Illinois Health and Hospital Association

August 16, 2022

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

Re: Calendar Year 2023 Home Health Prospective Payment System Rate Update (CMS-1766-P)

Dear Administrator Brooks-LaSure:

On behalf of Illinois' hospital-affiliated home health agencies, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year (CY) 2023 Home Health Prospective Payment System (HH PPS) proposed rule. We appreciate the Centers for Medicare & Medicaid Services' (CMS) efforts over the last two years to balance the impact of the COVID-19 public health emergency (PHE) with the need to continue shaping and modernizing the Medicare program. This is particularly true for home health, where CMS has had to balance the pandemic against the implementation of the Patient Driven Groupings Model (PDGM), effective Jan. 1, 2020.

To that end, IHA appreciates CMS' approach to date in modifying the PDGM as providers adjust to the new payment model. Delaying negative adjustments to the 30-day payment rate over the past two years was paramount in allowing Home Health Agencies (HHA) to continue delivering high quality care during an unprecedentedly challenging time. Unfortunately, the PHE is ongoing and external factors continue to have a significant negative impact on HHA operations.

Given these ongoing challenges, we are very concerned with CMS' proposed CY 2023 rate update of -4.2%, made negative by the proposed permanent behavioral adjustment of -7.69%. In Illinois, we estimate that CMS' proposed policies for CY 2023 will result in 5.12% decrease in payments across Illinois HHAs compared to CY 2022, which amounts to approximately $4.6 million fewer dollars flowing to Medicare-enrolled HHAs. While many Americans see COVID-19 as an issue that ebbs and flows, our healthcare providers have experienced a constant COVID-19 presence since March 2020. The ongoing PHE solidified the need for adequate Medicare payment, and CMS must ensure providers are financially able to provide quality healthcare, especially as the demand for home health continues to grow. **We strongly urge CMS to reexamine**

TRUSTEES & OFFICERS

Chair
Ted Rogalski
Genesis Medical Center

Chair-Elect
J.P. Gallagher
NorthShore – Edward-Elmhurst Health

Immediate Past Chair
Vacant

Treasurer
Robert Sehring
OSF HealthCare

Secretary
Keith Parrott
Ascension Illinois

President
A.J. Wilhelmi
Illinois Health and Hospital Association

Steven Airhart
Hartgrove Behavioral Health System and Garfield Park Behavioral Hospital

Damond W. Boatwright
Hospital Sisters Health System

Jeremy Bradford
SSM Good Samaritan Hospital

Rex Budde
Southern Illinois Healthcare

Katherine Bunting
Fairfield Memorial Hospital

Trina Casner
Pana Community Hospital

Ruth Colby
Silver Cross Hospital

M. Edward Cunningham
Heartland Regional Medical Center

William Dorsey, MD
Jackson Park Hospital and Medical Center

Dean M. Harrison
Northwestern Memorial HealthCare

Omar B. Lateef, DO
Rush University Medical Center

James Leonard, MD
Carle Health

Michael McManus
Memorial Regional Health Services

Israel Rocha Jr.
Cook County Health

José R. Sánchez
Humboldt Park Health

William Santulli
Advocate Aurora Health

David Schreiner
Katherine Shaw Bethea Hospital

Steven D. Tenhouse
Kirby Medical Center

Shawn P. Vincent
Loyola Medicine

Brenda J. Wolf
La Rabida Children's Hospital

the policies and rate update methodologies utilized in this proposed rule, and finalize a rate update that better reflects the economic reality HHAs currently face.

Proposed CY 2023 Rate Update

We are disappointed with CMS' proposed CY 2023 HH PPS rate update. As stated above, after accounting for all proposed payment and policy changes, we estimate that Illinois HHAs will experience a net decrease in HH PPS payments of 5.12% compared to CY 2022. **Including sequestration causes the rate update to further drop to -7.12%.** This rate update is woefully inadequate given the fiscal realities of the healthcare sector at present.

In this proposed rule, CMS relies on IHS Global Inc.'s first quarter 2022 forecast to calculate the market basket update. The first quarter 2022 forecast is based on historical data through the fourth quarter of 2021. Using these data, CMS proposed a market basket update of 3.3%. While CMS' methodology accounts for some of the economic realities of the COVID-19 pandemic, it clearly does not track with the realized increased cost of providing healthcare.

Consider a January 2022 analysis by Kaufmann Hall which found a 20.1% increase in hospital expenses per patient from 2019 to 2021.[1] This includes a 36.9% increase in per patient cost on drugs, a 19.1% increase in per patient cost on labor, and a 20.6% increase in per patient cost on supplies compared to pre-pandemic levels. All of these estimates vastly outpace the proposed CY 2023 market basket update from CMS.

Further, as of July 13 the annual inflation rate for the United States is 9.1%.[2] CMS' proposed CY 2023 market basket update does not come close to keeping pace with inflation. Inflation and COVID-related price hikes are on top of a Medicare program that only reimburses hospitals at about 88% of cost in Illinois. CMS's negative rate update will clearly only widen this gap between cost and reimbursement, further increasing reliance on private payers and threatening providers' ability to meet the growing needs of the Medicare population.

A recent analysis from McKinsey & Company that demonstrates three challenges to effectively meeting patient care needs that the U.S. healthcare system will face by 2025. These include a decreased supply of the registered nurse workforce, increased inpatient demand from or related to COVID-19, and continued work setting shifts and increased demand due to a growing and aging population.[3] The third challenge directly impacts HHAs, and considering the Medicare fee-for-service population is driving this third concern, now is the time for CMS to enhance HHA resources, not limit them.

---

[1] https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf
[2] https://www.usinflationcalculator.com/inflation/current-inflation-rates/#:~:text=The%20annual%20inflation%20rate%20for,10%20at%208%3A30%20a.m.
[3] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/assessing-the-lingering-impact-of-covid-19-on-the-nursing-workforce

PDGM Behavioral Adjustment

IHA understands that when the Balanced Budget Act of 2018 passed, Congress instructed CMS to implement the PDGM and included explicit guidance on how CMS should consider budget neutrality. The overall goal was to maintain HHA payments so they mirrored what was spent under the prior case-mix system. This requires CMS to annually review HHA spending, and determine whether they over- or under-paid compared to what would have been spent pre-PDGM. Congress requires CMS to complete this annual review through CY 2026.

We understand that CMS has identified both permanent and temporary overpayments since migrating HHA payments to the PDGM. Further, we appreciate CMS' recognition that recouping all of these overpayments in CY 2023 would be devastating to HHAs, and agree that a partial clawback is most appropriate. That said, **the proposed 7.69% payment offset is egregious given the economic realities described above.**

Further, we ask CMS to reevaluate its past and present assumptions since implementing the PDGM. Initially, CMS considered three issues: clinical group coding, comorbidity coding, and low-utilization payment adjustment (LUPA) add-ons. CMS assumed that migrating to the PDGM would result in HHAs changing their documentation and coding practices in a variety of ways to maximize reimbursement. These assumptions included that HHAs would put the highest paying diagnosis code as the principal diagnosis code in order to capture a higher-paying clinical group, increasing the number of secondary diagnoses on the HHA claim to capture a larger comorbidity adjustment, and providing additional visits if the episode of care was one to two visits away from the LUPA threshold in order to receive a full 30-day payment.

CMS analysis found that these three assumed behavior changes did occur after PDGM implementation. However, its analysis indicated other behaviors, such as changes in the provision of therapy and changes in functional impairment levels, also occurred. Specifically, CMS determined that changes in case-mix weights were largely driven by a decrease in therapy utilization. The decrease in therapy visits led to a decrease in case-mix weight, and therefore a decrease in aggregate expenditures when compared to pre-PDGM HH payments.

CMS posits that these changes in therapy utilization were occurring prior to the onset of the COVID-19 PHE. Further, CMS believes its methodology controls for the effects of the COVID-19 PHE because it uses the same data in calculating both its pre-PDGM and post-PDGM payment scenarios.

While we understand CMS' explanation, COVID-19 was and continues to be an unprecedented external shock that will undoubtedly have long-term effects on utilization and service provision patterns. There have also been several PHE-related factors that might impact HHA therapy utilization for years to come, and CMS simply does not yet have the data necessary to completely disassociate therapy utilization patterns from the PHE. These factors include but are not limited to: postponed care utilization that could lead to changes in patient

acuity over time; labor shortages that affect an HHA's ability to provide timely care; and general increased costs across economic sectors which may lead some potential home health patients to forgo care in the short-term leading to worse health outcomes and higher costs in the long-term. CMS acknowledges these issues in the proposed rule, and solicits comments on how the PHE affected home health service provision and utilization. **Given CMS' concern in this area, it seems prudent to postpone the full behavioral adjustment until there are more updated data and additional analyses revealing the true impact of the COVID-19 PHE on home health utilization.**

Further, CMS' assumption that therapy utilization decreases are independent from the effects of the COVID-19 PHE begs the question: does the structure of the PDGM directly cause a decrease in the cost of HHA care? If that is the case, then it is not so much provider behavioral changes leading to overpayments, but the system itself resulting in overpayments. **We urge CMS to consider whether its underlying PDGM assumptions are accurate, and to reevaluate how the PDGM may affect HHA service patterns.**

Finally, given CMS' continual push to provide the right service at the right time in the right place, and the slow migration away from acute inpatient care toward care provided in the home, it is counterintuitive that CMS would propose such a significant negative behavioral adjustment that will ultimately make it harder for HHAs to hire skilled labor and provide the outstanding care Medicare beneficiaries deserve. **IHA strongly urges CMS to reevaluate its proposed permanent behavioral adjustment and consider postponing its full implementation until more comprehensive data and analyses are available.**

OASIS Data Collection

IHA appreciates CMS' desire to obtain a more comprehensive understanding of HHA outcomes through the collection of all-payer OASIS data. We are concerned, however, about the increased burden this will put on HHA providers.

By CMS' own estimates, the collection of all-payer OASIS data will require a substantial increase in time and resources. In the proposed rule, CMS estimates that expanding OASIS data collection to all patients will result in a 30% increase in estimated hourly burden and clinical cost for HHAs. This translates to a total annual increase in cost of approximately $23,529, and an additional 296.3 hours of work per HHA.

The U.S. Bureau of Labor Statistics projects the number of openings for home health and personal care aides will increase nearly 37% by 2028.[4] Therefore, we believe it is ill-advised for CMS to require more from an already thin workforce. In light of this reality, we urge CMS to reconsider expanding OASIS data collection to all patients regardless of payer until the labor market stabilizes.

[4] https://www.bls.gov/emp/tables/occupations-most-job-growth.htm

Additionally, we suggest CMS rigorously review OASIS data collection requirements to ensure all collected data elements are meaningful and used by the agency to promote quality care for home health patients. Such a review will ensure CMS collects effective data, and support CMS' goals to better understand the universe of care provided by HHAs beyond the Medicare population.

Health Equity in the HH Quality Reporting Program (QRP)

Illinois HHAs are deeply committed to improving health equity, and share CMS' goal of reducing health disparities for historically underserved communities. IHA appreciates the opportunity to address CMS' request for information on health equity in the HH QRP, specifically CMS' proposed development of a structural composite measure.

IHA has embarked down a health equity path with our members, working to ensure equity is a strategic priority across care settings. Data collection and analysis are in progress, with quality improvement serving as the lens through which we are working with hospital leadership across Illinois.

Specifically, IHA has created the Racial Equity in Healthcare Progress Report (Progress Report), a document launched statewide in 2021. More than 130 hospitals have engaged with the Progress Report, and IHA is now leading collaboratives to assist Illinois providers as they continue to make progress toward more equitable environments. For an in-depth overview of the genesis, structure and purpose of the Progress Report, please refer to our Guidance Document.

Many of the documents, initiatives, and educational opportunities CMS proposes for the HH QRP structural composite measure are embodied in IHA's Progress Report. A similar initiative has been proposed nationally by the American Hospital Association, and it is our understanding that providers across the country are working diligently to understand where they are at and where they need to go to address health disparities and move our country toward a more equitable future.

In light of this ongoing work, we urge CMS to consider data-driven quality measures as it moves forward. Allowing patients, providers and oversight organizations to track progress from the foundation that the proposed structural composite measure would create will be paramount in the coming years. To facilitate such tracking, we also encourage CMS to ensure all HH QRP measures are endorsed by the National Quality Forum, and are regularly reviewed to maximize value while minimizing provider burden.

Administrator Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi

President & CEO
Illinois Health and Hospital Association