



August 29th, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: CMS-1780-P. Comments relating to Medicare Program; 2024 Home Health Prospective Payment System Proposed Rule

Submitted electronically via: <https://www.regulations.gov>

Dear Administrator Brooks-LaSure,

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 mission driven aging services providers that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

As we noted in previous letters, we commend the Biden Administration, from the early days of the campaign, for taking a strong stand on ensuring quality in long-term care services and particularly for promoting services in home and community settings. However, the articulation of this vision is impeded by the Administration's proposed 2.2% cut to home health services in this proposed rule. If implemented, CMS will have cut home health payment permanently by nearly 10% in two years (-9.356%). As we detail below, these cuts are coming at times when our members costs and demand for services are rising and cannot be met. Continuing to implement these cuts will have a devastating effect on older adults who rely on these services. Further, it runs counter to the Administration's stated goals of promoting equity and the use of home and community-based care. From our vantage point, the combined impact of the proposed payment changes and current workforce and inflationary pressures would lead to waves of closures and the inability of providers that remain to take on new referrals.

The impact of CMS' proposals stands in stark contrast to the Administration's stance on the importance of long-term care. Since his campaign, President Biden has spoken to the needs of older adults. He released a plan on 21st century caregiving and the impact on workforce. He also called for a major investment in home and community-based services – \$400 billion. We were vocal in our support of these initiatives and were thrilled to see a focus on older adults, considering the devastating impact of COVID-19 on the population our members serve. Again, we ask how we can help to achieve these lofty goals when the financial equation simply does not add up?

The workforce crisis is real. All LeadingAge provider members, across settings, are experiencing workforce shortages. Unlike retail or other business sectors, aging services providers cannot raise their prices. They are reliant on Medicare and Medicaid dollars to provide high-quality care. Taken as a whole, CMS' proposals in the Medicare space are going to hurt that mission rather than help it. It is more expensive to hire staff and there are often not staff available.

The Administration has an admirable focus on equity; LeadingAge has integrated a renewed focus on diversity, equity, and inclusion as well. This pursuit is undercut when staff, many of whom are immigrants or people of color, are likely losing money simply driving from patient home to patient home. Our members are supporting them as best they can, but once again are limited by the dollars provided to them by Medicare reimbursement. The COVID-19 pandemic devastated our members and the older adults they serve. It cracked open the weaknesses in our fragile ecosystem of care for older adults regardless of where they call home. Their caregivers, our members, are burnt out but persist because caring for older adults is their mission and passion. They should not be rewarded for that passion with fewer resources. We should take what we have learned from these past three and a half years and put more money into the system so that our members can modify, adapt, and grow rather than continue to figure out where they can cut costs and ultimately, cut services. The impact could be even more devastating than service cutbacks -- because of the proposed payment cuts, we are hearing from several of our members that they are seriously considering ceasing to offer home health services. Others have already sold their home health business or ceased operations. This will only create more access issues.

LeadingAge and its members strive to provide the highest quality, person-centered care across the entire continuum. We want to take the lessons learned from this pandemic and work with you to envision and enact a future where high-quality long-term care is accessible and affordable for all. Many of the Administration's bold statements about long-term care and home and community-based care point to historic support to accomplish this high standard. Cutting the funding for essential services makes it impossible to turn that vision into reality. We hope you take the recommendations in this letter and move forward with payment updates that allow nonprofit, mission driven home health agencies to continue to recover and exist into the future.

STATE OF INDUSTRY

Referral rejections

People want to stay in their home and community, but both financial pressures and staffing pressures are making it increasingly more challenging to access care. This trend will continue if CMS moves forward with the proposed payment cuts. According to data from a CarePort survey¹ of home health agency referral data for more than 2000 hospitals and health systems:

- Referral volume for home health has grown since the pandemic – it is higher than before the pandemic. CarePort reports that between its 2022 and 2023 reports, home health agency referral volume increased by 11%.
- In that same time, there was 40% increase in home health agency referral rejection rates. December 2022 saw the highest average referral rejection rate at 76% up from 54% in 2019.
- This data aligns with reports from hospitals and our members that indicate that referrals to home health, which are important in order to successfully transition patients from hospital to home, are increasingly problematic, impeding the discharge process. In turn, the average length of stay in the hospital has increased 11% between 2019 and 2022.

Staffing

Additionally, Homecare Homebase reports that the percentage of referral rejections due to the staffing have risen as well – from 3.8% at the beginning of 2020 (when PDGM was implemented) to 12.1% at the beginning of 2023. The staffing crisis is a perfect storm – the competition for staff has never been stiffer due to the pandemic. Home health agencies had difficulty competing for staff with hospitals, insurance companies, and other opportunities prior to the pandemic; that competition is even fiercer now. The continued downward

¹CarePort®, 2023 Evolution of Care Report, released July 25, 2023.

pressure on payment could not come at a worse moment – the result is going to be decreased access to care, especially for those who need it most.

Equity and Patient Acuity

The home health benefit is a critical benefit for equity. Relative to the Medicare population as a whole, the home health benefit serves an older, sicker, more diverse, and poorer population. They are more likely to be living alone, with no consistent caregiver. This is the precise population that CMS is focused on in its equity strategy² and that are so challenging to keep in the home and community. Cutting home health payment will mean less access to services for these most vulnerable beneficiaries. As one of our members said, “We will be the last ones there serving the poorest and most underserved in our communities...but each year of cuts makes it harder for us to continue to do that and remain in business.”

	All Medicare Beneficiaries	All Medicare Home Health Users	Medicare Advantage Home Health Users
Beneficiary Characteristics			
% People of Color	25.5	26.4	30.4
% Age 85+	54.5	60.9	60.8
% Income 200% or less than FPL	10.7	28	24.8
%Living Alone	29.7	36.6	37.1
%Dual Eligible	17.6	30.6	29.7 ³

Additionally, as demand for care rises, data from CarePort⁴ shows that compared to 2019 averages, patients in the hospital are now 6% more acute at discharge. Patients with higher acuity typically have more complex care needs and a higher risk of complications and readmissions after discharge. To address these more complex needs, providers need to arrange more services post-discharge, such as physical therapy, behavioral health, and medication management. These factors can make it more challenging to manage care and ensure a safe and successful transition from hospital to home or another post-acute care setting. Once again, relative to the Medicare population, beneficiaries utilizing home health are more likely to have multiple chronic conditions, including potentially severe mental illness, and ADL limitations. Their health is more likely to be on a downward path – home health is critical to maintaining function as well as improving health. If we truly want to honor wishes of staying home as long as possible, home health is an important component of that equation.

Health Characteristics	All Medicare	All Medicare Home Health	Medicare Advantage Home Health
%3+ Chronic Conditions	58.2	76.1	82.5
%2+ ADL Limitations	5.4	23.8	23.1
%Report fair or poor health	20.5	41.3	43.8

² <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>

³Data from Home Care Chartbook 2022, prepared by KNG Health Consulting, LLC for the Research Institute for Home Care. This is a replication of Table 1.1, accessed at <https://researchinstituteforhomecare.org/wp-content/uploads/RIHC-Home-Care-Chartbook-2022.pdf>

⁴CarePort®, 2023 Evolution of Care Report, released July 25, 2023.

%Are in somewhat worse health than last year	17.8	39.3	40.5
%Severe Mental Illness	27.3	37.8	39.4 ⁵

PAYMENT PROPOSALS

In the CY 2024 Home Health Proposed Rule, CMS is proposing to apply an additional -5.653% permanent cut to Medicare’s HHA rates, which already reflect a -3.925% reduction put in place for CY 2023. This amounts to a -9.356% cut that would apply in perpetuity. In 2024 alone, by CMS’s own calculations, the -5.653% cut would remove \$870 million from the home health benefit. This level of cut is going to cause agencies, particularly nonprofit, mission driven agencies, to close. A number of our members have already started looking at shutting down their home health lines of service or selling them – these cuts will accelerate that trend. For those that remain, referral rejection rates will remain high. Additionally, CMS underscores that they are basing these cuts on behavioral changes – but the cuts will *drive* additional behavioral change. Many of our members focus on serving the most vulnerable, most complex in their communities. They are increasingly going to have to look at their patient mix and reject the more complex patients in order to attain a case mix that makes it possible to maintain solvency. The proposed cuts, therefore, are driving behavior away from the beneficiaries who *utilize* home health the most and *need* it the most – the population that CMS is also encouraging providers to figure out how to serve.

On top of these permanent cuts, CMS is also proposing that an additional \$3.44 billion in cuts be levied under the “temporary adjustment” authority at some point in the near future. Medicare’s home health benefit in Parts A and B totaled approximately \$16.1 billion in annual spending in 2022, meaning temporary cuts to claw back that amount will have severe and longstanding consequences, no matter how CMS moves forward.

LeadingAge recommends that CMS delay the proposed permanent adjustments and continue to delay the temporary adjustments. Since CMS maintains its position that their hands are tied regarding the directive to make all adjustments in aggregate, CMS should share as part of their annual budget request or through other avenues what authority changes they would recommend in order to be able to adjust the payment system more equitably. Through its assumptions about clinical groupings and comorbidity coding, CMS is assuming that HHAs are adjusting their behavior to get more payment regardless of whether the clinical reality of the patient matches the criteria to be paid more. We understand that concern and that CMS is wary of this pattern – we are sure some agencies are indeed taking advantage and participating in bad behavior regarding clinical groupings and coding. However, the reality is that there are higher acuity patients – whether they are dually eligible, coming from a safety net hospital, living in the community with few resources – for whom reimbursement and acuity are mismatched. We ask that CMS consider how to integrate this acuity more effectively into the behavioral assumption methodology as well as how to better account for acuity overall and ask Congress for the authority to adjust payment accordingly.

All Payer

While the proposed payment cuts are only in Medicare fee for service, the reality is that the impacts of cuts in Medicare fee for service have ripple effects. In 2023, 30.8 million people are enrolled in a Medicare Advantage

⁵Data from Home Care Chartbook 2022, prepared by KNG Health Consulting, LLC for the Research Institute for Home Care. This is a replication of Table 1.1, accessed at <https://researchinstituteforhomecare.org/wp-content/uploads/RIHC-Home-Care-Chartbook-2022.pdf>

plan – that is 51% of the eligible Medicare population and 54% of total Medicare spending (\$454 billion dollars). The average Medicare beneficiary has access to 43 Medicare Advantage plans in 2023, the largest number of options ever.⁶ Considering Medicare fee for service payment in a vacuum is simply not an option in this environment. Medicare Advantage plans generally pay less than Medicare FFS and have substantially higher administrative costs for our members. 91% of Medicare Advantage enrollees must get prior authorization to receive home health services.⁷ The process of obtaining repeat authorizations for visits, fighting payment denials, navigating third party aggregators/portals/administrators (eg MyNexus, CareCentrix, NaviHealth), ensuring supplies are in place to start service, and other administrative tasks takes time and resources. MedPAC claims that payment must be adequate because providers accept contracts from Medicare Advantage – this interpretation does not reflect that providers must accept Medicare Advantage contracts to stay competitive in the market. Additionally, Medicare Advantage plans have gotten increases from CMS year over year – it was a 3.32% increase this year – and rarely is any of that increase passed along to providers.

As you can see from the charts above, our members must also take Medicare Advantage to stay true to their missions of serving those who need it most. They see competitors limit access for Medicare Advantage patients due to the administrative and financial burdens of accepting MA – but this pattern limits access for patients. This pattern is even more alarming if you look at agencies that take Medicaid patients. Our members have no leverage to negotiate rates in either Medicare Advantage or in Medicaid.

It is not ideal that Medicare FFS is acting as a financial counterbalance to Medicare Advantage and Medicaid. The government needs to work on ensuring rate adequacy across all payers before disrupting overall access to care through further cuts to fee for service Medicare. If policy options that ensure rate adequacy in both Medicare Advantage and Medicaid, smoothing of costs across payers might be appropriate. But in the current environment, continued reductions in Medicare fee for service payment will simply result in reduction in access.

Wage Index

We ask that CMS, at a minimum, provide a higher payment update as they have done in other sectors based on the most recent forecasts of the inpatient hospital market basket increase and productivity adjustment. We also encourage CMS to continue to examine policies to help assuage ongoing wage index inequities. The current workforce crisis has created access issues across the country for individuals seeking home health services but rural communities, which have larger portions of the aging population, have been hit hardest.⁸ We ask that CMS work with the Congress to reinstitute the rural add-on payment, and policies to reform the wage index such as examining the impact of MedPAC's proposal⁹ on home health agencies or one that would allow home health agencies and other post-acute providers to utilize a reclassification board similar to hospitals. Home health providers are not afforded these same options to adjust their wage indices yet must compete for the same types of caregiving professionals as and with hospitals.

⁶<https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>

⁷<https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>

⁸ NYU. "Quality of Home Health Care Differs in Rural vs. Urban Settings." Jan. 2022. Available from: <https://www.nyu.edu/about/news-publications/news/2022/january/quality-of-home-health-care-rural-vs-urban-settings.html>

⁹ Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2023 Jun. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch9_MedPAC_Report_To_Congress_SEC.pdf

Rebasing and Revising

On its face, it makes sense for CMS to rebase and revise the home health market basket in order to represent changes over time in the price of goods and services. However, we find it striking and puzzling that the proposed 2021-based major cost weights weigh categories like wages and salaries, benefits, and transportation *below* what they were in the 2016 baseline. Our members consistently report that those costs are higher, both in raw numbers and in proportion to what they were in 2016. No matter the category – labor, benefits, supplies, insurance, travel – all of our members consistently report that their costs are *much higher now than in 2016*. LeadingAge recommends that CMS hold off on the rebasing and revising proposal until this data is further explored, perhaps through the use of a technical expert panel.

REQUEST FOR INFORMATION ON HOME HEALTH AIDES

LeadingAge recognizes the value of home health aides in the home health benefit and across the continuum of care. We conduct research and advocacy on this workforce looking at issues such as better training, higher job quality, more career advancement opportunities, a living wage, immigration policy, and long-term care financing all in the pursuit of a more equitable long term care system.¹⁰

This vision of a better system runs into the reality of the current one all too often and utilization of aides in the Medicare home health benefit is a prime example. When we asked our members why the decrease in aide utilization CMS modelled has occurred over time, we heard the following themes.

1. Payment

As discussed throughout this comment, the downward financial pressure on home health agencies is heightened right now and agencies have to focus on reimbursable care. The reality is that aide visits do not count toward LUPA thresholds. The number of visits per episode have gone down under PDGM and agencies are focusing on making sure they provide enough of the skilled services – nursing and therapy – to achieve the goals of the plan of care. Our members all noted that if they choose another discipline to send out besides nursing and therapy, it is social work. Social work is key to keeping patients, particularly complex patients, at home. Without social work, beneficiaries and families are often unaware or overwhelmed trying to coordinate other services and benefits which could easily result in a rehospitalization. On the other hand, the skilled services, particularly therapy, are ordered with the goal of maintenance or improvement of function – and these functional changes might offset the need for aide services. While our members would like to be able to support all the skilled and unskilled needs of their patients, it is not possible with the current fiscal constraints.

2. Stability

Medicare home health is, by definition, an intermittent benefit. Typically, aides are looking for jobs where they can be guaranteed a certain number of hours. Because of the nature of the payment system and the focus on the plan of care, the need for aides in Medicare home health is highly variable. Aides often choose work where they can see the same clients consistently over time and be sure they get sufficient hours. Aides also need access to reliable transportation and time and hours to establish a trusting relationship with a beneficiary – factors that might not be achievable in an intermittent relationship. Coordination of benefits – especially in states with more HCBS options – is confusing and often causes beneficiaries to refuse aide services from a home health agency out of fear of losing their current aide services under a Medicaid benefit. Finally, because of the intermittent utilization and continually depressed payment rates, home health agencies are often

¹⁰<https://www.ltsscenter.org/>
<https://leadingage.org/aging-services-workforce-now-leadingage-workforce-grassroots-advocacy-campaign/>
<https://leadingage.org/topic/workforce/>

outcompeted for aides by nursing homes, hospitals, personal care agencies, and non-health care related industries like retail. We need a holistic approach to making aide jobs better through training, pay, growth, and benefits. This approach will not be achieved through one Medicare benefit that is focused on intermittent care.

3. Regulatory Oversight

Members noted that patients that utilize more aide services, eg longer stay home health patients, make them more likely to be the target of audits. The combination of lower payments and more oversight mean that home health providers are even more focused on short term patients because taking on longer stay patients make them targets for scrutiny *and* are financially unsustainable. There is inconsistent policy on the utilization of aides across Medicare contractors and amongst Medicare Advantage plans which makes it harder for agencies to utilize aide services in a consistent manner.

If CMS wants to see greater utilization of home health aides, we recommend:

1. Clarifying policies across the agency regarding the use of aides in home health;
2. Increasing reimbursement overall and specifically looking at tying reimbursement to aide services;
3. Working with Congress and other parts of CMS on exploring how to best integrate aide services in the Medicare program and/or through the development of long-term care financing; and
4. Working with Congress and other agencies on how to improve the job of being a home health aide through pay, benefits, training, career advancement, and other factors.

HOME HEALTH QUALITY REPORTING PROGRAM

COVID-19 Vaccine: Percent of Patients Who Are Up to Date Beginning with CY2025: Our main concern with this measure is with the proposed addition of data collection and reporting on the raw % of HH clients who are “up to date” with their COVID-19 vaccine. The proposed measure offers no exclusions for refusal to get vaccinated, contraindications, or individuals who refuse to share the information. It would be reported on a revised OASIS. OASIS has been revised frequently over the past several years and yet another adjustment would be a disruption to operations.

Furthermore, CMS argues that reporting this data at discharge incentivizes providers to educate their clients about the importance of receiving this vaccine. While called a process measure, the only process it is assessing is whether the HH provider asked the person if they were “up to date” on their COVID-19 vaccine. No proof or documentation is required. For these reasons, we would argue this is not a measure of provider quality of care but instead only measure of a HH client’s decision making on this matter and the ability of a HH provider to document this action. A process measure would be, for example, what % of home health clients who were not up to date on their COVID-19 vaccines were offered one by the HH provider? This would differentiate HH providers based upon their direct actions and as such, would be appropriate for QRP (assuming home health agencies were given the financial and logistical tools needed to administer the vaccine). As written, this measure does not assess action or inaction by a provider but merely a client’s decision to accept a dose of a vaccine. Whether or not a person decides to receive a vaccine is not a reflection of provider quality but instead may reflect issues of access, or personal or cultural preferences. Regional variation in vaccine uptake has been documented by KFF.¹¹ Also, clients have the right to refuse a vaccine.

¹¹<https://www.kff.org/medicaid/issue-brief/a-look-at-vaccine-and-booster-rates-in-nursing-facilities-as-new-boosters-become-available/>

The inclusion of this measure is an inappropriate use of the HH and all PAC QRPs. If CMS wants the data collected and reported, it would be more appropriately placed exclusively in Care Compare as a data point vs. described as a quality measure.

In addition, HH providers cannot deliver these vaccines due to storage concerns (e.g. cold temperature storage required). Unlike Medicare beneficiaries cared for in congregate settings who might want to know what percentage of residents are vaccinated in a location where they must share space, this is not the case for HH clients. These individuals receive services in their own homes and as such have knowledge of the vaccine status of those with whom they reside. In addition, why does the responsibility of COVID vaccination reside with a HH provider when the individual has had the opportunity to be vaccinated by myriad other providers? If this is such an important public health concern, why are all health care providers not held equally accountable for educating and administering these vaccines before the person is discharged or leaves their office? This measure was not supported by the PAC/LTC work group of the Measures Application Partnership. LeadingAge does not support the adoption and/or public reporting of the COVID-19 patient vaccination measure without revisions.

LeadingAge support the removal of M0110 - episode timing and M2220- therapy needs measures from the QRP.

Request for Information on Principles for Selecting and Prioritizing HHQRP Quality Measures and Concepts Under Consideration for Future Years

LeadingAge generally supports the principles for selecting and prioritizing home health quality reporting program measures. Stakeholder engagement, through technical expert panels or other means, should be part of the process as well.

Regarding the measurement gaps, we have a few concerns. Cognitive function and behavioral/mental health do not make sense as performance measure domains in home health care due to the episodic nature of the benefit. Most HHAs have limited time, resources, and expertise to provide interventions that would directly impact a patient's cognition, behavioral and/or mental health. Only HHAs that have dedicated mental health divisions are positioned to impact a patient's behavior or mental health to any significant degree. If CMS wants to examine how to better align the behavioral health clinical grouping with the needs of these patients, that could be an area for future consideration for CMMI or other entity looking at how to better serve older adults with behavioral or mental health needs. With regards to pain management, CMS recently eliminated this domain as a performance measure in home health due to the opioid crisis so would need to be sure to be sending a consistent message to providers if new measurements were developed.

PROPOSED CHANGES TO HOME HEALTH VALUE BASED PURCHASING (HHVBP)

LeadingAge members are in varying states of readiness for HHVBP. The pandemic along with the stress of ongoing operations in a staffing crisis with consistent payment reductions has made it challenging to focus on HHVBP. One item mentioned by members is the heavy weight on HHCAHPS. The types of beneficiaries our members serve – lower socioeconomic status, more complex, often dual eligible – are less likely to fill out the HHCAHPS. We request CMS look at how to account for discrepancies in HHCAHPS return rates based on the population served in the HHVBP.

With regards to changing the base year, we had some mixed feedback, but generally do not support changing the base year – home health agencies have been readying themselves based on the current base year and changing it could jeopardize quality improvement initiatives and operations.

PROPOSALS FOR HOME INTRAVENOUS IMMUNE GLOBULIN (IVIG), LYMPHEDEMA THERAPY, AND DISPOSABLE NEGATIVE PRESSURE WOUND THERAPY (DNPWT)

LeadingAge supports these proposals. We ask for clarification that if a home health agency is not able to provide IVIG infusion that a beneficiary not lose access to their ability to receive the infusion as an outpatient under Part B at a physician's offices or an infusion center while receiving home health. With lymphedema therapy, we ask that CMS confirm that items and services under this new benefit are not subject to the home health consolidated billing rules.

HOSPICE SPECIAL FOCUS PROGRAM

LeadingAge is broadly supportive of the idea of a special focus program (SFP). Targeting low performing hospices for increased oversight via a specific program makes sense and is aligned with our overall thoughts on wanting to support high quality hospice. We appreciate that CMS and the Technical Expert Panel (TEP) considered our comments regarding the methodology of the nursing home special focus facility program and did not use a strictly geographic methodology in determining eligibility for the SFP. In the CY2022 Home Health Rule, we asked for a technical expert panel (TEP) to be named to put together the special focus program. We were pleased to see CMS take this recommendation but as we will outline in these comments, we believe that there were some key recommendations made by the TEP that CMS did not take. Our members are concerned that the algorithm, as proposed, would not achieve the goal of targeting the poorest performing programs.

We, along with other national associations representing hospices, outlined some concerns in a letter submitted to the Administrator on August 16, 2023. For the reasons identified in that letter and those highlighted below, we ask that CMS work with the existing SFP Technical Expert Panel (TEP) to

- improve the SFP algorithm methodology prior to its planned implementation on January 1 2024,
- implement a nationwide pilot of the updated algorithm with all hospices, during which SFP results will not be publicly posted, and hospices will be provided interim reports of their performance ranking under the updated SFP algorithm metrics.

This may require a delay in implementation and that CMS issue a new proposed rule with the modified algorithm to give stakeholders the opportunity to comment.

Being selected for the SFP is consequential, as it should be. We strongly believe that CMS should get this program right. A program that ends up in the SFP undeservedly will suffer reputational damage that may not be easily repairable. More importantly, the goal of the program is to look at the poorest performing programs and using all available resources to be sure that the *right* hospices are in this program is important for the hospice industry, CMS, and beneficiaries.

We also want to underscore that the SFP program is a program intended to be targeting poor performing hospices. It was written with intent toward looking at the *quality* of care. This is a concept distinct from fraud. We were surprised to see the SFP mentioned as a tool for dealing with *fraud* from Deputy Director Corrigan in her blog on August 24th. In a letter to HHS Secretary Becerra and CMS Administrator Brooks-LaSure dated September 28, 2021, Congressman Jimmy Panetta and Tom Reed, the authors of the HOSPICE Act (legislation passed in 2020 that overhauled the hospice survey process), confirmed that the intention of the legislation was to “*give CMS the tools and resources needed to help poor-performing hospices address deficiencies through education, training, and enforcement remedies.*” They note their desire to prioritize education over punishment for poor-performing hospices, and to differentiate poor-performing hospices from truly fraudulent providers, saying, “*We want to help struggling hospices improve and deliver quality care and give CMS the ability to target bad actor organizations with appropriate penalties.*” We hope in its work that CMS is able to walk and chew gum at the same time – in other words, improve the SFP so that it can be used to focus on poor

performing hospices AND continue to modify its program integrity efforts so that the right hospices are targeted for audits and other PI oversight.

Transparency

One major concern we have is regarding transparency of who will be selected for the program. CMS details the methodology regarding an algorithm to highlight the 10% of hospices that will be eligible for the SFP. However, there is no detail as to how CMS will select *from* that bottom 10%. How does CMS plan to narrow down from the 10%? What criteria are being used? This is a critical point into which we are provided no insight (nor are beneficiaries). LeadingAge asks that CMS provide additional information regarding how they will narrow down from the bottom 10% to those that will actually be in the SFP.

We also are curious if CMS is going to examine the 300 hospices that were cited in the OIG report specifically for consideration for the program and ask that CMS give information on this issue. We also ask that CMS provide interim performance reports or preview reports to *all* hospices prior to the implementation of the SFP. This would provide all hospices with information needed to improve quality – which is the goal of the SFP. Finally, we ask that CMS provide information on why they deviated so much from the TEP recommendations particularly as it relates to scaling CLDs and complaints by hospice size and the weighting of the CAHPS input (more on these below).

Role of survey

Scaling: In the proposed SFP, condition level deficiencies and substantiated complaints are not scaled to account for the number of beneficiaries that a hospice serves. This is in contrast to the model presented to the TEP for its consideration which did scale the CLDs and substantiated complaints per 100 beneficiaries (except for hospices in the smallest size quartile for which the raw number was used). Scaling the data is critical to ensuring that programs are comparable. A large provider who has two substantiated complaints with an ADC of 450 should not rise to the same level of concern as two substantiated complaints for a program with an ADC of 50. If the goal of the SFP is to find the poorest performing programs, scaling both eligibility and graduation criteria and looking at these data as ratios rather than raw numbers is a change to the methodology that must occur.

Survey Backlog: We believe that the role of survey deficiencies is an important part of the algorithm and of Congressional intent regarding this program. Survey agencies, like our members, are currently understaffed and therefore, behind on surveys in many places. In states with fewer hospices, like those with a certificate of need laws, states and/or accrediting organizations are more likely to be up to date on surveys. As a result, these hospices are more likely end up in the bottom 10% for consideration for the SFP because the rolling three-year survey lookback will be up to date for these hospices. Other programs who have not had a survey who would be appropriate for the program may be left out as a result. Additionally, we are concerned that surveyors will fall behind even further with the implementation of the SFP because some of the survey workforce will need to do the additional SFP surveys.

Surveyor Consistency and Education: We are also concerned about education of surveyors. Part of the HOSPICE Act's intention was to increase education across the board and there was a specific provision about surveyor training. While CMS has updated the training, we remain concerned about the adequacy of the training available, whether surveyors are receiving it, and the equality of training across surveyors and accrediting organizations. Our members report surveyors that survey on home health requirements, surveyors that are not using the new Appendix M (and are using outdated COVID requirements, for example) and myriad other issues. If surveys are not uniform, the algorithm is going to be biased as well. We also note that auditors

and hospices should receive the same education (once the quality issues are resolved) so that everyone is working from the same playbook.

Some CLDs and complaints may be counted twice: Hospices with deemed status through an accrediting organization (AO) may have a complaint survey from both the AO and the state agency (SA) if a complainant lodged a complaint with both entities. This could result in a substantiated complaint being counted twice. Additionally, if the AO and the SA cite the same CLDs related to a complaint, the CLD will also be doubly counted. CMS should implement a mechanism that ensures that substantiated complaints for the same incident are only counted once.

CAHPS

We agree the patient and family voice should be included in any algorithm for the SFP but the goal of the special focus program is to target poor performing hospices and was based on an OIG report that specifically focused on survey deficiencies. We are concerned that CAHPS scores are double weighted when only 50% of hospices report the four CAHPS Hospice survey measures that are part of the proposed algorithm. If deficiencies regarding quality of care are the primary concern, we do not want those impacts to be diminished in the program. Some specific thoughts from our members on the role of CAHPS in SFP include:

- Hospice CAHPS are filled out by bereaved caregiver and are often reflective of overall experience at end of life which may unintentionally conflate other settings besides hospice. So a lower CAHPS score could have to do with the overall end of life experience and not with the hospice itself.
- The proposed algorithm puts a lot of weight on CAHPS when there will be high variability in terms of who gets one returned. Our members felt that the heavy weight on CAHPS presented a double-edged sword – if they pursue trying to get CAHPS returned, which is the right thing to do from a quality perspective, it might end up getting you into the program because of the heavy weighting.
- Poor performers may in fact be below the CAHPS threshold (or avoiding it completely). The algorithm as proposed would incentivize not participating in CAHPS.

The TEP agreed with our members. CMS' SFP TEP contractor, Abt Associates, gave CAHPS a weight of only 0.25 in the algorithm presented to the TEP "...because approximately two-thirds of hospices do not have a CAHPS® score reported."¹² Despite this, CMS is proposing to veer substantially from the algorithm presented to the TEP by double weighting the CAHPS scores, effectively giving the input with the greatest data limitations the most influence in determining SFP candidates. Based upon an analysis utilizing publicly available data on QCor and in the data sheets at data.Medicare.gov to approximate CMS' proposed SFP algorithm, it appears that those hospices without a CAHPS score have more CLDs per beneficiary and more complaint survey deficiencies than those with a CAHPS score. This highlights the proposed structure's bias towards hospices that report CAHPS, and away from hospices that might need the SFP's increased oversight and education more (as evidenced by their higher number of CLDs and complaints).

LeadingAge recommends that CMS consider alternatives for including CAHPS in the SFP algorithm. We ask that CMS revisit the TEP recommendation to weight CAHPS at .25. Additionally, CMS could consider weighing more heavily hospices that are eligible but choose not to report CAHPS in the SFP algorithm. While these providers will be subject to a 4% payment penalty, they might be further incentivized to participate in CAHPS if not doing so would increase their chances of being in the SFP.

¹² [2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report](#), Abt Associates, April 2023.

Hospice Claims Index

LeadingAge does not object to HCI being utilized in the SFP algorithm. With 21.7% of hospices not assigned a publicly-reported HCI score¹³, a significant number of hospices would not be captured based on this indicator, and therefore as currently structured, it might not be sufficient to compare all hospice providers evenly. Based on analysis of qCOR and claims data, we found providers without HCI scores were less likely to be included in the 10th percentile and, therefore, less likely to be included in the SFP. In addition, according to analysis based on publicly available data, hospices that did not have an HCI score had dramatically more CLDs per beneficiary yet were less likely to fall into the bottom 10% of hospices. Thus, hospices more deserving of the SFP were less likely to be included. We ask CMS to continue its work with the TEP to consider how to be sure that providers without an HCI can be appropriately represented in the algorithm.

We want to use this opportunity to raise our ongoing concerns with the GIP/CHC measure in the HCI. A hospice only needs to do greater than 0 days of GIP or CHC, across all locations, to get a 1 on this metric. This should not be the standard for quality care. We ask that CMS revisit this measure definition and change the threshold for scoring a “1” to a threshold that actually dings hospices for not providing GIP or CHC. We would be happy to discuss ideas for what that threshold should be with CMS.

Graduation and termination from the SFP

We understand that in order for a hospice in the SFP to graduate out of the program, they must have no CLDs cited or Immediate Jeopardy (IJs) citations for any two six-month SFP surveys, no pending complaint survey triaged at an immediate jeopardy (IJ) or condition level and must return to substantial compliance with all requirements. The concerns about the lack of scaling the CLD and substantiated complaint data as previously stated above should also be considered in graduation or termination. For example, one CLD in a hospice with an average daily census of 50 signals greater concern about quality of care than one CLD in a hospice with an average daily census of 1000 or greater. Perhaps scaling the number of CLDs by average daily census would be most appropriate. For instance, graduation criteria could require:

- 0 CLDs if ADC is < 500
- 1 CLD if ADC is 501 – 2000
- 2 CLD if ADC is >2000

Our members once again brought up inconsistency as a factor in the graduation criteria. Some states come out and do complaint surveys immediately – others sit on complaints for months before acting so an agency who thinks they are on the verge of graduating does not know that there is an outstanding complaint that has not yet been acted upon. They suggest that graduation should be more closely tied to a plan of correction. CMS should also provide monthly updates as to who has graduated from the program.

Technical Assistance

LeadingAge requests that CMS issue more guidance on steps a hospice should take to move toward graduation. There is no information in the rule on how a hospice is supposed to improve if put into the SFP – they are simply supposed to do better on future surveys. The TEP suggested that technical assistance be mandatory for hospices during their time in the program and that national standards for technical assistance be developed and shared. It also recommended creating a list of approved technical assistance providers. We agree with these recommendations and urge CMS to implement them.

¹³ Industry analysis of data from 2021 Medicare Claims data accessed from Hospice Analytics' INFOMax platform in July 2023, CAHPS and HCI data obtained July 2023, as most recent available data for each, from Care Compare and data.medicare.gov, CLD and Complaints data obtained from QCOR, and number of hospices based upon any hospice CCN with data in 2021 Medicare Claims data, Care Compare, and/or QCOR CLD or Complaints data.

Additional COPS to Consider

LeadingAge recommends that the Organization and Administration of Services be included in the list of CoPs under consideration of survey data, especially around governing body oversight, hospice administrator, multiple locations, training and orientation, and 24/7 availability. (418.100)

HOSPICE INFORMAL DISPUTE RESOLUTION

We appreciate the proposal to introduce informal dispute resolution into the hospice program. We ask that CMS modify the proposal to ensure that if a hospice seeks resolution via IDR, the IDR decision is finalized prior to enforcement penalties being imposed with an exception for the case of immediate jeopardy. CMS has not established a set timeframe during which the survey entity must process the IDR request. Considering that state agencies are struggling to conduct surveys on open complaints and revisits to ensure corrective action has occurred¹⁴, it is likely that IDR requests will not be a priority for SAs and will remain open for a significant period of time. LeadingAge recommends that CMS institute a timeline for survey entities to complete the IDR process and recommends 30 calendar days from the date the dispute is filed.

PROVIDER ENROLLMENT

Hospice Specific

Categorical Risk Screening: LeadingAge supports the proposal to revise § 424.518 to move initially enrolling hospices and those submitting applications to report any new owner (as described in § 424.518's opening paragraph) into the "high" level of categorical screening; revalidating hospices would be subject to moderate risk-level screening.

36 Month Rule: LeadingAge supports the proposal to extend the "36 month rule" to hospice so as to require that when a hospice undergoes a change in majority ownership (CIMO) by sale within 36 months after the effective date of its initial enrollment or within 36 months following the hospice's most recent CIMO, the provider agreement and Medicare billing privileges will not convey. We also support CMS mirroring the same exceptions for hospice that apply to home health.

Definition of Managing Employee: LeadingAge supports the proposal to revise the managing employee definition in § 424.502 by adding hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

General

Deactivation for 12 months of non-billing: LeadingAge supports the proposal to revise 424.50(a)(1) to change the threshold for deactivating a non-billing provider from 12 months to 6 months.

Provisional Period of Enhanced Oversight: LeadingAge supports the proposed changes to CMS' provisional period of enhanced oversight (PPEO) authority.

Retroactive Provider Agreement Terminations: LeadingAge supports the proposed change that allows providers to request a retroactive termination only if no Medicare beneficiary has received services from the facility on or after the requested termination date.

¹⁴ CMS, [Fiscal Year 2022 \(FY22\) State Performance Standards System \(SPSS\) Findings](#)

Please do not hesitate to contact us with any questions regarding these comments.

Mollie Gurian

Mollie Gurian
Vice President, Home Based and HCBS Policy
LeadingAge