Illinois Health and Hospital Association

August 27, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave SW
Washington, D.C. 20201

**RE: CY 2022 Home Health PPS Proposed Rule (CMS-1747-P)**

Dear Administrator Brooks-LaSure:

On behalf of our member home health agencies, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year (CY) 2022 Home Health Prospective Payment System (HH PPS) proposed rule. IHA thanks the Centers for Medicare & Medicaid Services (CMS) for its streamlined approach in developing this rule, allowing HH agencies to continue focusing on their response to the COVID-19 pandemic. In particular, we appreciate CMS' data-driven process in determining the appropriate patient driven grouping model (PDGM) behavioral offset. Our full comments follow, and we look forward to working with the administration on behalf of our home health providers as CMS works to finalize the CY 2022 HH PPS rule.

## PDGM Behavioral Offset

As stated above, IHA appreciates CMS' proposal to refrain from altering the PDGM behavioral offset finalized in the CY 2020 HH PPS final rule. Specifically, we are pleased that CMS finalized an offset of 4.36% rather than the proposed 8.01% cut in the CY 2020 HH PPS final rule, and that CMS decided to continue utilizing a 4.36% behavioral adjustment in CY 2022. Illinois HH providers understand that CMS analysis indicates it is currently overpaying HH providers compared to its prior case-mix methodology and must eventually adjust payments to achieve budget neutrality. IHA appreciates and supports CMS' decision to solicit additional comments on its methodology rather than implementing additional cuts. We also urge CMS to continue using the current behavioral offset until the COVID-19 pandemic is more controlled and the formal public health emergency (PHE) ends. As this fourth surge proves, our healthcare system remains in a precarious situation with experts unable to predict when and how the PHE will end. Providing consistency in policies and resources is critical at this time as HH providers continue grappling with the pandemic and learn how to adapt to our new normal once the PHE ends.

## Changes to HH Conditions of Participation (CoPs)

On behalf of our members, IHA thanks CMS for the numerous waivers enacted during the COVID-19 PHE to alleviate regulatory burden and expand health care capacity.




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Additionally, we agree with CMS' proposal to make some of these waivers permanent, modifying current HH CoPs.

Specifically, IHA supports the proposed change to HH aide supervision that provides increased flexibility in conducting supervisory assessments. We agree that allowing for occasional use of virtual supervisory assessments (two within a 60-day period per agency) and removing supervising RN direct observation requirements are appropriate changes even after the end of the COVID-19 PHE. We also understand and appreciate the expanded requirement for RNs and aides to conduct/complete retraining and competency evaluations for skill deficiencies to all skills related to the identified deficiency.

Further, expanding the provider types available to perform initial assessment visits and comprehensive assessments assists in expanding access to care, particularly in areas that may also experience provider shortages. Therefore, IHA supports CMS' proposal to implement the Consolidated Appropriations Act of 2021 (CAA) provision allowing occupational therapists to conduct assessments when occupational therapy and either physical therapy or speech language pathology are on the initial HH plan of care but skilled nursing services are not.

**Reporting Timeline for New HH Quality Reporting Program (QRP) Measures and Standardized Patient Assessment Data Elements (SPADEs)**

In the CY 2020 HH PPS final rule, CMS adopted two new quality measures (Transfer of Health Information (TOH) to the Patient and TOH to the Provider) and several SPADEs. In comments on the CY 2020 HH PPS proposed rule, IHA expressed reservations over CMS' proposal to add some of the SPADES to the HH QRP, strongly encouraging CMS to rigorously evaluate the appropriateness of proposed data elements for the HH setting, as well as the frequency with which they should be captured.

Despite IHA comments and similar sentiments from across the HH industry, CMS finalized adoption of these measures, and intended to implement data collection and reporting beginning Jan. 1, 2021. However, in the May 2020 interim final rule (IFR) responding to the COVID-19 PHE, CMS delayed implementation and compliance requirements for these new measures. In the IFR, CMS delayed implementation and compliance until one full calendar year after the year in which the COVID-19 PHE ends. Additionally, CMS delayed releasing an updated version of OASIS-E, which is the patient assessment instrument providers use to report HH QRP measures.

In this year's HH PPS proposed rule, CMS walked the IFR delay back and now proposes implementation and compliance beginning Jan. 1, 2023, regardless of the status of the COVID-19 PHE. While IHA sincerely hopes that the COVID-19 PHE ends in 2021 and the pandemic comes under control domestically and abroad, we have learned time and again that it is difficult to predict the trajectory of the pandemic. IHA understands that when CMS wrote the CY 2022 HH PPS proposed rule, COVID-19 case rates were decreasing as vaccination rates went up. However, the emergence of the Delta variant has halted progress, and we now see many providers in Illinois once again inundated with COVID-19 patients. We urge the agency to

revisit its proposed timeline, and revert to the IFR timeline of implementing these quality measures one full year following the year in which the COVID-19 PHE ends. We understand the importance of many of these data elements, particularly the social determinants of health (SDOH) SPADEs. However, until the pandemic is under control, we urge CMS to afford itself, and the Medicare providers that it governs, increased flexibility and refrain from naming a hard date on which data collection and reporting will begin.

**HH Value-Based Purchasing Program (VBP)**

In the CY 2022 HH PPS proposed rule, CMS proposed expanding and requiring HH agency participation in its HH VBP model, which currently affects HH agencies in nine states, to all 50 states, the District of Columbia and territories beginning Jan. 1, 2022. CMS explained the HH VBP model was approved for expansion based on three factors: (1) improved quality of care without increased spending; (2) impact on Medicare spending (i.e., an expanded model would produce additional Medicare savings); and (3) no alteration in coverage or provision of benefits for Medicare beneficiaries due to expansion of the program.

Additionally, CMS proposed assessing HH agency performance in the HH VBP on eight quality measures. The National Quality Forum (NQF) only endorsed four of these measures, though all are currently collected under the HH QRP and thus including them in the HH VBP does not increase provider burden. That said, CMS simultaneously proposed removing two of the measures from the HH QRP: Acute Care Hospitalization During the First 60 Days of HH Use and Emergency Department Use without Hospitalization During the First 60 Days of HH Use.

Finally, CMS proposed waving certain steps of the pre-rulemaking process for measure selection, including:

- Forgoing convening a multi-stakeholder group(s) to provide input to the Secretary of Health and Human Services (Secretary) on proposed measures;
- Transmitting input from the multi-stakeholder group(s) to the Secretary;
- Consideration of the Secretary's input;
- Publishing the rationale for including measures in the HH VBP that are not endorsed by an entity such as the NQF in the Federal Register; and
- Conducting an impact assessment on the use of measures every three years.

First, while we appreciate CMS' analysis of the HH VBP, we question the haste with which CMS proposes implementing the program nationwide. We do not doubt that there are savings to be had from nationwide participation in the HH VBP. However, we question whether the savings from implementing the HH VBP nationwide this coming calendar year will be so great that it makes sense to abruptly curtail the current HH VBP demonstration model, particularly as the COVID-19 pandemic continues to affect patients and providers and impact different states and localities disproportionately. Relatedly, unless CMS' proposed VBP cohorts account for the disparate impacts of COVID-19, it would not make sense to compare large HH agencies in areas that are experiencing COVID-19 surges with large HH agencies in areas that are not.

Additionally, we would strongly urge CMS to ensure that the measures collected for the HHVBP mirror measures collected for the HH QRP. Removing the two claims based measures from the HH QRP but keeping them in the HH VBP will ultimately increase provider burden because HH agencies will have to ensure validity of VBP measure calculations that they would not have to otherwise.

Finally, we strongly urge CMS to forgo its proposal to remove certain pre-regulatory steps from its measure selection process. While we understand that flexibility in measure selection may lead to certain efficiency gains for CMS, we would urge the agency to ensure it relies on measure development experts when adding new data collection efforts and public reporting requirements to the HH VBP and QRP. IHA does not expect CMS to employ experts in the field of measure development and evaluation, but we do expect CMS to call on external expert opinion in considering modifications to all of its quality programs. Allowing the HH VBP program to deviate from protocols long established and used by the other Medicare quality programs decreases transparency and sets bad precedent. There are frankly too many vulnerable Americans dependent on Medicare and the services furnished by Medicare providers to rely on a less thorough and transparent measure development process.

For these reasons, we ask CMS to:

1. Reconsider the Jan. 1, 2022 rollout and implementation of the HH VBP;
2. Finish the current HH VBP demonstration model, seeing the model through to its original completion date;
3. Ensure that HH VBP measures align with HH QRP measures to provide consistency across Medicare quality programs (a stated CMS goal in other Medicare PPS annual rules this year); and
4. Maintain current processes when developing, considering, and implementing new quality measures in any Medicare quality program, particularly for those measures that are not NQF endorsed.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule. Please direct questions or comments to IHA.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association