August 22, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1803-P

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

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

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Calendar Year (CY) 2025 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services Rate Update; and Other Medicare Policies (CMS-1803-P) proposed rule which was published in the July 3, 2024 *Federal Register*.

In our detailed comments below, Premier urges CMS to:

- Advance a final rule that results in significant home health payment increases for CY 2025;
- Revise its existing definition of infusion drug administration calendar day to allow for reimbursement of home infusion professional services each day that an infusion drug physically enters the patient's body, irrespective of whether a skilled professional is in the individual's home;
- Address persistent issues that may limit the ability of providers to report social determinants of health (SDOH) data elements and ultimately the accuracy of this data;
- Expand value-based purchasing measures through the Universal Foundation initiative that uses quality measures that apply to as many CMS quality-rating and value-based care programs as possible;
- Reward home health agencies with a health equity adjustment through a methodology that sets a 70 percent payback percentage each year under the value-based purchasing model; and
- Work with Congress to advance incentives for the apportion of interoperable electronic health information technology to support efficient reporting for long-term care facilities, including the acute respiratory illness data reporting proposal.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 325,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and

contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

In the proposed rule, CMS estimates that Medicare payments to Home Health Agencies (HHAs) in CY 2025 under the Home Health Prospective Payment System (HH PPS) would decrease in the aggregate by -1.7 percent compared to CY 2024. This decrease reflects the proposed 2.5 percent increase to the home health payment update percentage, a 3.6 percent statutory decrease to account for behavioral assumptions related to implementation of the Patient-Driven Groupings Model (PDGM), and a 0.6 percent decrease to account for outlier payments.

Premier shares the concerns of CMS and many other stakeholders regarding the fiscal instability of HHAs resulting from the combined effects of skyrocketing labor costs, inflation, the COVID-19 public health emergency (PHE) and the payment reforms resulting from the PDGM that was first implemented in CY 2020, just weeks before the PHE began. While the PHE ended over a year ago, its impact on HHA's financial stability still persists. In addition to PHE disruptions, Premier is concerned about the negative effects of labor costs and overall inflation on HHAs. Any disruption in payment to home care providers is likely to have unintended consequences on direct patient care as HHAs and other ancillary providers, such as home infusion providers, are impacted by payment reductions.

Premier is also concerned 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 now and into the future. Premier firmly believes increased labor costs are not transitory. Long before the PHE, many staff were in short supply and growing closer to retirement age. For example, according to pre-pandemic research published in 2018, healthcare was projected to be short more than one million nurses by 2020 as a result of nurse retirements, an aging U.S. population and a stagnant talent pipeline.[1] Since that time, the effects of the pandemic have only exacerbated matters, prompting a significant increase in clinician resignations and retirements; for example, more than 500,0000 nurse retirements were estimated for 2022.[2] A recent analysis finds that by 2025, it is expected that the United States may have a gap of between 200,000 to 450,000 nurses available for direct patient care, equating to a 10 to 20 percent gap.[3]

The combined effects of a strained labor market, inflation, implementation of the PDGM, and the lasting effects of the PHE ***lead Premier to urge CMS to advance a final rule that results in significant home health payment increases for CY 2025***. Premier recognizes that statutory constraints may limit the actions CMS may take and therefore, we urge CMS to continue to monitor the PDGM 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.

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[1] Zhang, Ziaoming, et al., "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit," American Journal of Medical Quality, 2018, Vol. 33(3) 229–236, https://edsource.org/wp-content/uploads/2019/02/Zhang-Daniel-Pforsich-Lin-2017-United-StatesRegistered-Nurse-Workforce-Report-Card-and-Shortage-Forecast_-A-Revisit.pdf
[2] American Nurses Association, "Nurses in the Workforce," https://www.nursingworld.org/practice-policy/workforce/
[3] McKinsey & Company, "Assessing the Lingering Impact of COVID-19 on the Nursing Workforce" May 11, 2022, https://www.mckinsey.com/industries/healthcare/our-insights/assessing-the-lingering-impact-of-covid-19-on-the-nursing-workforce

III. MEDICARE COVERAGE OF HOME INFUSION THERAPY SERVICES

In previous comments on CMS rulemaking (CMS-1689-P, RIN 0938-AT29, CMS-1689-FC, RIN 0938-AT29, CMS-1711-P, 0938-AT68, CMS-1730-P, RIN 0938-AT-06, CMS-1474-P, CMS-1766-P, CMS-1780-P), ***Premier has raised serious concerns that CMS adopted a narrow and inappropriate definition of "infusion drug administration calendar day" that only reimburses when a skilled professional is present in a patient's home***. The definition oversteps Congressional intent in passing the services payment structure in section 50401 of the Bipartisan Budget Act of 2018 (BBA) (Pub. L. 115-123) and section 5012 of the 21st Century Cures Act of 2016 (CURES) (Pub. L. 114-255). It is concerning that CMS continues to move forward with a home infusion therapy (HIT) policy that runs counter to the government's overall goals of moving high quality patient care to the most clinically appropriate and less expensive care settings.

Premier's concerns are rooted in the belief that inadequate payment creates patient access barriers to HIT services. Strong evidence to reinforce this belief comes from CMS' own data, released in February 2024, showing that the HIT benefit, has failed to attract a sufficient number of providers to ensure equitable access to HIT services and that structural reform of the Medicare HIT benefit is necessary in order to establish equitable access to services across the U.S.[4] The CMS report finds that only 60 providers billed for HIT services in the second quarter of 2023, despite that there are almost 1,000 home infusion pharmacies; 11,000 home health agencies and a significant number of other providers that have the ability to provide these services. Similarly, with the large number of patients who can benefit from HIT, the report showed that fewer than 1,300 patients were billed for HIT services in each quarter that the data was collected. Indeed, Premier has heard anecdotally from our members across the continuum about the challenging decisions they must make for their Medicare patients as a result of CMS' implementation of the benefit. Further, no other payors – commercial, Medicare Advantage, the Veterans Administration – require a professional to be physically present in the home to reimburse for a patient's HIT services. Clearly, the Medicare HIT benefit must be revised to ensure patient access and to conform with Congressional intent.

Premier repeats its call for CMS to revise its existing definition of infusion drug administration calendar day to be consistent with Congressional intent and to allow for reimbursement of home infusion professional services each day that an infusion drug physically enters the patient's body, irrespective of whether a skilled professional is in the individual's home.

IV. HOME HEALTH QUALITY REPORTING PROGRAM (HHQRP)

Proposed New Patient Assessment Data Elements

CMS proposes to collect four new items as standardized patient assessment data elements in the SDOH category beginning with the CY 2027 HH QRP via the Outcome and Assessment Information Set (OASIS). The four assessment items proposed for collection are: one living situation item, two food items, and one utilities item.

Premier supports expanding the HHQRP to include additional elements capturing SDOHs. ***Premier encourages the agency to consider ways to address persistent issues that may limit the ability of HHAs to accurately capture SDOH data elements, including additional guidance and resources.*** Staff responsible for administering the OASIS will need additional guidance as they often see a listing of SDOH information in the patient's history, but nothing documented on how the SDOH is related to an associated problem or risk factor directly. Many times, this impact is inferred from the information in the record but not fully documented specifically by the provider, which complicates an already arduous process. Similarly, providers may not be accustomed to routinely capturing this information as part of their provision of care for a patient and may thus require training and education. Additionally, expressing certain social risk factors, such as living

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[4] CMS and Abt Associates. Home Infusion Therapy Monitoring Report. February 2024.
https://www.cms.gov/files/document/hit-monitoring-report-feb-2023.pdf

situation, food and utilities, can be uncomfortable for patients, which could result in underreporting. As a result, the SDOH data elements may not accurately represent the entire population.

V. EXPANDED HOME HEALTH VALUE-BASED PURCHASING (HHVBP-E) MODEL

Future Performance Measure Concepts for the Expanded HHVBP-E Model

In the rule, CMS includes a request for information on performance measure concepts changes to the HHVBP-E model that would continue the implementation of the model that began with the 2023 performance year. ***Premier commends CMS for advancing the HHVBP-E and supports arrangements that allow providers to develop innovative approaches for delivering care in value-based arrangements.*** As CMS considers adding performance measures to the HHVBP-E, ***Premier encourages CMS to advance a building-block approach through the "Universal Foundation" initiative that uses quality measures that apply to as many CMS quality-rating and value-based care programs as possible***[5]. This approach allows CMS to test and analyze measures across settings that supports advancing measures that are valid and reliable and gives providers consistency with reporting requirements.

The U.S healthcare system is at a critical juncture in which we must rapidly scale alternative payment approaches that allow providers to be in the driver's seat of care transformation. Providers with their local roots and direct role in care delivery are best situated to design population health solutions that are targeted to the needs in their communities, including addressing health equity. Moreover, moving from fee-for-service (FFS) to value shifts the fundamental incentives from reactive, sickness-based care to proactive, wellness-based care. Without this change, the incentive to achieve health equity is significantly undermined. This will require new partnerships between payers and providers that incent providers to be responsible for the quality and cost of care.

Health Equity in the HHVBP-E Model

In the proposed rule, CMS discusses how the HHVBP-E could advance the same Health Equity Adjustment (HEA) approach that will begin in the Skilled Nursing Facility (SNF) VBP starting with the FY 2027 program year. Under the SNF policy, the HEA is calculated using a methodology that considers a SNF's performance on quality measures and the proportion of the SNF's residents with residents with dual eligibility status (DES). SNFs that perform well on the SNF VBP quality measures and serve a higher proportion of residents with DES will earn HEA bonus points. ***Premier supports rewarding HHAs with a HEA to account for the operational challenges and high costs of care for certain patients.***

Recognizing that DES is one of many elements when considering health equity, ***Premier encourages CMS to continue its work to test, refine, and advance additional measures that produce a valid health equity measures for the HHVBP-E. Prior to moving forward with health equity measures for the HHVBP-E, Premier encourages CMS to first assess the impact of health equity measures CMS has implemented in non-HH care settings.*** Through this process CMS should develop consistent methodology for measuring health equity that is applicable across all care settings, including HHAs***.*** Further, should CMS advance a HEA for the HHVBP-E model, it is essential that ***the percentage payback be increased to cover the HEA. Premier strongly encourages CMS to structure the HEA methodology that will result in a 70 percent payback percentage each year*** – the maximum authorized in statute under section 1888(h)(5)(C)(ii)(III) of the Social Security Act. This will provide additional incentives to high performing HHAs and accelerate CMS efforts to advance health equity.

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[5] Aligning Quality Measures Across CMS – The Universal Foundation, New England Journal of Medicine, February 1, 2023, https://www.nejm.org/doi/full/10.1056/NEJMp2215539

VI. Long-Term Care (LTC) Facility Acute Respiratory Illness Data Reporting

CMS proposes replacing the current COVID-19 reporting standards for LTC facilities, which sunset at the end of CY 2024, with a new standard that addresses a broader range of acute respiratory illnesses. ***Premier continues to urge CMS to weigh the reporting burden on providers against any potential benefit gained from data collection, especially during any future PHE.*** The main priority for providers in a PHE is ensuring patients are getting the care that they need. For example, collecting and reporting patient-level data requires providers to invest significant human and monetary resources to ensure they have the processes in place to track this information. CMS should work with state governments, local health departments and the provider community to better identify how data could be shared across entities and the type of data that would be valuable in responding to PHEs.

Premier is pleased that the Administration continues to highlight the benefits to patient care of implementing electronic infection control monitoring and reporting capabilities in post-acute care settings. Premier continues to work with Congress and a coalition of providers on developing legislation that would incentivize the adoption of interoperable electronic health information technology, including electronic clinical surveillance technology in long-term and post-acute care settings and facilitate data-sharing and improve patient care. ***Premier urges CMS to work with Congress to advance incentives for the apportion of interoperable electronic health information technology to address concerns raised by CMS in the proposed rule about the burden placed on LTCFs in data reporting.***

VII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the CY 2025 Home Health Prospective Payment System proposed rule. Premier looks forward to working with CMS and other stakeholders to develop reforms that strengthen our nation's HHAs and care for vulnerable populations.

If you have any questions regarding our comments or need more information, please contact me at soumi_saha@premierinc.com.

Sincerely,

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Senior Vice President of Government Affairs
Premier Inc.