

August 27th, 2021



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 electronically

Subject: 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

Dear Administrator Brooks-LaSure:

LeadingAge is pleased to offer the following comments in response to the CY2022 Home Health Payment System Update. We represent more than 5,000 aging-focused organizations that touch millions of lives every day. Alongside our members and 38 state partners, we address critical issues by blending applied research, advocacy, education, and community-building. We bring together the most inventive minds in our field to support older adults as they age wherever they call home. We make America a better place to grow old. For more information: www.leadingage.org

Prospective Payment System Design and Payment Update

The 1.8% payment update is welcome with the increased costs to deliver home health services particularly in light of the significant impact of supplies such as personal protective equipment that is vital during the pandemic, but it is not sufficient. The pandemic is not over – in fact, with the emergency of the Delta Variant, cases are on the rise in most parts of the country. We would ask that CMS consider this as they consider the payment update for home health agencies.

The transition to the payment driven groups model (PDGM) would have been complex from an operational perspective in the best of times. CY 2020 and 2021 have not been normal years and the adjustment to a new payment model coupled with an ongoing pandemic continues to be a challenge for home health agencies. We hear from our members about how they have had to change many aspects of their operations and workflows in response to PDGM – from how to make it work across the organization to the literal change management process to how to manage length of stay. All of these are new competencies and while our members are rising to the occasion, implementing these changes (often remotely) is still an administrative and operational feat. Referrals and workforce challenges also

contribute to slower behavior change – trying to stabilize staffing in order to take care of patients is the priority for our members.

We would ask that CMS hold the case-mix weights and LUPA thresholds constant as a way to provide a level of consistency while home health agencies continue to adapt to the new structure of the Patient-Driven Groupings Model (PDGM) and continue to meet the needs of the individuals they care for through the challenges posed by the pandemic. It is important to note that agencies continue to face significant expense increases coupled with revenue losses that are directly attributed to COVID-19. It should be noted that the behavior assumption adjustments that are currently depressing the rates available are incorrect with the major increase in the percentage of periods of care that fall into LUPA payment as opposed to full payment for those periods. We strongly recommend that CMS base payment policy on evidence as opposed to behavior assumptions going forward so as not to repeat the harm that the current assumptions have compounded on top of the revenue effects of COVID. We were pleased last year that CMS recognized that changes should not be made for 2021 not only given the relative lack of available data but also the unprecedented changes to home health utilization as a result of the pandemic. We ask for the same consideration for CY2022.

We also request that CMS consider how to integrate the frail patient population into the PDGM model. Since the change from the home health PPS to PDGM, our members have struggled to work with referring practitioners for frail patients. An example given is an 88-year-old who falls and hurt her shoulder – a referring practitioner may not want to put someone of that age through all the diagnostic testing necessarily to determine eligibility for services. However, this does not mean this person would not benefit from home health services. Without the diagnostic information, our agencies cannot work with that patient to provide care. We ask that a clinical category based on symptoms for the frail elderly be created so that our agencies can receive some payment to work with this vulnerable population.

Proposed Changes to the Home Health Conditions of Participation

We support the proposals to implement the Consolidated Appropriations Act (CAA) of 2021 as it relates to occupational therapy as well as the conforming changes in regulation around home health aide supervision. We want to emphasize that the ability to offer remote care via telehealth and during the pandemic has been vital for home health agencies and the people that they serve. We appreciate and support last year's change to make permanent the changes at 409.43(a) related to the use of telecommunications and technology in the plan of care and the expanded examples at 409.46(e) to go beyond remote patient monitoring. It is useful to hear that there are plans to modify the cost report instructions regarding the line for administrative expenses for technology and telecommunication so they will reflect a broader use of telecommunications technology. However, our members note that financial and operational obstacles remain to making the investment into technological extensions for their clinical care offerings despite the ability to include administrative expenses on the cost report. We recommend that CMS continue to explore ways to reimburse home health agencies for telehealth in a way that supplements in-person visits, recognizing the statutory impediment.

Home Health Value Based Purchasing Program

We wish to offer the following feedback on the proposed expansion of the Home Health Value Based Purchasing Program (HHVBP)

- **Postpone implementation until the calendar year that is one year post public health emergency.** The public health emergency continues with no end in sight and staffing is still a major concern. We ask that the implementation of the model be delayed until a more stable time in the trajectory of health care delivery.
- **Give providers time to adjust before ramping up to 5% withhold.** Only nine states have participated in this program to date. We recommend that the universal program start where the model started – withholding 3% -- and phase in to the full 5% over time. All home health agencies should have the opportunity to adjust to the model in the same way that those in the 9 model states did.
- **Share savings:** HHVBP has saved Medicare \$141M in one year in just nine states, mostly from preventing hospitalizations. In a true value-based environment, there would be an opportunity to share in the savings CMS realizes from reduced hospital use. We ask that CMS consider adding a shared savings component to the program in future years.
- **Impact should reflect patient stabilization and maintenance as well as improvement:** A high percentage of our Medicare patients are referred from hospitals and thus are high acuity patients. Home health agencies do their best to help them improve but stabilization should be recognized as success when that is appropriate. Stabilization as a goal is consistent with the law as re-emphasized in the *Jimmo* settlement from 2011.
- **Stronger risk adjustment model:** HHVBP needs to recognize that some home health agencies simply care for a much sicker and more complex population than others. That has to factor into the risk adjustment model so agencies can be compared fairly and to ensure that incentives are aligned to care for patients with complex health and social determinant needs.
- **Quality Measures Not Always Under Control of HHA.** One example is m2020 regarding oral medication. If an HHA serves a large assisted living population, for example, someone else is managing the medications and that measure will not change from admission to discharge. The model needs to take these types of discrepancies into account so the HHA is not penalized.

Survey and Enforcement Requirements for Hospice Programs

We offer the following comments on the implementation of the hospice survey and enforcement changes legislated by the CAA of 2021.

Key recommendations

- *Establish at least one technical expert panel (TEP) that focuses on the public display of survey findings and the special focus program. This work could occur as two separate TEPs.* Regarding the public display of survey findings, it is critically important that the information displayed to the public be accessible and readily understandable by the public as they seek hospice care. Congress recognized this by requiring that findings be “prominent, easily accessible, readily understandable, and searchable for the general public and allows for timely updates.” We strongly believe to accomplish this goal, a TEP needs to be convened focusing on the questions of how to accomplish these goals and through what metrics. Simply putting the 2567s onto Care Compare is only a first step; it will not achieve Congressional goals nor will it be a productive means for patients and families to understand what to look for as a warning sign regarding a hospice.

For the special focus program (SFP), this is a new program for hospices. We support Congress and CMS in their efforts to try to identify poor performers and provide them with a targeted program for improvement prior to termination. How this program functions, its goals, its metrics for entrance and exit – these are all critical factors to actually promoting quality improvement. We want this program to be as effective as possible. A TEP would allow for nuanced and specific evaluation of how to achieve those goals and we encourage CMS to convene one. We ask that the SFP not be implemented until this TEP finishes its work. We also strongly support the proposal that the hospice SFP not use the quota system utilized in the nursing home Special Focus Facility (SFF) program – it is more important to capture the actual lowest performers regardless of geography.

- *Apply remedies consistently*

As noted in the [House Ways and Means Committee Report](#), Congressional intent was that the new enforcement remedies for the hospice program align with home health and other similarly situated programs. This intent is also reflected in the utilization of the same Congressional statutory language. We ask that the payment suspension remedy be applied only to new Medicare hospice patients, not to all – this is consistent with home health and with Congressional intent. It will also be a very dramatic remedy in the hospice program. Hospice receives more of its revenue from Medicare than other settings so payment suspension, even for new patients, will have a dramatic impact on finances.

Some other factors for CMS to consider:

- **Timeframe for posting.** It should be clear on Care Compare and to hospices how often surveys are posted and updated. On other parts of Care Compare, the timeframes for when surveys are posted is unclear.
- **One citation does not mean a bad hospice.** Care Compare should note, especially prior to the meeting of the TEP, that a single citation does not necessarily mean a poor-quality hospice.
- **Inpatient Units.** It should be clear which hospices have inpatient units and which do not so patients and families can compare survey results more consistently. Additionally, the TEP needs to be charged with clear display not only of regular survey results, but also life safety code results.
- **Matrix to judge scope and severity of deficiencies.** A matrix of some type should be developed to guide scope and severity of deficiencies. CMS could look to other examples such as the nursing home scope and severity tool or the Joint Commission's matrix approach. In either case, hospices need to be able to connect certain deficiencies with the probability of getting certain types of enforcement remedies. This should include the Life Safety Code deficiencies.
- **Survey and Enforcement Consistency.** Such a matrix should also help with surveyor training and consistency. CMS central office should provide guidance and oversight regarding interpretation of the matrix, what remedies align with what type of enforcement remedies, and interpretation of the deficiencies. A deficiency in Texas

should be the same as a deficiency in Maine and help from CMS central office is the best path to ensure this consistency across providers and states.

- **Team composition.** The members of the survey team should have hospice experience and/or significant training in the hospice program if they are surveying multiple types of programs. The utilization of professionals besides nurses for hospice surveys should be limited to members of the hospice interdisciplinary group (IDG) and they should also receive significant training. We also recommend that former hospice administrators be considered as potential surveyors. Finally, we ask that CMS clarify whether a survey team MUST consist of more than just an RN or CAN consist of other members of the IDGG. It is not clear from the rule text.
- **Conflict of Interest.** One idea is that CMS develop a code of ethics for surveyors to try to capture the intent of this provision rather than every instance in which a conflict of interest could be taking place. We also recommend that CMS consider prohibiting surveyors from surveying a hospice who ever had a family experience with that hospice – whether good or bad. Additionally, CMS should consider a 2-year ban on staff from competitor hospices (based on geography) surveying one another.
- **Validation surveys.** Validation surveys should take place as close in time to the original survey as possible. With increasingly short lengths of stay, the chances that the validation survey is capturing the same patients is minimal.

Thank you for your consideration of these comments.

Sincerely



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