuum, home health providers have been called upon to respond to changes in the types of patients they are seeing, their care needs, and how and where care is delivered. Policy and payment changes and updates must include consideration of these unique circumstances and the lessons we have learned during this difficult time.

CHA has serious concerns about the impact of CMS' proposed payment adjustments and requests that CMS take steps to eliminate punitive and unwarranted decreases in reimbursement. These steps are necessary to account for the significant cost increases experienced by HHAs during the past few years. Specifically, we urge CMS to:

- **Consider additional methods and data sources to calculate the base market basket update**
- **Delay implementation of the budget neutrality adjustment as currently proposed.** CMS' current proposal is based on flawed assumptions and does not adequately account for the significant cost increases experienced by HHAs during the past few years.

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 ■ Office: (202) 488-3740 ■ FAX: (202) 488-4418

1215 K Street, Suite 700, Sacramento, CA 95814 ■ Office: (916) 443-7401 ■ www.calhospital.org

CHA also urges CMS to delay the requirement for the implementation of the updated outcome and assessment information set (OASIS) for all payers until at least January 2025, in alignment with other post-acute care settings. While we support the implementation of a robust and standardized quality reporting program (QRP), HHAs need additional time to adjust to this change, particularly in recognition of the many challenges and changes they have absorbed in recent years.

CHA supports and appreciates CMS' proposals to:

- **Continue for CY 2023 the use of existing OASIS items M1800-1860 for the purposes of case mix and payment in recognition of the limitations of the current data to compare to Section GG.** CHA urges CMS to continue its analysis of the correlation between these OASIS items and similar items in Section GG toward a goal of determining the feasibility of adopting Section GG items as standardized patient assessment items and decreasing the administrative burden of collecting and reporting duplicative data.
- **Collect additional data on home health claims regarding the use of telehealth and remote patient monitoring.** CHA commends CMS' recognition of the value of these new technologies and applauds CMS' interest in investigating their impact on home-based care delivery and social determinants of health.

Market Basket Update

CMS proposes a market basket increase for FFY 2023 of 3.3%. This is then reduced by the 0.4 percentage point "productivity adjustment" required under the Affordable Care Act (ACA). The resulting proposed HH market basket update equals 2.9% (3.3% minus 0.4 percentage points for productivity reduction).

CHA is deeply disappointed in the proposed 2.9% market basket update as it is wholly inadequate relative to the input cost inflation experienced by HHAs. While CHA appreciates that CMS will refresh the market basket update in the final rule using more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation — particularly for labor.

Even before the application of the productivity adjustment (discussed further below), the methodology — based on IHS Global Insight data — has continually failed to keep up with cost growth year-over-year. From 2015 to 2019, home health per-visit cost growth exceeded the Medicare market basket update by a cumulative 13.1 percentage points¹. Now, in the face of input price growth at levels not seen in 40 years,² it is clear, based on rapidly rising labor costs, that CMS' current method for updating the market basket is ill-suited for adjusting Medicare payments in a highly inflationary environment. **Therefore, we ask CMS to consider other methods and data sources to calculate the final rule "base" (before additional adjustments) market basket update that would better reflect the rapidly increasing input prices facing HHAs.** If CMS fails to provide an adequate market basket update, CHA is deeply concerned about access to home health services for Medicare beneficiaries.

¹ CHA analysis of Medicare home health agency cost reports

² <https://www.npr.org/2022/02/10/1079260860/january-inflation-consumer-prices-cpi-economy-federal-reserve>

Market Basket Update — Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be -0.4 percentage points. CMS uses the total factor productivity (TFP) adjustment as calculated by the Bureau of Labor Statistics. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in TFP.

CHA believes the assumptions underpinning the productivity adjustment are fundamentally flawed. As such, we strongly disagree with the continuation of this punitive policy — particularly during the PHE. The productivity adjustment to the market basket update assumes that HHAs can increase overall productivity — producing more goods with the same or fewer units of labor input — at the same rate as increases in the broader economy. However, providing home-based care to patients is highly labor-intensive.

This level of care must be provided on-site and has a high “hands-on” component. Therefore, under the current regulatory structure, HHAs cannot improve productivity using strategies like offshoring or automation that are common in other sectors of the economy that produce goods (auto manufacturing) or services (restaurants that use automated ordering systems to reduce overall staffing count).

Given that CMS is required by statute to implement a productivity adjustment to the market basket update, CHA asks the agency to work with Congress to permanently eliminate this unjustified reduction in hospital payments.

Proposed PDGM ‘Budget Neutrality’ Adjustment

CMS is required by law to determine the impact of differences between assumed and actual behavior on estimated aggregate expenditures, beginning in CY 2020 and ending with CY 2026, and make permanent and temporary adjustments as necessary. To comply with the statutory requirements, the agency analyzed the CY 2020 and CY 2021 30-day payment rates to account for changes in actual versus assumed behavior that would have caused payments to be different than what was finalized for those two years.

Based on claims data, CMS found that the CY 2020 30-day payment rate with actual behavior changes would be \$1,742.52, compared to \$1,864.03 when using the assumed behavioral changes that had been adopted in the CY 2020 final rule. Using this new CY 2020 rate, CMS recalculated a CY 2021 30-day payment rate of \$1,777.19, using the adopted update factors and with assumed behavior changes from the CY 2021 final rule.

CMS then analyzed CY 2021 claims data to determine a 30-day payment rate of \$1,754.99 to account for actual behavior changes, which is -7.69% lower than the adopted CY 2021 rate of \$1,901.12. As a result, CMS proposes to apply a permanent adjustment of 0.9231 to the CY 2023 base payment rate to prevent the need for a larger adjustment in future years. If finalized, this adjustment will reduce HHA payments by approximately \$2 billion.

CHA appreciates the detailed discussion of CMS’ analysis related to the proposed Patient-Driven Groupings Model (PDGM) “budget neutrality” adjustment. **However, we are deeply concerned that the methodology is badly flawed, as it does not account for the reduction in therapy visits that resulted under the PDGM.** Using a methodology that accurately accounts for the reduction in therapy visits,

analysis by Dobson DaVanzo of 2020 PDGM data finds that payments were 2.5% below budget neutral levels³.

CHA notes that budget neutrality requires that the estimated aggregate home health PPS expenditures in CY 2020 are equal to the estimated aggregate expenditures that otherwise would have been made in the absence of the change to a 30-day unit of payment. To conduct its analysis, CMS used CY 2020 data to determine what payments would have been under the 153-group case-mix system and 60-day unit of payment. CMS determined the actual CY 2020 30-day base payment rate was higher than it would have been under the 60-day payment system.

However, the methodology used by CMS is inaccurate. Under the 60-day system, case mix and payments are largely driven by therapy visits, while the PDGM case mix and payments rely on clinical characteristics. One of the most significant changes in moving from the Home Health Resource Group to PDGM system was that therapy thresholds were eliminated under the new model. As a result, when PDGM was implemented, it was accompanied by an approximately 30% payment-driven drop in therapy utilization. The natural result of this is much lower calculated budget-neutral payments when CY 2020 data are repriced under the 60-day payment system. As CMS acknowledges in the 2023 skilled-nursing facility proposed rule, failing to account for changes in the provision of therapy services leads to an overcorrection⁴.

CHA asks CMS to delay any budget neutrality adjustment until after it has analyzed the 2020 home health data using a model that properly accounts for the changes in therapy provision. If the preliminary analysis by Dabson DaVanzo is confirmed, we ask CMS to take corrective action to increase rates by the amount HHAs have been underpaid as required by the Bipartisan Budget Act, and we reiterate our previous requests that CMS provide additional information and data to support its current assumptions about the impact of provider behavior changes on payment. This includes an analysis of the projected impact on different types of HHAs, including hospital-based HHAs.

Functional Impairment Levels

Under the PDGM, the functional impairment level is determined by responses to certain OASIS items associated with activities of daily living and the risk of hospitalization. A home health period of care receives points based on responses from these functional OASIS items, which are converted to a table of points. The sum of all these points is used to group home health periods into low, medium, and high functional impairment levels, designed so that about one-third of home health periods fall within each level. For 2023, CMS proposes to use the 2021 claims data to update the functional points and functional impairment levels by clinical group and use the same previously finalized methodology to update the functional impairment levels for CY 2023.

CMS also reports on its analysis of the current functional items used for payment and analogous Section GG items. HHAs began collecting standardized patient assessment data addressing functional status in Section GG, as part of the OASIS beginning in January 2019.

³ <http://pqhh.org/wp-content/uploads/2022/06/DDA-PPT-PDGM-Budget-Neutrality-Assessment-using-SNF-Methodology- Final-Read-Only6-Read-Only.pdf>

⁴ CY 2023 SNF PPS Proposed Rule, 87 FR 22720; <https://www.federalregister.gov/d/2022-07906/p-193>

CMS says its analysis continues to demonstrate a correlation between the current responses to the M1800-1860 items and the GG items. However, CMS notes that responses to Section GG items include a significant amount of Activity not Attempted responses, limiting its ability to map Section GG responses to corresponding M1800-1860 OASIS items. CMS continues to use the M1800 to 1860 items for case-mix purposes.

CHA appreciates CMS' recognition of the limitations of the current data and supports its plan to continue for CY 2023 the use of existing OASIS items M1800-1860 for the purposes of case mix and payment. However, we remind CMS that the continued requirement for HHAs to complete duplicative items addressing functional status represents an unnecessary administrative burden and may lead to confusion in reporting. We encourage CMS to continue and expedite its efforts to validate the Section GG items and make a determination regarding the most appropriate and accurate method of assessing functional access for home health beneficiaries.

Telecommunications Data Collection

CHA applauds and supports CMS' recognition that telecommunications technology — when deployed as part of the home health plan of care — is an effective complement to in-person visits. This is evidenced by its implementation of provisions to allow HHAs to use various types of telecommunications systems in addition to remote patient monitoring and to include certain costs in allowable administrative costs, as reported in a broad category of administrative costs in the HHA Medicare cost report.

CMS believes that collecting data on the use of telecommunications technology on home health claims would allow it to analyze the characteristics of the beneficiaries utilizing such services and would provide a broader understanding of the social determinants that affect who benefits most from these services, including what barriers may potentially exist for certain subsets of beneficiaries.

CMS now proposes to begin the collection of data on the use of telecommunications technology on home health claims by January 1, 2023, on a voluntary basis, and will require this information to be reported by July 2023. CMS also solicits comments on the use of three new G-codes that identify when home health services are furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system; synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system; and the collection of physiologic data digitally stored and/or transmitted by the patient to the HHA, that is, remote patient monitoring. CMS would capture the utilization of remote patient monitoring through the inclusion of the start date of the remote patient monitoring and the number of units indicated on the claim.

CHA supports this proposal and urges CMS to provide information and training to ensure providers are prepared to accurately report this important information. In addition, we encourage CMS to consider additional changes to support HHAs' ability to improve care and care access through telehealth and remote patient monitoring. Incorporating telehealth as an integral modality for care delivery in home health is critical to ensuring access to care and timely service delivery, particularly at a time when HHAs must meet increased demand, conserve resources, and limit unnecessary visits and potential for exposure. CHA member hospitals are making significant investments to develop the infrastructure necessary to meet the needs of Medicare beneficiaries both now and in the years to come.

It is critical that future policy provide adequate reimbursement and regulatory support to allow providers at all levels of the care continuum to develop the health care system of the future.

All-Payer OASIS Data Collection

CMS proposes to require that a home health OASIS be completed for each patient cared for by the HHA, regardless of payer. CMS proposes to require HHAs to submit all-payer OASIS data for purposes of the home health QRP, beginning with the CY 2025 program year. The requirement will be phased in. For the CY 2025 program year, all-payer OASIS data will be required for two quarters (discharges between January 1 and June 30, 2024). Four-quarter (full year) reporting will begin with the CY 2026 program year (i.e., discharges between July 1, 2024, and June 30, 2025), and advancing annually by one year for each subsequent program year.

CHA supports the goal of standardizing the collection and reporting of patient assessment data and quality reporting measures across post-acute care settings. CHA member HHAs also recognize the value of collecting and reporting data on patients regardless of payer type. In fact, some CHA member HHAs report that they currently complete the OASIS on all admissions, rather than limiting completion to Medicare beneficiaries only. However, CHA is concerned that expanding the requirement for completion to all payers will result in significant additional cost, further strain limited HHA resources, and does not allow sufficient time for necessary preparation, particularly in consideration of the impact of PDGM and the ongoing PHE.

CHA urges CMS to delay the requirement for the implementation of the updated OASIS for all payers until at least January 2025, to allow for the opportunity for HHAs to develop a clearer understanding of the necessary time commitment and operational considerations.

We appreciate CMS' recent decision to delay for one year the requirement to complete the inpatient rehabilitation facility (IRF) patient assessment instrument for all payers, as noted in the IRF PPS final rule. In that context, we believe that implementing a similar delay in the HHA setting for OASIS will provide additional time to operationalize this significant change, without limiting CMS' goals of aligning quality reporting across care settings.

CHA appreciates the opportunity to comment on the home health PPS proposed rule for CY 2023. If you have any questions, please do not hesitate to contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Pat Blaisdell, vice president, continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/

Megan Howard

Vice President, Federal Policy