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Brentwood, TN 37027

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

Submitted electronically

RE: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-term Care Hospital Quality Reporting Program Requirements (CMS-1747-P)

Dear Administrator Brooks-LaSure,

The Association of Home Care Coding and Compliance (AHCC), the national membership organization for home health coding and compliance professionals appreciates the opportunity to comment on changes to the Home Health Prospective Payment System as outlined by the Centers for Medicare and Medicaid Services Calendar Year 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirement proposed rule.

Decision to Modify COPs to make certain COVID-19 PHE Waivers permanent.

AHCC agrees with the proposal to allow virtual supervisory assessments of home health aides for patients receiving skilled care, as well as the related proposed changes to the requirements for supervision, competency assessment, and retraining for aides who are providing care to patients receiving all levels of home health care. These changes reflect that growing use of technology, including video conferencing, as a way to protect patients from diseases such as COVID-19 and to improve the efficiency of home health agencies.

As written, the proposed rule would limit an agency to two (2) virtual visits in a sixty-day period. We understand this to mean that, for each certification period, only two (2) virtual

visits may occur over interactive telecommunications systems. Although we appreciate the significant flexibility that such a requirement allows, we note that there is no logical reason to limit the visits in this fashion. We applaud the proposal to recognize that the aide need not be present when an assessment occurs and that the important part of this process is the communication with the patient about their care. Moreover, as this requirement applies to patients' skilled care requirements, skilled professionals will be in the patient's home to assess the patient's condition and whether the care being provided is achieving the stated goals. This means that the agency should be free to perform all aide supervisory visits, other than the annual in-person assessment necessary to evaluate the aide remotely. We do not believe agencies will perform all visits remotely, due to the commitment in the industry to be "in-person" with the patient. However, removing an artificial limit on the number of virtual assessment visits will reduce the compliance burden that comes with having to track virtual visits against a cap. HHAs will simply be able to perform the assessment in the way that best fits with the patient's care, patient's desires, staffing availability and, should it continue, the agencies response to the COVID-19 Pandemic.

We also support the proposal to modify the Conditions of Participation to implement the changes required by the CAA 2021, Division CC, Section 115 to allow the OT to conduct the initial assessment visit and complete the comprehensive assessment, when OT is on the home health plan of care, including the proposal to add an OT LUPA payment using the PT LUPA payment as a model until more robust data is available.

We also request CMS provide any data available on telehealth utilization. This data could shed light on measures the industry has taken in response to COVID-19 to keep their patients safe. Since providing telehealth is a cost to HHAs for which there is no return revenue, this data would be extremely beneficial to Congress should they consider amending the Social Security Act to allow payment for telehealth in the future and therefore should be publicly available. Specifically, physical therapy, occupational therapy and speech-language pathology provide telehealth services, with established reimbursement, under other payors, and have shown positive outcomes and patient satisfaction.¹ The Agency for Healthcare Research and Quality (AHRQ) published a white paper titled, "*The Evidence Based for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic*" that states telehealth is a solution to current problems and an innovation whose time has come. Through systematic reviews, AHRQ reports there exists a large amount of evidence supporting telehealth for patients with chronic conditions. Most importantly, the cited evidence was published prior to the onset of COVID-19, proving telehealth use can and should be included in models for care delivery in normal circumstances.²

¹ <https://www.apta.org> (last accessed June 4, 2021).

² <https://effectivehealthcare.ahrq.gov> (last accessed June 4, 2021)

Decision to forego making any behavioral adjustments

You noted in the proposed rule that your “preliminary analysis shows an additional payment decrease would more appropriately account for behaviors reflected in CY 2020, after the implementation of the PDGM and 30-day unit of payment. However, we anticipate potentially seeing further variability in this percentage as we continue to analyze full claims data from CY 2020 and subsequent years and considering that the COVID-19 PHE is still ongoing.” Your analysis concluded that home health payments under PDGM were 6% higher than what payments would have been had PDGM not been implemented.

You indicated that this change was the result of an increase in case mix. However, due to the uncertainty resulting from the ongoing impact of the COVID-19 PHE on utilization data, you are not making any adjustments at this time. On behalf of an industry that is continuing to respond to the impact of the pandemic, we applaud the choice to forego any adjustments to home health payments in this rule.

Although you are forgoing any changes at this time, you have indicated that you may need to make larger reductions to home health reimbursement in the future. We are concerned that this could present serious economic challenges for the industry, especially if a significant, ongoing negative adjustment is imposed while the industry is continuing to struggle to recover from the economic impact of the COVID-19 Pandemic.

We are concerned, because your comments went beyond discussion of the 6% disparity, to a discussion that home health reimbursement under PDGM may be 34% higher than agency costs. As part of this discussion, you noted MedPAC’s 2021 report, which posits that PPS payments have consistently “significantly exceeded HHAs costs.” The discussion in the comments concerns us that a more significant cut may be considered. You are not acting at this time, because you acknowledge that the 2019 Cost Report data may not paint an accurate picture of current costs to the industry.

We agree with your assessment. One key factor that supports your assessment are the apparent distortions to the labor market that have occurred due to the pandemic. These distortions have impacted labor costs significantly. According to the latest data from the DOL’s Bureau of Labor Statistics, the cost of wages and salaries for private sector employers increased 3.5% over the 12-month period ending in June 2021.¹ This is significant to our members, because labor costs represent the single largest component of portion of costs to home health providers who typically expend well in excess of 60% of total reimbursement on the direct costs of providing care.

¹ <https://www.bls.gov/news.release/eci.nr0.htm> (last accessed August 15, 2021).

Home health agencies' labor costs are being impacted by both a decline in available workers and competition for those workers from many sources. These two factors work to drive up wages. Another significant difference between now and the world before the PHE is the recent return of significant inflation, which projects to continue for some time and impact costs in the coming years. According to the BLS, the percent change in the all items category of the CPI for the 12-month period ending July 2021 was 5.4%.² This is a significant increase in costs. Before taking steps to address either the 6% difference or the alleged 34% difference between reimbursement and costs, CMS must carefully consider the labor and economic landscape, which is much different than prior to the pandemic.

Provision of more robust utilization data

As we reviewed the comments on utilization and costs, we became concerned that the data analysis offered was rather cursory. A more detailed breakdown of utilization data and cost data would be useful to the industry, as it would allow the industry to gather data that is more responsive to CMS' concerns. One area where a more detailed, or different, analysis of therapy utilization data might be useful is in the analysis of therapy utilization in concurrent and then subsequent episodes. A breakdown of therapy utilization linked to primary diagnoses which, in the past, were not associated with therapy utilization would provide valuable insight into how agencies are shifting the way they provide care. Changes in utilization are not always linked to payment but are often linked to changes in care practices. Breaking down therapy utilization data to show how therapy utilization amongst diagnoses had changed would provide valuable insight in how agencies are using therapy in light of the increased Functional High impairment numbers cited in the proposed rule. This could identify an altered, but appropriate, use of therapy to address high functional impairment patients who are not "traditional" therapy categories. Such a change in utilization would not justify a change in payment or a behavioral adjustment.

Any analysis of utilization in 2020 must recognize the impact of the pandemic on the delivery of care in the home. Reductions in visits, regardless of discipline, were not completely within the control of the home health agency. There have been many reports of access to patients being limited by assisted living facilities, family members, caregivers and patients themselves in an effort to reduce potential exposure risks. Agencies had to make adjustments based on these limitations and this led to situations in which visit frequencies and durations were reduced within a single discipline or the absence of a discipline from the entire plan of care. Although not ideal, providers were doing what they could to provide as much care as possible to these patients.

The overlap of PDGM implementation and the pandemic requires a more comprehensive and detailed analysis of utilization data for 2020 **and** 2021 as the impact of the PHE has continued beyond 2020.

² <https://www.bls.gov/news.release/cpi.nr0.htm> (last accessed August 15, 2021).

A more detailed examination of the utilization data would also support more thoughtful comments from the industry regarding appropriate changes to PDGM.

Continued focus of reducing agency reimbursement

As noted above, the proposed rule seems to indicate that a future reduction in home health reimbursement is needed and should be expected by the industry. As an association representing 3,000+ home health coding and compliance professionals, we would like to suggest that now is not the time to decrease home health spending, but to increase it. The past 18 months have demonstrated the importance of a robust home health industry to our nation's response to a global pandemic. Patients were safer and more comfortable at home than in facilities. In fact, as of June 2021, reported statistics suggest that more than 30% of all deaths attributed to COVID-19 occurred in nursing homes.³ Our industry provided a way to safely care for patients outside of SNF and other facilities that, early on in the pandemic, were unprepared to handle a pandemic. As the pandemic progressed, more patients desired care at home, due to the safety it provided. We believe that the preference for receiving care in one's home will not abate once the public health emergency is over.

When the increased need for home health during a pandemic is added to the overall trend towards care in the home and the overall cost-effectiveness of care in the home when compared to other models, we think that more home health spending is appropriate. CMS receives more quality care per dollar from home health than from other modalities of long-term care. As such, we believe that a measured approach to adjusting home health reimbursement is appropriate. As the demand for home health care continues to grow, the industry must be in a position to meet that demand. This means having adequate funding to hire nurses, therapists, and aides to care for a growing patient population. This need to increase staffing arises against a backdrop of a shrinking pool of employees and increased competition for personnel across the healthcare continuum, which is driving wages and salaries in homecare ever higher.

We are not advocating for increased profitability of agencies. We agree that we must all work together to utilize Medicare funds in a manner that ensures the long-term health of the Medicare system. However, we do not think that home health reimbursement actually outstrips home health costs by 34% and that using this number as a basis to adjust payments may lead to an over correction that negatively impacts the industry. This could lead to a reduction in access to home health care at a time when access to home health care should be expanded.

³ <https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html>

One reason why the 34% number may be inaccurate is that it is based upon home health agency cost report data, which may not adequately reflect the home health industries' costs. The home health industry comprises more than 12,000 Medicare certified providers who vary in complexity, sophistication, size, and resources. Because cost reports are complex and agency sophistication and resources vary, cost report accuracy varies. We are concerned that this variation leads, in many cases, to cost reports understating agency costs. As such, reliance on home health cost report data alone may not adequately capture the overall picture of the economic realities facing the industry and could lead to adjustments to reimbursement rates that were inappropriate.⁴

We suggest that to protect against this, other data sources might be considered to provide a method to evaluate the reasonableness of the cost report data. For example, if a review of trend data on nursing salaries, labor costs and similar relevant data, such as that developed by the Department of Labor Bureau of Labor Statistics showed an annual increase in labor costs, but cost report data suggested a decline, then this would suggest caution when making broad pronouncements based upon the cost report data. Review of other data sources such as this may provide a means to evaluate the Cost Report data and better gauge agency costs. If adjustments are made based upon inaccurate cost data, the impact on reimbursement could negatively impact the industry at a time when the need for, and value of, a robust home health industry could not be clearer. To be clear, we are not suggesting abandoning the use of cost reports, but of developing tools to evaluate whether the picture painted by the cost report data tracks other relevant cost indicators to ensure that rate setting decisions are based upon accurate data.

Again, we appreciate the opportunity to comment on the proposed rule. We hope you will consider our concerns before moving forward with plans to roll out the PDGM as currently proposed.

Sincerely,

The Association of Home Care Coding and Compliance



Jan Milliman, HCS-D

Director

Association of Home Care Coding and Compliance

⁴ An expression often used by computer programmers is apt here, "Garbage in, Garbage out."