



August 16, 2022

Chiquita Brooks-LaSure
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: CMS-1766-P: CY 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements

Dear Administrator Brooks-LaSure,

On behalf of our over 5,000 members and partners including mission-driven organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge is pleased to offer the following comments in response to the CY2023 Home Health Prospective Payment System Proposed Rule.

General Comments

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, this year's home health prospective payment system (PPS) proposed rule runs counter to the letter and spirit of these well-articulated values and goals. Cutting Medicare home health payments by an aggregate 4.2% including a 7.69% negative adjustment to the base payment, coupled with an effort to recoup an additional \$2 billion from home health providers, 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. The calendar year (CY) 2023 home health PPS proposed rule with its proposed major funding cut, on the heels of insufficient increases to the skilled nursing facility (SNF) and hospice settings sends a chilling message to providers of these services, particularly nonprofit and mission focused organizations. If finalized, these cuts will significantly worsen the staffing crisis in these service lines and limit access to care for older Americans who need it.

As the only association that represents providers across aging services settings, we take a holistic view of the potential impact of this year's PPS rules. They do not bode well for older people. LeadingAge members provide Medicare skilled nursing, home health, and hospice services. Both the SNF and home health PPS proposed rules call for drastic cuts to payment. On the SNF side, we appreciate that CMS spread the final parity adjustments over two years, but the state of the sector is such that any cuts contribute to unsustainability. Similarly on the hospice side, we appreciate CMS' recognition of inflationary costs and their impact on hospice providers. However, the 3.8% increase is still insufficient to cover increased costs and return of sequestration. While the overall impact of CMS' rules is blunted from the initial proposals, there is the potential for death by a thousand cuts across the continuum of 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 fragile long-term care ecosystem could simply cease to exist, especially our mission-driven, high-quality members.

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. One member recently reported having her first applicant for an open position which was posted for six months. This is not an uncommon story – in fact, what is more common is not getting any applications at all. Providers have also absorbed additional costs for personal protective equipment, COVID tests, and other equipment that have simply gotten more expensive. For home health and hospice providers, the cost of gas alone is enough to warrant increases rather than decreases in payments. Home health care remains a service people want – our members are still reporting heightened levels of referrals but are increasingly unable to take those patients because of staffing shortages.

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 home health aides and certified nursing assistants, 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 two and a half years and put more money into the system so that our members can modify, adapt, and grow in response to the pandemic rather than continue to figure out where they can cut costs and ultimately, cut services.

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.

Home Health Prospective Payment System Update

LeadingAge makes a number of recommendations regarding CMS' proposals regarding the home health prospective payment system, particularly related to the proposed permanent prospective adjustment and the proposed temporary retrospective adjustment. Our key recommendations are:

- **We strongly recommend that CMS base payment policy on evidence as opposed to behavioral assumptions going forward to not repeat the harm that the current assumptions have compounded on top of the revenue effects of COVID-19.**
- **We ask that CMS delay the permanent adjustment for at least one year and be dependent on the release of relevant data. We also ask that CMS not implement any temporary adjustments based on behavior. If CMS moves forward with utilizing behavioral assumptions to inform temporary retrospective adjustments, we ask that it be delayed until a methodology to target the adjustment at providers who were truly outliers on the behavioral assumptions.**
- **LeadingAge strongly opposes the application of behavioral assumptions in CY2023 and requests that they not be applied in the future until data used to assess the assumptions is public and able to be analyzed. If behavioral assumptions are going to be utilized, CMS must consider how to reward good provider behavior; not just penalize bad behavior.**

Market Basket Update

CMS proposes a 2.9% market basket update to the home health (HH) prospective payment system (PPS) for calendar year (CY) 2023. However, CMS stated in proposed rulemaking that if more recent data become available after the publication of the proposed rule and before publication of the final rule, CMS would use said data to determine the home health payment updated percentage. In the FY2023 Hospice Wage Index Final Rule, CMS stated that IHS Global Inc.'s second quarter 2022 forecast had increased resulting in CMS increasing the final CY2023 hospice market basket increase by 1.1 percentage points.¹ **LeadingAge asks CMS to apply the updated data to the home health market basket update for CY2023.**

We want to emphasize that the proposed 2.9% increase is not sufficient to cover the current needs of home health providers. All programs took on major, ongoing expenses due to COVID-19. While the resources from the government have been immensely helpful, the ongoing expenses for personal protective equipment (PPE), increased costs for gas, and other increased expenses now have to be worked into home health agency budgets and many of our members' margins were already thin; increased payment this year and into the future will continue to be essential.

¹ FY2023 Hospice Wage Index Final Rule. <https://www.federalregister.gov/public-inspection/2022-16214/medicare-program-fiscal-year-2023-hospice-wage-index-and-payment-rate-update-and-hospice-quality>

Behavioral Assumptions

Note on Statute

For both the permanent prospective adjustments and the temporary retrospective adjustment, CMS relies on their statutory duty to make these adjustments. The language of the statute for both adjustments, in our view, gives the Secretary flexibility in use of the administrative process to make these adjustments. Both pieces of statute mention the “at a time and in manner determined appropriate.”² This is not a time for a rate decrease given all of the compounding factors impacting the industry. On the temporary retrospective adjustment, we appreciate that CMS is not immediately implementing the adjustment – it is utilizing that flexibility as it did in CY2022.

We ask that CMS delay the permanent adjustment for at least one year and be dependent on the release of relevant data. We also ask that CMS not implement any temporary adjustments based on behavior. If CMS moves forward with utilizing behavioral assumptions to inform temporary retrospective adjustments, we ask that it be delayed until a methodology to target the adjustment at providers who were truly outliers on the behavioral assumptions.

Permanent Prospective Adjustment

CMS proposes a negative 7.69% behavioral adjustment to the patient-driven grouping model (PDGM) for CY2023. When CMS implemented the PDGM in CY2020, the intent was for the new payment model to be budget neutral, resulting in neither an increase nor a decrease in Medicare home health payments.

LeadingAge strongly opposes the application of behavioral adjustment in CY2023 and requests that it not be applied in the future until data used to assess the assumptions is public and able to be analyzed. If behavioral assumptions are going to be utilized, CMS consider how to reward good provider behavior; not just penalize bad behavior.

The degree to which CMS is assuming the three behavioral changes (in addition to therapy provision changes) by providers due to PDGM take an unnecessarily cynical view of home health agencies. It also paints all agencies with a broad brush, despite many nonprofit and mission driven agencies which made no change to their clinical practice and patient care philosophy to adapt to the new payment environment.

Clinical Payment Groups and Comorbidity Coding

Clinical Payment Groups: CMS assumed that HHAs would change their documentation and coding practices to put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day episode in a higher paying clinical grouping. Data released by MedPAC in July 2022 contradicts this assumption. They said: “The mix of cases by clinical payment group also did not change significantly. These relatively unchanged indicators for patient acuity suggest that the types of patients served by home health agencies did not change significantly in 2020, despite Medicare’s implementation of significant payment policy changes and the disruptions of the COVID-19 public health emergency that

² The Bipartisan Budget Act of 2018. Pub. L. 115-123, enacted February 9, 2018.

year.”³ MedPAC’s findings are consistent with discussion we had with LeadingAge members about coding changes during the move to PDGM.

We heard from many members that they are likely not reflecting the acuity of the patients being seen in their documentation. One member shared they work closely with a safety-net hospital in their area which has a higher acuity of patients who are often dually eligible, require more education to understand their disease process, and more visits to prevent hospitalizations. Many members also voiced concern that they are serving populations that other agencies simply do not want to serve because of the low payments. For example, patients who have conditions which will require maintenance care like Parkinson’s Disease. These patients are complex and time consuming to care for and the reimbursement, as it stands now, pays less for patients who need intensive care.

Caring for all patients, including the more complex patients is the mission of our membership, but it has an impact on the number of new referrals and episodes they can accept. Unfortunately, the core incentives of PDGM remain the same, volume over value. MedPAC’s data clearly finds that “agencies with higher episode volumes had higher margins. The agencies in the lowest volume quintile in 2019 had an aggregate margin of 11.6 percent, while those in the highest quintile had an aggregate margin of 22.4 percent.”⁴

Comorbidity Coding: CMS’ behavioral assumption is that the ability to code more comorbidities in the claims, rather than the five allowed in OASIS, leads home health providers to include more comorbidities to ensure more 30-day periods of care will receive a comorbidity adjustment. This behavioral assumption is not unreasonable. Indeed, data on reported comorbidities appear to indicate a slightly higher scoring than anticipated. However, Medicare home health beneficiaries are among the most vulnerable Medicare populations.⁵

According to research from the Commonwealth Fund, the severity of illness and comorbidity was higher among Medicare home health users admitted from the community in 2020 than in 2019.⁶ Community admits accounted for 74.3% of home health episodes in 2020.⁷ When speaking with our members, we found many also saw increased comorbidity and acuity in patients leaving hospitals. Many found that

³ Medicare Payment Advisory Commission. July 2022 Data Book. Section 8: Post-acute care. Available at: https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec8_SEC.pdf

⁴ Ibid.

⁵ Ma, Chenjuan et al. “Patient-Rated Performance of Home Health Agencies and Hospitalization Risk: A Propensity-Score Matched Analysis.” *Innovation in aging* 5. Supplement_1 (2021): 533–534. Available at: <https://www.ajmc.com/view/cms-hcc-risk-scores-and-home-health-patient-experience-measures>

⁶ Commonwealth Fund. “Changes in Medicare Home Health Use During COVID-19 and the Implications for Health Equity and Caregiver Availability.” June 28, 2022. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2022/jun/changes-medicare-home-health-use-during-covid-19>

⁷ Medicare Payment Advisory Commission. July 2022 Data Book. Section 8: Post-acute care. Available at: https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec8_SEC.pdf

especially since the pandemic, hospitals discharged patients sooner leading to patients with more complications in the community requiring more resources from home health agencies.

Adjusting for Higher Acuity Beneficiaries: 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.

One option is to integrate Hierarchical Condition Categories (HCC) scores into behavioral assumptions to create a more holistic view of the home health population; they should also be considered given the start of nationwide Home Health Value Based Purchasing (HHVBP). A paper from 2018 found a negative association between CMS HCC risk scores and patient experience measures in home health. In other words, the current risk factors insufficiently adjust for the variation in beneficiaries’ clinical and functional conditions that affect patient experience. The paper notes, “Considering the negative association between agency-level CMS HCC risk score and patient experience measures, home health agencies with a high proportion of clinically complicated beneficiaries are likely to be financially penalized under the HHVBP. Home health agencies can also simply dump or avoid beneficiaries with complicated conditions to improve their performance in the patient experience measures...access to care with complicated clinical and functional conditions can become problematic, given the fact that more than 80% of home health agencies are for-profit entities that pursue profit maximization.”⁸

CMMI clearly stated their goal of having all Medicare fee-for-service beneficiaries in an accountable care relationship by 2030.⁹ Integrating HCC scores into existing fee-for-service payment structures will help incentivize the entire system to recognize accountability while at the same time incentivizing all providers to care for the most vulnerable and costly patients. We also believe, because the CMS HCC risk score is based on Medicare home health beneficiaries’ enrollment data and inpatient and outpatient claims data, it would be more difficult for agencies to practice upcoding that may affect the CMS HCC risk score. CMS’ behavioral assumptions focus on upcoding – agencies that overstate the acuity of their patients. There is no accounting for payment to the agencies actually providing the care for these beneficiaries and we ask that CMS consider ways to ensure the benefit is truly working for underserved patient populations.

⁸Ma, Chenjuan et al. “Patient-Rated Performance of Home Health Agencies and Hospitalization Risk: A Propensity-Score Matched Analysis.” *Innovation in aging* 5. Supplement_1 (2021): 533–534. Available at:

<https://www.ajmc.com/view/cms-hcc-risk-scores-and-home-health-patient-experience-measures>

⁹ Center for Medicare and Medicaid Innovation. “Strategic Direction.” July 5, 2022. Available at:

<https://innovation.cms.gov/strategic-direction#:~:text=All%20Medicare%20fee%2Dfor%2Dservice,cost%20of%20care%20by%202030>

Low Utilization Payment Adjustment Thresholds

LeadingAge noted in previous comments that the behavioral 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. When discussing LUPAs with members, many found no differences between their CY2019 and CY2020 or CY2021 LUPA rates.

In fact, many agencies were and are still working to reduce LUPA rates in order to provide needed care to their patient population. Articles published on the realities and inconsistencies of Medicare home health visits highlight the fact that less care can be detrimental to patients and their family caregivers.¹⁰ Families have gone weeks without an agency contacting them leading to complications and in some cases, worse outcomes.

We question whether an agency that increases visits to avoid LUPAs is engaging in behavior that should result in a negative behavioral adjustment. The beneficiary is getting more visits – if CMS has data that more visits are not resulting in better outcomes, we would like to see that. Otherwise, it seems like the existence of the LUPA threshold incentivizing more in person visits does not seem like bad behavior. In our own effort to research the issue, we could not identify any peer-reviewed academic research study stating that increasing visits reduced the quality of care.

Methodological Flaws and the Need for Additional Data

It is not clear in the data provided by CMS in the proposed rule if their methodology considered the change in LUPA thresholds from the 60-day CY2019 PPS to the 30-day CY2020 PDGM. Under the previous PPS, LUPAs were classified as four or fewer visits during the 60-day episode of care. Under PDGM, LUPAs have different thresholds during the altered 30-day episode based on each of the 432 case-mix groups with a minimum two visit threshold. CMS' LUPA behavioral assumption is based on data available at the time of the CY2020 home health proposed rule that suggested one-third of PPS home health episodes which were one or two visits away from the four or fewer LUPA threshold were provided additional visits to receive the full 60-day payment.

With PDGM's fluctuating LUPA visit thresholds based on case-mix, it would be difficult to compare the previous LUPA behavior to potential PDGM LUPA behaviors. Additionally, there is a reduction in the time period that agencies have to achieve and additional two visits to receive the full 30-day payment under PDGM. Previously, agencies had an additional 30-days to accomplish additional visits to avoid LUPAs. We are unclear from the information in the rule if CMS adjusted the LUPA considerations to account for these two different payment factors.

We also request that the data for determining the behavioral assumptions regarding LUPAs thresholds be made available in order to fully understand the methodological assumptions made by CMS.

¹⁰ Kaiser Health News. "Pandemic-Fueled Shortages of Home Health Workers Strand Patients Without Necessary Care." February 3, 2022 <https://khn.org/news/article/pandemic-fueled-home-health-care-shortages-strand-patients/>

Therapy Provision Change

Prior to the implementation of PDGM, less than 30% of nonprofit home health agencies planned to decrease therapy utilization in response to payment changes.¹¹ Changes in therapy provision were also well underway prior to PDGM with the elimination of therapy thresholds for CY2019 payments. In the FY2023 Skilled Nursing Facility (SNF) Proposed Rule, CMS made accommodations for behavior changes in therapy provision changes in the patient driven payment model (PDPM).

“Given this reduction in therapy provision since PDPM implementation, we found that using patient assessment data collected under PDPM would lead to a significant underestimation of what RUG-IV case-mix and payments would have been (for example, the Ultra-High and Very-High Rehabilitation assignments are not nearly as prevalent using PDPM-reported data), which would in turn lead to an overcorrection in the parity adjustment.”¹²

Similar to CMS’ rationale for not using data collected under PDPM for the FY2023 SNF payment due to the potential for overcorrection, CMS should not use the methodology from the CY2022 proposed and final rule to assess 2020 PDGM budget neutrality as it could lead to overcorrection.

Methodological Flaws and the Need for Additional Data

CMS’ methodology to determine provider behavioral adjustments for budget neutrality in the proposed rule compares PDGM in CY2020 and CY2021 to what would have happened if PDGM were not implemented, and the 4 Equation PPS payment model (4EQ) were continued. The stated goal of the methodological analysis is to observe PDGM behavior changes and compare to payments that would have been made to the same patients grouped under 4EQ PPS. Our concern with this methodology is that this comparison assumes that there is just one policy that providers may respond to with behavior changes – that is, PDGM – when in fact there are two: PDGM and 4EQ PPS.

CMS groups patients under 4EQ PPS and fails to make any attempt at addressing provider behavior under 4EQ PPS. As a result, the ensuing analysis does not calculate what payments would have been like if PDGM were not implemented and 4EQ PPS continued as policy. Specifically – the simple, hypothetical payment after grouping via 4EQ PPS for patients served under PDGM does not represent what payments would have been like if 4EQ PPS were still the payment policy utilized today.

For example, CMS provides empirical evidence of provider behavioral response to 4EQ, by showing therapy shifts by providers in anticipation of the termination of 4EQ – but we disagree with the interpretation of these findings in the context of the subsequent analysis. This drop in therapy utilization

¹¹ Home Health Care News. “Nonprofit, Health System-Based Agencies Likeliest to Weather PDGM’s Therapy Storm.” June 5, 2019. Available at: <https://homehealthcarenews.com/2019/06/nonprofit-health-system-based-agencies-likeliest-to-weather-pdgm-therapy-storm/>

¹² Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels, 87 Fed. Reg. 22720 (April 15, 2022) to be codified at 42 CFR pt 413). Available at: <https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

is a confirmation that CMS was successful in eliminating therapy thresholds and creating a true prospective payment model in PDGM as required by the Bipartisan Budget Act of 2018.

To compare provider behavior under PDGM to what would have happened absent PDGM, CMS must incorporate an estimate of provider behavior under 4EQ as if 4EQ continued as the payment policy before calculating the 4EQ equivalent. There are several statistical approaches to do this; we offer two suggestions:

- At the PPS episode level, simulate therapy utilization to 2018 levels, then regroup. This is preferred due to the dependency of the 4EQ model on the number of observed therapy visits.
- An alternative would be to conduct resampling or weighting methods to demonstrate the behavioral impact in CY2020-CY2021, if the distribution of the Health Insurance Prospective Payment System (HIPPS) codes resembled the 2018 levels.

In addition, CMS also needs to recalibrate the regression coefficients under 4EQ for CY2020, CY2021, and going forward for behavioral adjustment purposes per CMS procedures, as they do for PDGM, to create an equivalent approach to compare PDGM to the hypothetical continuation of 4EQ. This is consistent with policy announced in the CY2015 home health PPS final rule. At that time, CMS finalized a policy to annually recalibrate the home health PPS case-mix weights, because “annual recalibration of the HH PPS case-mix weights ensures that the case-mix weights reflect, as accurately as possible, current home health resource use and changes in utilization patterns.”¹³

Without continued maintenance of the PPS model in CMS’ behavioral impact analysis, the result will be a fee-for-service penalty resulting from changes in therapy utilization that is applied to the PDGM Model.

We also request that the data for determining the behavioral assumptions regarding therapy visits, including the HIPPS codeset, be made available in order to fully understand the methodological assumptions made by CMS.

We strongly recommend that CMS base payment policy on evidence as opposed to behavioral assumptions going forward to not repeat the harm that the current assumptions have compounded on top of the revenue effects of COVID-19.

Temporary Retrospective Adjustment

As LeadingAge stated in previous comments, CY2020 and 2021 were not normal years due to the adjustment to the new payment model coupled with an ongoing pandemic. CMS’ assessment that home health agencies, in aggregate, were overpaid by \$2 billion is simply unbelievable and unprecedented. While we recognize the difficulty of comparing actual expenditures under the current model to what could have happened under the previous PPS, the unintended consequences of the current

¹³ Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies. 79 Fed. Reg. 66,031 (Nov. 06, 2014) (to be codified at 42 C.F.R. pt. 409, 424, 484, 488, 498). Available at: <https://www.federalregister.gov/documents/2014/11/06/2014-26057/medicare-and-medicaid-programs-cy-2015-home-health-prospective-payment-system-rate-update-home>

methodology could be catastrophic for nonprofit, mission driven agencies who have smaller margins than their for-profit counterparts. MedPAC found that nonprofit agencies had an average margin of 12.4 percent compared an average margin of 22.7% for profits.”¹⁴

We recommend that CMS not move forward with the temporary retrospective adjustment. If CMS were to move forward with the proposed \$2 billion in temporary retrospective adjustments, the recoupment of funds simply should not be applied to all agencies. Instead, CMS should conduct detailed, agency level analyses to identify agencies who had high margins, whose behavior changes were egregious with regard to manipulation of diagnosis and comorbidity coding for payment, and who cherry pick certain types of more lucrative, less intensive cases. CMS should target recoupment on those entities.

Health Equity

In CMS’ Framework for Health Equity 2022-2023, it is clearly stated that there are opportunities to evaluate the impact that social risk factors have on payment and value-based purchasing programs.¹⁵ This aligns with our earlier comment regarding considering incentivizing positive provider behavior, not just penalizing negative behavior. While LeadingAge is appreciative of the opportunity to provide comments on future approaches to health equity in the expanded Home Health Value Based Purchasing Model below, we are deeply disappointed that CMS did not consider any social risk factors in their calculation of behavioral adjustments for PDGM. **In future rulemaking, we urge CMS to consider social risk factors in their adjustments to payment including but not limited to dually eligible status and complex frailty.**

Proposed Permanent Cap on Home Health Wage Index Decreases

We support the proposal to impose a permanent cap on home health wage index decreases. However, we believe the percentage cap should be lower than the proposed 5% and the cap should be applied in a non-budget neutral way and be made retroactive for all provider types. Applying the cap in a non-budget neutral way will ensure that when significant economic downturns occur, all home health agencies will be protected from significant reductions. Based on feedback from LeadingAge members, we also found that most wage indices do not swing by 5% but even a 2% wage decrease impacts operations. Due to the home-based nature of home health care, we also found agencies can serve multiple Core Based Statistical Areas (CBSA), and while a 5% cap is helpful to maintain payment stability, agencies serving multiple CBSAs will find it difficult to consistently account for differences across their service area. Providing a lower cap on decreases will allow agencies serving multiple CBSAs to better predict costs. We supported CMS’ original decision announced in 2021 to place a one-year cap on wage indices decreases of more than 5%. However, that cap was only extended for a second year to hospitals which should be rectified with a retroactive application of the permanent wage index cap proposal to CY2022 payments. **We urge CMS to finalize the permanent cap on home health wage index decreases**

¹⁴ Medicare Payment Advisory Commission. July 2022 Data Book. Section 8: Post-acute care. Available at: https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec8_SEC.pdf

¹⁵ The Centers for Medicare and Medicaid Services. *CMS Framework for Health Equity 2022-2023*. <https://www.cms.gov/files/document/cms-framework-health-equity.pdf>

to 2% in a non-budget neutral way and retroactively apply this policy to CY2022 home health payments.

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.¹⁶ **We ask that CMS work with the Congress to reinstitute the rural add-on payment, and policies to reform the wage index such as revisiting MedPAC’s 2007 proposal¹⁷ 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.

Collection of Data on Use of Telecommunications Technology under Medicare Home Health Benefit

LeadingAge strongly supports CMS’ proposal to collect information on the use of telecommunications technology under the Medicare home health benefit. LeadingAge’s Center for Aging Services Technologies or CAST, has written an extensive white paper on the potential uses of telehealth and remote patient monitoring technologies in aging services including the benefits of such technologies for supporting older adults.¹⁸

LeadingAge recommends clarifying the types of remote patient monitoring which will be allowable under the new G-Codes to ensure that RPM is adding to the value of care not simply tracking someone’s steps from a wearable product like a smart watch.

We appreciate that CMS is not currently planning to limit the use of the new G-Codes by services and disciplines. Our members have shared that, while the use of telehealth is limited due to lack of reimbursement, its use has extended staff resources during the most significant staffing crisis aging service providers have faced. Examples include, nursing staff performing care plan oversight using telehealth services while they quarantine for COVID-19 infections, using telehealth for triage situations, and to extend weekend and overnight staffing capabilities.

CMS requested specific feedback on allowing telehealth flexibilities to be used by home health aide services, which typically require staff to be in-person and hands on. Many states have adopted increased scopes of practices for aides that could allow use of telehealth for improved outcomes. For instance, Colorado recently adopted certifications for medication aides who can administer medications as well as

¹⁶ 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>

¹⁷ Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2007 June. Chapter 6, An alternative method to compute the wage index; Available from: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun07_Ch06.pdf

¹⁸ LeadingAge CAST. “Telehealth and Remote Patient Monitoring for Long-Term and Post-Acute Care: A Primer and Provider Selection Guide.” Available at: <https://leadingage.org/white-papers/telehealth-and-remote-patient-monitoring-long-term-and-post-acute-care-primer-and>

“Observe and report to the Supervising Licensed Nurse any and all reactions and side effects to medications that are exhibited by a Client.”¹⁹ If a home health aide were able to monitor a patient remotely for adverse reactions after a visit it may improve outcomes for that patient and reduce potential avoidable hospitalizations or ED visits. We ask that CMS not restrict application of G-Codes to home health aide services.

Ending the Suspension of Collection of OASIS for All Patient Regardless of Payer

While an informal survey of LeadingAge members found that many do collect OASIS data on all patient regardless of payer, there are still members who have a significant portion of patients covered by private insurance who do not collect OASIS data. In the CY 2020 Home Health Proposed Rule, CMS included a request for information on the requiring OASIS reporting on all patients regardless of payer. Many commentors raised questions that remain unanswered in the current proposal including:

- What patient populations will be excluded from reporting? Many home health agencies support post-partum mothers and children through private insurance, a population that was not originally considered in OASIS development, would agencies be required to submit information on these population? What about charity patients who have no payer source to link the data to?
- Would patient level affirmation such as consent or release forms be necessary to submit data to CMS? Has CMS assessed the burden of this type of patient-level authorization?
- How would CMS account for many private insurers not requiring homebound status as part of their home health eligibility? How would outcome measures, claims-based measures, and five-star ratings be adjusted to account for the differences in eligibility criteria across all private insurers? Additionally, has CMS assessed the financial burden for agencies who are not reimbursed by private insurers for the collection of OASIS data? Will CMS require private payers to standardize the delivery of home health benefits as well as OASIS collection?

In addition to the number of outstanding questions, the burden of collection remains high in a time when workforce shortages remain severe and will for the foreseeable future. LeadingAge previously submitted comments to the Office of Management and Budget arguing that given the workforce crisis aging services is experiencing, the calculation of cost burdens for the implementation of OASIS-E were out of sync with the current staffing realities for home health agencies.²⁰ Regardless of the factors driving the current shortage, the United States is on track to have a shortage of 3.6 million nurses for 82 million aging adults due to demographics by 2030.²¹ With nurses completing nearly 76% of the OASIS

¹⁹ Section 3 CCR 716-1-1.19 - RULES AND REGULATIONS FOR THE CERTIFIED NURSE AIDE IN RELATION TO MEDICATION AIDE AUTHORITY. Available at: <https://casetext.com/regulation/colorado-administrative-code/department-700-department-of-regulatory-agencies/division-716-division-of-professions-and-occupations-board-of-nursing/rule-3-ccr-716-1-nursing-rules-and-regulations/section-3-ccr-716-1-119-rules-and-regulations-for-the-certified-nurse-aide-in-relation-to-medication-aide-authority>

²⁰ LeadingAge Comment Letter on OASIS-E Proposed Collection. April 2022. Available at: <https://leadingage.org/leadingage-comments-proposed-oasis-e-changes>

²¹ American Association of Colleges of Nursing. *Fact Sheet: Nursing Shortage*. <https://www.aacnnursing.org/news-information/fact-sheets/nursing-shortage>, U.S. Department of Health and Human Services, *Supply and Demand Projections of the Nursing Workforce: 2014-2030*. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf>

documentation, a CY2025 implementation of all patient OASIS collection would be an undue burden to agencies and their staff.

Without more concrete details on the how this data will be used to positively impact additional patient populations and the private insurers who are responsible for their care, LeadingAge cannot support this proposal to end the suspension of OASIS collection on all patients regardless of payer in CY2025.

Changes to Expanded Home Health Value Based Purchasing (HHVBP) Model

HHVBP Baseline Year

LeadingAge deeply appreciates the HHVBP technical assistance (TA) team's due diligence in reviewing measure trends to determine the impact of COVID-19 on the measure set which will be used to assess agencies starting in January 2023. CMS proposal to change the baseline year from CY2019 to CY2022 included thoughtful rationale for the decision and LeadingAge supports the change of baseline year.

However, CMS should delay implementation of the Expanded HHVBP Model until CY2024 due to the proposed six-month delay in providing final Individual Improvement Thresholds, Achievement Thresholds, and Benchmark Data.

Timely Filing: The Affordable Care Act amended the time period for filing Medicare fee-for-service claims. According to statute, claims must be filed no later than 12 months (or one full calendar year) after the date when the services were provided. Medicare Administrative Contractors are also provided additional discretion for timely filing of claims. Because Medicare providers routinely use this filing deadline for a number of reasons, it is not unreasonable to assume that by July 2023 all claims of an individual agency may not be filed, meaning the claims-based measures, which CMS is intending to account for in the change of base year, may not accurately reflect all claims. Timely filing deadlines will also impact Achievement Thresholds and Benchmarks which are determined in part by an agency's cohort. This means that the delay in timely filing of claims for one agency may throw off the overall Achievement Threshold or Benchmark and therefore the individual agency Improvement Thresholds for an entire cohort. Finalizing this proposal as written, would not provide a fair and accurate Achievement Threshold, Improvement Thresholds, or Benchmarks for agencies to work from in the first year of this expanded demonstration.

Original Demonstration Discrepancies: CMS claims this change would be consistent with the original HHVBP Model which made individual agency Improvement Thresholds available to agencies in the summer of the first performance year, CY2016. However, this is an ineffective and harmful comparison for two reasons. First, for the original demonstration, the first two years had **NO** payment adjustment incentive. In the CY2023 proposed rule, CMS did not make any proposed changes to the previously finalized 5% payment adjustment incentive for the expanded model's first year of accountability. Second, the cohorts in the first demonstration were state based. In the expanded demonstration cohorts can include agencies for multiple state which gives agencies from the original nine states an unfair advantage in operationalizing the demonstration over their competitors in other states. Changing the baseline year without complete data available to home health agencies in the first six months of their accountability is setting them up for failure.

HHVBP Health Equity

LeadingAge supports the Administration's focus on improving health equity and supports the inclusion of adjustments to the expanded HHVBP model to account for the diversity of Medicare beneficiaries. Regarding the items proposed in this year's rule, adjustments in peer comparison groups and measuring the agency proportion of dual eligible beneficiaries would be most actionable.

Recent studies have found that Black and Hispanic home health patients had lower probability of high-quality agency use compared to White counterparts within the same neighborhoods, the same was found regarding income differences.²² Incorporating patient level data like race and ethnicity or the proportion of dually eligible patients served by an agency into the development of cohorts would create more level playing fields for agencies in historically marginalized areas to improve. The current simplistic cohort designations do not consider the diversity of patient population and have the potential to negatively impact providers in underserved areas.

Request for More Information on Health Equity

We applaud the Biden-Harris Administration on their sweeping commitment to health equity. In 2021, LeadingAge made a commitment in to increase focus on governance, diversity, equity, and inclusion within LeadingAge member organizations.²³ To achieve this work, we have launched a series of initiatives including member networking opportunities, education on equity, diversity, and inclusion for member organizations, and supporting public policy to make aging services responsive to underserved populations. The LeadingAge LTSS Center @UMass Boston published a research brief in late 2021 with insights about diversity, equity, and inclusion from leaders of LeadingAge member organizations.²⁴

The OASIS-E instrument, set to go into effect January 1, 2023, contains the means to measure impact on social determinants of health in a way consistent with efforts in other settings, creating standardization across post-acute care providers. However, OASIS-E's implementation is not without draw backs. The severe workforce shortage of nurses has persisted and the bulk of OASIS-E completion falling to nurses. The additional cuts discussed above will only continue to decrease home health agency's ability to be competitive in one of the worst workforce markets in decades. Adding a structural measure with requirements for home health agencies to track even more data on health equity and underserved populations along with other self-reported demographics is an undue burden and should be paused until OASIS-E is fully implemented and data from that tool can be integrated into this work.

We look forward to partnering with CMS on this important work and hope there will be more opportunities to comment on health equity. This is a critical learning opportunity for providers across

²² Fashaw-Walters, Rahman, M., Gee, G., Mor, V., White, M., & Thomas, K. S. (2022). Out Of Reach: Inequities In The Use Of High-Quality Home Health Agencies: Study examines inequities in the use of high-quality home health agencies. *Health Affairs*, 41(2), 247–255. <https://doi.org/10.1377/hlthaff.2021.01408>

²³ LeadingAge. LeadingAge 2021-2023 Strategic Plan. Dec. 2020. Available from: <https://leadingage.org/sites/default/files/2021%20LeadingAge%20Strategic%20Plan.pdf>

²⁴ LeadingAge LTSS Center @UMass Boston. Creating a Diverse, Equitable, and Inclusive Workforce Culture: Perspectives of LeadingAge Members. Nov. 2021. <https://www.ltsscenter.org/research-how-are-leadingage-members-advancing-dei-values/>

the continuum of aging services but unfortunately the playing field is not yet level for all providers including home health agencies. Some providers may need to start at square one with differentiating social determinants of health from race and ethnicity and understanding the root causes of health inequality including racial bias and racism. We hope as this work advances there will be time and investment provided to support all home health agencies to improve health equity without penalty regardless of a provider's current efforts.

Structural Composite Measure

Again, LeadingAge strongly supports CMS' efforts to improve health equity and we recognize the patient populations who access home health care often do not reflect the diversity of Medicare enrollees. We also recognize home health is not the only setting in Medicare looking at the implementation of structural measures for health equity. The hospital, skilled nursing facility, and hospice proposed regulations all included proposals for a health equity structural measure. The structural measure that CMS proposed for hospitals and skilled nursing facilities had significant stakeholder input including a Technical Expert Panel (TEP) process. We are grateful that CMS took our recommendations from the FY2023 Hospice Wage Index comments to initiate a TEP for home health and hospice health equity measures.

The National Quality Forum's Measure Application Partnership (MAP) also reviewed the measure and only provided a conditional approval. The MAP suggested: 1) a commitment from CMS to look at outcomes in the future, 2) providing more clarity on the measure and supplementing interpretations with results, and 3) verifying attestation provided by the accountable entities.²⁵ We echo the MAP's concerns regarding introducing a structural measure which does not measure the quality of care received or assess whether health equity efforts improved care delivery. **We request CMS work towards measures developed with the MAP's 2021 suggestions.**

We also have significant concerns regard the reporting burden of this proposed structural measure. CMS has indicated home health agencies would be able to submit information attesting to the completion of components of the structural measure through a portal. This could be an undue administrative burden for many agencies to collect and collate many diverse sources of documentation of health equity efforts. We also believe CMS should ensure home health providers have equal access to trainings on culturally and linguistically appropriate services and other health equity training programs to educate their staff. CMS can help agencies access this training by hosting regional opportunities, webinars, and vetting qualified evidence-based trainers like the Augustus A. White Institute.²⁶ We have several outstanding questions on the proposed information submission process: Who will review the reported information? Who will assess the quality of the reported information? How will home health agencies submissions be compared to other agencies? What is considered a completed action?

²⁵ Measure Applications Partnership 2021-2022 Considerations for Implementing Measures in Federal Programs: Clinician, Hospital, and Post-Acute Care Long-Term Care, Final Report. March 2022. https://www.qualityforum.org/Projects/i-m/MAP/MAP_2021-2022_Considerations_for_Implementing_Measures_Final_Report.aspx

²⁶ The Augustus A. White III Institute for Healthcare Equity. <https://aawinstitute.org/what-we-do/>

Scoring Structural Measure Domains

We believe, given the newness of these health equity efforts, home health agencies should receive credit on the proposed health equity composite structural measure for any actions, even if partial. So, if an agency achieves one of the three measures under a domain, they will receive one of three possible points for that domain and that would be added up across the other domains.

Proposed Structural Measure Domains

Domain 1

The first domain is on its face an achievable measurement opportunity for home health providers and would provide CMS detail on how agencies engage in their communities. We do want to caution CMS against measures in this domain that could be considered “check box” measures. Simply having a strategic plan or meeting with community members regarding care disparities does not necessarily contribute to outcomes for patients. CMS should continue to look for meaningful ways to improve health equity in partnership with home health stakeholders.

Domain 2

This domain looks at an agency’s education and training plans and resources for board members, staff, and volunteers.

One concern is the cost of the training for board members and staff. Many agencies do not have additional resources to dedicate to training efforts outside already mandated compliance like OASIS-E and Home Health Value Based Purchasing.

Another concern is the evidence-based quality of training and training resources. How will CMS determine if the content is evidence-based and leading to quality training outcomes for home health patients? If this is simply implemented as a structural measure, will CMS have the authority to reject an attestation that does not clearly show the education and training provided was evidence-based?

Domain 3

In this domain, CMS looks at how “leaders and staff could improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting organizational culture of equity” however, the bulleted examples of attestation are all regarding health equity focused hiring practices. We understand CMS’ goal of moving home health agencies to become inclusive and diverse workplaces reflecting their communities, but hiring practices are not the only place these efforts can be promoted. Given the ongoing health care workforce shortage, we do not believe these suggested attestations are appropriate to evaluate an agency’s commitment to health equity. Additionally, one of the measures proposed for both hospital and skilled nursing facility settings, Hospital Commitment to Health Equity measure, does not include any attestations to hiring practices. We encourage CMS to consider using the following modification of the hospital measure language for this domain:

“Question. Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your home health agency engages in the following activities. Select all that apply:

- Our home health agency senior leadership, including chief executives and the entire agency board of trustees, annually reviews our strategic plan for achieving health equity.
- Our home health agency senior leadership, including chief executives and the entire agency board of trustees, annually reviews key performance indicators stratified by demographic and social factors.”

Publicly Reporting Health Equity Structural Measure

We support CMS’ interest in providing information on health equity to the public. However, we do not believe as proposed now, this structural measure would be able to help families navigate care compare and identify a home health agency with the unique skill to provide care to their loved ones. CMS proposes to “display descriptive information from the data home health agencies provide,” given the broad opportunities to attest to health equity efforts this could be anything from sharing information on their strategic plan to what trainings they have provided for employees making it difficult to compare agencies. It is simply more information for families to wade through. **CMS should not publish information on this proposed health equity measure on Care Compare until such time as OASIS-E is fully implemented and other metrics of health equity have been tested in home health and other additional Medicare settings of care. Any implementation of this structural measure should be voluntary at first.**

Update on Advancing Health Information Exchange

Post-acute providers, including home health agencies, never received any meaningful use dollars to implement health IT or interoperability resources. If CMS implements new programs, standards, or requirements, LeadingAge and CAST would advocate for the establishment of initiatives to encourage and accelerate the adoption of interoperable EHRs, particularly among smaller, stand-alone, and rural home health providers. Such initiatives might include state and federal legislation authorizing grants or low-interest loans to assist with initial health IT investments. Regulatory agencies would be encouraged to provide ongoing payment incentives to providers that adopt these technologies and demonstrate that they meet certain quality and cost measures.

Promoting Transparency

LeadingAge supports the Administration’s efforts to promote competition and transparency in our nation’s health care system. The recent public release of multiple years of data on mergers, acquisitions, consolidations, and changes of ownership for Medicare enrolled hospitals and nursing homes is the first step in creating a better understanding of consolidation’s impact on the health care system. Researchers, state governments, and consumers will now have more tools to evaluate prices, the quality of care, and make thoughtful decisions about their personal health.

Much like hospital and nursing home ownership trends, recent research has shown:

- In the last two decades, the home health industry has grown tremendously however, non-profit ownership accounts for only 11% of providers and was the only ownership type that declined between 2005-2018.^{27, 28}
- Between 2018 and 2019, private equity was involved in 50% of deals in the home health industry reaching an all-time high in 2020.²⁹
- Nearly half of the ten largest home health agencies, accounting for 26% of the market, were owned by private equity groups.³⁰

LeadingAge members are transparent in their ownership structure and board governance and are held accountable to their local communities and government at all levels. We value these obligations of transparency and accountability because they strengthen our organizations and communities that we serve, especially when receiving taxpayer monies for the delivery of services to our vulnerable seniors.

We ask CMS to make data on mergers, acquisitions, consolidations, and changes of ownership public for Medicare certified home health agencies.

We thank you for your consideration of the issues highlighted above. My contact information is below if you wish to discuss any of the recommendations.

Sincerely,



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²⁷ Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2022 Mar. Chapter 8, Home Health Services; p. 243. Available from: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch8_sec.pdf

²⁸ Geng, Mansouri, S., Stevenson, D. G., & Grabowski, D. C. (2020). Evolution of the home health care market: The expansion and quality performance of multi-agency chains. *Health Services Research*, 55(6), 1073–1084. <https://doi.org/10.1111/1475-6773.13597>

²⁹ Scheffler, Richard M., Alexander, Laura M., Godwin, James R. Soaring Private Equity Investments in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk. *American Antitrust Institute, Petris Center at the School of Public Health University of California, Berkeley*. May 2021. Available from: <https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf>

³⁰ LexisNexis. “Home Health Care Industry Targeted in Criminal Antitrust Probe.” MLex Market Insight, 20 April 2020, <https://mlexmarketinsight.com/news-hub/editors-picks/area-of-expertise/antitrust/home-health-care-industry-targeted-in-criminal-antitrust-probe>