UnityPoint at Home

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August 16, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1766-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1766-P - 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; published at Vol. 87, No. 120 Federal Register 37600-37683 on June 23, 2022.

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

Dear Administrator Brooks-LaSure,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Home Health rules for calendar year 2023. UnityPoint at Home is the Home Health Agency (HHA) affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment, pharmacy, palliative care, hospice care, and (in certain locales) public health. In 2021, UnityPoint at Home provided more than 322,000 visits to consumers in Iowa and Illinois. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the Center for Medicare and Medicaid Innovation's Global and Professional Direct Contracting Model, was an initial participant in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa and was a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. **As a member of National Association for Home Care & Hospice (NAHCH), UnityPoint at Home generally supports the formal comment letter submitted by NAHCH to this proposed rule.** In addition, UnityPoint at Home respectfully offers the following comments to the proposed regulatory framework.

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

CMS proposes a permanent 7.69% rate reduction for CY 2023. CMS also proposes a permanent 5% cap on

negative wage index changes for HHAs and to recalibrate the case-mix weights and LUPA (Low Utilization Payment Adjustment) thresholds using CY 2021 data.

Comment: UnityPoint at Home opposes the proposed permanent 7.69% rate reduction. On the heels of the COVID-19 pandemic when more health care services are being pushed to the community and patients' have expressed a desire for more home-based services, this rate reduction threatens access to home health services for Medicare beneficiaries and Medicaid members by threatening the financial viability of HHAs. This proposal is ill-advised as it is based on faulty assumptions without regard to actual data and access to services by all patients, including rural patients and Medicaid patients.

Despite minimal positive payment adjustments over the last several years, these adjustments have not kept pace with increased costs attributable to labor, technology, and mileage. Beginning in CY 2020, rate increases were decreased in part based on CMS's overly broad application of behavioral assumptions. **Under the current proposal to substantially decrease overall rates, 51.5% of freestanding HHAs nationwide are projected have a net overall negative margin.**[1] For Iowa and Illinois, these percentages are elevated – 65.1% and 53% respectively. Nationally, it is likely that this rate reduction will cause HHA closures, geographic service area reductions, and overall service reductions. As a nonprofit with small operating margins, UnityPoint at Home struggles with CMS' use of behavioral assumptions when data is available and relevant. **UnityPoint at Home reiterates our request that CMS employ a targeted approach to behavioral assumptions based on data from the PEPPER reports which is monitored and may be tied to value-based outcomes**. The continued reliance on behavioral assumptions by CMS is adversely impacting small and nonprofit HHAs.

Finally, **it is counterintuitive for CMS to reduce HHA funding when this funding underpins the success of the HHVPB program**. Elsewhere in the rule, CMS estimates that HHVPB will result in $3.4 billion of Medicare savings over four years extrapolated from the nine-state demonstration project. The projected cost savings did not include a permanent 7.69% rate reduction. We question the level of care that will result when HHAs are under-resourced and whether CMS financial bonuses will reflect similar outcomes.

UnityPoint at Home supports the 5% negative adjustment cap on a permanent basis prospectively.

HOME HEALTH QUALITY REPORTING PROGRAM (HHQRP)

CMS is proposing to require the collection and reporting of non-Medicare/non-Medicaid data for HHA patients. HHAs would be required to submit all-payer OASIS data for purposes of the HHQRP, beginning January 1, 2024. The CY 2023 20-measure set remains unchanged from last year.

Comment:

Clarifications Sought: UnityPoint at Home requests that CMS clarify the scope of this proposal. **First, the proposed rule appears to apply to all patients receiving skilled services without exception and regardless of payer – is this the intent of CMS?** Presently OASIS collection excludes pediatric and maternity patients as well as personal-care only patients. It is difficult to provide input on impact and administrative burden without understanding the scope of OASIS reporting. When populations currently

[1] National Association for Home Care and Hospice, 2022 comment letter to CMS-1766-P

excluded from HHA skilled services are intended to be included, this change can distort outcome data. **Second, it is unclear from the rule whether all-payer OASIS data will be stratified by payer and reflected as such on CMS quality measure reports – will all-payer data be stratified by payer?** Payer mix varies vastly by HHA, with percentages of Medicaid and Medicare patients generally higher for nonprofit HHAs. If OASIS data is not stratified, quality results will be skewed.

Delay in All-Payer Submission: As CMS contemplates launching an all-payer quality reporting system starting January 1, 2024, it is of note that OASIS-E is scheduled for implementation on January 1, 2023. With the adoption of any new reporting version, OASIS-E will likely take more than one reporting cycle to resolve kinks and assure accuracy. This rapid succession of reporting changes (e.g. all-payer reporting back-to-back with OASIS-E reporting) will increase assessment volumes and time/effort per assessment. These additional administrative requirements are on top of workforce shortages which are rampart nationwide and disproportionately impact health care. To equip HHAs to successfully submit all-payer data, **UnityPoint at Home requests CMS consider delaying the submission of all-payer data for one year, until January 1, 2025.**

OASIS Fundamental Omission: For CY 2023, the HHQRP includes 20 measures – 13 OASIS-based, 6 claims-based, and the CAHPS Home Health Survey. OASIS measures are used to monitor service quality and patient outcomes. Patient stabilization is not recognized within OASIS. In fact, **five of the 13 OASIS measures assume patient/functional improvement ("improvement" appears in the measure title), which is misaligned and even an inappropriate/unrealistic outcome for up to 40% of home health patients**. For this 40%, home health services are a result of a referral from the community and are not a post-acute care episode. For community referrals, the patient goal is stabilization or maintaining health quality/function, rather than outright or incremental improvement. Although we understand that the IMPACT Act (Pub. L. 113–185) required CMS to create a uniform quality measurement system to compare outcomes across post-acute care providers, Standardized Patient Assessment Data Elements (SPADE) measures should not apply outside post-acute care settings and should recognize and value stabilizing and maintaining a patient within the community.

For UnityPoint at Home, these community referral patients are also disproportionately covered by Medicaid. As CMS explores all-payer reporting, the outcomes on OASIS improvement measures for patients enrolled in Medicaid versus other payers should be examined for disparate impact. It would be inequitable for HHAs with heightened Medicaid payer mixes to be penalized in future HHQRP or HHVBP models.

HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

CMS is proposing to change the HHA baseline year from CY 2019 to CY 2022 for existing HHAs with a Medicare certification date prior to January 1, 2019, and change the Model baseline year from CY 2019 to CY 2022 starting in CY 2023.

Comment: As an initial participant in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa, UnityPoint at Home supports the expansion of the HHVBP to all states. **UnityPoint at Home also supports the CMS proposal to update the benchmark year**. Furthermore, **we encourage CMS to annually update**

the benchmark using a similar cadence – so for the 2023 proposed rule, the Model baseline year would change from CY 2022 to CY 2023 starting in CY 2024.

HOME INFUSION THERAPY SERVICES

CMS is updating the home infusion therapy services payment rates for CY 2023 as required by law. Section 1834(u)(3) of the Act specifies that annual updates to be equal to the percent increase in the Consumer Price Index for all urban consumers (CPI–U) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment for CY 2023.

Comment: UnityPoint at Home continues to be concerned with the overall approach to this benefit and have offered consistent commentary in our formal letters to CY 2019, 2020, and 2021 proposed rules. As currently structured, we still believe CMS has established a complex, costly and inefficient process for a very limited benefit.

As a result, this important benefit is underutilized according to the CMS' HIT Monitoring Report (January 2022).[2] The report indicated that only five suppliers are furnishing almost half of the total service visits. Within the last 60 days, both Optum Infusion and Corum (CVS Specialty Infusion Services) announced that they are closing a significant number of their home infusion pharmacy locations. We attribute the lack of participation in Medicare's home infusion benefit to its implementation scope coupled with an unclear definition of "infusion drug administration calendar day." Specifically, **the HIT benefit only reimburses HIT suppliers on days when a nurse is in a patient's home**. We also reiterate our concern that as structured **this benefit requires a 20% beneficiary co-pay for the processional services** that are not otherwise covered in full under the home health benefit.

REQUEST FOR INFORMATION: TELECOMMUNICATIONS

CMS is soliciting comments on the collection of data on the use to telecommunications technology under the Medicare Home Health Benefit beginning July 1, 2023. CMS is proposing the use of three new G-codes identifying when home health services are furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system; synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system; and the collection of physiologic data digitally stored and/or transmitted by the patient to the HHA (e.g., remote patient monitoring). Comments may include other G-codes and relevant clinicians.

Comment: UnityPoint at Home supports the use of the three G-codes as proposed. Beyond the three codes that are specified, we believe that unnecessary coding complexities will result from additional G-codes specifying clinician type or services provided. Instead we suggest that CMS consider utilizing a modifier to G-codes for these purposes as was instituted during the COVID-19 public health emergency for physician services.

REQUEST FOR INFORMATION: HEALTH EQUITY

CMS is seeking stakeholder feedback on efforts around health equity measure development for the Home

[2] "From Q1 2019 to Q1 2021, the quarterly average of HIT service visits remains low" - https://www.cms.gov/files/document/hit-monitoring-report-january-2022.pdf

Health QRP and the potential future application of health equity in the Expanded HHVBP Model's scoring and payment methodologies.

Comment: UnityPoint at Home values health equity and focuses on reducing care variation with all patients no matter race, ethnicity, gender, sexual orientation, or other demographic or social risk characteristics. UnityPoint at Home appreciate CMS' commitment to addressing health equity and looks forward to partnering with CMS in advancing this important focus. We have provided additional comments below, which aligns with UnityPoint Health's formal comments to CMS-1752-P, Hospital Inpatient Prospective Payment Systems proposed rule:

- Additional Measure Stratification. In order to accurately focus on driving palpable change in health equity, measure stratification becomes vital to the process. **Stratification must be robust to highlight variations in local market populations, including imbalanced race/ethnicity distributions or other identified equity attributes.** For less densely populated areas where imbalanced populations tend to exist, results can be disproportionately impacted by sentinel events to minority populations as compared to highly populated urban locations with greater balance. Existing quality measure serve well to define health care quality, but equity should be defined as gaps in these measure amongst attributes and targeted for improvements. UnityPoint Health and UnityPoint at Home recommend "descriptive" modeling using traditional predictive modeling techniques to study equity imbalance by only including equity attributes as models features with the health measure as the target, fitting a predictive model, and then examining the feature importance. Highly predictive features in this context suggest the type and magnitude of equity imbalance in a given population. In conclusion, **UnityPoint Health and UnityPoint at Home strongly discourage use of an algorithm to estimate race and ethnicity and recommends using existing quality measures utilizing predictive modeling techniques to study health disparities.**

- Expanded Demographic Data Collection/Reporting. In order to accurately measure data, the data itself must be of high quality. Challenges exist today in effectively capturing this type of information. Manual collection by health providers leads to high administrative burden and would require standardized data collection protocols, many of which do not exist today. However, UnityPoint Health and UnityPoint at Home agree collection of self-reported data is the most precise method to capture current and accurate race and ethnicity information. Data lag can be significant between census surveys and performance periods and high variance, even at the census block level, given social determinates of health (SDOH) factors. Using a proxy would still require patient addresses to map to census locations identifiers. UnityPoint Health has a 55%-60% match rate when taking patient addresses, geocoding to a census block, and joining results. While proxies are not ideal for capturing data, should CMS choose to continue development utilizing this method, it will be imperative for health care providers to have the opportunity to address self-identified inaccuracies as well as a process to appeal data and outcome results should they deem appropriate. **UnityPoint Health and UnityPoint at Home urge CMS to consider offering health care providers financial assistance to develop and deploy health equity efforts, including funding support in addressing the capture of self-reported data,** a gold standard as noted by CMS**.**

- Challenges to Health Equity Measurement. UnityPoint Health and UnityPoint at Home are supportive of health equity and developing a framework for measuring so that health care providers can be transparent and accountable in closing the gap in health equity. CMS should consider:
  - **Development of standard data definitions**, taking into account diverse patient populations and a variety of geographical regions.
  - **Establishment of a diverse stakeholder taskforce** to partner with CMS and ensure effective, accurate and actionable measurement.
  - **Standardization of the use of "equity"** as defined in the Executive Order on Advancing Racial Equity and Support for Underserved Communities.

While UnityPoint Health and UnityPoint at Home appreciate the Administration's pervasive emphasis on health equity through the rulemaking process and its interest in closing disparity gaps, the measurement framework is still within the early development phase and its impact on reimbursement and operations is unclear. **We encourage CMS to be thoughtful of these provider implications and to use a carrot approach, not a stick approach. We recommend CMS to study the large variation in defining health equity as well as additional ways in which to accurately collect and measure demographic and social risk factors.** UnityPoint Health and UnityPoint at Home look forward to partnering closely with CMS in future efforts driving health equity.

ADDITIONAL INPUT – AT HOME CARE DELIVERY AND PAYMENTS

In November 2020, CMS announced the Acute Hospital Care at Home waiver, building upon the Hospital Without Walls program. Acute Hospital Care at Home is for beneficiaries with defined acute conditions who require acute inpatient admission to a hospital and who require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis.

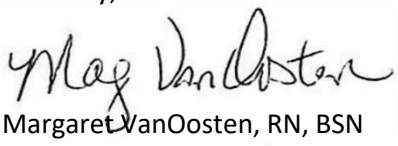
Comment: With the inevitable end of the Public Health Emergency (PHE), CMS should consider facilitating a demonstration program to test and create case uses beyond the limited diagnoses currently recognized under the Acute Hospital Care at Home waiver. UnityPoint Health, under the leadership of UnityPoint at Home, was one of the first six health systems with extensive experience providing acute hospital care at home approved for the new hospital waiver. UnityPoint Health was the first to enroll a patient and to bill and be reimbursed under this waiver. As of June 8, 2022, 105 health systems with 239 hospitals in 36 states have applied and been approved to participate in this waiver. Given the infrastructure investment needed to stand up this program and the uncertainty of its duration being tied to the PHE, it is likely that more hospitals would participate under a program that has a longer duration and regulatory standing. **UnityPoint at Home encourages CMS to continue a platform to test the Acute Hospital Care at Home services upon the termination of the PHE.**

Additionally, UnityPoint at Home would welcome the opportunity to further discuss the potential for operationalizing a full array of Medicare At Home services with CMS. While we recognize that CMS stood up the hospital at home waiver as a result of the COVID-19 pandemic to avoid exposure to and spread of the COVID-19 infection, its efficacy beyond the pandemic is undeniable. Best practices and lessons learned from shifting care delivery to patients' homes should be built upon, with the purpose of expanding At

Home services from other care settings. UnityPoint at Home has implemented an At Home care model that is a safe, high quality and cost-saving alternative for patients. By shifting care to home with the proper supports, UnityPoint at Home has maintained high patient satisfaction rates (99+%) and achieved outstanding clinical outcomes, including markedly reduced readmission and preventable ED visit rates. This was accomplished through a post-acute care bundling strategy under an accountable care organization waiver in which appropriate services are wrapped around the patient. Our bundles include a hospital to home (2-hour response time), primary care at home (4-hour response time), palliative care at home, and skilled nursing facility at home. In 2023, UnityPoint at Home will offer At Home services in some of our commercial health plan contracts.

We are pleased to provide input on this proposed rule and its impact on our patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,



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