Trinity Health At Home

August 29, 2023

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-1780-P: Medicare Program: Calendar Year 2024 Home Health Prospective Payment System Proposed Rule.

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 12 states; our average daily census is approximately 9,000 patients. We appreciate the opportunity to comment on CMS-1780-P, the FY 2024, 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 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations*, including 21 home health agencies, and 14 hospice agencies in 12 states*, the second largest PACE provider in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is $21.5 billion with $1.4 billion returned to 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 all providers of Home Health. We implore you to make changes. **Most importantly, we urge CMS to adjust the percentage update to account for real-time expenses experienced by Home Health providers**. If not, these proposed changes, coupled with underpayment from 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 will ultimately require care. The cost to deliver this care will grow. Home Care is not only where people prefer to receive care, but also a much 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 essentially push more people into high-cost care options by eliminating access to home health.

Our Comments are as follows:

2024 Proposed Payment Rates: In the proposed rule, CMS estimates that Home Health agencies (HHAs) will experience, in aggregate a 2.2% Medicare reimbursement cut as compared to FY 2023 rates. This decrease reflects the base payment rate increase by a net Market Basket Index of 2.7%, an estimated 0.2% increase that reflects the update to the fixed-dollar amount (FDL) that is used in determining outlier payments, and a 5.1% decrease that reflects the effects of the prospective permanent behavioral assumption adjustment. This decrease in Medicare payments will contribute to our growing staffing challenges. THAH is budgeting a 4.2% increase in salaries for FY 2024. This is in addition to significant sign-on bonuses for multiple disciplines, including RNs. This increase is critical to recruiting and retaining staff. We are experiencing an extreme shortage of home health aides nationwide for a variety of reasons. But the most compelling reason is we cannot compete with other industries in salary because our reimbursement simply does not allow us to do that. CMS does not reimburse agencies enough to ensure that individuals who work as home health aides make a living wage and receive benefits. They are instead electing to work in other industries that can simply raise their prices to account for higher wages. Healthcare providers operate on a fixed reimbursement, with no ability to shift costs to payors or consumers. They can only absorb the added costs out of the existing budgets, which are already strained from years of increased inflationary costs, staffing shortages and inadequate rate adjustments that fail to meet the demands of the current economic environment.

Many Home Health agencies, including our own, are at a tipping point. While CMS is only addressing the Medicare payment rate in this proposed rule, it does so at the neglect of Medicaid and Medicare Advantage reimbursement rates. Home Health agencies do not receive subsidies of any kind, such as Disproportionate Share (DSH) payment methodologies, which would allow for higher numbers of those served who are either uninsured or underinsured. It is important that CMS recognize those reimbursement rates as part of this equation and contributory to the fiscal sustainability of Home Health. CMS must address the Home Health payment rates in Medicaid and Medicare Advantage before attempting to correct for budget neutrality errors. Without this part of the equation, the true impact of these cuts is not yet recognized.

THAH is urging CMS to adjust the percentage update to account for real-time expenses experienced by Home Health providers. We advocate for evidence-based reimbursement rates from Medicare, Medicaid and Medicare Advantage that are sufficient to cover the full range of costs to provide high-quality care and services including supply needs, training, and fair wages for staff. In addition, THAH is proposing a 10-15% one-time increase to address the current workforce crisis.

Home Health remains a preferred solution to treat the growing frail and elderly population in a cost-effective and desired setting. THAH is committed to their care and understands the growing need. But, if this steep Medicare cut is realized, access for all will be diminished.

Home Health Quality Reporting Program (HHQRP): CMS is proposing two new measures to the HHQRP.

1. Discharge Functioning Score: THAH does have concern with the construct of this measure. We propose that the agency have full access to their measure data before including in the HHQRP. We also believe that the agency should have ample time to review the data prior to inclusion. THAH also has concerns around the accuracy of the expected functional score calculation and requests further clarification of the methodology.
2. Covid-19 patient vaccination: This new proposed measure does not allow for exclusions, such as patient refusal or contraindications as an exception to the measure calculation. THAH encourages CMS to include these exceptions to the measure. In addition, the definition of up-to-date under CDC guidance has potential to change. The proposal will require Home Health agencies to track CDC guidance on a quarterly basis and then adjust their processes to track whether patients have

received the doses equivalent to the up-to-date definition. This will create an added burden to adapt to any new recommendations. This will take additional time and staff resources. If CMS moves forward with this measure, THAH urges CMS to afford sufficient time for reporting each time the CDC changes recommendations.

THAH supports the CMS proposal 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."

Home Health Value Based Purchasing (HHVBP): CMS proposes changing the baseline year to 2023 for the 2025 performance year. THAH believes this change would cause disruption in our quality improvement program and strategies that are already implemented. We have worked to improve our quality using the 2022 data. Switching now could show an unanticipated consequence of failure to improve quality. We do not support changing the baseline year.

CMS is proposing modifying the quality measures used in HHVBP with the weight calibration beginning with the 2025 performance year. THAH does not believe we have sufficient data on the agency's performance and ability to strategize improvements if needed. This measure is untested in the Home Health setting and could cause disruptions in current and ongoing quality improvement strategies.

Home Health Quality Reporting Program Request for Information (HHQRP RFI): THAH agrees with the principles for Selecting and Prioritizing HH QRP Measures. However, we support the addition of stakeholder engagement, such as, technical expert panels.

HH QRP Measurement Gaps: Measurement gaps were identified in the domains of cognitive function, behavioral and mental health, and chronic conditions and pain management**.**

THAH does not support cognitive function and behavioral/mental health as a performance measure domain in home health care. This is impractical for the home health setting.

a. The behavioral health clinical group percent for 30-day periods of care consistently rates the lowest.

b. Most HHAs have limited time, resources, and expertise to provide interventions that would directly impact a patient's cognition, behavioral and/or mental health.

c. Only HHAs that have dedicated mental health divisions are positioned to impact a patient's behavior or mental health to any significant degree.

Access to Home Health Aide Services Request for Information: Why is utilization of Home Health Aides continuing to decline? THAH has experienced difficulty in recruiting and retaining Home Health aides. The workforce shortage for this discipline has only intensified since the pandemic. People are reluctant to enter the home of others for fear of exposure. In addition, the demand for higher wages has been challenging as other industries have enticed health care workers away from the field with offers often much more than our agency can compete with. This goes back to reimbursement and our inability to simply charge more to cover the cost of staffing. The further proposed rate cuts will only magnify this problem.

Hospice Program integrity and provider enrollment: THAH believes strongly in the value of Hospice for patients experiencing a terminal illness. We also believe that the integrity of the program should be protected from those entities who wish to profit from the unbridled growth and sale of Hospice licenses. As a not-for-profit, mission focused hospice provider, we applaud CMS for working to protect the reputation of

this important end-of-life service. However, for legitimate providers, like THAH who wish to expand their service area by acquiring existing hospice licenses, the Provisional Period of Enhanced Oversight (PPEO) does add a level of complexity that equates to increased administrative burden. We urge CMS to consider a 30-to-60-day review for providers with a long history of accreditation.

Categorical Risk Screening: THAH supports risk screening, but we request clarity on the "owner" fingerprinting proposed requirement. Trinity Health, as a not-for-profit corporation does not have a singular owner but a fiduciary Board of Trustees with oversight to the overall operations, financial management and regulatory compliance. As to whom CMS would require a fingerprint of is very unclear in this proposed rule and would need further defining.

36 Month Rule: CMS proposes to expand Section 424.550(b)(1) to require that when a hospice undergoes a change in majority ownership (CIMO) (more than 50 percent) by sale within 36 months after the effective date of its initial enrollment or within 36 months following the hospice's most recent CIMO, the provider agreement and Medicare billing privileges will not convey. This rule already exists in Home Health and THAH supports it under the Hospice rule. This will prevent easily selling off new hospice licenses to the highest bidder. THAH also supports the exceptions to the 36-month rule spelled out in the proposed change.

THAH also fully supports the proposed additional checkbox of ownership to include private equity and real estate investment trust. We believe it is important for patients to have a clear understanding of hospice ownership to fully vet a provider.

Special Focus Program: Quality and patient satisfaction are at the forefront of our work in Hospice daily. THAH has set standards high for our staff and providers to be certain we deliver on that promise. With that expectation, we support the Special Focus Program to ensure quality throughout Hospice nationwide.

Lymphedema Therapy Benefit: THAH fully supports Medicare coverage for lymphedema compression treatment items.

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 me at donnaw@trinity-health.org or 251-504-7353.

Sincerely,

/s/

Donna Wilhelm, Vice President of Advocacy and Government Relations
Trinity Health Continuing Care