August 25, 2021

Chiquita Brooks-LaSure, Administrator
U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1747-P
P.O. Box 8013
Baltimore, MD 21244-1813

Re: File Code CMS-1747-P, Medicare Program; Proposed Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2022

To Administrator Brooks-LaSure:

The Home Care Association of New York State (HCA), Inc., on behalf of its 200 plus member home health agencies (HHAs) serving approximately 166,000 Medicare home health beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the Calendar Year (CY) 2022 Medicare Home Health Prospective Payment System (HHPPS).

This letter will provide HCA's major comments on the 2022 HHPPS proposed rule, addressing elements of the rule that are a major concern for home care and should be revised, as well as those proposals which we believe to be positive steps for the system.

Concerns with Maintaining the Behavioral Adjustment and CMS's Budget Neutrality Methodology

HCA is very concern that CMS's CY 2022 proposed rule continues to include the Patient Driven Groupings Model (PDGM) "behavioral adjustment" cut that has been an ongoing issue of HCA and the entire home care industry. In the CY 2020 final rulemaking, CMS implemented a -4.36 percent behavioral adjustment which CMS plans to keep in place for CY 2022.

Throughout the rulemaking process, CMS asserts that the PDGM aligns with the Bipartisan Budget Act (BBA) of 2018 which required budget neutrality for any new home health payment methodology. However, HCA strongly believes there is no reasonable statistical justification for this cut. HCA supports true budget neutrality as a precondition for any payment changes and continues to strongly oppose this adjustment.

While HCA and our provider members along with the other state and national associations all support efforts to better align Medicare payments with patient characteristics, we nevertheless still have the following ongoing concerns with CMS's proposal to maintain this -4.36 percent behavioral adjustment along with the budget neutrality methodology utilized:

- CMS should replace its suggested methodology for assessing whether behavioral changes of HHAs resulted in PDGM achieved budget neutrality in comparison to the HHPPS HHRG payment model with a methodology that focuses on behavioral changes, not change in average case mix weight (CMW).

  The replacement model must include a recognition that PDGM triggered changes in behavior in the measures that affected CMWs, particularly changes in therapy utilization, timing of visits, frequency of visits, and source of care. Any behavioral change impact on a budget neutrality determination cannot rely on a CMW comparisons through a simple application of the HHPPS-HHRG payment model to 2020 care delivery as such ignores the PDGM behavioral changes that affect HHPPS-HHRG case mix weights. The proposed methodology is fatally flawed in that it does not assesses whether HHA behavior changes under PDGM impacted Medicare home health spending in 2020.

- CMS should apply a PDGM-related budget neutrality adjustment methodology that exclusively is focused on PDGM-triggered behavioral changes. The change assessment methodology proposed by CMS encompasses changes unrelated to HHA behavioral changes under PDGM. Under 42 USC 1395fff(b)(3)(D), CMS may only make permanent or temporary rate adjustments related to the impact of assumed behavior changes and actual behavior changes on estimated aggregate expenditures. Other factors that impact expenditures, including any design flaws in the payment model or changes in patient case mix are not subject to the rate adjustment authority.

- The only behavioral changes of note that affect Medicare spending are:

  - An increased level of Low Utilization Payment Adjustments (LUPAs) that are significantly higher than CMS estimated, which decreases overall Medicare home health spending.

  - An increased functional domain scoring which is unknown as to the distribution of real versus nominal changes which increases Medicare home health spending.

  - Reduction in therapy visits triggered by changes in financial incentives under PDGM in contrast to the HHPPS incentives with therapy thresholds. We believe that CMS should not use CY 2020 therapy utilization data to determine budget neutrality.

HCA Recommendations

Due to the tremendous impact that COVID-19 has had on all healthcare providers including HHAs in 2020 and 2021 and how it has affected service delivery for one of Medicare's most vulnerable beneficiary populations (home health), HCA offers the following recommendations:

CMS should withdraw or eliminate its ongoing -**4.36 behavioral adjustment for CY 2022**, until CMS has an opportunity to review and analyze real versus nominal HHA behavior in CYs 2020 and 2021, especially when many HHAs have been dramatically impacted by COVID-19, which has resulted in significant financial hardship as well as unprecedented operational challenges including the loss of staff due to actual death or concerns with simply working in close proximity to patients. In fact, one of our larger CHHA in the New York City (NYC) Metropolitan area is estimating decreased revenues between $75-100 million in CY 2021 and has seen over 40 staff members lose their lives to COVID-19.

CMS should also consider the following factors:

- The impact home health had on reduced hospitalizations in Medicare.
- The impact of COVID admissions as primary diagnosis.
- The substitution of telehealth for in-person visits.
- Applying the HHPPS case mix model to 2020 and 2021 claims.
- Compare outcomes after application of real versus nominal findings.

Concerns with CMS's Proposal to Recalibrate the Case-Mix-Weights for CY 2022

HCA is very concerned with CMS's decision to recalibrate the 432 CMWs for CY 2022, when considering the simple fact that 2020 and 2021 have been chaotic years due to the pandemic that may or may not continue in CY 2022 and that current HHA clinical practice has been tied just as much to COVID-19 as with the PDGM.

HCA also believes the increased use of telehealth visits in 2020 and 2021 can not be ignored as a significant factor in care utilization and that the volume of telehealth visits are not the equivalent of an actual in-person visit.

HCA Recommendation

CMS should withdraw its proposal to recalibrate PDGM CMWs based on 2020 care utilization data. The purpose of recalibration is to reset CMWs for subsequent years based on the premise that the base year used for recalibration reasonably reflects care delivery expected for the year when the recalibration applies. It is not a reliable expectation to assume that the chaotic year of health care utilization in 2020 is an appropriate foundation for 2022. HCA also believes that telehealth utilization and costs should be factor into any recalibration and if, not considered, then CMS should continue to use the current CMWs for CY 2022 and postpone recalibration until CY 2023.

HCA Encourages Wage Index Refinements

CMS's CY 2022 proposed rule once again reviews a notification issued in September 2018 by the Office of Management and Budget (OMB) that established revisions to the delineations of Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineations in these areas. While

CMS believes that HHAs should be subject to the most current OMB delineations, CMS acknowledges that the revisions in several cases can be significant for some HHAs nationwide. These include changes in status from urban to rural, rural to urban, shifts of counties from one urban Core Based Statistical Area (CBSA) to another and CBSA name and number changes.

To initially mitigate the impact of these changes and address any short-term instability that may arise from these changes, CMS applied a 5 percent cap on any decrease in a geographic area's wage index value from CY 2020 to 2021. However, no 5% reduction cap is being applied in CY 2022.

HCA has also consistently raised issues with CMS's decision to maintain the current policy of using the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next.

This is particularly evident in CMS's proposed rule where we are very concerned about our HHAs in the following CBSAs who are proposed to see significant reductions from their current CY 2021 wage index to the proposed CY 2022 wage index:

- 24020: Glen Falls: -4.16 reduction;
- 35004: Nassau – Suffolk Counties: -2.05 reduction; and,
- 99933: Rural Designation (24 Counties): -1.42 reduction.

Based on the latest Cost Report data in New York, approximately two-thirds of HHAs operating in the state experienced negative operating margins in 2018. Financially struggling HHAs in these CBSAs cannot sustain these Medicare wage index reductions.

Also, we continue to believe that the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting home health costs, particularly in states like New York, which has among the nation's highest labor costs, now greatly exacerbated by our state's implementation of a phased-in $15 per-hour minimum wage hike, the balance of which is unfunded by Medicare. This mandate, when fully phased-in, will cost over a stunning $2 billion for New York HHAs across all payors (Medicaid, Medicare, managed care, commercial insurance and private-pay) and will never be adequately addressed due to CMS's ongoing disposition to continue using the pre-floor, pre-reclassified hospital wage index to adjust home health costs.

In addition, unlike the hospitals nationally who are given the opportunity to appeal their annual wage index, HHAs do not have appeal rights with regards to its wage index. This lack of parity between different health care sectors further exemplifies the inadequacy of CMS's decision to continue to use the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates. Specifically, hospitals in the Albany-Schenectady-Troy CBSA have been working hard with Congress and CMS to appeal its wage index, which is clearly needed, but any inroads or success they may reach, unfortunately, would not apply to HHAs in the same CBSA.

HCA Recommendations

HCA appreciates CMS's willingness to consider major reform of the home health index in the 2021 rulemaking. This has been an ongoing concern of HCA throughout the years but unfortunately, CMS has dismissed our calls for wholesale revision of the home health wage index. In this year's final rule, we ask CMS's consideration in implementing a 2 percent cap on any decrease in a geographic area's wage index value from CY 2021 to 2022, especially considering the difficult financial impact the COVID pandemic has caused many HHAs in 2020 and 2021.

CMS Market Basket Update Should Account for Costs Related to the Public Health Emergency

CMS has proposed a 1.7% rate adjustment for CY 2022 based on 2.4% Market Basket Index (MBI) and a 0.6% Productivity Adjustment (PA). HCA is aware that CMS modified both the MBI and PA in the previous final rules. However, those modifications nor the proposed CY 2022 rate adjustment in home health services adequately account for the increased costs of care in 2021 that are highly likely to continue for HHAs in 2022. Foremost among those cost increases that are not adequately represented in the MBI is personal protective equipment (PPE) and other infection control costs.

Based on data our colleagues at the National Association for Home Care and Hospice (NAHC) have obtained they believe the PPE costs alone have increased per visit costs by approximately $11.50 or nearly 5% of the current base episodic rate. The PPE cost increases began in 2020 and have continued in 2021. The MBI reflects increase in the cost of goods and labor, but it does not address new costs or volume increases in the use of such items as PPE.

While the end point of the Covid-19 pandemic is unfortunately not known, it is reasonable and fair to conclude that the use of PPE will be maintained at levels comparable to 2020 throughout CYs 2021 and into 2022. As such, the increased cost of care, as experienced in 2020-2021, as it relates to PPE is likely to continue in CY 2022.

CMS could include a PPE cost add-on to the 2022 payment episodic and per visit payment rates. Conceptually, an add-on has been used in Medicare home health services previously to reflect the administrative costs of OASIS and other administrative activities for LUPA-only patient care. HHAs are prepared to support the add-on costs of PPE to the point of reliable data. These are examples of a method CMS can employ to address unforeseen cost changes that are not reflected in the MBI.

HCA Recommendation

CMS should establish a process and methodology to modify HHA payment systems and rates during a Public Health Emergency (PHE) to address new costs triggered by the PHE or unpredicted limitations in payment models.

Phase Out of the No-Pay RAP and Implementation of the Notice of Admission Process in CY 2022

In the proposed rule, CMS iterates its finalized policy from the CY 2020 final rule regarding the implementation of a new one-time Notice of Admission (NOA) process starting in CY 2022. In that rule, CMS finalized the reduction - to zero – of up-front payments for Requests for Anticipated Payments (RAPs). This removal of the up-front payment applies for all 30-day episodes of care beginning on or after January 1, 2021.

Starting in CY 2022, HHAs will submit a one-time NOA that establishes the home health period of care and covers all contiguous 30-day periods of care until the individual is discharged from Medicare home health services. Also, for the one-time NOA for CYs 2022 and beyond, CMS finalized a payment reduction if the HHA does not submit the NOAs for CY 2022 and beyond within 5 calendar days from the start of the care (SOC).

HCA Concerns and Recommendation

While HCA understand the need for a one-time NOA process, we believe CMS must first address the following important issues:

- CMS should not assess the late submission penalty for the NOA until all No-Pay RAP problems identified in CY 2021 and have negatively impacted many HHAs are resolved.

- CMS should provide clear and timely instructions to HHAs related to the resolution of all of the No-Pay RAP system issues identified in CY 2021.

- CMS should include payer changes to the list of exceptions to the NOA timely submission penalty. CMS should require the MACs to request an ADR if addition information is required to decide on a payer change exception. This is particularly needed in payer changes to and from Medicare Advantage (MA) plans, rebilling after cancellation and overlap with hospice revocation or another HHA service period.

- CMS should include other providers overlapping in the CWF as a listed exception to the NOA timely submission penalty. CMS should require the MACs to request an ADR if addition information is required to decide on whether the HHAs was prevented from submitting a timely NOA due other another provider's actions.

- Instruct the MACs to not apply the timely submission penalty if the original NOA is submitted timely but must be canceled and resubmitted.

HCA also recommends that CMS increase the 5-day submission from SOC requirement to 7 calendar days since the current 5-day requirement penalizes HHAs for starting a case on a Friday and then they only have 2 or 3 business days to submit the NOA, since many HHAs billing offices are not open on weekends. HCA also feels CMS should require all Medicare provider types to institute an NOA or face penalties similar to HHAs.

Concerns with CMS's Proposal to Expand the Home Health Value Based Purchasing (HHVBP) Model Nationwide in CY 2022

One of the most significant changes in the rule is CMS's proposal to expand the Home Health Value Based Purchasing (HHVBP) Demonstration model to the entire nation beginning January 1, 2022, as the first performance year and CY 2024 as the first payment year. This initiative would result in a proposed maximum or minimum payment adjustment, upward or downward, of 5 percent on CY 2024 final claims. As a result of this proposed expansion, CMS would end the existing HHVBP model one year early for HHA participants in the original model's nine states.

While HCA is generally supportive of CMS's VBP expansion proposal, we do have many concerns and suggested recommendations, which include the following:

- **Additional Time is Needed to Help HHAs Prepare for HHVBP:** With CMS's CY 2022 final rule not expected to be released until the end of October, there is simply not enough training or planning time for HHAs to strategically implement a program of this magnitude. We believe the original HHVBP demonstration model gave agencies significantly more time to prepare and while HHAs in the original nine states may be ready, the HHAs in the other states need more preparation time in order to maximize the opportunity for success.

- **Keep Total Performance Score (TPS) Analysis to State by State at Least for the First Year:** If CMS is to implement this HHVBP expansion in CY 2022, HCA recommends keeping the Total Performance Score (TPS) measure to a state by state comparison, so the states not involved in the pilot the last four years have a fair chance to develop, teach and implement their program before moving to a national comparison up against nine states that have already implemented this program since 2016.

- **The TPS Measures Fail to Reflect the Full Scope of the Home Health Benefit:** Specifically, HCA believes CMS's improvement standards are relied upon too heavily which will negatively impact HHAs with chronic care, palliative care and end of life patient populations, since CMS's current risk adjuster does not account for these differences sufficiently and CMS does not adequately address maintenance outcomes in HHAs overall TPS.

- **5 Percent Positive or Negative Adjustment is too Much as a First Year Starting Point**: While HCA understands that CY 2022 is the first performance year of the HHVBP with CY 2024 being the first payment year, we still are very concerned that the 5 percent payment adjustment is too high from a potential risk standpoint. HCA asks CMS to reconsider this amount and suggests a first-year payment adjustment of no more than 3 percent either way (positive or negative).

  HCA also believes CMS's proposed payment incentives are also insufficient especially when considering that some HHAs that contribute to overall Medicare

savings are still subject to possible payment penalties. HCA believes that CMS should share Medicare savings with any HHA that contributed to the increased savings.

HCA Urges Extension, Examination of Adequacy and Corresponding Refinements to Rural Add-On Tiers

Contrary to the perception that New York is largely urban/metropolitan, nearly 40 percent (24) of the state's counties meet the latest rural designation established by CMS and many of the remaining geographic areas are essentially rural in character.

Furthermore, over the last fourteen years, most of the county-sponsored Certified Home Health Agencies (CHHAs) in New York's rural counties have either closed or sold their agency. A 2018 cost report analysis by HCA found that approximately 67 percent of all Medicare certified agencies operating in New York's rural counties had negative operating margins, which is a contributing factor in the overall diminution of rural home health services. Indeed, more than half of New York's rural communities have only two or fewer providers of skilled care for Medicare and Medicaid home health services. If any more of these 8 agencies close, access to skilled home care will be seriously threatened for residents in rural areas of New York.

Recommendations

Because of these facts, HCA is very concerned with the phase-out of the rural add-on from 2019 through 2022. While we understand that CMS is compelled to follow the tiered rates mandated by Congress, we urge CMS to closely monitor the adequacy of the Medicare HHPPS payment so that agencies can continue to provide important care to Medicare beneficiaries in rural areas. We also urge CMS to seek Congressional authority, if necessary, to extend and modify the rural add-on as necessary to appropriately reflect access-to-care and labor conditions.

Continued Concerns Regarding the Use of Telehealth Under the Medicare Home Health Benefit

Last year, CMS finalized its proposal regarding plan of care (POC) requirements within Section 409.43(a) related to telehealth as issued in the Coronavirus Aid, Relief, and Economic Security (CARES) Act interim final rule published on March 30, 2020.

The home health POC must include any provision of remote patient monitoring or other services furnished via a telecommunications system and describe how the use of such technology is tied to the patient-specific needs as identified in the comprehensive assessment and will help to achieve the goals outlined in the POC.

The amended POC requirements in Section 409.43(a) also state that these services cannot substitute for a home visit ordered as part of the POC and cannot be considered a home visit for the purposes of patient eligibility or home health payment. However, CMS is

now allowing HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost report. Additionally, CMS is including not only remote patient monitoring but other communications or monitoring services, consistent with the POC for the individual.

HCA supports and appreciates CMS's efforts to promote the use of telecommunication technologies and the acknowledgment that technology has the potential to play a large role in enhancing the delivery of healthcare in the home. During the COVID-19 pandemic and now with the spread of the Delta variant, telehealth has been and will continue to be used to support Medicare beneficiaries when in-home services are not advisable or available. However, our members have expressed concern over the requirements for the POC when telecommunication visits are ordered. Unless there is some flexibility in these requirements, HHAs are at risk for unreasonable claim denials. The POC requirements coupled with CMS's position that visits conducted via telecommunication are not reimbursable are likely to serve as a deterrent to provide telecommunication technologies to Medicare home health beneficiaries.

Recommendations

CMS should provide flexibility regarding the documentation requirements on the POC and permit documentation throughout the medical record be used to support the use of telecommunication technology. Requirements for the POC should be limited to the practitioner's order that permits the HHA to use telecommunication technology in managing the patient's clinical condition. **Additionally, CMS should develop a model for claims reporting and payment for home health visits provided by telecommunication**.

Also, it is unclear whether audio only visits are included as telecommunications technologies for home health visits. Audio only visits have been permitted during the PHE, however, the amended language at § 409.46(e) to allow a broader use of telecommunications technology to be reported as an allowable administrative cost on the home health agency cost report does not appear to include audio only technology. CMS should also permit telecommunication technologies to include audio only (e.g. telephonic) technology.

Changes to the CoPs at Section 484.80(H): HHA Supervisory Visits

In the rule, CMS proposes to make permanent some selected blanket regulatory waivers issued during the Public Health Emergency (PHE) as well as other regulatory text changes. HCA supports these proposals and thanks CMS for allowing this additional flexibility to continue.

CMS has also proposed several changes to the home health Conditions of Participation (CoPs) regarding home health aide (HHA) supervisory visits. First, CMS proposes to revise the HHA supervision requirements to allow for virtual supervision and adding the requirement that the skills related to any deficient skills be addressed. However, CMS is

also proposing to limit those virtual or telecommunication supervisory visits to two per 60-day period. While HCA supports CMS's proposal to allow virtual supervisory HHA visits, we believe the two-visit limit is too low to be of significant value to many agencies and their patients. **HCA requests that CMS allow there to be at least four virtual HHA supervisory visits per 60-day period.**

HCA also supports changes CMS made to the regulatory language to not require an on-site HHA supervisory visit every 60-days for patients not receiving any skilled services. We believe semi-annual on-site HHA supervisory visits as an alternative for patients not receiving any skilled services is adequate.

Updated Survey and Enforcement Requirements for Hospice Programs

Because of language in the Consolidated Appropriations Act (CAA) of 2021, CMS continues to review and revise its health and safety requirements and survey processes to ensure that they are effective in driving quality of care for hospice programs.

In this proposed rule, CMS includes provisions to implement Division CC, Section 407(a) of the CAA of 2021 with respect to transparency, oversight and enforcement of health and safety requirements for hospice programs. According to CMS, these proposed provisions enhance the hospice program survey process by requiring the use of multidisciplinary survey teams, prohibiting surveyor conflict of interest, expanding CMS-based surveyor training to accrediting organizations (AOs) and requiring AOs with CMS-approved hospice programs to begin use of the Form CMS-2567.

HCA's Concerns and Recommendations

HCA offers CMS the following concerns and recommendations regarding these hospice program oversight changes in the CY 2022 proposed rule:

Transparency Issues

- HCA encourages CMS's Technical Expert Panel (TEP) to identify the most relevant hospice survey performance information and share this with the public and other stakeholders to provide input on the appropriate structure for the Special Focus Program.

- With regards to the AOs submission of Survey Reports, we ask CMS to engage all stakeholders regarding changes to CMS Form 2567 and ensure there is enough time allowed for AOs to adapt system to these changes.

- HCA offers the following concerns and recommendations regarding the posting of survey findings: Only posting survey reports may cause confusion; CMS should post all survey information in a single location that is easily accessible; CMS should notate for any deficiencies when a hospice has achieved full compliance and once again becomes deemed; a single citation is not an indication of systemic issues; and

- CMS should set a public schedule for these postings.

Additional recommendations follow on a multitude of issues.

Survey Qualifications and Potential Conflicts of Interest

- Surveyors should be tested using new training modules.
- CMS should allow sufficient time so that surveyor entities can get their surveyors trained without further survey backlogs.
- Continuing surveyor eligibility — surveyors need to be up to date on training and conduct a minimum number of surveys for a particular provider type to maintain credentials
- Make informal guidance and interpretations available to all surveyors and to hospices in an organized way.
- Education/training should address psychosocial, emotional and spiritual components of hospice care.
- Training should emphasize that citations are based on evidence of trends rather than a single violation.
- Conflict of Interest: Has CMS thought about other types of conflicts of interest, such as employment by a competing hospice and how to deal with that possibility?

Survey Teams

- Could CMS please clarify whether a survey team can be comprised of multiple Registered Nurses (RNs)?
- HCA asks that CMS consider all members of the survey team have relevant experience in hospice care.

Consistency of Survey Results

- HCA is concerned that CMS is not requiring reviewers to identify inappropriate citations, which should be part of effort to achieve greater consistency.
- Validation surveys can be problematic as they often do not occur at the same time and may not reflect what the initial surveyor saw when on site. HCA would support consideration of concurrent surveys.
- HCA requests that CMS create survey protocols that include decision-making support but contain sufficient flexibility to allow for surveyor judgment; protocols shall take into account the manner and degree of offense in making a determination that a citation is appropriate.

Special Focus Program

- HCA supports additional and targeted oversight and termination of Medicare certification, as appropriate, for hospices not delivering quality care and putting patients at risk.

- HCA believes the TEP should, at a minimum, consist of consumers, hospice providers, and state agency surveyors, who are considered experts in the Medicare survey process and stakeholders who have had extensive experience with the hospice survey process.

- Special Focus Program (SFP) surveyors should have training beyond the basic hospice surveyor training for this and other aspects of the SFP.

- Graphics and details about the SFP should be carefully developed to convey information accurately and without undue alarm.

- There should be timely public reporting of correction of deficiencies.

Enforcement, Remedies and Civil Monetary Penalties (CMP's)

- Training should be provided to CMS Regional Office staff in the factors to be used in making determinations on when remedies should be applied and CMS should develop processes to ensure these remedies are consistently applied by all of the regional offices.

- CMS should carefully consider payment suspensions for hospices. This is because: (1) a proposed suspension of all or part of hospice payments is not consistent with home health agencies treatment, where payments for new admissions are suspended; (2) approximately 90% of hospice patients are Medicare beneficiaries which is different than other provider types; and, (3) payment suspensions could create access to hospice care, especially impacting smaller, independently owned hospice providers who may be disproportionally burdened financially by imposition of certain remedies as compared with larger hospice providers or hospice providers that are part of a larger healthcare network.

- In states like New York with hospice Certificate of Need (CON) requirements suspending all payments to which a hospice could result in the only hospice in a region of the state closing due to financial constraints instead of working towards performance improvement and the delivery of quality hospice care.

- CMS should develop specifications for penalties collected to be used at the national level and/or state level for hospice program improvements as per the CAA of 2021.

- CMS should consider hospice provider-initiated improvement plans resulting in positive outcomes and sustained compliance over the course of the "look back" period in determining whether to cite a deficiency and/or assign a CMP for previous noncompliance.

- Temporary managers / administrators should go through basic CMS surveyor training before beginning their assignment in the hospice organization and have hospice management / administrator experience. CMS should also clarify that an individual within the hospice organization that has proven success in leading a

compliant hospice program (i.e., from another hospice entity within the organization) could be utilized.

Conclusion

HCA thanks CMS for this opportunity to submit comments and respectfully requests CMS's consideration of our concerns and recommendations. I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or (518) 810-0661.

Sincerely,

Patrick Conole, MHA
Vice President, Finance & Management
Home Care Association of New York State, Inc.