August 27, 2021

Submitted via Regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, Maryland 21244-1850

Re: CMS–1747-P: 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

Dear Administrator Brooks-LaSure:

I am writing on behalf of Visiting Nurse Association Health Group ("VNA Health Group") to provide comments on the payment and policy changes in the Centers for Medicare and Medicaid Services' ("CMS") CY 2022 Home Health Prospective Payment System ("HHPPS") proposed rule ("Proposed Rule").[1] VNA Health Group greatly appreciates the opportunity to comment on this Proposed Rule. I have also included our responses to the CMS information request regarding "Advancing Health Information Exchange" and "Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs," which are attached hereto as Exhibits "A" and "B", respectively.

As you may know, VNA Health Group is one of the largest non-profit providers of Medicare home health services in New Jersey and is also one of the largest non-profit home health providers across several geographies serving Medicare beneficiaries, including Northeast/Mid-Ohio and Southern Florida. It is driven by its dedication to its Mission, which is expressed in every patient visit by its staff of compassionate and caring health care professionals. VNA Health Group also provides extensive home health services to people with Medicaid, those who are affected by persistent poverty and inequality, and those with no insurance at all. By providing home health care, hospice, visiting physician services and community-based care, VNA Health Group builds on an organizational history of over 100 years to serve vulnerable populations such as the elderly, at-risk children, those with disabling and chronic illness, and people facing the end of life. The population we serve spans individuals across racial, ethnic and socio-economic and minority statuses. VNA Health Group is dedicated to helping individuals and families achieve their best level of well-being, and provides compassionate, coordinated, innovative and cost-effective care in the homes and communities it serves. The critical, essential key to unlocking these services for our patients is our dedicated clinical and operational staff, without whom none of our Mission

[1] 84 Fed. Reg. 35874 (July 7, 2021).

would be fulfilled. Competition for skilled and unskilled workers to serve our patients, especially in smaller markets in New Jersey adjacent to larger ones like New York City, is fierce. CMS' support for payment policies that recognize these differentials, and compensate them fairly, has been essential to our ability to attract and retain a talented, dedicated and compassionate workforce.

VNA Health Group has been proud to partner with CMS in improving its home health, home care, and hospice programs. We have served as a lead agency for the implementation of several Centers for Medicare and Medicaid Innovation initiatives including: Community-Based Care Transitions Demonstration Program; Medicare Choices Model; Comprehensive Primary Care Plus; and Integrated Care for Kids. In all of these models we have invested substantial time and resources in collaborating with CMS to develop and evaluate the possibilities of new models of home care.

Nonetheless, the current COVID-19 pandemic has been a true test of VNA Health Group's resolve to continue to fulfill its Mission. Our dedicated team of workers, nothing short of "healthcare heroes," has been crucial in the pandemic response. Despite significant risk to their own health and safety, these heroes stepped up (and continue) to serve acutely ill COVID-19 patients of all demographics to help offload hospitals and emergency rooms during surge periods. As many of our own staff took ill from the SARS CoV-2 virus, their coworkers worked longer hours and assumed extra shifts to ensure that vulnerable, at-risk patients got the care they needed. We are concerned about the current Delta variant surge as well. According to New Jersey Hospital Association reports there has been a fourfold increase in the number of people hospitalized in Central New Jersey with COVID-19 in just the past month (7/15 - 8/16). We know as this surge expands, and before vaccine boosters can be distributed to the elderly, we will be called on to help bring and keep more people safely home. The challenges of the pandemic are far from over in our communities.

In addition, and due to our unique position as a community health provider, we recognized that many people who wanted protection against the SARS CoV-2 virus lacked access to COVID-19 vaccines because they were homebound. We piloted a "Vaccine at Home" program to deliver vaccines to homebound patients and their families and became one of the highest performers in New Jersey in terms of the number of homebound COVID-19 vaccinations administered. In an even larger initiative, we partnered with the VNA of Central Jersey Community Health Center (comprised of four Federally Qualified Health Centers) to help to deliver nearly 90,000 doses of COVID-19 vaccine – most of which were in administered in disadvantaged, underserved, minority communities.

Separately and unfortunately, we are now gravely concerned that we face an even more dire and perhaps insurmountable economic situation based on a proposal in the Proposed Rule that we respectfully request CMS mitigate. We refer to a dramatic reduction in our area wage index (AWI) that, if unadjusted, will strike at the very heart of our ability to serve our Mission. By reclassifying several of the counties we serve, the Proposed Rule would result in a seventeen percent (17%) decrease in our Medicare AWI. We respectfully urge mitigation on behalf of the communities we serve and on behalf of our Mission.

In the CY 2021 Home Health Agency Final Rule[2], CMS finalized a proposal to adopt revised Office of Management and Budget (OMB) geographic delineations. Due to concerns regarding the significant financial impact of this change on home health providers in certain areas due to steep decline in wage index values that resulted, CMS also finalized a one-year 5 percent cap on wage index reductions to mitigate substantial financial impacts on home health providers – a policy that

[2] 85 *Fed. Reg*. 70298 (November 4, 2020)

was extended to acute care hospitals in the FY 2022 Hospital Inpatient Prospective Payment System Rule. The Proposed Rule would end the transition in 2022 – an outcome so adverse that without further mitigation, we will be forced to curtail services and limit access to populations in need. Accordingly, we respectfully request that CMS reverse the Proposed Rule and reinstate the 5 percent cap for 2022 for home health providers.

We have also provided responses to CMS' requests for information regarding advancing health information exchange and closing the health equity gap in post-acute care quality reporting programs, in Exhibits "A" and "B" hereto.

FY2022 Wage Index

As noted above, we wish to express our serious concerns with the agency's proposal to use the FY 2022 pre-floor, pre-reclassified hospital wage index with no 5 % cap on decreases as the CY 2022 wage adjustment to the labor portion of the Home Health Prospective Payment System rates.

To further elaborate on the peril facing our communities if the 5 % cap is not reinstated for 2022, four New Jersey counties (Middlesex, Monmouth, Ocean, and Somerset) will shift from their previous CBSAs to a newly created CBSA for FY 2021. Together these counties represent our largest patient catchment areas and demand the bulk of our services. The shift to the new CBSA will force substantial financial rearrangements; CMS itself noted it will result in a nearly 17 percent decrease in the wage index for the impacted providers. Further, the new CBSA has a wage index that is 25% lower than the New York Metro CBSA, which is a significant competitor for healthcare related workers and within commuting range of the counties affected.

While CMS did provide transitional relief to affected providers in the form of a 5% cap on any decrease in a facility's wage index from the previous year (a policy that was recently extended for acute care hospitals for an additional year), this additional transitional relief was not proposed to be applied to the CY 2022 Home Health Prospective Payment System.

Without a transition policy in place, and in particular the 5% cap for 2022, the CBSA change and other reductions in the wage index in New Jersey will be catastrophic to the VNA Health Group. It will result in overall Medicare home health payment reductions to VNA Health Group of more than $11M per year. Our VNA Health Group hospice care providers are also projected to experience $3M in cuts annually, resulting in an overall revenue reduction of more than $14M. As a non-profit, this would prove disastrous. Unlike for-profit entities, we do not have access to capital markets and commercial lenders to make up this shortfall, and even if we did have access we would never be able to service such a debt load. We already depend heavily on charitable donations to support many of our health programs and would never be able to make up these projected losses through a charitable giving campaign. Nor can we lean on our patrons; our donor base is already significantly diminished from the extra they were able to give during the pandemic.

The timing of the Proposed Rule is particularly deleterious for home health providers, generally, and for VNA Health Group in particular. The COVID-19 pandemic continues to severely disrupt the care delivery system, bringing significant financial pressures throughout the industry. A recent survey by the National Association for Home Care & Hospice found that 45.8% of home health agencies in the New York/New Jersey COVID-19 "hot spot" experienced revenue reductions greater than

15% and that 37.6% of those providers reported revenue reductions of greater than 20%.[3] This is in addition to significant, COVID-19 related cost increases that far exceed the financial supports that have been provided to home health agencies through the CARES Act Provider Relief Fund and other relief mechanisms.

The revenue reductions affected VNA Health Group disproportionately hard. In order to continue to operate, we had to furlough or even lay off non-essential workers; we implemented across-the board salary reductions; and we reduced or eliminated employee benefits. To protect our home health staff, we not only followed state and federal guidance but also implemented additional COVID-19 protocols that included two-person safety teams, heightened safety training, and disinfecting washes prior to and after each visit – all without any additional reimbursement for the visits that we made. Because of Small Business Administration rules around organization size, we did not receive grants or loans to cover payroll and other expenses.

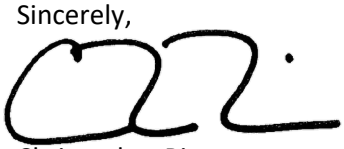
After weathering that storm, we are now facing significant staffing shortages, as those same nurses, therapists, and other providers we relied on to get us through that time are exhausted. They are burned out, afraid, and have little more left to give. They balk at reentering a home health employer where they have been asked to make sacrifice after sacrifice – with little to no reward. A cut of this magnitude would severely impact our ability to pay competitive wages to retain our current staff or recruit new providers, especially when those same providers could travel a very short distance to the New York Metro CBSA, with its 25% higher wage index. Without adequate staff, VNA Health Group would not be able to accept referrals for the frail elderly and vulnerable patients at the core of our service population.

Without a transition policy to mitigate the effects of the newly created CBSA, it is likely that our organization will be unable to continue providing care for New Jersey's most vulnerable patients.

Therefore, on behalf of the VNA Health Group – an organization currently facing increased costs, reduced revenue, and significant reimbursement cuts amid the ongoing COVID-19 crisis, we ***strongly urge CMS to adopt a transition policy for home health providers that mirrors the 5% cap on AWI reductions included in the FY 2022 Hospital IPPS Final Rule (CMS-1752-F). In addition, we ask that the new CBSA wage index be reevaluated using more current wage data, include information from the 2020 Census, and that it be updated for FY2023.***

VNA Health Group greatly appreciates the opportunity to comment on the Proposed Rule. Should you have any questions regarding any aspect of these comments, please contact me at 848-231-1207 (mobile) or Christopher.rinn@vnahg.org.

Sincerely,



Christopher Rinn
Chief Government Affairs Officer
Visiting Nurse Association Health Group

[3] National Association for Home Care & Hospice (2020). National study shows home health care is in a fragile state. Available at: https://www.nahc.org/wp-content/uploads/2020/03/NATIONAL-SURVEY-SHOWS-HOME-HEALTH-CARE-ON-THE-FRONTLINES-OF-COVID-19-AND-CONTINUES-TO-BE-IN-A-FRAGILE-FINANCIAL-STATE.pdf

EXHIBIT A

Request for Information: Advancing Health Information Exchange

- What EHR/IT systems do you use and do you participate in a health information exchange (HIE)?
    - Homecare Homebase
    - New Jersey Health Information Network (NJHIN)

- How do you currently share information with other providers and are there specific industry best practices for integrating SDOH screening into EHRs?
    - Most data sharing is electronic. Physicians can access the EHR to review and sign plans of care. With other providers, there is the capability to send secure electronic documents (e.g. PDFs).
    - Recommended SDOH screenings that could be implement into EHRs: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and Health Leads SDOH Screening Tool.

- What ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to HHAs?
    - Healthcare providers need to be reimbursed for introducing innovative technologies due to the cost of supporting these services. One approach would be to provide a bonus payment if patient outcomes can be improved by utilizing technology and reducing beneficiary expenses. For example, giving a bonus payment to organizations that successfully deploy technology (e.g. virtual care) and improve patient outcomes and reduce the overall cost of care (e.g. reduce readmissions).

- What additional resources or tools would post-acute care settings, including but not limited to HHAs, and health IT vendors find helpful to support testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?
    - CMS needs to mandate that vendors use the FHIR standard to share information that is not only used for quality reporting but also among all the vendors that supply electronic tools for HHA's. For example, currently if an HHA selects a new digital wound management software application, there is no standard approach for sharing data between the EMR and the wound application. The same is true with remote patient monitoring, patient portals, medication management applications, etc. Every new technological advancement that requires data sharing, is currently an opportunity for EMR vendors to charge for a new interface. FHIR and APIs can help to reduce the cost of new implementations and potentially improve care delivery.

- Would vendors, including those that service post-acute care settings, including but not limited to HHAs, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?
    - It is likely that vendors would participant in pilots. However, CMS and vendors will need to consider the cost and timeline of the pilot. Consideration should not only be given to involving large EMR companies but also smaller companies that are innovating in wound care, remote patient monitoring and virtual care platforms.

EXHIBIT B

Request for Information: Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

- We are seeking comment on the possibility of expanding measure development, and the collection of other Standardized Patient Assessment Data Elements that address gaps in health equity in the Home Health Quality Reporting Program
    - The OASIS-E will improve the data gathered on race, ethnicity and other SDOH. In the future, it will be possible to better understand the health equity gaps by looking at how these patient characteristics may influence access to care, timeliness of receiving care and risk adjusted outcomes. In addition, the information can be used to assess the types of patients served by providers in a specific geographic area.

- Recommendations for how CMS can promote health equity in outcomes among HHA patients. We are also interested in feedback regarding whether including HHA-level quality measure results stratified by social risk factors and social determinants of health (for example, dual eligibility for Medicare and Medicaid, race) in confidential feedback reports could allow HHAs to identify gaps in the quality of care they provide
    - Stratified health outcomes would be helpful to organizations attempting to reduce health disparities. It also would be useful to explore having separate risk adjustment models within payer categories (Medicare, Medicaid and Dually Eligible) because patients in these groups are not the same with respect to comorbidities, age and other factors and it may make it easier to identify health disparities.

- Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate.
    - Currently at the agency level, OASIS data is used to analyze outcomes using payer information, race/ethnicity, age and zip code. These analyses can be used to identify health disparities of specific populations.

- Given the importance of structured data and health IT standards for the capture, use, and exchange of relevant health data for improving health equity, the existing challenges HHAs encounter for effective capture, use, and exchange of health information include data on ethnicity and other social determinants of health to support care delivery and decision-making.
    - HHAs can capture and communicate structured data related to health equity and the social determines of health. In fact, the OASIS-E will support these efforts. However, without similar structured data from other providers and IT standards it is highly unlikely that this information will be shared with HHAs. CMS needs to recommend the adoption of a standard set of SDOH data elements and require that the information be shared electronically among providers.