August 29, 2023

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1780-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: File Code CMS-1780-P, Medicare Program; Home Health Calendar Year 2024 Prospective Payment System Rate Update & Wage Index Update

To CMS Officials:

The Home Care Association of New York State (HCA) is a statewide not-for-profit organization representing approximately 200 home care and hospice providers, allied organizations, managed care providers and individuals committed to the advancement of quality hospice and home care services in New York State.

On behalf of our certified home health agency (CHHA) members that serve many of the approximately 150,000 Medicare home health beneficiaries annually in New York, we appreciate the opportunity to provide comments on the U.S. Centers for Medicare and Medicaid Services (CMS) Medicare Program Home Health Calendar Year (CY) Prospective Payment System (PPS) Rate Update and Wage Index Update.

General Overview of CMS's CY 2024 Proposed Rule

CMS's proposed rule updates the Medicare home health payment rates for CHHAs serving Medicare beneficiaries in CY 2024.

In addition to the payment updates, the rule contains numerous proposed changes and updates that HCA is interested in providing comments and in some cases recommendations. These include the following:

- CY 2024 Rate Reduction of 5.653% that CMS calculated as warranted under its Budget Neutrality Patient Driven Groupings Methodology (PDGM) for CY 2020 thru 2022.
- CY 2024 Home Health Wage Index update.
- Proposed 2.7% CY 2024 Home Health Market Basket update.
- Proposal to remove five measures from the current Home Health Value Based Purchasing (HHVBP) applicable measure set and add three measures starting in CY 2025.

- Proposal to adopt two new Home Health Quality Reporting Program (HHQRP) measures and remove one existing measure. Additionally, CMS is proposing to begin public reporting of additional measures in the HHQRP.

- Request for Information (RFI) on Access to Home Health Aide (HHA) Services.

- Proposal for Disposable Negative Pressure Wound Therapy (dNPWT).

- In response to program integrity concerns related to hospice and other providers, CMS is proposing several changes to existing Medicare provider enrollment regulations.

Concerns with CMS's Budget Neutrality Methodology & -5.653% Adjustment

HCA is very concern with CMS's CY 2024 proposed rule, which puts the stability of home health care at risk due to CMS proposing the application of a fatally flawed budget neutrality methodology for assessing whether the PDGM payment model led to budget neutral spending in years 2020 through 2022.

With the beginning of PDGM on January 1, 2020, no one could have forecast the degree of disorder and impact that Covid-19 would bring in patient mix, significant alteration of the home health patient census, practice changes in all sectors of health care, and the response from patients and prospective patients. Yet, in the midst of this unprecedented health care crisis, the Medicare home health program underwent the transition to a wholly new, untested payment model. Now, based on the experiences in 2020 through 2022, CMS proposes to reduce home health reimbursement rates by 5.653% while also suggesting the possibility of collecting over $3.4 billion in alleged overpayments at some future date.

HCA and other state and national association colleagues continue to emphatically disagree with the budget neutrality methodology that CMS employed to arrive at this proposed rate adjustment. National spending on **Medicare home health is down, fewer patients are receiving care, patient referrals are being rejected because providers cannot afford to provide the care needed within the payment rates**, and CHHAs nationally and here in New York have closed their doors or restricted service territory to reduce care costs. If CMS's methodology was truly budget neutral, we would not see these actions occurring. The fatally flawed budget neutrality methodology that CMS continues to insist on applying will have a direct and permanent effect on access to care. When you add in the impact of shortchanging home health agencies on an accurate cost inflation update of 5.2% over the last two years, the loss of home care access is foreseeable. Because of this we recommend that CMS withdraw its proposed rate adjustment and open discussions with stakeholders regarding the nature of appropriate and compliant methodologies for assessing the mandated budget neutral transition from the HHPPS payment model to PDGM. The future of essential home health services is at stake.

Similarly, the country is facing health care cost inflation that requires quick financial supports to maintain care access. CHHAs have been hit with significantly rising labor costs

as the nursing and therapy shortage has triggered wage increases, sign-on and retention bonuses, and other compensation cost increases not previously experienced in our economy. In addition, the latest gas cost increases particularly affect the delivery of care to people in their homes. These and other cost increases must be addressed in the annual market basket index up along with other measures that account for real-time changes in costs. The proposed market basket update does not come close.

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 ongoing concerns with CMS's proposal to implement this proposed -5.653 percent cut associated with the budget neutrality methodology.

HCA Recommendations

HCA strongly recommends that CMS use its authority under 42 USC 1395fff to **withdraw or postpone** any proposed payment rate adjustments related to its budget neutrality assessment to avoid significant access barriers for thousands of potential home health beneficiaries as well as financial disaster and probable closure of many more CHHAs in the near future.

Seventy – Five percent of New York's 111 CHHAs are already experiencing negative overall operating margins (based on 2021 Cost Report data provided to HCA) and the cumulative impact of these proposed cuts by CMS would reduce or carve out an additional $200 million of the Medicare home health program in New York as providers are already facing significant fiscal and labor shortage challenges, threatening patient care and access. Small, rural, and medically underserved communities will be especially harmed.

HCA also recommends the following:

- CMS should replace its suggested methodology for assessing whether behavioral changes of CHHAs resulted in PDGM achieved budget neutrality in comparison to the HHPPS Case-Mix Weight (CMW) payment model with a methodology that focuses on actual behavioral changes. Any 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-CMW payment model to a PDGM care delivery as such ignores the behavioral changes that affect HHPPS-CMWs. CMS's proposed methodology is fatally flawed in that it does not assesses whether CHHA behavior changes under PDGM impacted Medicare home health spending in 2020 through 2022.

- 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 CHHA 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 through 2022 therapy utilization data to determine budget neutrality.
- CMS should recognize the disruptive and permanent financial impact of its forecasting error with respect to the annual Market Basket updates from 2021 and 2022 and implement a one-time adjustment to account for the 5.2% forecasting error.

CMS should also consider the following factors:

- The impact home health had on reduced hospitalizations in Medicare and the overall savings to the Medicare program because of the Home Health Value Based Purchasing (HHVBP) program.
- The negative and disruptive financial impacts of its proposed wage index changes and case mix weight recalibrations on care access as it finalizes the 2023 payment rates and any systemic reforms.
- The impact of COVID admissions in 2020 through 2022 as a primary diagnosis.
- The substitution of telehealth for in-person visits.
- Compare outcomes after application of real versus nominal findings.

Proposed CY 2024 Home Health Wage Index Update

Background

As part of the CY 2023 Home Health final rule, CMS established a permanent approach to smooth year-to-year changes in providers' wage indexes by placing a 5 percent cap on all wage index decreases in future years, regardless of the reason for the decrease. Under this change, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

CMS also finalized that if a geographic area's prior CY wage index is calculated based on the 5 percent cap, then the following year's wage index would not be less than 95 percent of the geographic area's capped wage index in the prior CY. The 5 percent cap will be implemented in a budget neutral manner and would be applied after the application of the hospice wage index floor. If there is a 5 percent decrease from the previous FY's wage index value after the application of the hospice wage index floor, then the 5 percent cap on wage index decreases would also be applied. CMS will be analyzing the effects of this policy on an ongoing basis in the future in order to assess its appropriateness.

For CY 2024, the proposed home health wage index would be based on the Fiscal Year (FY) 2024 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2019, and before October 1, 2020 (FY 2020 cost report data).

HCA Comments & Concerns

While HCA supports a cap on losses in wage index values, we believe that the CMS should consider lowering the cap to 3% in order to protect CHHAs who are already operating with negative or razor-thin operating margins and are still experiencing multiple negative consequences due to the COVID pandemic, such has increased costs and loss of staff.

Although CMS has repeatedly dismissed HCA's longstanding request for wholesale revision and reform of the home health and hospice wage index, we also reiterate our support for more far-reaching reforms to the wage index methodology used under Medicare fee-for-service (FFS) programs.

We believe the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting hospice and home health costs, particularly in states like New York, which has among the nation's highest labor costs and continue to increase.

Yet another ongoing concern for hospices and other small CHHAs is the need for parity with other health care providers (i.e., hospitals, nursing homes, etc.) that draw from the same labor pool. While the same data is used to establish the basic wage index values applicable to most provider types, hospitals receive special consideration in a number of ways, including that they are permitted to seek geographic reclassification from their assigned geographic area (thereby receiving higher wage adjustments to their payments).

This situation has come to fruition specifically in New York's Albany-Schenectady- Troy Wage Index (CBSA 10580), where inpatient hospital facilities in this area have successfully appealed its wage index and CMS has proposed a FFY 2024 Wage Index of over 1.20 for these providers, whereas hospice providers in the very same CBSA, are facing a proposed FFY 2024 Wage Index of 0.8079. This significant variance in the 10580 CBSA wage index makes it much more difficult for home health and hospice providers to recruit nurses and other professional and para-professional staff when hospitals can offer those same individuals a much higher salary and benefit package due to this large variance in the Wage Index.

HCA's Recommendations

The time is long overdue for CMS to develop and implement a wage index model that is consistent across all provider types so that all providers have a level playing field from which to compete for personnel. Finally, all providers should be guaranteed that their wage index value does not drop below the rural wage index value applicable in the state of operation.

In the meanwhile, HCA will be working with New York's Congressional Delegation to introduce legislation that will allow Medicare hospice and home health providers the same provision as inpatient facilities who can appeal and reclassify its wage index to CMS.

Proposed 2.7% CY 2024 Home Health Market Basket Update

By statute CMS is required to utilize the inpatient hospital market basket update (currently projected at 3.0% for CY 2024) less a productivity adjustment (currently estimated to be 0.3 percentage point for CY 2024) to arrive at the annual payment update for home health services. As a result, CMS projects the home health market basket update percentage for CY 2024 to be 2.7%.

This value may change if more recent data becomes available prior to publication of a final CY 2024 home health payment rule. The 2.7% update is generally in keeping with update values over the last 10 years, which have trended between 2.4% and 3.0%. While we understand that CMS has limited discretion relative to calculation of the annual payment update, we are deeply concerned that the projected payment update for home health (as well as hospice) provider members will be inadequate to address the accelerating financial demands that home health has been facing over the course of the last three years. HCA CHHA members have voiced numerous issues that are creating these financial strains, including:

- Severe workforce shortages caused by caregiver burnout and other reasons associated with the previous Public Health Emergency (PHE).

- Increased costs related to management fees, outsourcing, recruitment, staff retention.

- Raising prices and other inflationary pressures such as the increased costs for supplies, drugs, personal protective equipment (PPE) and other items essential to the delivery of high-quality hospice care.

- Resumption of the 2% Medicare Sequestration cut.

HCA Comments & Recommendations

HCA is very concerned that the market basket update factors are not sufficiently sensitive to appropriately reflect the rapid financial changes and challenges that home health and hospice providers have experienced over the past 2-3 years. While we understand that CMS

has limited flexibility relative to the inputs it uses to calculate the market basket update, we strongly encourage you to explore all options available to address the financial strains that providers are undergoing, including the following:

- Examine trends relative to HIS Global's forecasts to determine whether more recently available data than used for the final CY 2024 rule would result in a higher market basket update and determine whether additional updates could be made during the course of CY 2024 to provide additional support to home health and other providers.

- Direct various divisions of CMS to examine potential options for home health regulatory relief, with a particular focus on policies that could help to address issues that contribute to the existing workforce crisis, including reductions in paperwork and more appropriate utilization of various clinical personnel.

- Engage stakeholders in discussions regarding current and old waivers and flexibilities related to the recently ending PHE and policy changes that might be advisable as a result of those experiences.

CMS's Home Health Value Based Purchasing (HHVBP) Program & Proposed Changes for CY 2025

Proposed Reimbursement Cuts Could Threaten Future Medicare Savings from the HHVBP

Two years ago, CMS finalized its proposal to expand the highly successful HHVBP demonstration program from nine states to a nationwide application. While HCA had some initial concerns, generally were supportive of the program and its nationwide expansion. The program stood as one of the few value-based payment experiments to date with Medicare savings millions annually through reduced hospital admissions and more brought about through high quality home health services. CMS estimated that the nationwide expansion would reduce Medicare expenditures by nearly $3.4 billion over five years.

To get that savings takes dedication and innovation by HHAs. That effort comes with a cost in resources. The proposed rule reducing payment rates by 5.653% and the combined effect of a 5.2% shortfall in the annual market basket update, a modified wage index, and the instabilities coming through case mix weight recalibrations are certain to diminish needed resources to succeed in HHVBP. There is only so much CHHAs can do to produce the highest quality of care when the resources need to deliver care are reduced. While we expect that CHHAs will continue to provide incredible high quality of care as they have dome following other rate reductions, HCA believes that many have reached a breaking point financially.

The proposed rate reduction may be viewed by some as CMS's lack of respect for the value of home health services, which is at odds with the objective evidence in HHVBP that home health care brings a dynamic value to Medicare and the patients its serves. HCA believes

that CMS maintains an understanding of the value of home health services and will recognize the need to preserve that value by postponing the proposed rate cut in 2024.

Proposed Changes to the Nationwide HHVBP Model

In the rule, CMS is proposing to remove the following measures from the HHVBP measure set beginning with the CY 2025 performance year:

1. OASIS-based Discharged to Community (DTC).

2. OASIS-based Total Normalized Composite (TNC) Change in Self-Care.

3. OASIS based TNC Change in Mobility.

4. Claims-based Acute Care Hospitalization (ACH) During the First 60 Days of Home Health Use.

5. Claims-based Emergency Department (ED) Use without Hospitalization During the First 60 Days of Home Health.

The five measures will be replaced with the following three measures:

1. Claims-based Discharge to Community-Post Acute Care (DTC–PAC) Measure for CHHAs.

2. OASIS-based Discharge Function Score (DC Function) measure.

3. Claims-based Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure.

HCA has the following concerns:

We are particularly concerned with replacing the TNC self-care and TNC mobility measure with DC functioning measure. This measure has not been tested in the home health setting, includes a limited set of self-care items, and most importantly, CHHAs will have virtually no experience with the measure in time to establish meaningful quality improvement strategies with an implementation date of CY 2025. CMS anticipates that CHHAs will not have their first preview report on the measure performance until October 2024, three months before the HHVBP 2025 performance year.

HCA also does not support changing the base line year to 2023 beginning with performance year 2025. CHHAs will have focused their quality improvement efforts for the first two performance years of the model based on results from 2022 data, then be back at square one with needing to reevaluate and revise their quality improvement efforts for quality measure scores based on 2023 data. CMS needs to appreciate the burden in terms of costs and resource use it will cause for HHAs to redirect the focus of their quality improvement programs.

CMS proposals for such dramatic changes is very concerning since CMS would have had limited, if any, data on CHHAs' performance in the expanded HHVBP program when the proposals were written.

If providers are concerned that their performance and subsequent payment adjustment will be negatively impacted because of the changes to the model, coupled with the CMS payment rate cuts to CHHAs, they will not be incentivized to care for complex patients or patients with Social Determinants of Health (SDOH) that can impact improvements in health.

HCA's Recommendation

CMS should abandon its proposals to replace the TNC self-care and TNC mobility measures with the DC functioning measure and to change the base line year to 2023 in the HHVBP model for performance year 2025.

Request for Information on Access to Home Health Aide (HHA) Services

We appreciate CMS's efforts on bringing greater attention to the need for more home health aides (HHAs) and the crucial role aides can play for Medicare homebound residents. HCA has heard from our CHHA members and the following are our responses to some of CMS's questions:

Why is utilization of home health aides continuing to decline if the need for these services remains strong?

The central issue is that the need for HHA and personal care services far exceeds providers' ability to meet that need. Demand is particularly strong in home and community-based services and long-term services and supports. These services are primarily funded by Medicaid, either directly or through managed care plans. Many individuals who elect to be paid caregivers work as consumer-directed personal assistants, where there is often less regulatory oversight, less training, and higher pay. The Medicare home health benefit requires a certified home health aide.

The relationship between the aide and the patient should also not be discounted. Aides and beneficiaries of their services prefer long-term relationships, given the inherently intimate work being performed (cooking, bathing, dressing). The Medicare home health benefit is usually short-term and intermittent.

The heart of the issue, though, is the inadequacy of public funding needed to employ this workforce at a level to meet demand. We appreciate that the Administration has tried to address this issue (e.g. Better Care Better Jobs Act) and hope that this remains a priority.

To what extent are higher acuity individuals eligible for Medicare (for example, individuals with multiple co-morbidities or impairments of multiple activities of

daily living) having more difficulty accessing home health care services, specifically home health aide services?

Higher acuity beneficiaries are more likely to be in harder to serve communities where staffing is more difficult. Higher acuity beneficiaries are also more likely to be dually eligible. If they have impairments to their activities of daily living (ADLs), they would be eligible for Long Term Care Services (LTSS) (which in New York, is provided by Medicaid Managed Long Term Care Plans (MLTCs). In such cases they would have regularly scheduled HHA or personal care hours through Medicaid as part of their person-centered service plan (PCSP). We stress that these services are by definition long term, whereas Medicare home health provides short term aide services directly connected to a skilled need.

Are CHHAs paying home health aides less than equivalent positions in other care settings (for example, are aides in the inpatient hospital setting or nursing home setting paid more than in home health)? What are the reasons for the disparity in hourly wages or total pay for equivalent services?

Hospitals and nursing homes can pay certified nursing assistants (CNAs) more than CHHAs pay HHAs because the overall reimbursement in those sectors is higher than home health. While it is not equivalent, a CNA is the most comparable nursing home or hospital position to a CHHA home health aide. CNAs earn about $25/hour in New York City. Home health aides in New York generally earn at least a state mandated minimum wage for aides and personal care assistants, which is $17/hour in NYC, and about $21/hour including benefits. Together with the labor union representing home health aides (SEIU 1199) and consumer advocates, HCA and our CHHA members have advocated at the state level for sustainable Medicaid home care rates that include higher wages for home health aides. Minimum hourly rates for home health aides and personal assistants will increase to $18.55 in January 2023.

Proposal for Disposable Negative Pressure Wound Therapy (dNPWT)

CMS is proposing that home health claims reported for a dNPWT device would no longer be reported on type of bill (TOB) 34x. Instead, for dates of service beginning on or after January 1, 2024, CHHAs would report the Healthcare Common Procedure Coding System (HCPCS) code A9272 (for the device only) on the home health TOB 32.

Additionally, the services related to the application of the device would be included in the home health prospective payment system and would be excluded from the separate payment amount for the device. The home health services for the administration of the device would be geographically adjusted and the payment amount for HCPCS A9272 would not be subject to geographic adjustment.

HCA's Recommendation

HCA supports the proposed changes to the payment for dPWT and CMS's plan to issue educational materials and guidance. HCA encourages CMS to issue the guidance materials

as soon as practicable to provide CHHAs and vendors ample time to make the necessary adjustments in their claim reporting processes.

Home Health Quality Reporting Program (HHQRP) Proposals

In this rule, CMS is proposing to adopt two new measures and remove one existing measure. Along with removing two OASIS items. Additionally, CMS is proposing to begin public reporting of additional measures in the HHQRP.

CMS is proposing to adopt the Discharge Function Score (DC Function) measure in the HHQRP beginning with the CY 2025 HHQRP. This assessment-based outcome measure evaluates functional status by calculating the percentage of home health patients who meet or exceed an expected discharge function score. CMS is also proposing to replace the topped-out, cross-setting Application of Functional Assessment/Care Plan process measure. Like the cross-setting process measure it is replacing, the proposed measure is calculated using standardized patient assessment data from the current assessment tool. Under the proposal, CHHAs would no longer be required to report a Self-Care Discharge Goal (that is, GG0130, Column 2) or a Mobility Discharge Goals (that is, GG0170, Column 2) on the OASIS beginning with patients admitted on April 1, 2024.

HCA has concerns around the measure structure, the use of statistical computations for the missing data, the calculation of the expected discharge function score, and the proposed time frame for public reporting.

Although validity testing has been conducted for the measure, the risk adjustment model, and the statistical computations for the missing values, the measure has never been tested in the home health setting. HCA believes the measure's accuracy can only truly be proven though the application on actual home health patients and measured over time.

The other concern is the limited self- care items in the measure. HCA understands that these self-care items were chosen for consistency among the other Post Acute Settings (PACs) specifically, Long Term Care Hospitals (LTCHs). However, the measures for bathing and dressing have been the focus of quality improvement programs for CHHAs for many years and are included in the Star Rating System, while the assessment items for bathing and dressing are included in the PDGM payment model. The assessment items and measures for eating, oral hygiene, and toilet hygiene are not included in the HHQRP, the Star Rating System, or PDGM. Eating and toilet hygiene are included in the total normalized composite measures for the HHVBP that expanded nationwide only in January 2023.

CHHAs do not have data available that might help predict how they will perform on this measure and will not have enough time to implement any meaningful quality improvement strategies around the measure if CMS finalizes the measure for inclusion in the 2025 HHQRP as proposed. CMS's belief that because the OASIS data elements used to calculate this measure have been collected since 2019, CHHAs have had sufficient time to ensure successful reporting of the data elements needed for this measure. Although CHHAs may be familiar with assessment items that contribute to the measure, they have had no

experience with the measure itself. HCA does not agree that familiarity with reporting the assessment items equates to familiarity with the DC function measure.

CMS plans to begin "publicly displaying data for the DC Function measure beginning with the January 2025 refresh of Care Compare, or as soon as technically feasible, using data collected from April 1, 2023, through March 31, 2024. Provider preview reports would be distributed in October 2024, or as soon as technically feasible." CHHAs will not see their first performance report on the DC functioning measure until at least October 2024, three months before the scheduled public reporting. Additionally, much of the data included in the public reporting post will be from 2023. CMS's urgency to publicly report the new DC function measure without providing CHHAs a chance to understand the measure and implement any necessary quality improvement processes is unnecessary and unfair to home health providers. CMS has up to two years from the application date of an Impact Act measure to begin publicly reporting on the measure.

HCA Recommendation

HCA can neither support nor oppose the measure since there is not enough information on the potential impact on CHHAs' QRP. However, HCA does not support the proposed public reporting schedule. CMS should begin data collection on the DC functioning measure January 1, 2024, and provide performance reports with available data to CHHAs no later than January 1, 2025. We believe that public reporting should not begin before **January 1, 2026**.

COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Beginning with the CY 2025 HHQRP

In the rule, CMS is also proposing to adopt the COVID–19 Vaccine: Percent of Patients / Residents Who Are Up to Date measure beginning with the CY 2025 HHQRP. CMS has intentionally not included any exclusions into the measure (i.e. patient refusals or medical contraindications). CMS notes that the focus is on a measure which would provide and publicly report vaccination rates for consumers given the importance of this information to patients and their caregivers. It is unclear how vaccination rates where reasonable exclusions are not permitted in the measure calculation helps the public better understand true vaccination rates. Raw vaccination rates could reflect negatively on the CHHAs.

Additionally, the Centers for Disease Control and Prevention (CDC) "up to date" guidance has potential to change. CDC has not set a schedule or criteria for ongoing COVID-19 vaccinations and therefore following guidance that is likely to change makes the implementation of the measure difficult and confusing.

Furthermore, the measure would require an update to the OASIS assessment tool for data collection and submission. CHHAs have had to adjust to frequent updates to the OASIS assessment tool over the past several years which has been very burdensome for clinicians and disruptive to agency operations. Even minor changes to the OASIS can be problematic.

HCA's Recommendation

HCA does not support the adoption and/or public reporting of the COVID-19 patient vaccination measure and recommends that CMS withdraw this proposal.

Other HHQRP Proposals

CMS is proposing to remove the ‘‘Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function’’ (Application of Functional Assessment/Care Plan) measure from the HH QRP beginning with the CY 2025 HHQRP.

CMS is also proposing to public display the (1) Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure (TOH-Provider) and (2) Transfer of Health (TOH) Information to the Patient—Post-Acute Care (PAC) Measure (TOH-Patient) assessment-based measures with January1, 2025 Care Compare refresh, and, lastly CMS is proposing to remove the M0110—Episode Timing and M2220—Therapy Needs items from OASIS–E, effective January 1, 2025.

HCA supports all of these proposals to the HHQRP.

CMS’s Program Integrity Concerns Related to Hospice and Other Providers

HCA appreciate CMS’s and the Technical Expert Panel’s (TEP’s) work in development of the proposed Hospice Special Focus Program (SFP). We strongly support the SFP’s goal to “identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements” and believe the appropriate quality indicators are essential in identifying hospice providers who would most benefit from the program. HCA has concerns that the quality indicators identified in the proposed CY 2024 Home Health rule will not fully identify all hospices at high-risk of delivering poor-quality care and may also result in hospices that take care of large numbers of patients being disproportionately and unfairly categorized as poor performers merely as a result of their size.

We also have the following concerns:

SFP Algorithm Concerns

CMS should work to improve the SFP algorithm prior to its application to hospices and implement a preview year where all providers are given preview reports of their performance ranking under the algorithm metrics. This may require a delay in implementation and that CMS issue a new proposed rule with the modified logarithm to give stakeholders the opportunity to comment. This would help providers understand the algorithm and where they need to target improvements to ensure high-quality care. It would also provide more time to refine the algorithm to be sure the program is capturing an appropriate subset of hospices.

Survey Data Concerns

Although we agree that survey data should be part of the algorithm for the SFP, there are concerns with the survey process and data that CMS must address prior to utilizing this indicator:

- **Scaling the data**: The TEP reviewed an SFP model where both Quality-of-Care Conditioned-Level-Deficiencies (CLDs) and substantiated complaints were scaled as CLDs/substantiated complaints per 100 beneficiaries served, except for hospices in the smallest size quartile (less than 57 beneficiaries, in this instance) for which the raw number was used. This was to ensure that larger hospices were not at a disadvantage compared to smaller hospices. However, this was not included in the proposed SFP design. Scaling the data is essential to ensure programs are comparable. For example, a large provider who has received two substantiated complaints for an average daily census (ADC) of 500 does not raise the same level of concern as a provider who has two substantiated complaints but an ADC of 50. If the goal is to ensure beneficiaries are receiving patient-centered, quality hospice care, it is necessary to review these data as ratios rather than raw numbers.

- **Out-of-date surveys**: Due to the COVID-19 pandemic and appropriate increased oversight, many hospices have not received a survey every 36 months as required by federal regulations. This creates an unequal review of complaints and CLDs for providers across the country.

- **Inconsistent surveys**: Many hospices have varied experiences with surveyors. CMS only revised the State Operations Manual, Appendix M – Hospice in January 2023, which included standardized training for all surveyors across both AOs and SAs. More time is needed to allow the updated survey guidance to spread throughout the industry to ensure greater alignment between different survey entities' processes and procedures.

Hospice Quality Reporting Program (HQRP): Hospice Care Index (HCI)

HCA supports the use of the claims data-based HCI measure in the SFP algorithm, but with 21.7% of hospices not assigned a publicly reported HCI score, we are concerned that a significant number of hospices would not be captured based on this indicator, and therefore as currently structured, it would not be sufficient to compare all hospice providers evenly. Based on an analysis from our colleagues at the National Association for Home Care and Hospice (NAHC), which found providers without HCI scores were less likely to be included in the 10th percentile and, therefore, less likely to be included in the SFP. In addition, according to analysis based on publicly available data, hospices that did not have an HCI score had dramatically more CLDs per beneficiary yet were less likely to fall into the bottom 10% of hospices. Thus, hospices more deserving of the SFP were less likely to be included.

Hospice Quality Reporting Program (HQRP): Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey

While HCA agrees the patient and family voice must be included in any algorithm for the SFP; however, there are major limitations with the existing CAHPS Hospice Survey data that we believe need to be addressed before CAHPS is incorporated into the algorithm.

CMS's own TEP raised similar concerns, with the TEP report stating that "TEP members strongly believed that CAHPS Hospice Survey data are critical to include in the SFP selection algorithm because those data capture family and caregiver experiences. However, members were concerned by CAHPS' limited availability" and "[TEP] Members were concerned by the limited availability of data, particularly since only one-third of hospices had a publicly reported CAHPS Hospice Survey Star Rating. Members also expressed concern that providers would not be "on the same playing field" based on data availability". Given the substantial gaps in CAHPS data, HCA is concerned that without modifications, its use will distort SFP selection, especially given it has twice the significance as the other criteria under the proposed algorithm. Challenges with CAHPS' data in the SFP include:

- **Lack of data**: Only 49.3% of hospices nationally have publicly available CAHPS Hospice Survey data. Hospices who do not submit CAHPS Hospice Survey data, or who are granted an exemption for size or newness, are far less likely to be eligible for the SFP based on the proposed algorithm. For this to be an effective addition to the SFP algorithm, there needs to be significant improvement to the survey return rate and increased provider participation. Similar to HCI, publicly available data shows hospices that do not have CAHPS data have higher rates of CLDs per beneficiary yet are treated more favorably in the proposed algorithm.

- **Algorithm weight**: CMS proposes to have the CAHPS scores be weighted at two times the other factors, even though the TEP was presented with an algorithm using a weight of 0.252. Overweighting CAHPS data to this degree will unfairly bias hospice providers that report this data and could incentivize hospices to not participate in the CAHPS Hospice Survey.

Transparency Into How SFP Hospices are Selected

In the proposed rule, CMS stated, "5,943 hospices would be eligible for participation in the SFP" and "the hospices selected for the SFP from the 10 percent would be determined by CMS." To ensure transparency, CMS must provide additional information as to how it will decide which of the bottom 10% of hospices will be selected for the SFP. The SFP should not be used as punishment but rather as an educational tool for struggling hospices. HCA is concerned that CMS provided no guidance on how it would utilize its discretion in selecting SFP candidates from the bottom 10% of performers; therefore, we are unable to provide informed comment on its impact on hospice providers.

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,

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