Trinity Health At Home

August 26, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1803-P: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies.

Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health at Home (THAH), a National Health Ministry of Trinity Health, is a faith-based organization that provides Home Health Care to patients in twelve states; our average daily census is approximately 9,000 patients. We appreciate the opportunity to comment on CMS-1803-P, the FY 2025, Home Health Prospective Payment System Update. Our comments and recommendations reflect a strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 121,000 colleagues and 36,500 physicians and clinicians caring for diverse communities across twenty-seven states. Nationally recognized for care and experience, the Trinity Health system includes 101 hospitals, 126 continuing care locations, including 21 Home Health Agencies and 14 Hospice Agencies, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. In fiscal year 2023, the Livonia, Michigan-based health system invested $1.5 billion in its communities in the form of charity care and other community benefit programs.

Our comments on the proposed rules for Home Health are provided with a sense of impending crisis as the proposed cuts would significantly impact our ability to remain financially sustainable, address staffing shortages, and continue to serve the most vulnerable patient populations. Likewise, the proposed cuts would negatively impact other sectors of the health care delivery system. We implore you to make changes. **Most importantly, we urge CMS to adjust the percentage update to account for the real expenses experienced by Home Health providers**. If not, these proposed changes, coupled with underpayment from commercial insurance, Medicare Advantage Plans and Medicaid, will lead to significant access challenges for those requiring care in the home.

The population is aging, and more people have chronic conditions that require care. The cost to deliver this care is growing. Home Care is the setting people prefer to receive care and is a less expensive option than inpatient or institutional care.

HOME CARE SAVES MEDICARE AND MEDICAID DOLLARS. Home Health is the solution to the increasing numbers of patients requiring therapy and nursing services, yet the proposed rule would push more people into high-cost care options by eliminating access to home health.

Our Comments are as follows:

2025 Proposed Payment Rates:

The rule's proposed net impact is a decrease of 1.7%, or $280 million, in payments after all policy changes, compared to CY 2024. This includes a proposed market basket update of 3.0%, reduced by a statutorily required 0.5% productivity factor ($415 million net increase). CMSs proposed 4.07% behavioral adjustment (applied to the 30-day payment rate) would reduce payments by an estimated 3.6% overall, or $590 million. In addition, CMS estimates that there would be an 0.6% decrease in overall payments ($100 million) because of an updated fixed-dollar loss ratio for outlier payments. CMS also provides an estimate of impact by type of HHA. It estimates that freestanding HHAs would see a 1.6% decrease and facility based HHAs would receive a 1.9% decrease relative to CY 2024. In addition, HHAs located in rural areas would receive a 0.3% decrease, while those in urban areas are estimated to realize a 1.8% decrease. The difference in rural and urban providers is attributable to changes in wage index levels.

THAH provides Home Health services in twelve states. The negative impact of these proposed cuts to our organization is dire. After modeling the numbers, accounting for the impact of multiple facets of this proposed rule including wage index changes, our analysis confirms that we would suffer a reduction in our Medicare reimbursement of $4.9 million in CY 25. The results are depicted in the chart below:

State	CY25 Impact	Rule Impact
PA	($1,974,681)	-3.22%
OH	($1,021,873)	-5.80%
MI	($746,361)	-2.13%
CT	($571,005)	-5.37%
IL	($384,333)	-3.01%
IA	($334,709)	-1.44%
GA	($145,788)	-2.10%
NY	($53,408)	-0.49%
MD	$48,161	0.55%
DE	$53,966	1.13%
CA	$94,007	2.02%
IN	$102,651	1.94%
	($4,933,374)	-2.42%

In addition to the proposed cuts, HHAs continue to struggle with recruitment and retention of qualified Home Health staff. We have budgeted a 3.8% wage increase for FY25 that translates to an annual cost of $6.1 million. This proposed cut would severely inhibit our ability to reward and retain staff. This creates a substantial barrier to access as workforce challenges continue to impact the industry. THAH tracks the number of referrals we are unable to take due to open positions. We compared the number of denials for the period of January-June of 2024 and January-June of 2019, pre-pandemic workforce. **The increase in referrals we cannot take due to staffing challenges has more than tripled**. As recruitment and retention become more difficult this number will continue to grow. See below:

- **For dates Jan – June '24**
  22% of the Non-Admissions were because of Unable to Staff
- **For dates Jan – June '19**
  7% of the Non-Admissions were because of Unable to Staff

THAH is troubled that the data CMS uses to predict real inflation and cost of labor does not reflect the current landscape and will result in a fifth consecutive year where the payment update is not reflective of the actual cost increases HHAs are experiencing. THAH firmly believes increased labor costs are not transitory. The cost to adequately staff an agency with skilled workers is not going down. Many positions remain in short supply and competition for home health workers is only growing.

Although CMS does not have oversight of commercial payors, it is important that the Agency understand the challenge they pose. Commercial payors do not cover the cost of providing Home Health care, yet they are making record profits. Our choices are clear: we go out-of-network with these payors and further limit access for patients or agree to dismal terms that put their profits over fair payment. Equally infuriating, commercial payors have adopted the unconscionable practice of denying payment after care has been provided.

THAH recognizes that statutory constraints may limit the actions CMS may take and therefore, we urge CMS to continue to monitor the PDGM payment model and make no negative adjustments for CY 2025. As CMS has done in the past with historic disruptions to providers, we urge CMS to use its discretion to ensure reimbursement predictability so that HHAs can continue to care for patients.

THAH wishes to clearly make the point that further erosion of our reimbursement in Medicare is unsustainable. To coin a phrase, Home Health is dying a death by a thousand cuts.

We urge CMS to significantly increase the percentage update to account for the real expenses experienced by Home Health providers.

New Patient Assessment Requirements in Outcome and Assessment Information Set, (OASIS): In the CY 2023 HH PPS final rule, CMS announced that it would end the temporary suspension of OASIS data collection on non-Medicare/Medicaid HH agency patients, meaning that HH agencies would be required to submit all-payer OASIS data for purposes of the HH QRP beginning with the CY 2027 program year. In this rule, CMS proposes processes to operationalize this requirement. As previously finalized, CMS will conduct a voluntary phase-in period for HH agencies to begin all-payer data collection with start of care (SOC) patient assessments conducted beginning January 1, 2025, followed by mandatory data collection with SOC assessments conducted beginning July 1, 2025.

THAH opposed the inclusion of OASIS assessment prior to this proposed rule and we continue to disagree with the inclusion of data collection on non-Medicare/Medicaid HH patients. OASIS is a CMS tool that should not include patients' data that are not under a CMS payment. We view this as an unnecessary sharing of Protected Health Information (PHI). In addition, the Start of Care (SOC) documentation is cumbersome and time-consuming, taking a minimum of 90-minutes for each assessment. Commercial Payors already do not reimburse the full cost of care and this requirement will result in increased agency losses. **Therefore, THAH strongly opposes the finalization of this proposed rule.**

New Standard with the Conditions of Participation: CMS proposes to add a new standard within the Medicare Conditions of Participation that would require HH agencies to develop, implement and maintain an acceptance to service policy that is applied consistently to each prospective patient referred for home health care. If finalized, the policy would require annual reviews addressing a minimum set of criteria related to the HH agencies' capacity, case load and case mix as well as current staffing. The agency also proposes that HH agencies make public information about their services (as well as any limitations, such as lack of specialty services). CMS makes this proposal considering "the challenges of finding the right HH agency and resultant potential delays in the timely initiation of home health care," as well as the agency's concern that "HH agencies are at higher risk of overextending their available resources when accepting new patients." THAH believes that all agencies should have an acceptance policy. It will benefit consumers and referral sources as they review the quality and care options available to them, allowing them to pick the agency that will best meet their health care needs. **THAH supports this new standard**.

Long Term Care Infection Control Data Reporting: CMS proposes to make permanent the existing requirements for nursing homes to report data on respiratory illnesses through the National Healthcare Safety Network, (NHSN). Currently, nursing homes are required to report COVID 19 data on cases, hospitalizations, and deaths, among other information, through NHSN. The requirements are set to expire on December 31, 2024. However, in this CY 2025 Home Health PPS rule, CMS proposes to make NHSN reporting a permanent requirement and to expand the reporting to include data on influenza and respiratory syncytial virus (RSV).

CMS proposes that beginning on January 1, 2025, nursing homes report the following data on a weekly basis through NHSN:

- Facility census
- Resident vaccination status for COVID-19, flu, and RSV
- Confirmed resident cases of COVID-19, flu, and RSV (overall and by vaccination status)
- Hospitalized residents with confirmed cases of COVID-19, flu, and RSV (overall and by vaccination status)

Nursing homes are currently the only setting required to report COVID-19 data to CMS through NHSN. Reporting requirements for hospitals ended on May 1, 2024, and reporting requirements for dialysis centers ended with the PHE in May 2023. The provisions in this proposed rule would continue to require a pandemic-level frequency of reporting.

The process of entering and submitting data is time consuming and diverts staff from direct resident care. Ensuring accurate and timely reporting is a challenge for facilities who have limited resources and staff with expertise to use the NHSN system. End users at Trinity Health Senior Communities (THSC) report that the system is slow and there are lengthy delays even after entering small amounts of data. CMS should study end user experience and improve the application. THSC leaders also report long wait times with the help desk and in gaining access to the system.

Nursing home providers do not know what is happening with the data they provide. Providers at our homes describe the data as going into a “black hole,” “What is happening with all this data?” “Feels like busy work of no value.”

Reporting through NHSN presents privacy concerns. Sharing resident sensitive information increases the risk of privacy issues such as data breaches and unauthorized access.

Based on Federal Regulations F880 facilities are required to have “a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases”. The national database is a duplicative process. This material is already reviewed by surveyors during annual certification survey. Additional reporting outside of the public health emergency is not necessary.

Additionally, CMS requests feedback on collecting data regarding race, ethnicity, and socioeconomic status related to this reporting. This is already being reported through Section A of the Minimum Data Set, (MDS). Questions on race, ethnicity, and socioeconomic status were added to the MDS effective October of 2023. **There is no benefit to the duplication.**

CMS also proposes giving flexibility for additional reporting requirements to be added without notice and comment rulemaking any time there is a declared public health emergency (PHE) or significant threat of a PHE. These flexibilities could include:

- Requiring reporting at a frequency up to daily

- Adding or modifying data elements relative to the PHE including reporting of confirmed infections among staff, supply inventory shortages, staffing shortages, and relevant medical countermeasures and therapeutics inventory, usage, or both.

THSC agrees that in the event of a public health emergency reporting to NHSN makes sense. Many lessons were learned during the Covid-19 pandemic. Preparation and speed of response will be critically important for any future public health emergencies. **However, the continued reporting requirements to NHSN are duplicative, burdensome, and unnecessary. Trinity Health Senior Communities disagrees with the finalization of this rule.**

HH Quality Reporting Program: Proposed Adoption of Four New Standardized Patient Assessment Data Elements (SPADE) and Modification of One Current SPADE: Living situation, Food Affordability and Sufficiency, and Utilities. THAH believes strongly that these indicators do impact one's health and there is immense value in knowing the challenges a patient is facing. However, as stated above the Admission Assessment is already long and tedious and takes upwards of 90 minutes for the clinician to complete. We ask that as CMS is reviewing new data to collect at admission, it considers the importance of other questions and eliminate those that have less impact. Although the intent of adding more questions is not to lengthen the process, it is an unintended consequence. **Therefore, THAH requests that CMS further streamline the admission assessment questionnaire, so clinicians have more time for direct patient care.**

Requests for Information (RFI):

Measure Concepts Under Consideration for Future Years. CMS seeks public comment on the importance, relevance, appropriateness, and applicability of certain quality measure concepts for future use in the HH QRP. These concepts include:

- A composite measure of overall immunization status
- Initiation and engagement of substance use disorder treatment
- Clinical screening and follow-up for depression
- Pain management.

THAH supports these additional measures, especially if CMS considered reallocating the weighting of the three current sections (OASIS based outcomes, Preventable Hospitalizations/ER visits with no admission, and Patient Satisfaction). The more components/factors that go into determining a score, the more accurate the results will be. THAH consistently provides comprehensive care to sick patients. Improving the measures will help us do that.

Rehabilitative Therapists Conducting the Initial and Comprehensive Assessment: In this proposed rule, CMS seeks feedback on whether the agency should shift its longstanding policy and permit all classes of rehabilitative therapists to conduct the initial and comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care. Specifically, CMS requests information and data on the competencies and training of these professionals as well as any experiences during the PHE with rehabilitative therapists conducting assessments.

THAH is supportive of CMS allowing all classes of Therapists (PTs, OTs, STs) to conduct the initial and comprehensive assessment for cases that have both therapy and nursing services ordered.

THAH currently has Therapy conducting these assessments and initiating care on cases when only Therapy is ordered (no nursing is needed, ordered). CMS should carefully monitor risk that agencies will accept more referrals that also need nursing than what they have capacity for---resulting in a delay for the

patient in receiving nursing care. HHAs will need to monitor themselves closely and put actions in place to prevent/minimize this from occurring.

THAH's increased use of therapists during the PHE was positive, with only a few concerns. To make sure we did not increase our liability risk or endanger patients, we put processes in place to closely monitor our increased usage of therapists and provided additional training on performing a comprehensive assessment, assessment accuracy and creating a plan of care.

HHA Scope of Services: CMS seeks public comment on the factors that influence the services HHAs provide, the referral process, limitations on patients being able to obtain HHA service (such as rural location or staff availability), plan of care development, and communication with patients' ordering physicians. These RFI responses will inform CMS' policy decisions to improve the HHA referral process and ensure the timely and appropriate delivery of home health care.

The biggest factor that impacts our agency's ability to provide care is the shortage of quality clinicians—nurses, therapists, aides, social workers. THAH anticipates that this limitation will grow as our patient acuity increases, and we take care of increasingly more complex patients. Complex patients require more time and care. Additional limitations include under reimbursement and inflation and wage pressures. It is becoming increasingly harder for agencies to admit complex patients to service.

Medicare Advantage (MA) plans continue to be an obstacle to care by severely limiting the number of visits that they will approve for a patient to have---this is resulting in patients not receiving all the care they need. Prior Authorization, underpayment, and limiting visits should all be on the CMS radar as potential inhibitors to access of care.

THAH also experiences delays in physician response, which can significantly slow the admission process or change of orders needed to complete plan of care. This pressure is felt by many providers as physician services are stretched further and further. This issue threatens patient safety by delaying necessary care.

Future Approaches to Health Equity: In follow-up to the RFI in the CY 2023 HH PPS proposed rule, CMS shares an update on how the agency has been exploring several potential approaches for integrating health equity concepts into the HH VBP program. These approaches include:

- Potential definitions to define historically underserved communities, such as dual eligible status, Area Deprivation Index, and Medicaid as sole payment source as well as concepts measuring rurality
- A Health Equity Adjustment that would provide "bonus points" to a HHA's total performance score under the model if the agency serves a higher proportion of residents demonstrating certain social drivers of health like dual eligibility status; and
- Other health equity measures that assess performance on particular measures for specific underserved communities.

THAH does have concerns with this RFI. Many agencies are geographically located in areas where the population is not as diverse and thus not able to attain bonus points. Health equity might better be achieved if CMS increased the episode reimbursement rate for underserved communities.

Conclusion

Trinity Health at Home appreciates the opportunity to submit our comments on the proposed Home Health rule. If you have any questions, please feel free to contact Donna Wilhelm, VP of Advocacy and Government Relations for Trinity Health Continuing Care at donnaw@trinity-health.org.

Sincerely,

/Daniel Drake/

Daniel Drake, President and CEO
Trinity Health Continuing Care