August 26, 2024

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

SUBJECT: CMS-1803-P,* Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies, *Federal Register (Vol. 89, No. 128), July 3, 2024

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) 2025.

HHAs are struggling with workforce stemming, in part, from financial issues. These staffing and financial challenges will likely increase when the agency's staffing requirements for long-term care facilities take effect for many facilities in May of 2026, putting further pressure on labor costs. The inability to afford staffing as a result of financial challenges is translating into access issues for Medicare beneficiaries to home health services. Based on analysis of Medicare home health agency cost report data, home health episodes decreased by 8%. This decrease came at a time when hospital adjusted discharges and acuity were increasing[1].

The inability to place a Medicare beneficiary with a home health agency negatively impacts Medicare beneficiaries as it delays their receipt of needed care in the most appropriate setting. It is in this context that our comments are made. Given the unique role of home health in the care continuum, home health 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.

[1] www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2022-12.pdf

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There are serious concerns about the impact of CMS' payment adjustments in the CY 2025 HH PPS rule. CHA requests the agency take the steps discussed below to eliminate punitive and unwarranted decreases in reimbursement that negatively impact access to home health care. These steps are necessary to account for the significant cost increases experienced by HHAs during the past few years. Specifically, CHA urges CMS to:

- **Provide a forecast error adjustment to the final 2025 market basket update that accounts for CMS' underestimation of the market basket in the years 2021, 2022, and 2023. This underestimating results from escalating labor costs that were not captured by the final rule market basket in those years.**

- **Rescind implementation of the budget-neutrality adjustment as currently proposed.** CMS' current proposal related to the Patient-Driven Grouping Model (PDGM) budget neutrality adjustment 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 PDGM budget neutrality requirements.

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 2024 forecast for 2025 with historical data through the fourth quarter 2023. The gross market basket update will be reduced by a -0.5% productivity adjustment, as mandated by the Affordable Care Act. The resulting proposed net market basket update equals 2.5% (3% minus 0.5% productivity adjustment) prior to the unjustified, PDGM parity adjustment (discussed below).

The proposed 2.5% market basket update is wholly inadequate relative to the input cost inflation experienced by HHAs. While CMS will refresh the market basket update in the final rule using more recent data, it is concerning that the revised update will still be insufficient relative to input cost inflation — particularly for labor.

Even before the application of the productivity adjustment, the methodology — based on IGI data — has continually failed to keep up with cost growth year-over-year. For example, BLS data show that nursing staff wages will grow by 7.7% in first quarter 2023 compared to first quarter 2022.[2] However, during that same time frame, the Medicare HHA PPS market basket only increased by 2.6%.

Further, costs per Medicare home health episode increased by ~9% in 2022 and an additional ~4% in 2023[3]. However, the increase in the net final rule market basket updates[4] were only 6.87% and -1.03% respectively, resulting in a significant underpayment of HHAs. This stems from CMS' use of an inadequate mechanism to update HH payment rates and unnecessary and improperly calculated PDGM budget neutrality adjustment. As an example, CHA notes that the CY 2022 and CY 2023 HH PPS final rule gross market basket updates were 3.1% and 4.1%, respectively. However, based on publicly available CMS data, the actual market basket update should have been 6% and 5.2%, respectively, based on IGI

[2] Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2024 HH PPS Proposed Rule; Dabson, Davanzo; August 28, 2023
[3] CHA analysis of home health agencies cost reports.
[4] Final rule market basket update, net of productivity, PDGM behavioral adjustments, and other budget neutrality adjustments.

data. This continued reduction in Medicare FFS payment — relative to input costs — is one of the reasons behind the steady decline in home care agencies[5] observed by MedPAC.

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[6,7]. Unfortunately, as discussed above, these concerns continue to be realized as a result of the impact that the COVID-19 public health emergency (PHE) continues to have on HH agency labor and other expenses. The actual market basket updates for CYs 2021, 2022, and 2023 should have been 3.1%, 6.0%, and 5.2%, respectively. Instead, CMS finalized unadjusted market basket updates of 2.3%, 3.1%, and 4.1% resulting in HH providers being underpaid relative to inflation. Further, it appears that the forecast 2024 Q3 market basket is considerably less than the finalized 2024 update.

2021, 2022, and 2023 HHA PPS Market Basket Update: Forecast vs. Actual[8]

FFY	Final Rule Projected MBU	MBU Based on Actual Data	HH PPS Under Reimbursement
2021	2.3	3.1	-0.8
2022	3.1	6.0	-2.9
2023	4.1	5.2	-1.1
Total	N/A	N/A	-4.8

CHA requests that CMS apply a *one-time* 4.8 percentage point "forecast error adjustment" to the proposed CY 2024 market basket update. 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 CYs 2021, 2022, and 2023. This request is similar to ones made by stakeholders in prior years. In its response to these requests in the CY 2024 HHA PPS final rule, the agency disagreed with the need for such an adjustment, noting that forecast errors can be positive and negative. Further, CMS observed that over 10 years — excluding years in which the market basket was set by statute — the finalized market basket updates were higher than actual updates based on subsequent data. This is no longer a credible argument against providing a forecast error adjustment. Over the last 10 years, the cumulative difference between the final rule (projected) market basket update is less that what the actual market basket update should have been, implying that HHAs have been underpaid, according to the agency's own proxy for cost growth, relative to cost growth by CMS for services provided to Medicare beneficiaries.

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.

CMS uses the same flawed methodology to determine the proposed 2025 temporary and permanent adjustments as it has in previously finalized rules. The calculation of the proposed 2025 temporary and

[5] https://homehealthcarenews.com/2023/07/with-access-to-care-in-question-number-of-medicare-certified-home-health-agencies-continues-to-fall/
[6] https://calhospital.org/wp-content/uploads/2023/08/CY-2022-2023-HH-Comments.pdf
[7] https://calhospital.org/wp-content/uploads/2023/08/CHA-CY-2024-HH-PPS-Proposed-Rule-Comment-Letter-Final-8.29.2023.pdf
[8] CHA analysis of final rule and actual Home Health PPS market basket updates; https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

permanent adjustments includes any of the remaining adjustments not applied in previous years (that is, 2020 to 2022), as well as the adjustment needed to account for 2023 claims. In calculating the full permanent adjustment needed to the CY 2025 30-day payment rate, CMS compares estimated aggregate expenditures under the PDGM and the prior system.

Using this calculation, based on a flawed methodology, the proposed rule asserts that a permanent prospective adjustment of -6.839% to the CY 2025 30-day payment rate for CYs 2020 through 2023 is required to offset for such increases in estimated aggregate expenditures in future years. Taking into account the permanent adjustment applied in CY 2024 of -2.890%, the current remaining adjustment of -4.067% in 2025 would account for the permanent adjustments for CYs 2020 through 2023. CMS proposes to apply this adjustment in the rule.

The proposed rule also notes that based on the flawed methodology, a $4.5 billion temporary adjustment is required. However, given the magnitude of this dollar amount, the agency does not propose to make it at this time. However, the rule states CMS will propose a temporary adjustment factor to the national, standardized base payment rate in "a time and manner determined appropriate."

CHA thanks CMS for not applying the temporary adjustment to the 2025 base payment rate. However, as detailed in prior comment letters, there are 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, 2022, and 2023 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 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 from 0.79 visits per 30-day episode in 2018 to 0.76 therapy visits in 2023. Therefore, CMS' use of data from CYs 2020, 2021, 2022 and 2023 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 do not 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 federal fiscal year 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, 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-

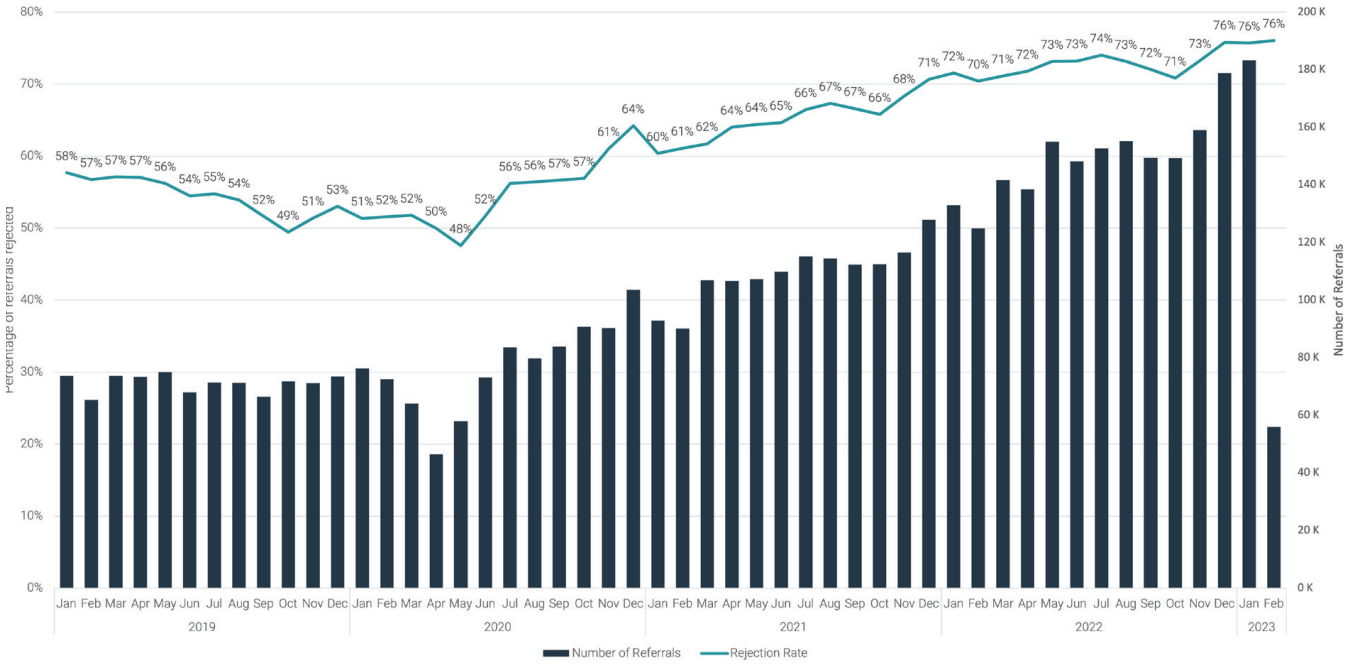
day payment amount. A legal analysis[9] of CMS' methodology concludes that its proposals on both permanent and temporary adjustments are unlawful. Key points of this analysis include:

- *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.

Despite CMS' assertions to the contrary in the CY 2024 OPPS final rule, the massive, unjustified payment cuts CMS is implementing are negatively impacting access for Medicare beneficiaries. While demand for post-acute care grows given an older, sicker patient population, hospitals are finding it increasingly challenging to place patients in the appropriate post-discharge care setting — including home health.

As illustrated in the table below, HHAs are receiving a higher volume of referrals overall and the number of referrals sent per patient is increasing. Furthermore, rejection rates to HHAs hit an all-time high at an average of 76% in December 2022, up from 54% in 2019.

Monthly Rejection Rate Among HHAs[10]
2019 - 2023



[9] http://pqhh.org/wp-content/uploads/2022/08/PQHH-2023-HH-Proposed-Rule-Comments-and-Appendicies1.pdf
[10] https://wellsky.com/the-wellsky-2023-evolution-of-care-report-reveals-critical-changes-to-care-delivery-in-the-past-year/

The delays in care implied by the increasing number of referrals sent per patient, and the increase in SNF utilization for some Medicare beneficiaries[11] when they cannot be placed with an HHA in a timely manner, is antithetical to the value-based care CMS espouses supporting. Not only is care delayed, but often it is received in a higher cost setting that is inappropriate for the patient. While CMS in the 2024 final rule attempts to deflect responsibility for these rejections on staffing shortages, these shortages are in part due to home health agencies' inability to pay the increased wages demanded by clinical workers given inadequate payment from the Medicare program.

Based on the technical and legal issues 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 lack of access to home health care. **In light of the these technical concerns, the impact to access, the legal analysis above, and the recent Supreme Court ruling in Loper Bright Enterprises et al. v. Raimondo, Secretary of Commerce, et al[12] CMS is again urged to withdraw the proposal included in the rule for both permanent and temporary adjustments, increase the CY 2025 payment update by the amounts inappropriately reduced based on this flawed methodology, and propose a methodology that aligns with statutory requirements.**

Long-term Care (LTC) Requirements for Acute Respiratory Illness Reporting

Under regulations established during the COVID-19 PHE, LTCs — including skilled-nursing facilities (SNFs) and nursing homes — are required to electronically report information on the presence and effects of COVID-19 in their facilities until Dec. 31, 2024. Facilities also are required to report information on resident and staff vaccination status for COVID-19 indefinitely. Similar to policies recently finalized for acute care hospitals, CMS proposes to continue some of the reporting requirements that are set to expire at the end of this year by revising the infection prevention and control requirements for LTC facilities to permanently require reporting to the National Healthcare Safety Network (NHSN) of data related to COVID-19, influenza, and respiratory syncytial virus (RSV). Specifically, LTCs would be required to report certain data elements (facility census, resident vaccination status for COVID-19, influenza and RSV; confirmed resident cases of COVID-19, influenza and RSV (overall and by vaccination status); and hospitalized residents with confirmed cases of COVID-19, influenza, and RSV) on a weekly basis beginning Jan. 1, 2025.

CMS further proposes additional data requirements for LTC reporting upon declaration of a national, state, or local PHE for a respiratory infectious disease. This could include increasing data reporting up to a daily frequency without additional notice and comment rulemaking, and requiring additional or modified data elements relevant to the PHE such as confirmed infections among staff, supply inventory, staffing and medical countermeasures. **CMS should reconsider this proposal and not finalize a policy that enables changes to future data reporting requirements without notice and comment rulemaking. Adding reporting requirements during a PHE could have detrimental effects on facility staff's ability to treat patients at the time where limited resources should be focused on direct resident care.**

[11] https://skillednursingnews.com/2023/03/skilled-nursing-vs-home-health-referral-trends-shift-due-to-acuity-staffing-shortages-regulation/
[12] https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf

During the COVID-19 PHE, hospital-based SNFs reported common concerns related to data reporting during COVID-19 surges when facilities experienced staffing challenges and struggled to come up with the resources to report on what they felt at the time was an excessive amount of data elements when they needed to dedicate those resources to treat patients. Frequently adding or modifying data elements and reporting requirements required that limited staffing resources be directed away from caring for residents and toward modifying data reporting systems, re-training staff on data collection and reporting, and ensuring staff availability for daily reporting.

Furthermore, frequent changes to the data elements without appropriate notice, clarity, and education can lead to misinterpretation of the requirements and inconsistency across the field in data reporting. For example, during the COVID-19 PHE, there were significant questions on what constituted an available bed versus an available "staffed" bed. This led to differences in how facilities were reporting this data, that largely went unaddressed until HHS could hold webinars to elaborate on the data element definitions and understand how differences across facility operations could lead to differing interpretations about how the data should be reported. **Any changes to data reporting requirements — even if during a future PHE — should be proposed with appropriate notice and adequate time to ensure data quality and enable facility resources to be balanced between direct resident care and meeting regulatory requirements.**

CHA appreciates the opportunity to comment on the HH PPS proposed rule for CY 2025. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742, or Pat Blaisdell at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy