August 16, 2022 ***e-comment submitted electronically***

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Attention: CMS 1766-P
7500 Security Boulevard
Baltimore, MD, 21244-1850

RE: Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements (CMS-1766-P)

Dear Administrator Brooks-LaSure:

The Tennessee Hospital Association (THA), on behalf of its over 150 healthcare facility members and 13 home health agencies, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed calendar year (CY) 2023 Home Health Payment System (HH PS) rule, CMS-1766-P.

While this rule includes no major changes to the structure of the HH PPS, we are very concerned about the unprecedented behavioral offset the agency proposes — 7.69 percent to the 30-day episode rate — which it states is necessary to achieve budget neutral implementation of the PDGM case-mix system. In addition, we are extremely concerned with CMS' proposed payment update given the extraordinary inflationary environment and continued labor and supply cost pressures home health (HH) agencies face.

Patient-driven Groupings Model (PDGM) Behavioral Offset

In compliance with the Balanced Budget Act (BBA) of 2018, CMS implemented the patient-driven groupings model (PDGM) case-mix system together with a 30-day payment episode on Jan. 1, 2020. PDGM bases payments on the clinical characteristics of the patient instead of the patient's therapy volume, which was the approach under the previous model. The new law called for a budget neutral implementation that centered on the new 30-day episode of care, not the new case-mix system.

CMS' budget neutral adjustment for CY 2020 was set prospectively based on three assumptions about providers' expected behavioral changes: HH agencies would alter their coding of primary as well as secondary diagnosis and that the number of low-volume cases would decrease. These three behavioral adjustments did not match actual behavior by the field in CY 2020 but CMS imposed an original offset of 4.36 percent.

In the proposed CY 2023 rule, CMS is proposing a second behavioral offset of 7.69 percent to the 30-day episode payment rate. CMS states that the application reflects statutory requirements to ensure that the PDGM remains budget neutral. This adjustment process will occur each year through 2026, as required by law, and this year's proposal is only an initial step in a multi-year series of adjustments.

THA is concerned that the data used to make these calculations has not been made public, which the agency has done in the past. Stakeholders cannot independently replicate or review the information used to determine final rates, and as such, cannot provide adequate comments on the rule. **THA requests that CMS stop the adjustment for CY 2023 until the data can be appropriately analyzed.**

CY 2023 Payment Update

CMS is only proposing a market basket update of 3.3 percent for CY 2023 that would be offset by a 0.4 percent productivity factor. When that is taken into consideration with the behavioral offset of 7.69 percent, the net impact to HH providers is a *negative* 4.2 percent. Both the timing and scale of this negative update would cause significant disruption to the field at the worst possible time, considering the current economic and COVID-19 pressures. Workforce burdens are also posing substantial challenges on HH agencies (HHAs), especially given their reliance on nurses and other personnel who are willing to take on the challenges of providing home-based care.

Healthcare providers remain on the front lines fighting COVID-19, while at the same time struggling with unrelentingly higher costs and additional downstream challenges that have emerged as a result of the impacts of high inflation and the pandemic. **We urge CMS to consider the changing healthcare system dynamics and their effects on HH agencies.**

Home health agencies are experiencing an increase in demand for care at home since March 2020; however, the ability to admit patients for services has declined due to staffing issues and increased costs. THA reviewed filed cost report data from our hospital based HHAs and found a decrease in Medicare visits but higher than normal cost. One agency reported a decrease of 33 percent in visits between 2020 and 2021 yet total costs increased 6 to 10 percent. In order to compete in the current labor market, salaries increased, with nursing increasing 10 percent and nursing administration costs increasing more than 30 percent. However, with staffing shortages, and strapped financial recourses, fewer patients are receiving care at home.

Inflation has exacerbated the economic instability, starting in CY 2021 and culminating at the 12-month high in June 2022 at 9.1 percent.[1] Many experts predict high inflation will remain through

[1] U.S. Bureau of Labor Statistics. "Consumer Price Index Summary" July 13, 2022. https://www.bls.gov/news.release/cpi.nr0.htm ; Statista. July 27, 2022. Monthly 12-month inflation rate in the United States from June 2021 to June 2022. https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us

the end of 2022, with lasting effects impacting future stability for hospitals and health systems in CY 2023 and beyond. Volatility in gas prices has also uniquely impacted home health agencies, where gas prices were 53 percent higher than the beginning of the year. These growing costs will negatively impact the ability of HH providers to meet the growing demand, continue to serve a significant rural population in Tennessee, and weather economic uncertainty.

As CMS has with previous 2023 payment rules, the agency should recalculate the payment updates with more current data that appropriately reflects the additional economic pressures home health agencies are enduring.

Proposed Reassignment of Certain Unspecified Diagnosis Codes
In general, THA supports CMS' proposed changes contained within the section for Proposed Reassignment of Specific ICD-10-CM Codes under the Patient Driven Groupings Model (PDGM). These proposed changes seem reasonable given the information provided to the ICD-10-CM codes, with the exception noted below.

THA acknowledges that CMS identified 159 ICD-10-CM diagnosis codes that are currently accepted as a principal diagnosis have more specific codes available for medical conditions that would more accurately identify the primary reason for home health services. CMS explained that in accordance with the expectation that the most precise code be used, CMS believes that these 159 ICD-10-CM diagnosis codes are not acceptable as principal diagnoses and therefore proposes to reassign them to "no clinical group'' (NA).

THA agrees that the most specific code should be used to identify all medical conditions. However, THA does not support CMS' decision to not accept these 159 ICD-10-CM diagnoses as acceptable principal diagnoses when by definition within the Medicare Code Edits Manual these diagnosis codes are supported for use as principal diagnosis. We request that CMS reconsider this decision.

Collection of Quality Data Regardless of Payer
Beginning Jan. 1, 2024, CMS would require all HHAs to submit all-payer patient assessment data from the Outcome and Assessment Information Set (OASIS) tool; the agency would use this data to calculate all OASIS-based measures. CMS estimates that this proposed requirement would result in HHAs having to increase the number of assessments they complete at each time point (start of care, resumption of care, follow-up and transfer of care) by 30 percent, with a corresponding 30 percent increase in their estimated hourly burden and estimated clinical purposes; this means it would add approximately 296.3 hours of clinician work per HHA. According to the agency, this will cost each HHA a yearly average of $23,529.82, culminating in increased costs to the field of $267,157,680 per year.

The HHA workforce is already overburdened by administrative requirements, and as CMS adds more SPADEs to the OASIS, there is less time for patient care. Because of the substantial increase in burden associated with this proposal, **THA requests that CMS extend the timeline**

for the implementation of this requirement until at least Jan. 1, 2025, to give providers time to prepare.

Conclusion

THA and our members appreciate CMS' consideration of these comments and welcome continued opportunities to work with the agency in improving the home health network. Thank you for the opportunity to share our thoughts and concerns. If you or your staff wish to discuss this letter, please contact me at anewell@tha.com.

Sincerely,

Amanda Newell
VP of Financial Policy