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August 26, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1803-P
P.O Box 8013
Baltimore, MD 21244-8013

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

Dear Administrator Brooks-LaSure,

The Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services have proposed several reforms affecting the Medicare home health benefit and the CY 2025 payment rates in the Notice of Proposed Rulemaking (NPRM). 89 Fed. Reg. 55312 (July 3, 2023).

The NAHC-NHPCO ALLIANCE (formerly the National Association for Home Care & Hospice), hereinafter "ALLIANCE," respectfully submits these comments regarding the proposals contained within the NPRM. The ALLIANCE is the largest trade association representing the interests of Medicare home health agencies (HHAs) and hospices nationwide including nonprofit, proprietary, urban, and rural based, hospital affiliated, public and private corporate entities, and government run providers of home care since 1982. ALLIANCE members provide most Medicare home care services throughout the U.S.

The ALLIANCE is also an original provider-member of the Leadership Council of Aging Organizations (LCAO) as it has put patients first in its health policy and advocacy positions since its inception. Each year, ALLIANCE members serve millions of patients of all ages, infirmities, and disabilities, providing an opportunity for individuals to be cared for in their own homes, the care setting preferred by most people.

Many members of our Forum of State Associations also support these comments. We are specifically joined on this letter by numerous state home care associations listed on the final page. Many others are filing their own comments too. State associations are an important voice in understanding the

impact of the proposed rules in their local settings. Their "on the ground" perspective deserves special attention.

We are aware that numerous other organization and representatives of the HHA community have submitted comments as well. We especially recommend that CMS provide thoughtful consideration to those comments submitted by the Partnership for Quality Home Health along with those submitted by several by our the EMR/IT business partner members that offer extensive "real-time" data analysis.

At the outset, we respectfully express that the existing and newly proposed payment rate cuts will continue to serve to significantly reduce access to essential home health services throughout the country and set the stage for further annual rate cuts that will dismantle this crucial benefit. That outcome stems from the application of a budget neutrality adjustment methodology that will perpetually rebase payment rates reflecting the natural and foreseeable reaction of home health agencies (hereinafter "HHAs") to reduced reimbursement. CMS understands HHAs, like all health services providers, will reduce costs in reaction to payment reductions. Cost reductions often can include service reductions involving the admission of patients, the scope of services offered, and the extent of services provided. Consequently, the CMS budget neutrality methodology will continue to trigger further payment rate reductions that will eventually destroy the value of the home health services benefit.

CMS has the authority and the responsibility to prevent such an outcome under 42 USC 1395fff to determine the "time and manner" of applying any rate adjustments under PDGM. CMS has the full discretionary power to go forward with the 2025 rate setting without the proposed 4.067% rate cut.

While we once again will not relitigate here our position that the budget neutrality methodology fails to conform with statutory mandates, CMS does have the clear authority to determine the time and manner of any permanent and temporary adjustments under the payment model and has used that power in past rulemakings. **We once again strongly recommend that CMS use that authority to withhold any such adjustments in 2025 to provide the opportunity for a full and deep review of the direction of the home health benefit, its impact on access to care, and options to preserve a longstanding benefit that has brought high quality of care and essential health care services to millions of Medicare beneficiaries since 1965, along with great value to the Medicare program through expenditure savings far in excess of any other Medicare benefit. Since the initiation of PDGNM in CY2020, CMS's own data shows the significant deterioration of the home health benefit and the increasing reduction in access across the country. As detailed below, fewer Medicare beneficiaries have access to the home health benefit and those that do face a significantly reduced scope and depth of care.**

Specific comments on all elements of the NPRM are below. We offer the following summary of our overall recommendations:

OVERALL RECOMMENDATIONS

A. Home Health Services Payment Rates

- CMS should postpone application of any further permanent adjustments related to PDGM budget neutrality to preserve current access to home health services and the scope of care available.

- CMS should maintain its position to withhold any part of the PDGM budget neutrality temporary adjustments in 2025.
- CMS should recognize the disruptive, continuing, and permanent financial impact of its forecasting error with respect to the annual Market Basket Index updates from 2021 and 2022 and implement a one-time adjustment to account for the 5.2% forecasting error.
- CMS should consider the negative and disruptive financial impacts of its proposed wage index changes and case mix weight recalibrations on care access as it finalizes the 2025 payment rates and any systemic reforms.

B. HH QRP

- CMS should limit revisions to the OASIS data set to intervals no less than 4 years from the last revision.
- CMS should consider imbedding the AHC-HRSN core question screening tool into the PAC assessments if feasible.
- CMS should monitor additions to the OASIS data set to ensure that the tool is manageable for HHAs.
- CMS should provide sufficient data on HHA quality measures and assessment items prior to implementing any changes in the OASIS data set.

C. HH QRP Measure Concepts

- CMS should not consider including in the HH QRP the "Adult Immunization Status" measure, or any similar measure related to vaccinations that requires extensive review of data sources.
- CMS must consider the limitations for HHAs to address a depression diagnosis when considering the measure concept for the HH QRP
- CMS should not move forward with a measure concept related to SUD for inclusion in the HH QRP

D. HHVBP Measure Concepts

- CMS must consider the complexity and potential burden for data collection when developing a measure to address the needs of the family caregivers for home health patients.
- CMS should not include the falls with injury measure into the HHVBP
- CMS should not include the MSPB measure in the HHVBP
- The ALLIANCE supports the inclusion of additional function measures in the HHVBP that complement the DC Function measure.

E. Home Health CoP Changes -Acceptance to Service Policy

- CMS should withdraw its proposal, at § 484.105(i)(1)(i) through (iv), for an acceptance to service policy and to require HHAs make publicly available information on services, and limitations on frequency and duration.
- CMS should continue to seek feedback from stakeholders to determine the root cause for the decreases in patient access to home health services.
- Withdraw the position that HHAs can only decline an admission to care based on a finding that it cannot safely and effectively meet the clinical needs of the patient**.**

SPECIFIC COMMENTS ON PROPOSED RULE AND POLICY CHANGES

The Proposed Payment Rate Cuts Further Exacerbate Significant Care Access Barriers for Patients and Will Bring the Home Health Benefit to a Point of Crisis

For several years, Medicare payment policies have seriously diminished the Medicare home health benefit. Concurrent with rate reductions, payment model changes, case mix weight recalibrations, and inaccurate cost inflation forecasts there continues to be a corresponding dilution of the home health benefit resulting in a significant, negative impact on care access. The ALLIANCE forecast this outcome in it CY2020 comments with added support for the contention each year thereafter. While CMS thankfully responded to those concerns by withholding any application of the growing temporary adjustments along with a reduced permanent adjustment in CY 2023 and CY 2024, the deterioration of the benefit and access to it continues. The outcome has been startling with several hundred thousand less Medicare beneficiaries annually using home health services, less care provided to patients, and fewer provider options. Such dramatic changes cannot be accounted for because of oversight activities, marketplace changes, or the increased enrollment in Medicare Advantage plans as an alternative to traditional Medicare enrollment. This deterioration is clearly displayed even in the limited data offered by MedPAC and data routinely available to CMS.

The 2023 MedPAC data analysis shows a decline of 400,000 home health users between 2017 and 2021. In-person visits per user declined by over 17% from 30.7 to 25.4. Active HHAs fell by 1,232 from 2016-2021. The active provider numbers continue to decline to date, except for California where program integrity issues have been raised. **This data does not depict a stable home health benefit in any form.**

As predicted by the ALLIANCE in its earlier PDGM comments, the data analysis shows a continuing decline in home health users, in-person visits per user, and active HHAs. **An ongoing pattern of loss of access to care cannot be ignored by CMS, particularly when the obvious cause is the flawed payment model established and introduced by CMS in 2020.** An alternative explanation does not lie in increased Medicare Advantage enrollment as the percentage of Medicare Fee-for-Service enrollees using home health services is declining, not just the gross number of users. Similarly, the explanation does not lie in a reduced inpatient population as the majority of HHA admissions is from the community and those enrollees that would have come from an inpatient stay to home health in the past still have health care needs even if they are no going to inpatient care. Finally, CMS cannot reasonably adopt the MedPAC view that there has been a reduction in use of home health along with a declining number of HHAs since 2013 as the explanation. The institution of PDGM re-triggered the benefit deterioration that began with the Affordable Care Act's rate rebasing mandate after just two years of a modicum of "stability."

All told, the PDGM era to date has shown a combination of:

- **Nearly 500,000 fewer Medicare beneficiaries accessing home health services**
- **A 22.4% decline in the proportion of Medicare fee-for-service beneficiaries accessing home health services.**
- **A 9% nationwide reduction in active HHAs accessible to beneficiaries**
- **A 15.6% reduction in the number of clinical visits in a 30-day period**

These data do not portray a budget neutral transition to PDGM. Instead, these data depict a crucial and essential benefit in the Medicare program, one that has demonstrated dynamic positive impact

through cost and care avoidance, which is on a continuing downward path to being effectively dismantled.

The chart that follows shows that fewer beneficiaries as a percentage of enrollees have accessed home health services in all 50 states since the initiation of PDGM in 2020. This should concern every Medicare enrollee, particularly as the US population ages overall while consumers increasingly express a very strong desire to age in place with health care services in their own homes. It should also concern CMS as Medicare heads towards significant financial challenges with its ongoing reliance on inpatient and institutional care. It is time for CMS to recognize, in its practices, what it has conveyed regarding the Home Health Value Based Purchasing demonstration program—home health services reduce overall Medicare expenditures—when used.

The following data from the CMS Market Saturation Report details the decline in home health utilization. CMS cannot ignore its own data and the obvious impact of PDGM during the period involved. Coincidences are not simply happenstance. Notably, both CMS and Congress recognized that Medicare payment changes lead to provider behavior changes. These data support that assumption. Reduced payment rates have led to reduced care access and usage. Correspondingly, the proposed further reductions in payment rates for CY2025 will lead to further reductions in care access and usage.

Home Health Utilization
FFS Beneficiaries as % of Total FFS Beneficiaries

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
National	8.5%	7.8%	7.9%	7.4%	6.6%
Alabama	10.5%	10.0%	10.0%	9.3%	8.1%
Alaska	3.3%	3.4%	3.6%	3.4%	3.1%
Arizona	5.9%	5.5%	5.7%	5.4%	4.8%
Arkansas	7.8%	7.5%	7.7%	7.3%	6.4%
California	9.3%	8.8%	9.1%	8.9%	8.3%
Colorado	6.0%	5.5%	5.7%	5.2%	4.5%
Connecticut	10.9%	10.0%	10.0%	9.3%	8.3%
DC	5.9%	6.0%	6.1%	5.1%	4.9%
Delaware	8.5%	7.7%	7.8%	7.4%	6.9%
Florida	11.7%	10.8%	10.7%	10.0%	9.0%
Georgia	7.9%	7.4%	7.4%	6.9%	6.0%
Hawaii	2.7%	2.8%	2.9%	2.9%	2.4%
Idaho	6.8%	6.5%	6.6%	6.2%	5.4%
Illinois	9.1%	8.2%	8.3%	7.8%	6.8%
Indiana	6.8%	6.4%	6.4%	5.9%	5.1%
Iowa	4.6%	4.6%	4.6%	4.1%	3.5%
Kansas	6.6%	6.5%	6.9%	6.4%	5.6%
Kentucky	8.6%	7.9%	7.8%	7.3%	6.3%
Louisiana	10.7%	10.2%	9.7%	9.1%	7.9%
Maine	8.3%	7.3%	7.2%	6.5%	5.6%
Maryland	7.8%	7.2%	7.3%	6.9%	6.1%
Massachusetts	10.9%	9.8%	10.2%	9.7%	8.8%
Michigan	9.4%	8.2%	8.2%	7.6%	6.6%
Minnesota	5.6%	5.4%	5.5%	5.2%	4.6%
Mississippi	11.7%	11.5%	11.4%	10.8%	9.5%
Missouri	7.1%	6.8%	6.8%	6.2%	5.4%
Montana	3.7%	3.6%	3.4%	3.1%	2.7%
Nebraska	5.6%	5.5%	5.5%	5.2%	4.6%
Nevada	9.2%	8.5%	8.7%	8.3%	7.5%
New Hampshire	8.8%	8.0%	8.1%	7.5%	6.4%
New Jersey	7.5%	6.7%	7.0%	6.6%	5.8%
New Mexico	6.3%	5.8%	6.0%	5.6%	5.0%
New York	7.8%	6.9%	7.1%	6.7%	5.8%
North Carolina	8.2%	7.5%	7.4%	6.9%	6.1%
North Dakota	3.1%	3.5%	3.5%	3.2%	3.0%
Ohio	8.2%	7.4%	7.5%	6.7%	5.8%
Oklahoma	11.4%	10.8%	10.7%	10.1%	9.0%
Oregon	5.2%	5.0%	5.0%	4.8%	4.2%
Pennsylvania	8.4%	7.7%	7.9%	7.3%	6.4%
Rhode Island	9.5%	8.7%	9.0%	8.5%	7.3%
South Carolina	8.4%	8.1%	8.5%	8.2%	7.4%
South Dakota	3.7%	3.5%	3.7%	3.5%	3.0%
Tennessee	8.4%	8.1%	8.2%	7.6%	6.7%
Texas	10.5%	9.3%	9.1%	8.3%	7.2%
Utah	9.0%	8.6%	8.8%	8.3%	7.2%
Vermont	8.7%	8.0%	8.3%	7.6%	6.7%
Virginia	8.3%	7.7%	7.9%	7.4%	6.4%
Washington	5.2%	5.0%	5.1%	4.9%	4.3%
West Virginia	8.0%	7.4%	7.6%	7.2%	6.1%
Wisconsin	5.2%	5.0%	5.1%	4.9%	4.2%
Wyoming	4.1%	4.3%	4.5%	4.1%	3.5%

Source: CMS, Market Saturation Utilization State-County.

https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

While the ALLIANCE does not consider the below MedPAC analyses to be wholly accurate in comparison to the CMS Market Saturation Reports, those analyses are categorically consistent with the downward trends displayed in the CMS data. Nearly 600,000 fewer users of home health services, a 6% decline in the proportion of FFS beneficiaries utilizing home health services between 2019 and 2022, reduced lengths of stay receiving home health services, and a significant decline in the number of in-person clinical visits to patients are all consistent with the Market Saturation Report data compiled by CMS.

MedPAC March 2023 Report to Congress

TABLE 8–2

In 2021, the share of FFS beneficiaries using home health care increased, while the number of in-person home health visits per user declined

	Prepandemic			Pandemic		Average annual percent change	
	2017	2018	2019	2020	2021	2017–2019	2020–2021
Medicare FFS home health users (in millions)	3.4	3.4	3.3	3.1	3.0	–1.7%	–1.1%
Share of FFS beneficiaries using home health care	8.8%	8.7%	8.5%	8.1%	8.3%	–1.3	2.5
Total visits (in millions)	104.8	103.9	99.7	81.1	76.8	–2.5	–5.3
In-person visits per user	30.7	30.8	30.2	26.6	25.4	–0.8	–4.2
30-day periods (in millions)				9.6	9.3		–2.9
30-day periods per 100 FFS Medicare beneficiaries				25	26		0.7

Note: FFS (fee-for-service). Percentage change was calculated on unrounded data.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2022 annual report of the Boards of Trustees of the Medicare trust funds.

MedPAC March 2024 Report to Congress

TABLE 7–2

In 2022, the share of FFS Medicare beneficiaries receiving home health care declined

					Average annual percent change	
FFS Medicare volume	**2019**	**2020**	**2021**	**2022**	**2019–2022**	**2021–2022**
Home health users (in millions)	3.3	3.1	3.0	2.8	–5.0%	–6.3%
Share of beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	–1.8	–3.0
30-day periods (in millions)	N/A	9.6	9.3	8.6	N/A	–7.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	25.3	25.5	24.4	N/A	–4.3
30-day periods per FFS Medicare beneficiary who received home health care	N/A	3.13	3.08	3.04	N/A	–1.3

Note: FFS (fee-for-service), N/A (not available). Percentage changes were calculated on unrounded data. CMS implemented a 30-day period as the unit of payment in the home health prospective payment system in 2020; data for prior years in this unit of payment are not available.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

MedPAC March 2023 Report to Congress

TABLE 8–4

In 2021, the number of in-person visits per 30-day period declined

	Prepandemic	Pandemic		2019–2021		2020–2021	
	2019	**2020**	**2021**	**Change in number of visits**	**Average annual percentage change**	**Change in number of visits**	**Average annual percentage change**
Skilled nursing	4.6	4.6	4.3	–0.3	–3.7%	–0.3	–8.0%
Physical therapy	3.5	2.9	3.0	–0.6	–10.0	0.1	1.1
Occupational therapy	1.1	0.9	0.8	–0.3	–18.3	–0.1	–1.5
Speech–language pathology	0.2	0.2	0.2	–0.1	–20.5	–0.1	–5.2
Medical social services	0.1	0.1	0.1	0.1	–20.8	–0.1	–8.4
Home health aide	0.7	0.6	0.5	–0.2	–18.5	–0.1	–14.5
Total	10.2	9.2	8.8	–1.4	–8.1	–0.4	–4.7

Note: Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the two years. Thirty-day periods are included in the year that the period ended. Components may not sum to totals due to rounding. Visit counts have been rounded. "Change in number of visits" and "average annual percentage change" columns were calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files for 2020 and 2021.

MedPAC March 2024 Report to Congress

TABLE 7–5

Since 2020, the average number of home health in-person visits per 30-day period has declined

Volume measure	2019	2020	2021	2022	Total change in number of visits 2019–2020	Total change in number of visits 2020–2022	Percent change 2019–2022
Total visits per 30-day period	10.2	9.2	8.8	8.6	–1.0	–0.6	–15.6%
Visits per 30-day period by discipline:							
Physical therapy, occupational therapy, and speech–language pathology	4.9	3.9	3.9	4.0	–0.9	<0.1	–18.6
Skilled nursing	4.6	4.6	4.3	4.1	<0.1	–0.5	–10.5
Medical social services and home health aide	0.8	0.7	0.6	0.5	–0.1	–0.1	–32.3

Note: Home health services initiated in 2019 were paid under 60-day episodes. For this table, home health care services initiated in 2019 were recalculated as 30-day periods to provide comparable units of service in the later years. Thirty-day periods are included in the year that the period ended. Components may not sum to totals due to rounding. Visit counts have been rounded. "Total change in number of visits" column was calculated on unrounded data.

Source: MedPAC analysis of 2019 home health Limited Data Set file and standard analytic files from 2019 through 2022.

CMS also offers important data on the level of care provided under the home health benefit in the NPRM that shows the continuing decline is services provided as each year of PDGM advances.

TABLE 3: UTILIZATION OF VISITS PER 30-DAY PERIODS OF CARE BY HOME HEALTH DISCIPLINE, CYs 2018-2023

Discipline	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023
Skilled Nursing	4.53	4.49	4.35	4.05	3.90	3.86
Physical Therapy	3.30	3.33	2.70	2.74	2.77	2.78
Occupational Therapy	1.02	1.07	0.79	0.78	0.77	0.76
Speech Therapy	0.21	0.21	0.16	0.15	0.14	0.14
Home Health Aide	0.72	0.67	0.54	0.48	0.43	0.41
Social Worker	0.08	0.08	0.06	0.05	0.05	0.05
Total (all disciplines)	**9.86**	**9.85**	**8.59**	**8.25**	**8.06**	**8.00**

89 Fed. Reg. 55312, 55318 (July 3, 2024).

The pattern is clear and unambiguous. Rate cuts under PDGM lead to care cuts.

The decline in the number of active, billing HHAs continues to plummet nationwide, with very frwe states excepted. Notably, California is the unicorn among the states with 534 active HHAs added between 2019 and 2023. Active is defined as billing for Medicare homne health services during that calenadr year. Active is contrasted with simply existing as a certified HHA as that status does not help define care access.

The data from the CMS Market Saturation Reports shows a 9% decline in the number of active HHAs since prior to PDGM. All but six states (AZ, CA, ME, NV, RI, and WA) show a sizeable decline in the number of HHAs that are active. California is suspected to have seen growth with a large number of new HHAs raising program integrity concerns. With California excepted, the decline in active HHAs during PDGM is in excess of 17%

STATE	2019	2020	2021	2022	2023	2019-2023	
Alabama	129	119	120	113	114	-15	-12%
Alaska	16	14	15	14	13	-3	-19%
Arizona	135	135	136	137	135	0	0%
Arkansas	101	98	94	96	93	-8	-8%
California	1,343	1,417	1,546	1,743	1,877	534	40%
Colorado	114	112	109	102	101	-13	-11%
Connecticut	84	80	68	67	65	-19	-23%
DC	26	26	26	25	22	-4	-15%
Delaware	25	21	24	21	21	-4	-16%
Florida	815	800	812	781	742	-73	-9%
Georgia	109	111	112	105	106	-3	-3%
Hawaii	14	12	13	12	10	-4	-29%
Idaho	53	53	51	47	49	-4	-8%
Illinois	597	532	527	498	482	-115	-19%
Indiana	171	160	152	140	133	-38	-22%
Iowa	128	123	117	113	110	-18	-14%
Kansas	112	106	104	98	96	-16	-14%
Kentucky	102	94	90	87	86	-16	-16%
Louisiana	175	173	171	170	165	-10	-6%
Maine	25	24	28	27	26	1	4%
Maryland	63	64	62	63	61	-2	-3%
Massachusetts	147	137	142	130	114	-33	-22%
Michigan	398	353	340	311	279	-119	-30%
Minnesota	111	111	107	94	86	-25	-23%
Mississippi	48	47	46	46	45	-3	-6%
Missouri	153	145	144	136	128	-25	-16%
Montana	26	25	24	23	23	-3	-12%
Nebraska	66	65	62	60	57	-9	-14%

Nevada	143	147	146	160	157	14	10%
New Hampshire	39	35	37	37	35	-4	-10%
New Jersey	52	49	52	49	46	-6	-12%
New Mexico	66	67	69	68	63	-3	-5%
New York	142	135	132	131	123	-19	-13%
North Carolina	173	166	166	160	157	-16	-9%
North Dakota	18	17	18	16	16	-2	-11%
Ohio	321	285	268	251	230	-91	-28%
Oklahoma	232	226	220	215	205	-27	-12%
Oregon	61	55	59	57	58	-3	-5%
Pennsylvania	274	246	244	226	209	-65	-24%
Rhode Island	22	24	24	22	22	0	0%
South Carolina	85	85	85	82	75	-10	-12%
South Dakota	28	24	26	25	24	-4	-14%
Tennessee	136	128	129	127	126	-10	-7%
Texas	1,490	1,346	1,242	1,138	1,056	-434	-29%
Utah	82	79	79	76	71	-11	-13%
Vermont	14	14	14	13	12	-2	-14%
Virginia	220	210	202	199	196	-24	-11%
Washington	63	64	68	67	68	5	8%
West Virginia	62	57	58	53	50	-12	-19%
Wisconsin	97	84	84	84	81	-16	-16%
Wyoming	30	29	32	28	26	-4	-13%
Total	**9,136**	**8,729**	**8,696**	**8,543**	**8,345**	**-791**	**-9%**
Total w/o CA	**7,793**	**7,312**	**7,150**	**6,800**	**6,468**	**-1,325**	**-17%**

Source: CMS Market Saturation Reports, https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

The ALLIANCE also considers the CMS Market Saturation Reports a superior data source on access to HHAs to that displayed by MedPAC as it relies on robust claims data analyzed by CMS itself. Nevertheless, even the MedPAC analyses in 2023 and 2024 depict a continuiing decline in available HHAs. Such a finding supports the concerns voiced by the ALLIANCE over the past PDGM years that the access to care has been materially diminished and is facing an ongoing threat to a complete loss in some parts of the country due to the continuing PDGM rate cuts based on the flawed budget neutrality assessment methodology applied by CMS.

MedPAC March 2023 Report to Congress

TABLE 8–1 **Rate of decline in home health agencies participating in Medicare has slowed**

	Prepandemic			Pandemic		Average annual percent change	
	2013	2018	2019	2020	2021	2013–2019	2020–2021
Active HHAs	12,788	11,699	11,569	11,556	11,474	–1.7%	–0.8%
Number of HHAs per 10,000 Medicare beneficiaries	2.4	1.9	1.9	1.8	1.8	–4.2	–2.1

Note: HHA (home health agency). "Active HHAs" includes all agencies operating during a year, including agencies that closed or opened at some point during the year. Average annual changes were calculated on unrounded data.

Source: MedPAC analysis of CMS's Quality, Certification and Oversight file and 2021 annual report of the Boards of Trustees of the Medicare trust funds.

MedPAC March 2024 Report to Congress

TABLE 7–1 **Annual rate of decline for home health agencies participating in Medicare has been approximately 1 percent per year**

					Average annual percent change	
	2019	2020	2021	2022	2019–2022	2021–2022
Active home health agencies	11,569	11,565	11,474	11,353	–0.6%	–1.1%
Number of home health agencies per 10,000 Medicare beneficiaries	1.88	1.83	1.79	1.75	–2.3	–2.7

Note: "Active home health agencies" includes all agencies operating during a year, including agencies that closed or opened at some point during the year. Average annual changes were calculated on unrounded data.

Source: MedPAC analysis of CMS's Quality, Certification and Oversight file and the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

Sources: March 2023 Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission, Chapter 8, Pages 242, 243, 245. https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/

March 2024 Report to Congress: Medicare Payment Policy. Medicare Payment Advisory Commission, Chapter 7, Pages 206-211. https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/

MedPAC's mischaracterization of the data trends as offering sufficient access to care should be given no weight as the numbers speak for themselves—care utilization is significantly down, less care is provided today than in prior years, and there are fewer HHA choices for beneficiaries. While full data is not yet available, there are clear indications that the reduction in patients using home health services and the volume of in-person visits continue to decline post-2022 along with the number of active HHAs.

Further indications of the fragility of the financial status of HHAs are found in cost report data from calendar year 2022. The ALLIANCE analyzed cost reports for all HHAs with a fiscal year end of

12/31/22 to evaluate the impact of CY2022 payment rates, cost inflation, service changes, and other factors related to 2022 influences and behavior in a consistent manner. The ALLIANCE methodology trimmed out reports with no data on revenue and/or costs along with an application of the common 90/10 natural log trim. The ALLIANCE evaluated both "Medicare margins" (the difference between reported fee-for-service Medicare revenue and reported fee-for-service Medicare costs) as well as "Overall Margins" (total home health revenue compared to total home health costs).

The ALLIANCE notes the following regarding the cost report data analysis:

1. Cost report data came from CMS at https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports/cost-reports-by-fiscal-year
2. Cost reports used were limited to those with 12/31/22 fiscal year ends. An estimated 30% of HHAs use alternative fiscal years.
3. Cost report inputs were used as reported.
4. CMS cost reporting standards do not consider certain usual and ordinary business costs, such as marketing, telehealth services and equipment, and certain taxes as "allowable" thereby depressing the amount of costs in the margin analysis.
5. The wide range in margins makes the nature of the cost report trimming affect the margin calculation.

Most notable from the cost report analysis is that HHAs experience a wide range of financial outcomes in both the "Medicare Margin" and the "Overall Margin." This outcome occurs regardless of HHA geographic location, urban or rural service area, tax status, or size. The wide range of financial outcomes of a payment model set out below itself demonstrates current fragility and uncertainty in the financial status of the organization along with the impact of any future rate changes. Most importantly, it demonstrates that relying upon averages is a high risk undertaking when setting or evaluating payment rates and any changes in payment rates, particularly as it relates to the impact on care access as averaging masks the impact that comes from losing those providers with margins below the average.

HHAs with FYE 12/31 data	**2022**	**2022**	**2023**	**2023**
Region	**Total Medicare FFS Reimbursement**	**Number of HHAs**	**Total Medicare FFS Reimbursement**	**Number of HHAs**
National	$11,625,894,736	5,639	$12,399,838,395	6.145
Medicare Margin	**Number of HHAs**	**Percentage of HHAs**	**Number of HHAs**	**Percentage of HHAs**
Greater than 20%	2,958	52.6%	3,326	54.2%
Between 0% and 20%	1,479	26.2%	1,546	25.1%
Less than 0%	2,681	21.2%	1,273	20.6%

It should be apparent that HHAs with current negative Medicare Margins would face significant financial difficulties in absorbing the proposed additional 4.067% rate cut for 2025 and 2.89% in 2024 based on FYE 2022 data alone. With those providers, serious negative impact on patients can be fully expected if the affected HHA is to continue operations.

For HHAs with Medicare Margins above zero percent, those difficulties are also serious and insurmountable without negative impacts on patients. As we have seen over the years, rate cuts have reduced access in several ways, including HHA closures, reduced service areas, reduced admissions, and reduced scope of services.

However, we advise CMS not to confine its access impact analysis to a silo built on Medicare Margins data. While payers may prefer to limit their rate impact evaluation to the relationship of its rate to provider cost, the economic model of HHAs necessitates a view consistent with the HHAs' evaluation of its overall financial condition. HHAs do not have the luxury of confining its evaluation to a payer-centered one. Instead, it must look at the overall combination of payers to determine the impact of any single payer change on its operations because HHAs' business is a variety of government or quasi-government-based payers where payment rates are assigned by the payer, not determined by the provider. For HHAs, most payments come from traditional Medicare, Medicare Advantage, Medicaid, the VA, and Tricare. Most HHAs have little or no commercial insurance or private pay home health services, unlike most other health care sectors.

HHAs serve patients and do not distinguish between traditional Medicare patients and those patients covered by Medicare Advantage, Medicaid, the VA, or other payers. HHA nurses, therapists, and home health aides provide patient care, not Medicare patient care, Medicare Advantage patient care. Medicaid patient care, or care that is different based on payer source. Professional standards of care make home health services payer-agnostic. The Medicare Conditions of Participation apply equally to all payers too.

It is notable that MedPAC evaluates the full financial outcome for inpatient hospital services and SNF services in its consideration of the impact of Medicare rates of payment on access to care. Such makes sense as health care providers do not operate in payer-related silos. As previously stated, the Medicare Conditions of Participation apply equally to all patients without regard to payer source. In home health services, all patients are subject to the OASIS patient assessment and quality of care measures along with public quality data reporting do not distinguish patients by payer source. The Medicare cost report does require delineation by Medicare, Medicaid, and "Other," but cost calculations blend all costs without regard to payer source.

The ALLIANCE recognizes that, based on cost report data and inputs from The ALLIANCE members, traditional Medicare payments may subsidize other payers such as Medicare Advantage or Medicaid. In some respects that is the reality that HHAs must deal with every year. In other respects, it may be a creature of cost reporting weaknesses. Either way, HHAs operate as an HHA, not a Medicare Fee-for-Service HHA. It is not unusual for one payer's revenue to be needed to subsize a shortfall from another payer.

While it may not be the best Medicare payment policy, currently it must be recognized as a central impacting feature of the financial status of HHAs. Changing payment rates in traditional Medicare has a ripple effect on the entire patient population of an HHA. That is particularly the case when the other payers are highly unlikely to step up and improve their payment rates as we have here in home health with Medicare Advantage and Medicaid, both having rate setting power that is sanctioned by CMS. Accordingly, CMS must recognize the need to apply its discretion on the application of PDGM permanent adjustments taking into consideration the overall impact of rate cuts on the ability of HHAs to

maintain full access to care. Here the proposed rate cuts are clearly highly disruptive in relation to continued care access. The "Overall Margins" of HHAs, as discussed below, demonstrates that the level of disruption is monumental.

The projected national Overall Margin for 2024 with the existing base rate cut shows that 52.7% of freestanding HHAs would be "underwater" with overall margins below 0% assuming no change in costs compared to 2022. The analysis is limited to freestanding HHAs due to the unavailability of such data from cost reports submitted by institution based HHAs. However, it can be safely assumed that the percentage would increase if those HHAs were capable of being included since the Medicare-related margins tend to be lower than freestanding HHAs as a starting point.

These data depict a substantial risk that a majority of HHAs would be in jeopardy of bankruptcy or closure with the proposed rate cut. Those HHAs' options to avoid that risk are highly limited, none of which would be good for the patient population and most have already been employed with the CY2023 rate cut. Those options include:

- Reducing the volume of visits in the episode of care. More than a full visit reduction on average would be needed to stay financially even.
- Reducing costs by narrowing the geographic scope of the service area to reduce travel time between visits or the need for a branch office. That action would effectively "close" the provider for a portion of previously served patients.
- Eliminate services to Medicare Advantage and Medicaid patients. This would require an HHA to address fixed and semi-variable costs that would remain through such a census reduction.
- Refocus Medicare home health services on certain patient populations that would not trigger financial losses in a manner consistent with nondiscrimination requirements.

Such changes in service are easy to predict since they are already ongoing due to the initial 4.36% rate cut at the start of PDGM, shortfalls triggered by inflation rate forecasting errors, and the 3.925% rate cut in 2023. Compounding the risk is the 5.2% forecast error in 2021 and 2022 as it relates to cost inflation and the resulting Market Basket Index (discussed further below). The proposed 4.067% rate reduction for 2025 will send the overall financial status of HHAs into the world of closures, bankruptcies, and patient service roadblocks and reductions. The data earlier presented and as further set out below shows that such a crisis has begun and will continue to grow nationwide. Exclusive of California, the number of active and somewhat accessible HHAs dropped by 332 between 2022 and 2023. With the cut imposed in 2024 and the proposed cut for 2025, that number can be reasonably expected to rise even further. Closure is that last action of financially troubled HHA would take. Prior to that, care access diminishes in a multitude of other ways including reduced coverage areas and limits on patient admissions.

State	HHAs	Overall Financial Projected Status	Percentage
Alabama	84	Percent of margins below 0%	47.6%
Alaska	6	Percent of margins below 0%	50.0%
Arizona	91	Percent of margins below 0%	65.9%
Arkansas	53	Percent of margins below 0%	47.2%
California	774	Percent of margins below 0%	58.3%
Colorado	65	Percent of margins below 0%	61.5%
Connecticut	28	Percent of margins below 0%	53.6%
Delaware	7	Percent of margins below 0%	42.9%
District of Columbia	4	Percent of margins below 0%	0.0%
Florida	484	Percent of margins below 0%	57.0%
Georgia	58	Percent of margins below 0%	48.3%
Guam	2	Percent of margins below 0%	50.0%
Hawaii	6	Percent of margins below 0%	16.7%
Idaho	34	Percent of margins below 0%	55.9%
Illinois	265	Percent of margins below 0%	53.2%
Indiana	87	Percent of margins below 0%	54.0%
Iowa	28	Percent of margins below 0%	39.3%
Kansas	38	Percent of margins below 0%	50.0%
Kentucky	37	Percent of margins below 0%	32.4%
Louisiana	98	Percent of margins below 0%	49.0%
Maine	11	Percent of margins below 0%	63.6%
Maryland	19	Percent of margins below 0%	21.1%
Massachusetts	56	Percent of margins below 0%	42.9%
Michigan	178	Percent of margins below 0%	55.1%
Minnesota	25	Percent of margins below 0%	48.0%
Mississippi	24	Percent of margins below 0%	16.7%
Missouri	57	Percent of margins below 0%	70.2%
Montana	7	Percent of margins below 0%	42.9%
Nebraska	19	Percent of margins below 0%	52.6%
Nevada	84	Percent of margins below 0%	50.0%
New Hamphire	5	Percent of margins below 0%	60.0%
New Jersey	26	Percent of margins below 0%	38.5%
New Mexico	22	Percent of margins below 0%	63.6%
New York	54	Percent of margins below 0%	51.9%
North Carolina	63	Percent of margins below 0%	30.2%
North Dakota		Insufficient Data	
Ohio	156	Percent of margins below 0%	56.4%
Oklahoma	134	Percent of margins below 0%	41.8%
Oregon	22	Percent of margins below 0%	45.5%
Pennsylvania	115	Percent of margins below 0%	41.7%
Puerto Rico	18	Percent of margins below 0%	50.0%
Rhode Island	14	Percent of margins below 0%	64.3%
South Carolina	35	Percent of margins below 0%	60.0%
South Dakota	4	Percent of margins below 0%	50.0%
Tennessee	65	Percent of margins below 0%	49.2%
Texas	703	Percent of margins below 0%	51.9%
Utah	51	Percent of margins below 0%	51.0%
Vermont	3	Percent of margins below 0%	66.7%
Virgin Islands	2	Percent of margins below 0%	100.0%
Virginia	116	Percent of margins below 0%	54.3%
Washington	47	Percent of margins below 0%	46.8%
West Virginia	29	Percent of margins below 0%	62.1%
Wisconsin	32	Percent of margins below 0%	37.5%
Wyoming	11	Percent of margins below 0%	45.5%
National		**Percent of margins below 0%**	**52.70%**

Source: FYE12/31/2022 Freestanding HHA cost reports, https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports/cost-reports-by-fiscal-year. The forecast is based on 2022 data trended forward with the 9.36% base rate cuts in 2023 and proposed for 2024 without regard to any cost changes that are greater than the 2023 MBI and proposed 2024 MBI. If cost to revenue changes were considered, it is expected that the number of HHAs with overall margins below zero would increase.

Most states are already in trouble with the existing 2024 rate cut. Extending a further cut of 4.067% in 2025 is bound to accelerate the decline in care access. Most geographic areas within each state are at risk of losing HHAs. In some areas, all HHAs are forecast to be faced with a negative net financial margin. The risk to access to care for Medicare beneficiaries and all others that need home health services is acute and undeniable. CMS cannot let that happen.

The Home Health Benefit Has Been Shrinking with Each Rate Cut: The Proposed 2025 Rate Cut Will Only Bring Further Shrinkage

In 1996, the number of visits per user of home health services was 74. By 2021 it had shrunk to 25.44. That shrinking occurred at various stages of payment model changes and payment rate reductions. The first generation of benefit shrinkage was in 1998, the first year of the ill-designed Interim Payment System (IPS), where average visits dropped to 51. With the onset of the Prospective Payment System in October 2000, the CY2001 average number of visits dropped to 31. With a few years of stability in the payment rates, visit volume per patient stabilized and rose slightly. However, within a six-year series of rate cuts, visits per patient dropped back down to an average of 31. With the additional rate cuts that began in 2014 and continued to 2017, per patient visit volume stayed steady, but by 2018 the number of patients served dropped by over 100,000 despite the growth in Medicare enrollment of more than 1.4 million.

With the onset of the PDGM system in CY2020, another drop in per patient visits occurred, reducing the average to 27.57. The second year of PDGM saw more of the same with the average reduced to 25.44 visits. While the level of services lost has been significant, the reduction in Medicare beneficiaries that use home health services has been even more dramatic, dropping from 3.6 million in 1996 to 3.02 million in 2021 despite a 2.7 million increase in traditional Medicare enrollees.

YEAR	Traditional Medicare Enrollees	USERS (1000s)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (1000s)	PAYMENTS PER PERSON	PAYMENTS PER EPISODE
1990	N/A	1967.1	36	N/A	$3,713,652	$1,892	N/A
1991	N/A	2242.9	45	N/A	5,369,051	2,397	N/A
1992	N/A	2506.2	53	N/A	7,396,822	2,955	N/A
1993	N/A	2874.1	57	N/A	9,726,444	3,389	N/A
1994	34,076	3179.2	66	N/A	12,660,526	3,987	N/A
1995	34,062	3469.4	72	N/A	15,391,094	4,441	N/A
1996	33,704	3599.7	74	N/A	16,756,767	4,660	N/A
1997	33,009	3557.5	73	N/A	16,718,263	4,704	N/A

1998	32,349	3061.6	51	31.6*	10,456,908	3,420	N/A
1999	32,179	2719.7	42	N/A	7,936,513	2,921	N/A
2000	32,740	2461.2	37	N/A	7,215,958	2.936	N/A
2001	33,860	2402.5	31	21.4*	8,513,702	3,545	N/A
2002	34,977	2544.4	31	20*	9,550,683	3,765	$2,329*
2003	35,815	2681.1	31	18.39**	10,069,628	3,770	N/A
2004	36,345	2835.6	31	18.0**	11,402,560	4,039	N/A
2005	36,685	2975.6	32	18.21**	12,779,158	4,314	$2,366*
2006	35,647	3026.2	34	18.45**	13,912,750	4,619	N/A
2007	35,490	3099.5	37	18.19**	15,565,441	5,046	$2,566*
2008	35,320	3171.6	38	19.1**	16,872,735	5,361	$2,705*
2009	35,360	3281.1	40	18.7**	18,733,108	5,747	N/A
2010	35,910	3434.4	37	18.0**	19,407,218	5,688	N/A
2011	36,458	3463.9	36	17.0**	18,362,264	5,357	$2,916*
2012	37,214	3459.6	34	17.0**	18,025,554	5,256	N/A
2013	37,613	3452.0	32	16.79	17,924,989	5,193	$2,687
2014	37,790	3417.2	32	16.66	17,736,862	5,190	2,703
2015	38,025	3454.4	32	16.60	18,203,863	5,280	2,762
2016	38,610	3451.5	31	16.63	18,117,018	5,249	2,780
2017	38,668	3392.9	31	16.60	17,830,844	5,255	2,823
2018	38,665	3365.9	31	16.67	17,934,054	5,328	2,876
2019	38,577	3281.4	31	16.57	17,850,864	5,440	2,952
2020***	37.776	3054.5	27.57	9.27	17,082,332	5,592	1881
2021***	36.356	3018.5	25.44	8.27	16.872,835	5.590	1.818

Sources: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cmsprogramstatistics ; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS

*Data from Medicare Payment Advisory Commission (MedPAC) various March Reports to Congress

** Data from CMS HHA cost reports

***The payment model shifted to a 30-day episode

Medicare Home Health Services Use Reductions Coincided with Payment Rate Reductions: The Proposed PDGM Cut Will Bring More

While payment rate and payment method are not the only contributing factors to service access and level of care changes in home health services, their impacts are natural and foreseeable. Since BBA 1997, home health services PPS episodic rates have been subject to numerous negative adjustments that began with the initial rate setting for FY2001. Due to the dramatic impact of the Interim Payment System in 1998-2000 and the BBA 1997 requirement that PPS be set in a budget neutral manner, the FY2001 payment rates were set at a level that was over $300 lower than provider costs $2115.50 versus $2416.01) due to a .88423 budget neutrality adjustment. https://www.govinfo.gov/content/pkg/FR-2000-07-03/pdf/00-16432.pdf. Thereafter, the episodic rates have been hit with multiple legislated and regulatory reductions. The table below sets out those reductions. The PDGM rate reductions have and will continue to have the same reduction in care access and level of services.

YEAR	MBI REDUCTION	PRODUCTIVITY ADJUSTMENT	BUDGET NEUTRALITY and CASE MIX WEIGHT ADJUSTMENT**	REBASING REDUCTION
FY2001			11.577%	
FY2002				
FY2003	1.1%		7%	
FY2004				
CY2005	0.8%			
CY2006	0.8%			
CY2007				
CY2008			2.75%	
CY2009			2.75%	
CY2010			2.75%	
CY2011	1.0%		3.79%	
CY2012	1.0%		3.79%	
CY2013	1.0%		1.32%	
CY2014				$80.65 (3.5%)
CY2015		0.5%		$80.65 (3.5%)
CY2016		0.4%	0.97%	$80.65 (3.5%)
CY2017		0.3%	0.97%	$80.65 (3.5%)
CY2018	2.0%		0.97%	
CY2019		0.8%	1.69%	
CY2020 PDGM begins			4.36%	
CY2021		0.3%		
CY2022		0.5%		
CY2023	5.2% forecast error	0.20%	3.925%	
CY2024		0.30%	2.89%	
CY2025 (proposed)		0.50%	4.067%	
TOTAL REDUCTIONS*	12.9%	3.8%	55.569%	$322.60 (14.0%)

Sources:

*This represents the sum of the cuts. However, the cumulative impact is much greater as each cut affects the base rate on a permanent basis.

** Reductions unrelated to adjustments made to achieve budget neutrality with case mix weight or wage index recalibrations

FY2001: https://www.govinfo.gov/content/pkg/FR-2000-07-03/pdf/00-16432.pdf

FY2002: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CMS-1147-NC.pdf

FY2003: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1198nc.pdf

FY2004: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/cms1473nc.pdf

CY 2005: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1265f.pdf

CY2006: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1301f.pdf

CY2007: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/cms1304f.pdf

CY2008: https://www.govinfo.gov/content/pkg/FR-2007-08-29/pdf/07-4184.pdf

CY2009: https://www.govinfo.gov/content/pkg/FR-2008-11-03/pdf/E8-26142.pdf

CY2010: https://www.govinfo.gov/content/pkg/FR-2009-11-10/pdf/E9-26503.pdf

CY2011: https://www.govinfo.gov/content/pkg/FR-2010-11-17/pdf/2010-27778.pdf

CY2012: https://www.govinfo.gov/content/pkg/FR-2011-11-04/pdf/2011-28416.pdf

CY2013: https://www.govinfo.gov/content/pkg/FR-2012-11-08/pdf/2012-26904.pdf

CY2014: https://www.govinfo.gov/content/pkg/FR-2013-12-02/pdf/2013-28457.pdf

CY2015: https://www.govinfo.gov/content/pkg/FR-2014-11-06/pdf/2014-26057.pdf

CY2016: https://www.govinfo.gov/content/pkg/FR-2015-11-05/pdf/2015-27931.pdf

CY2017: https://www.govinfo.gov/content/pkg/FR-2016-11-03/pdf/2016-26290.pdf

CY2018: https://www.govinfo.gov/content/pkg/FR-2017-11-07/pdf/2017-23935.pdf

CY2019: https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf

CY2020: https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf

CY2021: https://www.govinfo.gov/content/pkg/FR-2020-11-04/pdf/2020-24146.pdf

CY2022: https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf

CY2023: https://www.govinfo.gov/content/pkg/FR-2022-11-04/pdf/2022-23722.pdf

CY2024: https://www.govinfo.gov/content/pkg/FR-2023-07-10/pdf/2023-14044.pdf

CY2025: https://www.govinfo.gov/content/pkg/FR-2024-07-03/pdf/2024-14254.pdf

Current Care Access Problems Are Expected to Significantly Increase with the Proposed Rate Cut

In the CY 2024 rulemaking, the ALLIANCE and others presented stunning evidence about the growing barriers to care access faced by Medicare beneficiaries since the onset of PDGM. This evidence was dismissed by CMS in its rulemaking responses for a variety of reasons including that causation was not established, the data analysis may have relied on duplication of patients, and that the rejection of a patient by one HHA did not automatically translate to rejection by all HHAs.

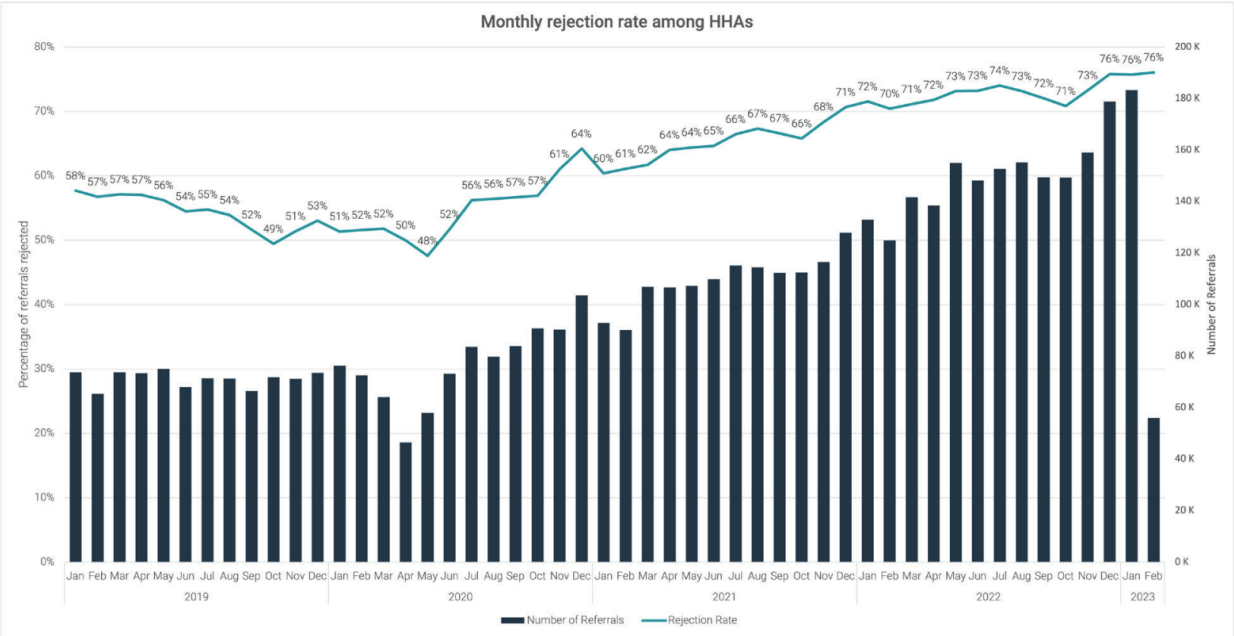
Such a position begs for something more than a dismissal of concerns. Instead, CMS, with its ability to evaluate global data on home health care access, must take steps to answer the questions posed through the analyses presented by HHAs and their representatives. CMS is best positioned to undertake that analysis. Something more from CMS than a casual dismissal of relevant data analysis is a CMS responsibility.

One of the CY 2024 rulemaking commenters, Homecare Homebase, took added steps for its CY2025 rulemaking comments on the extraordinarily relevant question as to what becomes of patients that are rejected for admission by an HHA. In using its vast database of Medicare claims and other data, the recent comments submitted by Homecare Homebase confirm the concerns that have been previously voiced. Its data analysis shows that 35% of referrals to its clients are rejected and do not find access with any other of its clients. Given the significant market share for Homecare Homebase, at a minimum this outcome warrants a deeper dive by CMS. Even if one-half of those referrals find an alternative HHA, the impact on patients and Medicare of the remaining half finding no care is unacceptable. When combined with the continuing reduction in the number of home health users annually since PDGM, an investigation is the duty of CMS.

Here are several previously referenced signs of the existing difficulties in care access:

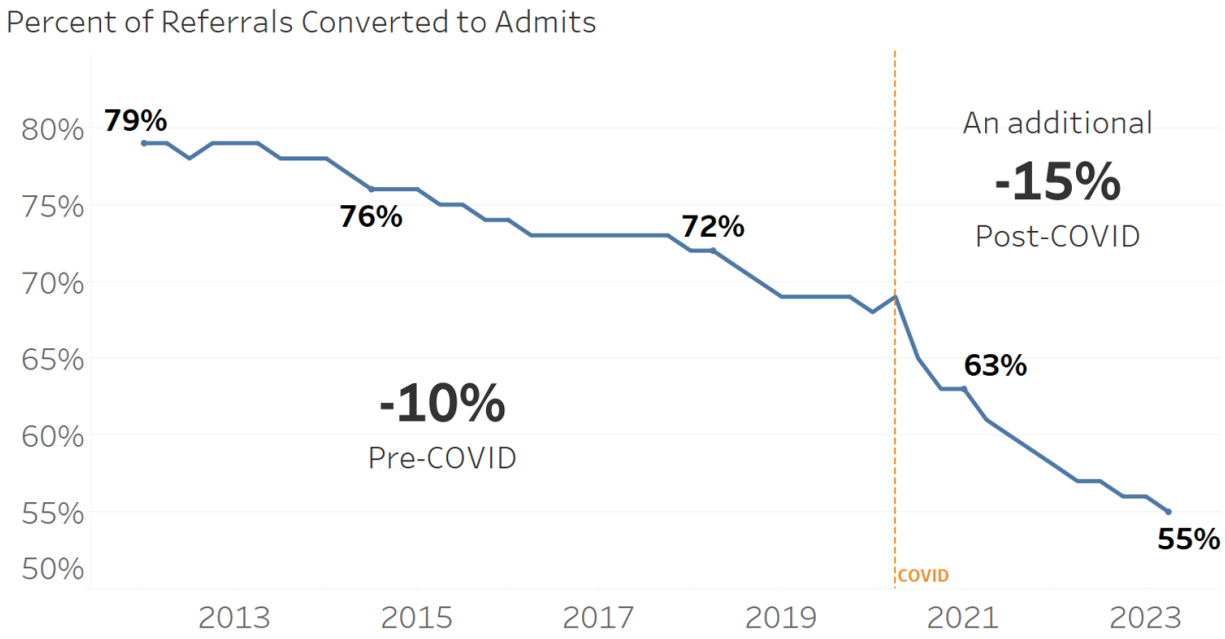
Hospital discharge data shows that hospitals are facing a growing level of patient referral rejections for prospective home health patients. This has led to delays in discharging patients to their homes, and extending costly inpatient stays as reported by the American Hospital Association. file:///C:/Users/wad/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/L69H8U3R/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf

The delays in hospitals discharging patients to home health services is certain to create a significant cost to the hospitals, but also to Medicare.



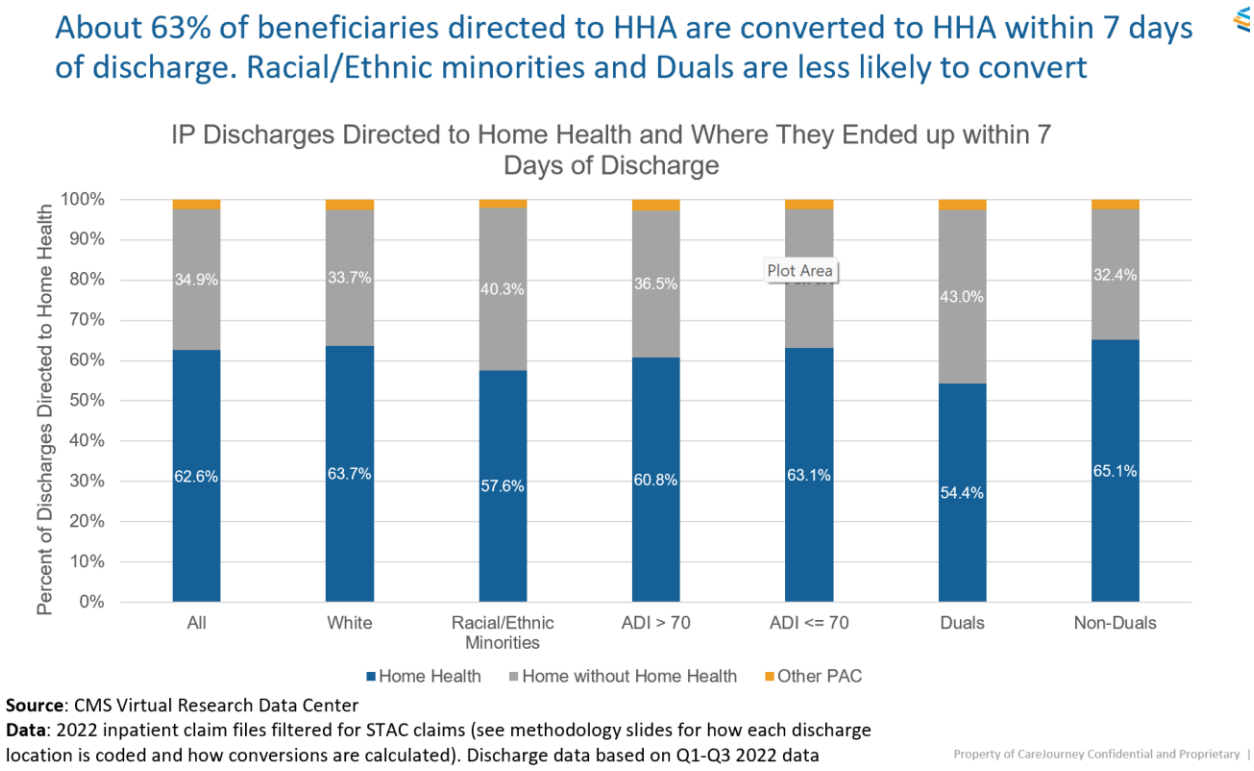
Source: July 25, 2023, WellSky Evolution of Care report, available at: https://careporthealth.com/about/results/the-evolution-of-care-2023/

Home Care Home Base, a large provider of EMR and billing services to HHAs further reports decreasing patient acceptance rates under the current PDGM payment rates.



Source: HCHB data, as presented in HCHB comments on this Proposed Rule.

Finally, data analytics company, Care Journey explains that only 63% of inpatient discharges are securing and initiating home health services within 7 days.



We characterized this data as "scary" in our CY 2024 comments. It has gotten worse and all trends point o the decline to continue. HHAs routinely express to the ALLIANCE that nurses are rejecting home health care employment every day due to compensation offers that fall short of what they can earn in other care sectors. Reducing payment rates at this time will certainly make care access even worse.

Additional Proposed Changes Affecting Medicare Payment Rate Will Greatly Increase the Disruptive Nature of the CY2024 Payment Rule Creating Further Risks to Care

The above analysis fully substantiates the ALLIANCE's concerns that the proposed rate cut in 2025 will be a disaster for home health services patients and HHAs. However, there are additional elements of the proposed rule that affect payment that can be fully expected to compound the negative impact of that rate cut. These other proposals include:

- The failure to correct the unprecedented error level in the forecast of HHA cost changes in 2021-2022.
- Significant shifts in the wage index values.
- Recalibration of the 432 case mix weights.
- Market Basket Index rebasing and revision of input weights.

The Financial Shortfall in the Market Basket Index Will Continue to Disrupt the Financial Stability of HHAs

CMS has confirmed that its modeling led to a Market Basket Index forecasting error for CY2021 through CY 2022. The ALLIANCE previously estimated that error to be 1.8 and 3.2 points in 2021 and 2022 respectively. In previous rulemaking, CMS declined to correct the error indicating it did not have such authority.As submitted in the ALLIANCE's CY 2024 NPRM comments, the estimated impact of that error cast is expected to result in an approximately $11 billion underpayment by Medicare over a ten-year period.

Projected Impact of 5.2 Forecast Market Basket Error in CY 2021 through CY 2030

Total Payments	Impact of CY 2021 and CY 2022 Forecast Error
2021	-$285,512,085
2022	-$867,452,091
2023	-$871,874,624
2024	-$1,115,186,361
2025	-$1,161,316,235
2026	-$1,225,352,343
2027	-$1,273,931,221
2028	-$1,342,554,653
2029	-$1,394,931,985
2030	-$1,449,139,655
Total	**-$10,987,251,254**

Source: Dobson | Davanzo

While CMS has not and is not likely to correct the error, the impact is nonetheless real for HHAs, creating another destabilizing force within the HHA community. When combined with the proposed rate reduction, the impact of significant swings in wage index values, and the recalibration of the 4432 case mix weights and resetting of the universe of LUPA thresholds, HHAs face multiple disruptions in operations that will affect patient access to care and the level of services available. The impact is not conjecture. Instead, it is a prognosis based on over a decade of experiences since 2011.

Significant Shifts in Wage Index Values Add to the Destabilization of the Home Health Benefit

Once again, the changes in wage index values significantly contribute to the instability on access to the home health benefit. As CMS well knows, HHAs are relegated to the pre-rural floor, pre-geographic reclassification inpatient hospital wage index while HHAs compete with hospitals that are subject to a different wage index for the same clinical and administrative staff. For 2024, CMS implemented a recalibration of the assigned wage index values, but also a resetting of the labor percentage of payment rates affected by the wage index. For 2025, in addition to the usual swings in the wage index for HHAs, CMS proposes to modify the county-level designations in CBSAs and rural areas. Since the home health NPRM was issued, CMS finalized these changes for other health care sectors operating on a federal fiscal year basis. As such, the disruptive effect of the proposed wage index changes

for home health can reasonably be presumed to be the reality for 2025 in home health services. These changes add to the complications wrought by the proposed rate reduction and other payment-affecting proposals.

The ALLIANCE compared the current 2024 wage index values with the proposed values post-5% cap for 2025, See, Appendix A attached).

Home Health Providers Significantly Impacted by Wage Index Change in CY 2025

Count	Number
Counties with wage index value change >/= -0.02	597
Counties with wage index value change >/= -0.03	370
Counties with wage index value change >/= -0.04	246
Counties with wage index value change >/= -0.05	71
Counties with wage index value change >/= -0.06	27
Counties with wage index value change >/= -0.07	9
Counties with wage index value change >/= -0.08	5
Counties with wage index value change >/= -0.09	2

The ALLIANCE recommends that CMS consider the impact of the wage index changes in determining whether to use its authority to postpone the proposed PDGM rate cuts to mitigate the expected overall access and care impacts already underway with home health services that will expand in 2025 with all these changes.

Medicare Stands to Lose Out in the HHVBP Demonstration as a Result of Expected Care Changes Triggered by the Proposed Rate Cuts

It was just two years ago that CMS moved to expand the successful Home Health Value Based Purchasing demonstration program from nine states to nationwide application. The ALLIANCE had been a supporter of the program since its initial design and fully supported the expansion. The program stood as one of the few value-based payment experiments to date with Medicare savings millions annually through reduced hospital admissions and more brought about through high quality home health services. CMS estimated that the nationwide expansion would reduce Medicare expenditures by nearly $3.4 billion over five years.

To get that savings takes dedication and innovation by HHAs. That effort also comes with a cost in resources. The proposed rule reducing payment rates by 4.067% and the combined effect of a 5.2% shortfall in the annual inflation update, a modified wage index, and the instabilities coming through case mix weight recalibrations are certain to diminish needed resources to succeed in HHVBP. There is only so much an HHA can do to produce the highest quality of care when the resources needed to deliver care are reduced. While we expect that HHAs will continue to provide an incredibly high quality of care as they have done following other rate reductions, we believe that they have reached a breaking point financially. As noted above, as rates of payment are decreased, access to care and the level of care available also decrease. These changes are bound to affect patient outcomes and the success of HHVBP.

The proposed rate reduction may be viewed by some as CMS's lack of respect for the value of home health services, which is at odds with the objective evidence in HHVBP that home health care

brings a dynamic value to Medicare and the patients its serves. The ALLIANCE believes that CMS maintains an understanding of the value of home health services and will recognize the need to preserve that value by postponing the proposed rate cut in 2025.

The ALLIANCE Maintains That the Methodology Applied by CMS to Determine Whether PDGM Is Budget Neutral Is Noncompliant with the Statutory Mandate

In the 2022 and 2023 HHPPS rulemaking, the ALLIANCE strenuously expressed its view that the budget neutrality assessment methodology used by CMS was fatally flawed both logically and under Medicare law. That view was supported by two independent legal analyses from highly respected law firms that included attorneys formerly with the CMS/HHS Office of General Counsel. The ALLIANCE will not repeat all the arguments presented to support that position.

While the U.S. District Court for the District of Columbia dismissed the case based on failure to exhaust the remedy of seeking expedited judicial review, the matter will be eventually refiled once that administrative step concludes. However, with the normal time involved in administrative appeals and the normal pace of litigation, it is unexpected that the matter will be resolved prior to January 1. 2025 effective date of the Final Rule that comes out of the pending proposed rule. For that reason, The ALLIANCE respectfully requests that CMS use its authority under 42 USC 1395fff to postpone the proposed 4.067% rate cut as the great harm outlined above must be avoided.

RECOMMENDATIONS:

1. **CMS should postpone application of any permanent adjustments related to PDGM budget neutrality to preserve current access to home health services and the scope of care available.**
2. **CMS should maintain its proposed position to withhold any part of the PDGM budget neutrality temporary adjustments in 2025.**
3. **CMS should recognize the disruptive and permanent financial impact of its forecasting error with respect to the annual Market Basket Index updates from 2021 and 2022 and implement a one-time adjustment to account for the 5.2% forecasting error.**
4. **CMS should consider the negative and disruptive financial impacts of its proposed wage index changes and case mix weight recalibrations on care access as it finalizes the 2025 payment rates and any systemic reforms.**

NON-PAYMENT PROVISIONS

III. Home Health Quality Reporting Program (HH QRP)

D. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning With the CY 2027 HH QRP.

CMS proposes collecting one item that addresses living situation, two food items, and one for utilities, along with a proposal to modify the currently collected transportation assessment item using the Outcome and Assessment Information Set (OASIS) data set. The ALLIANCE supports collecting these additional social determinants of health (SDOH) data items. Although HHAs consider these SDOH for effective care planning, there is no standardized mechanism for collecting and reporting the data, which could provide valuable information for HH QRP and other federal programs. CMS might want to

consider including in future rulemaking the AHC HRSN core questions screening tool within the post-acute care (PAC) assessment instruments if there are plans to continue to propose and adopt items from the tool.

However, we have concerns with the frequency that CMS has modified the HH QRP necessitating updates to the OASIS data set over the last several years. The addition of the proposed new and modified items will require yet another revision of the OASIS data set to be issued sometime in 2026 to accommodate the January 1, 2027, proposed collection date. Since the implementation of the Improving Medicare Post - Acute Care Transformation (IMPACT) Act there have been multiple revisions to the OASIS data set to accommodate the development of standardized assessment items and cross setting measures as required by the Act. HHAs have had to adjust to a revised OASIS data set and instructions in 2019, 2020, and 2023[1]. The last revision related to the IMPACT Act requirements was implemented in 2023 (OASIS E). However, CMS continued to implement additional changes to the HH QRP requiring another revision to the OASIS data set, effective January 1, 2025. CMS, again, is proposing additional changes to be implemented in 2027.

Changes to the OASIS data set, even small changes, increase resource use for agencies in terms of staff training, coordination with vendors, and altered productivity associated with the learning curve required for collecting new material. The burden is magnified by increased rate cuts and a protracted workforce shortage. Also, the addition of assessment items without modifications to reduce the data set could result in a very lengthy assessment tool.

An additional concern with frequent changes to the HH QRP is the delay in data reporting for HHAs. HHAs have consistently been the last of the PAC settings subject to the IMPACT Act to have their data set modified for cross setting assessment items and quality measures. CMS has convened technical expert panels to address inclusion/exclusion of cross setting assessment items and measures based on data derived from the other PAC settings without the home health data being accessible to the participants or the home health agencies themselves.

Recommendations: CMS should:

1. **Limit revisions to the OASIS data set to intervals no less than 4 years from the last revision.**
2. **Considered imbedding the AHC-HRSN core question screening tool into the PAC assessments if feasible.**
3. **Monitor additions to the OASIS data set to ensure that the tool is manageable for HHAs.**
4. **Provide sufficient data on HHA quality measures and assessment items prior to implementing any changes in the OASIS data set.**

G. HH QRP Quality Measure Concepts Under Consideration for Future Years— Request for Information (RFI)

CMS is seeking feedback on four measure concepts that are part of the "Universal Foundation" of quality measures. The measures include immunizations (i.e. Adult Immunization Status measure); depression (i.e. Clinical Screening for Depression and Follow-up measure); pain management; and substance use disorder (i.e. Initiation and Engagement of Substance Use Disorder Treatment measure).

[1] Outcome and Assessment Information Set OASIS-E1 Manual, Centers for Medicare & Medicaid Services, effective 01/01/2025, https://www.cms.gov/files/document/draft-oasis-e1-manual-04-28-2024.pdf

Immunization - Adult Immunization Status measure:

The recommended measure for the immunization concept includes the following vaccine rates and reasons for not receiving the vaccine.

> Four individual vaccine rates: 1. Influenza rate: Beneficiaries who received an influenza vaccine on or between July 1 of the year prior to the Measurement Period and June 30 of the Measurement Period. 2. Td/Tdap rate: a. Beneficiaries who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the Measurement Period and the end of the Measurement Period, or b. Members with a history of at least one of the following contraindications any time before or during the Measurement Period: i. Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine. ii. Encephalitis due to the diphtheria, tetanus, or pertussis vaccine. 3. Zoster rate: Beneficiaries who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, anytime on or after the beneficiary's 50th birthday and before or during the Measurement Period, or beneficiaries with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period. 4. Pneumococcal rate. Beneficiaries who were administered at least one dose of adult pneumococcal vaccine on or after their 19th birthday and before or during the measurement period, or beneficiaries with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.

HHAs would not have access to information on the multiple vaccination status of patients without a tremendous amount of research across a patient's medical records and /or interviews with practitioners familiar with the patient. HHAs will likely have to rely on the patient's recall of their vaccination status, leading to inaccurate or misleading responses. The burden for HHAs to collect multiple vaccine rates far outweighs any benefit that could be derived from collecting the information. Additionally, many of the provider representatives on the Post-Acute Care (PAC) and Hospice Quality Reporting Program Cross-Setting Technical Expert Panel[2] did not support the measure for the reasons associated with the burden to collect the information. Therefore, we believe that the measure concept, as proposed, is not appropriate for the home health setting from a practicable standpoint.

Recommendation: CMS should not consider including in the HH QRP the "Adult Immunization Status" measure, or any similar measure related to vaccinations that requires extensive review of data sources.

Depression- (i.e. Clinical Screening for Depression and Follow-up measure)

The typical HHA is not set up to treat patients presenting with depression. Interventions to address a positive depression screen would not be within the HHAs control to facilitate without significant resources and an infrastructure to address a depression diagnosis. Additionally, home health patients are often discharged from services before any outcomes through community referrals can be realized.

If CMS were to include a measure for depression screening and follow-up, the follow-up would need to be limited to a referral to the patient's PCP for further interventions. The Clinical Screening for Depression and Follow-up measure or similar measure that CMS is considering is one that is used for

[2] Standing Technical Expert Panel for the Development, Evaluation, and Maintenance of Post-Acute Care (PAC) and Hospice Quality Reporting Program (QRP) Measurement Sets Summary Report. https://www.cms.gov/files/document/december-2023-pac-and-hospice-cross-setting-tep-summary-report.pdf-3

individual practitioners who have the expertise and authority to prescribe pharmacological interventions and have a relationship with the patient that supports the necessary follow-up for such interventions. As stated above, HHAs do not have a consistent relationship with most patients that would allow for the HHA to treat the patient. Unless an HHA specializes in the delivery of psychiatric nursing care it does not have staff with the training and expertise necessary to determine if a referral to a psychiatrist, psychologist, mental health counselor or primary care physician is most appropriate. Additionally, HHAs provide care to patients for an average of 3.1 episodes[3] which is conducive to the necessary monitoring and follow-up for pharmacological interventions. HHAs cannot be expected to provide intervention aimed directly at treating depression such as pharmacological interventions or other follow-up that involves long term planning.

Recommendation: CMS must consider the limitations for HHAs to address a depression diagnosis when considering the measure concept for the HH QRP

Substance use disorder (i.e. Initiation and Engagement of Substance Use Disorder Treatment measure).

Like the depression diagnosis, HHAs are not set up to address patients with a substance use disorder (SUD), either as a primary or secondary diagnosis. HHAs are even less likely to accept a patient onto service with an active SUD due to their inability to effectively provide interventions or ensure that community support is available for the treatment of the disorder. Patients with a SUD require interventions provided by specially trained clinicians to treat SUD, along with intensive therapies. There is a known shortage of these clinicians and programs within most communities, and the typical HHA does not have specialty trained clinicians on staff. HHAs would have limited control over the availability of such programs much less the interventions provided. Additionally, there is no data source currently available that captures SUD and interventions for home health patients, therefore, an added burden will be created for agencies to collect and report data needed for the measure concept.

As such, a measure concept for patients with SUD in the home health setting is not appropriate, particularly as described in the suggested measure for this concept.

Initiation and Engagement of Substance Use Disorder Treatment -measure description

1. Percentage of patients 13 years of age and older with a new substance use disorder (SUD) episode who received the following (Two rates are reported):
    a. Percentage of patients who initiated treatment, including either an intervention or medication for the treatment of SUD, within 14 days of the new SUD episode.
    b. Percentage of patients who engaged in ongoing treatment, including two additional interventions or short-term medications, or one long-term medication for the treatment of SUD, within 34 days of the initiation.

Recommendation: CMS should not move forward with a measure concept related to SUD for inclusion in the HH QRP.

Pain management

The ALLIANCE supports performance measures around pain management and has relevance for home health patients. However, CMS removed the improvement in pain management measure from the HH QRP in 2020 due to the opioid crisis. Therefore, it is unclear what CMS is seeking in terms of a pain management performance measure in the current environment.

[3] Home Care Chartbook, 2023. https://researchinstituteforhomecare.org/wp-content/uploads/Final-RIHC-Chartbook-2023-1.pdf

IV. The Expanded Home Health Value Based Purchasing (HHVBP) Model
B. Request for Information on Future Performance Measure Concepts for the Expanded HHVBP Model

CMS is seeking information on four measure concepts for inclusion in the HHVBP: family caregiver measure; falls with injury (claims-based) measure; Medicare Spending per Beneficiary measure; and function measures to complement existing cross-setting Discharge (DC) Function measure:

Family Caregiver Measure

The measure would address whether the needs of caregivers for home health patients have been met. CMS does not provide much information on exactly what is to be measured and how this measure would be constructed. Therefore, it is difficult to comment in support of the measure concept. The immediate concern is the additional burden around data collection for the measure. CMS would likely need to revise the standardized assessment tool or modify the HH CAHPs survey, which are already lengthy tools, for collecting and reporting of the data. Additionally, an HHA's focus is on the care of the patient and not the needs of the caregiver. Further, it is unknown if a measure can be developed that accurately reflects whether a caregiver's needs have been met. It is also questionable whether a measure can be developed that will allow for accurate comparisons among HHAs.

Recommendation: CMS must consider the complexity and potential burden for data collection when developing a measure to address the needs of the family caregivers for home health patients.

Fall with injury (Claims Based) measure

The ALLIANCE has the same concern with a potential claims-based measure for falls as it does with the OASIS based measure. The falls with injury measure (claims or OASIS based) does not take into consideration the nature of home health services. Care is provided on an intermittent basis with the focus on the home environment. The measure will capture a fall with injury anytime during the home health episode irrespective of whether the HHA had any control over the patient's movements. For example, the patient falls while outside the home, such as on the way to the physician's office. Fall prevention programs aimed at safety in the home for a particular patient might not be transferable to the general community setting.

Recommendation. CMS should not include the falls with injury measure into the HHVBP

Medicare Spending per Beneficiary (MSPB)

It is unclear how CMS intends to use the MSPB measure in the HHVBP. It is important to note that the MSPB measure is not a quality measure but a measure for Medicare spending. The measure is assumed to be a measure of efficiency if the HHA's MSPB is less than the Medicare spending of the national median home health agency's MSPB. However, the amount spent on care does not necessarily correlate with the efficient provision of services or the quality of care.

Recommendation: CMS should not include the MSPB measure in the HHVBP.

Function measures to complement existing cross-setting Discharge (DC) Function measure:

Recommendation: The ALLIANCE supports the inclusion of additional function measures in the HHVBP that complement the DC Function measure.

3. Requests for Information
a. RFI Regarding Rehabilitative Therapists Conducting the Initial and Comprehensive Assessment

How do HHAs currently assign staff to conduct the initial assessment and comprehensive assessment? Do HHAs implement specific skill and competency requirements?

HHAs provide all professional staff with additional training specific to the agency policies and procedures, completing the OASIS data set, and applying practice to the home health setting. Additionally, new hires to HHAs would go through some type of orientation and period of supervision to determine their readiness for providing home health services. The orientation and supervision would be tailored to the individual's clinical skills and needs. The clinical professionals (therapist and registered nurses) would be expected to have the skills necessary to conduct an initial and comprehensive assessment of a patient, and therefore when permitted by regulation, be able to conduct the assessments as needed.

What types of mentorships, preceptorship, or training do these disciplines have qualifying them to conduct the initial assessment and comprehensive assessment?

Do the education requirements for entry-level rehabilitative therapist provide them with the skills to perform both the initial assessment and comprehensive assessment? Is this consistent across all the therapy disciplines? How does this compare with entry-level education for nursing staff?

What, if any, potential education or skills gaps may exist for rehabilitative therapists in conducting the initial assessment and comprehensive assessment

This response is intended to address the above questions. In discussion with representatives from the professional associations for physical therapy, occupational therapy, and speech language pathology (American Physical Therapy Association (APTA), American Occupational Therapy Association, (AOTA) and the American Speech-Language Hearing Association (ASHA)) all concurred that the education and training for therapists is aimed to prepare the respective therapists to adequately conduct an initial and comprehensive assessments on home health patients. However, any new graduate (therapist or registered nurse) would not be expected to conduct an initial and comprehensive assessment without participating in a mentorship program and demonstrating that they have the necessary skills to conduct the initial and comprehensive assessments. It is important to note that HHA's typically do not hire new graduate therapists, the preference for new hires, for all disciplines, is to have several years of clinical experience.

Additionally, CMS notes in the proposed rule the specific training required by each discipline. PTs must hold a Doctor of Physical Therapy. Physical therapy entry-level education requires a Doctor of Physical Therapy degree. The Commission on Accreditation in Physical Therapy Education (CAPTE) of American Physical Therapy Association (APTA) accredits entry-level physical therapist education programs. Graduates of these programs are then eligible to take the National Physical Therapy Examination and apply for State licensure. The curriculum includes the general clinical skills required to conduct the initial and comprehensive assessments, both in the identification of immediate care and support needs, as well as the assessment of the patient's general health, psychosocial, functional, cognitive, and pharmacological status, and clinical experience.

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SLPs must obtain a Certificate of Clinical Competence in Speech-Language Pathology as well as state licensure. SLP must obtain a master's, doctoral, or other recognized post-baccalaureate degree. Once students complete all academic coursework and a graduate student clinical practicum, they must also complete a clinical fellow.

This requires graduation from a program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language Hearing

Association (ASHA). Individuals applying for certification in speech-language pathology must have been awarded a master's, doctoral, or other recognized post-baccalaureate degree. Once students complete all academic coursework and a graduate student clinical practicum, they must also complete a clinical fellowship under the supervision of a SLP mentor. The clinical fellowship requires working at least 36 weeks and 1,260 hours and is intended to transition the fellow from a student enrolled in a communication sciences and disorders (CSD) program to an independent provider of speech-language pathology clinical services

OTs must hold either a Master's degree or Doctorate of Occupational Therapy. Education programs are accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the AOTA. The ACOTE establishes, approves, and administers educational standards to evaluate occupational therapy educational programs. Graduates of ACOTE accredited programs are eligible to take the National Board for Certification in Occupational Therapy (NBCOT) certification exam and apply for State licensure

What challenges did HHAs and therapists that conducted these assessments under the PHE waiver experience that may have impacted the quality of these assessments?

Home health agencies did not report any challenges with exercising the waiver that expanded the role of therapists in conducting the initial and comprehensive assessments. Nor was there any evidence that quality of care for patients was impacted, suggesting that assessments conducted by therapist were completed accurately.

During the PHE, HHAs relied on therapists to conduct the initial and comprehensive assessments that were existing employees with the agency and had a proven record of clinical competence. New hires for HHAs were virtually nonexistent during the PHE.

For the HHAs and therapists that conducted the initial assessment and comprehensive assessment under the PHE waiver, what were the benefits and were there any unintended consequences of this on patient health and safety?

Because the regulations permit a therapist to conduct the initial and comprehensive assessments if therapy is the only discipline ordered, there has always been precedent for a therapist to conduct the assessments. Long before the PHE, we had advocated for a change in the regulations at §484.55 that provided a similar flexibility as the PHE waiver.

HHAs have overwhelmingly reported that this flexibility was most beneficial during the PHE in their ability to provide care to patients requiring home health services and allowed for the timely initiation of care during unprecedented workforce challenges. HHAs also reported that the waiver was the most widely used of all the PHE waivers.

The application of that waiver into HHA operations during the PHE had the same effect as a three-year demonstration project. During that time there were no adverse effects on the quality of care for home health patients. The waiver was particularly beneficial for patients in rural areas where workforce shortages were, and remain, the most profound.

What challenges, barriers, or other factors, such as workforce shortages, particularly in rural areas, impact rehabilitative therapists and nurses in meeting the needs of patients at the start of care and early in the plan of care?

The recent Medicare payment cuts to HHAs and the workforce shortages have significantly impacted HHAs in rural areas. Rural providers have unique challenges that include longer travel distances between visits and greater competition for qualified workers. Additionally, home health therapists and nurses often serve as the primary source for health evaluations and care delivery in underserved areas. Rural agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and to integrate the use of technologies in agency operations. As a result, agencies have been forced to reduce service areas and refuse admission to patients whose care costs would place an agency at financial risk.

Reports from our rural provider members have sounded the alarm with closures and service area reductions. For example, one agency in rural Nebraska reported having to downsize from serving 13 counties (60-mile radius) to serving only one county (25- mile radius) with a drop in the average daily census (ADC) by 60% since 2020. An agency in rural Vermont has reduced its service area by a third with ADC down by nearly 50% over the past year. The state of Missouri alone has lost 56 home health agencies to closure since August 2017, and 14 of those just in the last 18 months. Sixty-six percent of these closures were in rural areas. It is reasonable to believe that this pattern of care delivery reductions and HHA closures is being repeated throughout rural America.

b. Plan of Care Development and Scope of Services Home Health Patients Receive

What factors influence an HHA's decision on what services to offer as part of its business model and how often do HHAs change the service mix?

Most HHAs do, or strive to, provide all services permitted under the home health benefit. Limitations to the services an agency provides is usually driven by available staff. Agencies report having difficulty recruiting and retaining nurses and home health aides, although we are also hearing of reports of difficulty in recruiting and retaining all discipline types, particularly in rural areas. Therefore, the change in services provided is often dictated by market forces and the availability of certain categories of staff.

What are the common reasons for an HHA to not accept a referral?

HHAs currently report that the most common reason for having to turn down referrals is because of workforce shortages particularly for nurses and home health aides, although HHAs also report difficulty in recruiting all disciplines to some degree. Some providers have reported a significant shortage of therapists in their region particularly in rural areas. Home health patients are being referred to home health with more complex conditions requiring multiple disciplines and the need for front loading of visits that the HHA may not be able to provide. Home health is experiencing a perfect storm of challenges whereby patients have greater needs, but the workforce is at a critical low.

Other reasons include incomplete referrals, particularly where the referral source is not able to identify a community provider to follow the patient or have the wrong provider listed. If the HHA cannot locate a practitioner to follow the patient timely, it places both the patient and agency at risk.

Discharge planners in acute/post-acute care facilities often routinely refer beneficiaries to home health care, irrespective of whether the beneficiary meets coverage criteria. It is not uncommon for inpatient referral sources to include a multitude of services on a referral irrespective of the needs of the patient. The HHA must explain to the beneficiary why they do not meet coverage criteria for some, or all, of the services ordered. Conversely, it is not unusual for HHAs to receive referrals for patients where the needs are too complex to be met in the home.

How do physicians and allowed practitioners use their role in establishing and reviewing the plan of care to ensure patients are receiving the right mix, duration, and frequency of services to meet the measurable outcomes and goals identified by the HHA and the patient?

Physicians and allowed practitioners use their role in establishing and reviewing the POC for adequacy of service delivery based on their professional judgement. HHAs may only provide care as ordered by a physician or allowed practitioner and therefore their role is critical in providing the appropriate mix of disciplines, and duration and frequency of services.

To what extent do physicians rely on HHA clinician evaluations and reports in establishing the mix of services, service frequency, and service duration included in the plan of care?

Community practitioners rely on the HHA's evaluation and reports to inform the plan of care. If a patient is being referred to home health from an acute/post-acute care facility the patient will have been followed by a hospitalist and/or a skilled nursing facility Medical Director who refers the patient to home health. The patient's primary care practitioner (PCP) resumes care only upon the patient's return home. The HHA is usually the first contact the patient has with a community healthcare provider. Therefore, the HHA's evaluation of the patient's condition and care needs relative to the home setting is necessary for effective care planning by the community practitioner. Even when a referral is received from the community PCP, the HHA provides a unique perspective for care planning in the individual's home.

What are the patient and caregiver experiences in receiving nursing, aide, and therapy services when under the care of a home health agency?

Sources for this information include the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey and the HHA complaint logs.

What additional evidence is available regarding negative outcomes or adverse events that may be attributable to the mix, duration, and service frequency provided by HHAs, including, but not limited to, avoidable hospitalizations?

CMS' discussion on negative outcomes for patients largely addressed those patients who were unable to access home health services timely. CMS cited several publications that addressed the workforce shortages related to the COVID-19 PHE. It is unclear what additional evidence CMS is seeking.

In what ways can referring providers and HHAs improve the referral process?

Improved communication between referral sources and HHAs is needed and should include consistent feedback regarding necessary information needed for a complete referral, coverage criteria for beneficiaries to receive Medicare covered home health services, and the HHAs capacity for acceptance with anticipated referrals.

CMS should support and encourage interoperability of health care information across providers. Interoperability will help facilitate the referral process by allowing HHAs to obtain the necessary information regarding the patient's current condition and care needs along with the past medical history and any social determinants of health that might impact care planning and delivery

What other factors may influence the provision of services that impact the timeliness of services and service initiation?

The increasing cost of providing care along with inadequate reimbursement from the primary sources of payment for home health services and the workforce shortage are not the only stressors on HHA resources. Federal policies that have impacted home health care operations include several recent initiatives that contribute to significant administrative burdens. For example, CMS' policy for the collection and reporting of the OASIS data set on all patients beginning in 2025. This policy alone has an unfunded $267 million price tag for HHAs, and for some HHAs, will have a significant impact on the availability for staff to meet the expanded collection requirement. Additionally, the nationwide Home Health Valiue Based Purchasing program and the Review Choice Demonstration requires HHAs to expend additional resources and disrupts agency operations. CMS must be mindful of the impact policies implemented by federal agencies have on HHA resources and operations.

What additional areas should CMS consider to address HHA patient health and safety concerns?

The problem of diminishing patient access to home health services is not a singular issue nor related solely to home health agency operations. As previously noted, there are multiple factors that are contributing to this systemic problem that need to be individually identified and addressed.

Therefore, CMS should develop a systematic approach to gathering additional information from all stakeholders with ideas for probable solutions. Although this RFI is a step in the right direction, CMS should not stop with this initiative to understand the root causes for patients' inability to access home health services.

VI. Home Health CoP Changes and Long Term (LTC) Requirements for Acute Respiratory Illness Reporting

A. Home Health CoP Changes

CMS claims they have received an increasing number of beneficiary complaints related to the difficulty finding a HHA to accept them for service. Beneficiaries complain that in some instances, HHA services are being altered or diminished from the original plan of care without an accompanying reduction in patient needs or achievement of the measurable outcomes and goals set forth in the plan of care.

In addition to the challenges of finding the right HHA and resultant potential delays in the timely initiation of home health care, CMS also expressed concern that HHAs are at higher risk of overextending their available resources when accepting new patients to HHA services. Delays in service initiation may indicate not only that referral sources have difficulty locating an appropriate HHA, but also that HHAs are accepting patients when and for whom they are not capable of delivering timely care.

To this end, CMS is proposing at § 484.105(i)(1)(i) through (iv), that HHAs would be required to include information regarding the HHA's case load and case mix (that is, the volume and complexity of the patients currently receiving care from the HHA), anticipated needs of the referred prospective patient, the HHA's current staffing levels, and the skills and competencies of the HHA staff. These proposed elements are designed to inform an HHA's assessment of its capacity and determine its suitability to meet the anticipated needs of the prospective patient that has been referred for HHA services.

CMS also proposes at § 484.105(i)(2) that HHAs make public accurate information regarding the services offered by the HHA and any limitations related to the types of specialty services, service duration, or service frequency, and that HHAs review that information annually or as necessary.

The ALLIANCE has concerns with CMS' proposal for the acceptance to service requirements, which include a prescribed acceptance to service policy and a requirement for HHAs to make publicly available information limitations on services, frequency and duration. The concerns CMS expresses around beneficiary access to home health services are not related to an agency's process for accepting admissions. HHAs are not able to accept patients onto service for multiple reasons. For example, available resources, an inability to identify a community practitioner, coverage criteria is not met, care needs are inappropriate for the home setting, to name a few.

However, in the current environment, the main reason beneficiaries are not able to access home health services is because HHAs do not have the capacity to accept all referrals. HHA capacity continues to shrink because of the increasing cost of providing services along with reduced reimbursement from the primary payer sources for home health services, compounded by an ongoing workforce shortage. HHAs are having an even greater time recruiting and retaining staff because of its precarious financial status that does not permit competitive compensation to clinicians in comparison to hospitals and other care settings. An additional challenge for staff recruitment and retention is the nature of delivering care in the home. Home care employees face a combination of occupational health and safety challenges that are not traditionally experienced by health care providers in other care settings.

Research studies have reported a range of 18% to 65% of home healthcare workers experiencing verbal abuse from patients. As many as 41% of home healthcare workers have reported sexual harassment. Between 2.5% and 44% of home healthcare workers have reported being physically assaulted. In one study, home healthcare registered nurses frequently reported demanding patients (34%), aggressive pets (27%), poor lighting in patient homes (21%), neighborhood violence/crime (19%), patients' challenging family members (18%), personal security fears (14%), drug use in patient homes (13%), firearms in the home (9%), and racial/ethnic discrimination (8%). Researchers have also reported that physical or verbal threats of violence were associated with providing home care services to patients with a history of violence or patients with mental illness or substance use disorders.[4] Although HHAs employ various strategies to protect workers these interventions also carry a cost and may not be enough to attract new hires.

In addition to staffing issues, we are hearing increasing reports of HHAs receiving incomplete referrals, particularly referrals for which there is not a community provider to follow the patient. The patient either has not identified a community practitioner or the referral source indicates an incorrect primary care practitioner. Referring patients to a HHA without identifying a community practitioner raises significant safety concerns for patients and liabilities for agencies. Because the HHA must conduct the initial evaluation visit within 48 hours of a patient's return home or referral, many HHAs will not accept these patients even if they believe a physician/practitioner can be identified readily.

CMS also expresses concern that "*delays in service initiation may indicate not only that referral sources have difficulty locating an appropriate HHA, but also that HHAs are accepting patients when and for whom they are not capable of delivering timely care.*" CMS seems to be setting policy on a presumed effect of delays in services, and does not provide any analysis on the scope of the problem or

[4] Felice, S.T., Goodwin, S.G., Oliveri, A., Socias-Morales, C., Castillo, D., & Olawoyin, R. (2021). Home Health care Workers: A Growing and Diverse Workforce at High Risk for Workplace Violence. Centers for Disease Control and Prevention. https://blogs.cdc.gov/niosh-science-blog/2021/09/02/hhc-violence

types of patients that have or may be impacted. CMS only states that they are "*..aware of anecdotal reports of home care agencies not providing care to meet patient needs."*

Although staffing changes can impact services provided and there will always be unforeseen circumstances, in any health care setting, that may alter capacity, HHAs do not routinely admit patients for which they cannot provide services. HHAs have admission policies in place that take into consideration the agency's capacity and clinical skills of staff when determining whether to accept a patient onto service. Additionally, there are standards at §484.60 to ensure HHAs only accept those patients for whom there is a reasonable expectation that the agency will be able to meet the patient's needs.

CMS' proposals for an acceptance to service policy and requiring HHAs make publicly available information on the HHA's service, duration and frequency, do not address the root causes around beneficiary access to home health services, and therefore, will not likely help to mitigate the problem. An acceptance to service policy as proposed will not increase an agency's capacity or help to address many of the other reasons for non-acceptance onto services. In terms of transparency and HHAs making publicly available information on services offered, many agencies list on their website the services they provide. This information is also available on the CMS Care Compare website. Perhaps referral sources are not consulting these resources. Also, there is confusion around what CMS expects regarding the HHA's listing limitations on frequency and duration of services that is to be made publicly available.

Furthermore, we have concerns with CMS' following stated position:

> "*…if an HHA accepts payment from both Medicare and another payment source, ''source X,'' the HHA's referral policy should be applied consistently to referrals for patients having Medicare or ''source X'' as a payment source. It is our position that HHAs should accept or decline patient referrals based solely on clinical considerations and the capacity of the HHA to safely and effectively deliver care to meet patient needs, rather than on financial factors related to the perceived adequacy of the payment rate that the HHA has already voluntarily agreed to accept upon establishment of relationships with its payment sources*."

CMS provides no statutory or regulatory references to support that position. While HHAs must comply with a variety of civil rights laws, there are none that prohibit an HHA from rejecting patients for admission based on a policy that limits admissions to patients with a payment source sufficient to cover the cost of care. Likewise, Medicare provider agreement requirements include no standard that obligates an HHA to admit all Medicare patients except those whose clinical needs cannot be met by that HHA. HHAs must accept Medicare payment as payment in full, but that requirement applies only for patients accepted into care by the HHA. Further, HHAS may not discriminate against Medicare patients in any respect where the restrictive admission standards do not apply equally to other patients.

With the standard referenced by CMS, an HHA could drive itself into bankruptcy where the referred Medicare patient census have a care plan and case mix adjustment categorization that provides reimbursement less than the cost of care. It is recognized that the PDGM prospective payment system will provide reimbursement that in some cases exceeds cost and other cases where the payment amount falls short of care costs. However, if an HHA is faced with a patient census that all or the majority fall into a financial loss outcome, that HHA will cease to exist and be inaccessible to all patients. A Medicare provider agreement is not the equivalent on indentured servitude.

If CMS believes that providers must act consistent with its above-referenced statement, the ALLIANCE respectfully asks that it provide a detailed rationale with full citations to any applicable statutory or regulatory authority or case law.

Recommendations: CMS should:

- **Withdraw its proposal at § 484.105(i)(1)(i) through (iv), for an acceptance to service policy and to require HHAs make publicly available information on services, and limitations on frequency and duration.**
- **Continue to seek feedback from stakeholders to determine the root cause for the decreases in patient access to home health services and develop policy and programs to help address these root causes.**
- **Withdraw the position that HHAs can only decline an admission to care based on a finding that it cannot safely and effectively meet the clinical needs of the patient.**

Conclusion

Thank you for the opportunity to submit these comments. As you will note from our comments, we take this process very seriously and we are confident that CMS will give our comments thoughtful consideration as well. The contents of the proposed rule will have a significant impact on the abilities of HHAs to serve individuals in need of essential home health services.

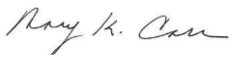
Very truly yours,

William A. Dombi

President and CEO-NAHC

President Emeritus and Of Counsel

NAHC-NHPCO ALLIANCE



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Vice President for Regulatory Affairs-NAHC

NAHC-NHPCO ALLIANCE

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