August 29, 2023

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

SUBJECT: CMS-1780-P, Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements; Federal Register (Vol. 88, No. 130), July 10, 2023

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 (HH) prospective payment system (PPS) proposed rule for calendar year (CY) 2024.

HHAs are struggling with workforce and financial issues in the aftermath of the COVID-19 public health emergency (PHE). It is in this context that our comments are made. Given the unique role of HH in the care continuum, HH providers have responded to changes in the types of patients they are seeing, their care needs, and how and where care is delivered. Policy and payment changes 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 the agency take steps to eliminate punitive and unwarranted decreases in reimbursement that have negatively impacted access to HH care. These steps are necessary to account for the significant cost increases experienced by HHAs during the past few years. Specifically, we urge CMS to:

- **Provide a forecast error adjustment to the final 2024 market basket update to account for CMS' underestimation of the market basket in the years 2021 and 2022 as a result of the COVID-19 PHE.**
- **Eliminate the productivity adjustment to the market basket update for any year impacted by the COVID-19 PHE.**

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- **Delay implementation of the budget-neutrality adjustment as currently proposed.** CMS' current proposal is based on flawed assumptions, does not adequately account for the significant cost increases experienced by HHAs over the past few years, and is not aligned with the statutory Patient-Driven Grouping Model (PDGM) budget-neutrality requirements.
- **Delay rebasing the labor-related share and include data from hospital-based HHAs.** As discussed below, CHA believes the decrease in the labor-related share is a direct result of factors related to COVID-19. Therefore, CHA believes that CMS, as it has done in other payment systems, should use alternative data to rebase the market basket update and labor-related share. Otherwise, HH providers will be negatively impacted by data polluted by COVID-19's effects. Further, given that costs for hospital-based HHAs are allowable under Medicare reimbursement principles, we believe CMS must include these data in the rebased labor-related share.
- **Conduct Additional Testing on Cross-Setting Discharge Function Score Measure.** CHA urges CMS to conduct additional testing on the proposed Discharge Function score measure. This would ensure it does not disincentivize HHAs from taking on complex patients and delay the adoption of the measure in the skilled-nursing facility (SNF) quality reporting program (QRP) until it has been endorsed by the consensus-based entity (CBE). Further, we oppose the inclusion of this measure in the HH value-based purchasing (VBP) program until HHAs have had several years of experience with the measure under the HH QRP.

Market Basket Update

CMS proposes a gross market basket update of 3%. The proposed update is based on IHS Global Insight Inc.'s (IGI) first-quarter 2023 forecast for 2024 with historical data through fourth-quarter 2022 and the proposed 2021-based HH market basket. The gross market basket update will be reduced by a -.3% productivity adjustment as mandated by the Affordable Care Act. The resulting proposed net market basket update equals 2.7% (3% minus .03% productivity adjustment) prior to the unjustified, PDGM parity adjustment.

CHA is deeply disappointed in the proposed 2.7% 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. The Bureau of Labor Statistics (BLS) data show that two-year quarterly compounded wage growth for HH care workers between 2020 and 2021 increased by 11.5%.[1] However, during that same time frame, Medicare payments to HHAs only increased by 4.7%.

Further, from 2018 to 2022, cumulative HH per-visit cost growth was 19%.[2] Over this same period, the increase in the final rule market basket update[3] was only 9.92%.[4] During this five-year period HH agencies were underpaid by 9.8%. This stems from CMS' use of an inadequate mechanism to update HH payment rates. As an example, CHA notes that the CY 2021 and CY 2022 HH PPS final rule gross market basket

[1] http://pqhh.org/wp-content/uploads/2022/10/PQHH-Home-Health-Labor-Cost-Survey_FINAL-Report_8.15.2022_1.pdf
[2] CHA analysis of Medicare home health agency cost reports
[3] Final rule market basket update, net of productivity, before any PDGM behavioral adjustments.
[4] CHA analysis of Medicare market basket update data.

updates were 2.3% and 3.1%, respectively. However, based on publicly available CMS data, the actual market basket update should have been 3.3% and 6.3%, respectively, based on IHS Global Insight Data.

In prior comment letters CHA, along with other stakeholders, expressed concern that the market basket update proposed (and subsequently finalized) in a given year was inadequate relative to input price inflation. Unfortunately, as discussed above, these concerns have been realized as a result of the impact that a unique event — the COVID-19 PHE — had on HH agency labor and other expenses. As discussed above, the actual market basket updates for CYs 2021 and 2022 should have been 3.3% and 6.3%, respectively. Instead, CMS finalized unadjusted market basket updates of 2.3% and 3.1%, resulting in HH providers being underpaid relative to inflation as illustrated below.

2021 and 2022 HH Market Basket Update: Forecast vs. Actual

	2021	2022	Total
Actual Market Basket Update	3.30%	6.30%	
Final Market Basket Update	2.30%	3.10%	
Simple Forecast Error	1.00%	3.20%	4.20%

CHA respectfully asks that CMS apply a *one-time* 4.2 percentage point "forecast error adjustment" to the proposed CY 2024 market basket update. We believe this update is necessary to account for the unprecedented input price inflation experienced by HH providers — particularly for labor costs — stemming from the COVID-19 pandemic. This inflation was not captured in the market basket updates for CY 2021 and 2022.

Market Basket Update – Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be -0.3 percentage points. The adjustment is based on IGI's fourth-quarter 2022 forecast.

CMS itself has acknowledged that providers are unable to achieve the productivity gains assumed by the general economy over the long run.[5] CHA appreciates this acknowledgment and agrees that the assumptions underpinning the productivity adjustment are fundamentally flawed. We strongly disagree with the continuation of this policy — particularly during the years subject to the COVID-19 PHE. The productivity adjustment to the market basket update assumes that HHAs can increase overall productivity — producing more visits with the same or fewer units of labor — at the same rate as productivity increases in the broader economy. However, providing home health care is highly labor intensive, as CMS' projection of the labor-related portion of the federal rate — 74.9% — implies in the CY 2024 proposed rule.

HH care must be provided on-site and has a high "hands-on" component. Therefore, agencies cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy that produce goods (robotic automation of manufacturing plants) or services (dine-in restaurants that use automated ordering systems to reduce overall staffing count). As an example, CMS' own research, conducted prior to the COVID-19 PHE, indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[6]

[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf
[6] ibid

CHA notes that during the COVID-19 PHE, productivity fell[7] as a result of increased staff turnover. Over 100,000 nurses are estimated to have left the field during 2021 and 2022[8] alone. During that time, as discussed above, high levels of temporary staffing were deployed to address the labor shortage. While substituting contract labor for employed staff allowed HHAs to continue delivering care to the communities they serve, it also had a negative impact on productivity. Temporary staff are not accustomed to a specific agency's workflows, which increases the number of hours required to provide patient care. Further, as noted by a respondent to a recent Partnership for Quality Home Healthcare (PQHH) survey, there is a steep learning curve for professionals newly entering HH practice from other clinical care settings. It can take up to one full year of mentoring before a new hire can practice independently. Further, an October 2021 survey conducted by Kaufman Hall found that many health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.[9]

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 to HH payments. Further, due to the extreme and uncontrollable circumstances associated with the COVID-19 PHE that reduced labor productivity, we ask CMS to remove the productivity adjustment for any fiscal year that was covered under PHE determination (e.g., 2020 -.3%, 2021 -.3%, 2022 -.5%, and 2023 -.1%) from the calculation of market basket for CY 2024 and any year thereafter.

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. In the proposed rule, the agency reviews its analysis of alleged changes to CY 2020 and CY 2021 30-day payment rates. Further, to comply with the statutory requirements, it analyzes CY 2022 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 that year.

For CY 2022, CMS followed the same methodology it used in prior years to account for alleged behavioral changes. Based on claims data, CMS found that the CY 2022 30-day payment rate with actual behavior changes would be $ 1,841.55, compared to $ 1,872.18 when using the assumed behavioral changes. This results in an additional permanent adjustment of -1.636%.

CMS calculates the 2024 permanent adjustment by combining the 2020, 2021, and 2022 permanent and temporary adjustments. In 2023, CMS implemented a -3.925% permanent behavior adjustment and claims it must account for it in the proposed 2024 permanent adjustment. CMS calculates that to offset the increase in estimated aggregate expenditures for CY 2022 based on the impact of the differences between assumed and actual behavior changes, and to account for the permanent adjustment of -3.925% taken in CY 2023 rulemaking, it would need to apply a -5.653% permanent adjustment to the CY 2024 base payment rate. Therefore, CMS proposes to apply a permanent adjustment of -5.653% to the 2024 base payment rate for a cumulative adjustment of -9.36%.

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[7] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf
[8] https://www.aha.org/news/headline/2023-04-13-study-projects-nursing-shortage-crisis-will-continue-without-concerted-action
[9] https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates

In addition to the permanent adjustment, CMS also estimates that it is also required to make a temporary adjustment to HH payments of $3.439[10] billion for the years 2020-2022. However, it does not propose to make such an adjustment at this time.

CHA thanks CMS for not applying the temporary adjustment to the 2024 base payment rate. However, as detailed in prior comment letters, we have concerns about CMS' methodology for calculating the PDGM behavioral adjustment from both a technical and legal perspective.

First, CMS does not compare the behaviors assumed by CMS in establishing the initial payment amounts for CY 2020 and the actual behavior observed on aggregate expenditures. Rather, CMS' proposal merely reprices 2020, 2021, and 2022 claims payments to establish an artificial target amount and reduces the 30-day payment amounts under PDGM to meet that target. It does this largely by adjusting payments downward for a reduction in therapy utilization, a factor that has no impact on aggregate expenditures and is contrary to the law.

The data presented in the proposed rule show that the change to PDGM with the elimination of therapy thresholds and from a 60-day episode to 30-day period was accompanied by an overall reduction in the volume of therapy visits. Therefore, CMS' use of data from CYs 2020, 2021, and 2022 to estimate what CY 2020 case-mix and payments would have been without the implementation of PDGM is fundamentally flawed as the data reflect the effects of PDGM, not what payments would have been in its absence. The counterfactual expenditure amount that meets the statutory requirements is impossible to determine using CY 2020 data as they exist. This is because the introduction and contaminating effect of the 30-day unit of payment under PDGM eliminated therapy thresholds as a determinant of case-mix and payments. By contrast, CMS acknowledged and corrected for this methodological concern for similar budget-neutrality methodologies addressed in the FY 2023 SNF PPS final rule, providing a model for how this issue should be addressed for HH agencies.

Second, given the significant technical issues associated with the methodology for calculating budget neutrality, we believe the agency is violating the basic requirements of the statute. Rather than ensuring the payment amounts are budget neutral, the methodology constitutes an unauthorized rebasing of the 30-day payment amount. A legal analysis[11] of CMS' methodology concludes that its proposals on both permanent and temporary adjustments are unlawful. Key points of this analysis include:

- *CMS' Proposed Rule Violates Three Separate Statutory Commands*: The proposal ignores the statutory provision it purports to be implementing by failing to correct its assumptions about how HH agencies would change behaviors in response to the new payment system. It also violates the statute's budget-neutrality command by reducing overall aggregate expenditures. Third, it uses therapy thresholds to determine payment, despite the statute's mandate to eliminate this practice.
- *CMS' Proposed Rule Is Arbitrary and Capricious*: In reaching its desired policy result to cut payments and reduce aggregate expenditures, the agency has treated similarly situated parties differently, relied on factors which Congress has not intended, failed to consider important aspects of the problem, and offered an implausible explanation for its decision that runs counter to the evidence before the agency.

[10] (2020) -$873,073,121 + (2021) -$1,211,002,953 + (2022) -$1,355,208,655 = (total) -$3,439,284,729
[11] http://pqhh.org/wp-content/uploads/2022/08/PQHH-2023-HH-Proposed-Rule-Comments-and-Appendicies1.pdf

These massive, unjustified payment cuts that CMS is implementing through the HH PPS are negatively impacting access for Medicare beneficiaries. Recent research shows that while referrals to HHAs have grown 11% since 2022, HHA rejection rates have increased 40% since 2022. This is despite rejection rates already reaching an all-time high in 2022.[12]

Based on the technical and legal analysis discussed above, CHA does not believe CMS' continued implementation of its current PDPM budget neutrality methodology meets the statutory requirements. This not only negatively affects quality and beneficiary outcomes but stands to increase Medicare spending if these patients are discharged to higher cost settings like SNFs due to the death of home health care. **We urge CMS to withdraw the proposal included in the rule for both permanent and temporary adjustments and develop and propose a methodology that aligns with statutory requirements.**

Labor-Related Share

For 2024, CMS proposes to update the labor-related share to reflect the proposed 2021-based HH market basket cost weights. The proposed labor-related share is 74.9%. This is down from 76.1%, a reduction of 1.2 percentage points. CHA is deeply concerned by the proposed decrease in the labor-related share for HHAs and believes it will reduce access to HH services in areas with high labor costs. We believe the calculation of the labor-related share — and therefore the proposed reduction in it — is technically flawed based on the data used to calculate it and the timing of the calculation.

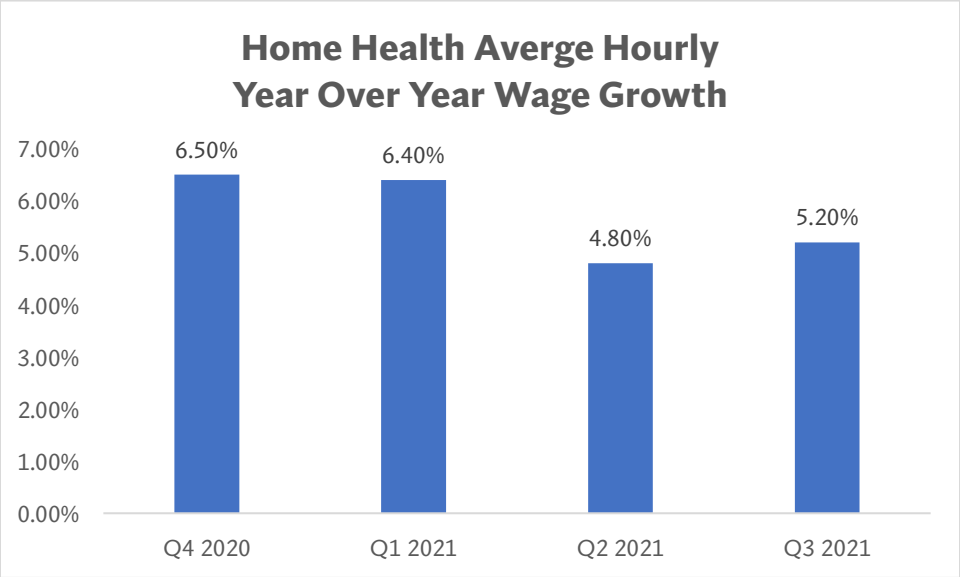
Data Sources: CMS proposes to rebase and revise the 2016-based HH market basket cost weights to a 2021 base year, reflecting 2021 Medicare cost report data submitted by freestanding HHAs. The proposed rule notes that it excludes hospital-based HHAs, which account for 7% of HH providers. However, in explaining this exclusion of a non-trivial number of HHAs, the proposed rule only offers that CMS is concerned that "cost data for hospital-based HHAs can be affected by the allocation of overhead costs."

CHA finds this concerning on multiple levels. First, in general, HHAs operated by hospitals or health systems are often the safety net or default provider, who accept and care for those patients that other HHAs can't or won't accept, secondary to payment issues or medical complexity. Therefore, excluding them excludes the costs – particularly the wage-related costs – associated with caring for a more complex population. Second, based on Medicare reimbursement principles, the home office overhead costs allocated to hospital-based HHAs are allowable costs. These costs are audited by Medicare's contractors and therefore are valid costs that must be included in setting the market basket update. Finally, CMS' explanation only states that the cost data *can* be affected by the allocation of overhead costs. It does not confirm that the cost data are affected or attempt to explain why, if the cost data are affected, it would be inappropriate to include them in the data used to calculate the rebased market basket weights. **Given that overhead costs for hospital-based HHAs are valid, allowable costs, CHA respectfully asks CMS to include them in the calculation of the labor-related share in the final rule if it recalculates it based on 2021 data (discussed below).** If CMS does rebase the labor-related share based on 2021 data and includes data for hospital-based HHAs, CHA's analysis of cost report data indicates that the labor-related share should be approximately 76%.

[12] https://www.fiercehealthcare.com/providers/hospitals-struggling-discharge-patients-post-acute-care-settings-wellsky-report

Data Timing: CHA believes that a decreased labor-related share based on 2021 data is counterintuitive given the increasing labor costs agencies are facing and believes this result is driven by COVID-19 skewing labor utilization. **Similar to other instances where the COVID-19 PHE tainted data used by CMS to set payment rates (e.g., 2022 IPPS final rule[13]), we respectfully ask the agency to use an alternative approach. Specifically, we ask the agency to continue using the market basket cost weights and labor-related share based on the 2016 data that are currently in use. In the 2025 HHPPS proposed rule, CMS can evaluate using 2022 data to rebase the HH PPS market basket update and labor-related share.**

CHA notes that the BLS HH average hourly wage percent changes year-over-year by quarter show significant wage growth for the FFY 2021, as illustrated in the chart below.[14] These data are counterintuitive to a decreasing labor-related share, given that staffing is the largest expense incurred by HHAs and these costs were rapidly growing for the period in question.



As discussed above, given that wages for HH aides were rapidly increasing during this period, CHA is concerned that a shortage of staff may be one of the factors that is artificially decreasing the labor-related share in the 2021 cost report data. The labor inflation experienced by all HHAs was driven by a well-documented shortage of clinical staff. During the pandemic, some clinicians exited health care, either permanently or temporarily, leaving HHAs with an average of 59% filled positions during first-quarter 2022, as reported by the PQHH in its 2022 survey.[15]

The exodus of staff from HHAs was exacerbated by other provider types recruiting clinicians from HHAs to address their own labor shortages. Over half of respondents also reported increased turnover for clinicians shifting employment to other care settings. Given that HHAs have payer mixes that are

[13] CMS typically uses cost report data from 3 years prior and claims data from two years prior to the fiscal year for which it is setting MS-DRG rates. However, in the FFY 2022 final rule, instead of using cost report data from FFY 2019 and claims data from FFY 2020, CMS used cost report data from 2018 and claims from 2019 due to concerns about COVID-19's impact on the underlying data.
[14] Source: Bureau of Labor and Statistics
[15] http://pqhh.org/wp-content/uploads/2022/10/PQHH-Home-Health-Labor-Cost-Survey_FINAL-Report_8.15.2022_1.pdf

dominated by governmental payers —whose payments do not cover the cost to provide care — many HHAs couldn't afford to retain staff. With these staff vacancy rates, HHAs attempted to retain contract clinical staff to meet patient care needs. However, 29% of the respondents to the PQHH survey reported a lack of contract field staff. CHA believes this partially explains the reduction in the contract labor component that CMS identifies as the driver in the reduction of the labor-related share.

While 2021 saw the highest average number of daily hospital admissions per 100,000 during the PHE,[16] demand (and therefore wages) for clinical labor in other settings of care (e.g., hospitals) was the greatest at this time. As demand for clinical labor — including contract clinical labor — has decreased from the peak of the pandemic in 2021, we believe that contract labor utilization by HHAs has normalized and increased (due to increased availability of contract staff) relative to the period CMS proposes to use to establish the labor-related share.

Further, changes to the HH care delivery model to minimize the risk of COVID-19 infection reduced the number of full-time equivalents (FTEs) needed to provide care — particularly among HH aides. Frequently, patients requested that HH providers limit the number of individuals sent to the home to minimize the risk of COVID-19 infection. In this environment, many tasks that — prior to the pandemic were done in person — were accomplished using telehealth during the pandemic. While this didn't reduce the number of visits, it would have reduced the total number of hours and FTEs required to provide care by eliminating the drive between patients' homes. Elimination of windshield time allowed for the same number of patients to be seen with fewer clinicians. While many of the telehealth flexibilities that allowed for the increased use of virtual visits remain in effect, CHA care delivery models are shifting back to in-home care due to patient preferences.

The COVID-19 pandemic has distorted the data CMS is proposing to use in rebasing the HH market basket and labor-related share. Therefore, CHA respectfully asks CMS to continue using the 2016 data for CY 2024. In the CY 2025 proposed rule, CMS can evaluate whether or not it would be appropriate to use the 2022 cost report data to rebase the HH market basket update and labor-related share. CHA is concerned that HHAs in markets that are negatively impacted by the inappropriate reduction in the labor-related share will be forced to reduce staffing to cut costs. As a result, this will force HHAs to turn away referrals. This drastic action — which will not only reduce access to home health care but hospital care as facilities cannot discharge patients in a timely manner — was cited by 71% of respondents to the PQHH survey as a consequence of being unable to hire clinicians.

Home Health Quality Reporting Program

Proposed Adoption of Discharge Function Score Measure and Removal of Overlapping Discharge Measure

Beginning with the CY 2025 HHQRP, CMS proposes to adopt a new assessment-based outcome measure that estimates the percentage of HH patients who meet or exceed an expected discharge score during the reporting period. In conjunction with this proposal, CMS would remove the current Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure that would overlap with the newly proposed measure.

[16] https://www.nytimes.com/interactive/2021/us/covid-cases.html

The proposed discharge function score measure includes an observed discharge function score that is calculated by summing individual function item values related to self-care and mobility from the HH Outcome and Assessment Information Set (OASIS). The expected discharge function score is calculated by risk-adjusting the observed score to control patient characteristics — including age, admission function score, and clinical conditions — to establish how much functional improvement would be expected for each home health episode. The measure uses a statistical imputation approach to account for missing OASIS elements when codes demonstrate that an "activity was not attempted (ANA)." If an OASIS item is coded as ANA, the imputation method inserts variables based on the values of other, non-missing items that are similar to the missing item to make assumptions about what the patient would have scored on that item if it had been attempted.

CHA strongly supports the inclusion of functional status measures in the HH QRP and across the post-acute care settings. We appreciate the resources CMS has invested in developing this cross-setting measure, including the technical expert panel (TEP) that was convened in 2021 and 2022. We also appreciate that CMS will not increase reporting burdens by using established OASIS elements and by proposing to remove an overlapping measure in conjunction with the adoption of the proposed measure. However, we urge the agency to delay finalizing the measure until it has received endorsement from the CBE. We offer several comments on considerations for possible refinements to the measure over time.

For example, we understand that the statistical imputation approach to addressing items coded as ANA was endorsed by the TEP as the method most likely to produce an unbiased estimate of the patient's function had the item been attempted. However, it is a very complex calculation and may be difficult to understand how performance is impacted by both HHAs and the public. We urge CMS to continuously evaluate this method, particularly to identify if it has differential impacts across the post-acute care settings. In addition, we urge CMS to provide additional coding guidance for ANA use for OASIS elements to better standardize and reduce the use of ANA codes.

We also urge CMS to consider additional factors for risk adjustment to help ensure that the measure does not disincentivize HHAs from taking on patients with greater medical complexity and care needs. For example, CHA members have reported that post-acute care patients with complex co-morbidities such as a diagnosis or history of COVID-19 or Long COVID can take much longer to recover than other patients, and this could be a factor that may impact a patient's expected function score. Under the Hospital Readmissions Reduction Program and the hospital Value-Based Purchasing Program clinical outcomes domain, CMS includes a covariate risk adjustment on measures for patient history of COVID-19 within 12 months of admission. While it may be too early to understand the impact of COVID-19 on functional outcomes, we urge CMS to monitor its data for future measure refinements. In addition, we urge the agency to consider how it could address the impact of social determinants of health (SDOH) on functional outcomes, including how data from the new SDOH elements in the OASIS-E could contribute to this work.

Proposed Adoption of Percentage of Patients/Residents Who Are Up to Date with COVID-19 Vaccination Measure

CMS proposes to adopt an assessment-based process measure that reports the percentage of home health patients who are up to date on their COVID-19 vaccinations per the CDC's latest guidance, beginning with the CY 2025 HH QRP. The data would be collected via a yes/no question on the OASIS, and the measure has no denominator exclusions and is not risk-adjusted.

CHA strongly supports COVID-19 vaccination and we do not oppose the concept of a patient or resident vaccination measure. However, much remains unknown about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19 vaccine will be available. It is unclear whether most patients would have an understanding of the CDC's specific definition of "up to date" when answering a yes/no question for the patient assessment, leading to potentially inaccurate data. Further, we are concerned that the publicly reported data will not be reflective of any actionable activity by the HHA, given the limited role of HHAs in vaccination efforts.

We note that during the pre-rulemaking process, the Measures Application Partnership (MAP) Coordinating Committee did not support the adoption of the measure, and urged CMS to reconsider exclusions for medical contraindications, complete reliability and validity measure testing, and seek endorsement from the CBE. We urge CMS to follow the recommendations of the MAP Coordinating Committee, and delay the adoption of such a measure until it has been thoroughly tested and endorsed by the CBE.

Home Health Value-Based Purchasing Program

CMS proposes several changes to the HH VBP program, including replacing several measures in the VBP program measure set beginning with the CY 2025 performance year/CY 2027 payment determination. Among the replacements, CMS proposes to replace the current OASIS-based Total Normalized Composite Change in Self-Care measure and the OASIS-based Total Normalized Composite Change in Mobility measure with the Discharge Function score that is newly proposed for the HH QRP beginning with the CY 2025 reporting year.

As noted in our comments on the HH QRP, we support the inclusion of functional status measures in QRPs, and we agree that improving the functional status of residents should be a priority for HHAs. However, we remain concerned that the measure's construction could incentivize HHAs to avoid caring for some of the most complex patients who may not easily achieve functional objectives or could penalize HHAs that do take on these patients. Further, we have urged CMS not to finalize this measure in the HH QRP until it has been endorsed by the CBE, and we believe that HHAs should have several years of experience with this measure to understand how they can improve performance before it is included in the HH VBP program. We oppose the inclusion of this measure in the HH VBP program at this time.

CHA appreciates the opportunity to comment on the HH PPS proposed rule for CY 2024. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or my colleagues Megan Howard at mhoward@calhospital.org or (202) 488-3742, or Pat Blaisdell at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy