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August 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of AMGA, I appreciate the opportunity to comment on the Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update, as published in the July 10, 2023 Federal Register. Home health services continues to see an increasing demand while providers continue to endure rising costs to provide these services. AMGA looks forward to the continued partnership with the Centers of Medicare & Medicaid Services (CMS), the Departments of Health and Human Services (HHS) to address the substantial post pandemic challenges our members continue to face.

Founded in 1950, AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA is pleased to offer comments on the CY 2024 Home Health Prospective Payment System Rate Proposed Rule for your consideration. Specifically, we are providing comments on the following:

- **AMGA Opposes Medicare Provider Enrollment Policies:** AMGA acknowledges and appreciates CMS's endeavors to introduce additional oversight measures aimed at addressing instances of hospice fraud, waste, and abuse within the Medicare program. However, AMGA does not agree with the proposed approach.
- **Home Health Value-Based Purchasing (HHVBP) Model:** AMGA endorses the CMS proposal to harmonize the measures utilized in the Home Health Value-Based Purchasing (VBP) Model with those in the Home Health Quality Reporting Program (HH

QRP). AMGA strongly believes that adopting a unified approach across all value-based models will help alleviate the administrative burdens faced by providers in quality measure reporting.

AMGA Opposes Medicare Provider Enrollment Policies

In accordance with Section 1866(j)(3)(A) of the Social Security Act, CMS is obligated to establish protocols to enhance oversight of new providers and suppliers across five key domains: (1) newly/initially enrolling Opioid Treatment Programs (OTPs), (2) newly/initially enrolling HHAs, (3) newly/initially enrolling The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, (4) newly/initially enrolling Medicare diabetes prevention program (MDPP) suppliers, and (5) newly/initially enrolling skilled nursing facilities (SNFs). For nascent home health providers, this phase of enhanced oversight, termed the Provisional Period of Enhanced Oversight (PPEO), has resulted in the deferment of anticipated payment requests. Presently, CMS retains the authority to deactivate billing privileges for Medicare providers or suppliers who have not submitted a Medicare claim for a continuous period of 12 months. However, in the proposed CY2024 rule, CMS intends to truncate this deactivation period to 6 months.

Furthermore, CMS is aiming to subject individuals with a 5% ownership stake or more in newly enrolling hospices, as well as hospices reporting new ownership, to the high-risk screening category. Building upon this escalated scrutiny, CMS suggests that if a change in majority ownership of a hospice through sale occurs within 36 months of the hospice's initial enrollment with Medicare (or its most recent change in majority ownership), the new provider or owner must enroll in Medicare as a new hospice. This process would entail undergoing a state survey or securing accreditation from an approved accreditation program.

AMGA is concerned that increased provider enrollment oversight is adding additional administrative burden and expense without truly supporting program integrity efforts. CMS has estimated an annual cost of \$1,081,782 for affected providers and suppliers. While AMGA appreciates CMS's efforts to address issues like fraud and quality in home health care, it suggests a more targeted approach rather than applying such a stringent standard more universally. AMGA finds the proposed measures overly burdensome and urges CMS to reconsider this approach.

Home Health Value-Based Purchasing (HHVBP) Model

CMS is proposing changes to the Home Health Value-Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP) to better align their respective quality measurement requirements. This involves the removal of five measures from HHVBP, to be supplanted by three new measures. It is noteworthy that CMS has previously embraced eight guiding factors that shape decisions related to measure removal. CMS is also proposing the formal codification of these factors to establish a more structured framework.

AMGA supports CMS's efforts to improve the effectiveness of measures and reduce administrative burdens. Over the years, AMGA has consistently advocated for better alignment within CMS value-based programs. To this end, AMGA established a Quality Measure Task Force that developed a comprehensive set of 14 core measures, which aligns with CMS's "Universal Foundation" of quality measures meeting criteria like clinical relevance, risk adjustment,

evidence-based foundation, patient-centeredness, and statistical robustness. This set of measures aims to save providers time and costs while enhancing care quality. By providing a uniform set of measures for value-based providers, the AMGA measure set aims to reduce variability in reported measures, lessening confusion and administrative load. This set includes measures such as the 30-day all-cause hospital readmission and admissions for acute ambulatory sensitive conditions composite, focusing on quality improvement, as well as outcome measures that evaluate care delivery for quality enhancement.

The proposed rule notes that CMS, for the HH QHP, is endeavoring “to move towards a more parsimonious set of measures while continually improving the quality of health care for beneficiaries.” AMGA is pleased to see CMS continuing its work with the Universal Foundation measures and is taking steps to further advance the overarching goals of quality improvement and streamlined assessment across these pivotal programs.

We thank CMS for consideration of our comments. Should you have questions, please contact Darryl M. Drevna, AMGA's senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA