OHCA
OHIO HEALTH CARE ASSOCIATION

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On behalf of the Ohio Health Care Association, an advocacy organization representing home health agencies dedicated to delivering high-quality, patient-centered care, we appreciate the opportunity to respond to the Office of Management and Budget's (OMB) Request for Information on identifying federal regulations for potential rescission. Our member agencies operate at the frontlines of healthcare delivery, providing essential services to Ohioans, particularly older adults and individuals with chronic or complex medical conditions.

We welcome OMB's commitment to regulatory review and respectfully submit the following recommendations for the removal or revision of specific regulations that impose unnecessary administrative burdens, create inefficiencies, or hinder the ability of home health providers to focus on direct patient care. These recommendations are grounded in our members' on-the-ground experience and aim to promote a more efficient, responsive, and sustainable home health care system while maintaining the highest standards of quality and safety.

- **Medicaid Access Rule – HCBS Payment Adequacy Provisions** 42 CFR 441.302 (k), 441.311(e), 441.464(f), 441.570(f), and 441.745(a)(1)(vi) –
  These provisions require providers to report the percentage of Medicaid payments spent on direct care worker compensation and, for certain services, mandate that at least 80% of the payment be allocated to that purpose. This regulation represents a clear example of government overreach and is more likely to hinder access to essential services than to improve it. We request that you rescind all items listed.

- **Medicaid Access Rule - HCBS Payment Rate Transparency** 42 CFR 447.203 (b)(1), 447.203 (b)(2) to (4)
  These provisions impose new reporting system requirements on Home and Community Based Services (HCBS) providers and states, resulting in significant additional costs. Many states have already developed effective methods for rate analysis, making this rule duplicative and unnecessarily burdensome. We recommend rescinding or substantially revising this requirement to allow states flexibility in leveraging their existing systems.

- **HCBS Settings Rule – Heightened Scrutiny** 42 CFR 441.301(c)(5)(v)
  CMS has not demonstrated the capacity to conduct heightened scrutiny reviews in a timely manner, as evidenced by significant delays in processing. One of our provider members, for example, waited five years for CMS surveyor approval of their location. Community integration should be assessed based on the individual's lived experience and can be effectively evaluated at the state level. Federal involvement in this determination has resulted in prolonged delays and reduced access to critical services for individuals in need.

- **Documentation Requirements for the Home Health Face-to-Face Encounter** 42 CFR 424.22(c)
  Medicare regulations are highly prescriptive regarding what constitutes a valid face-to-face encounter with a physician or non-physician practitioner. These requirements are intended to ensure that a physician has evaluated the patient for the condition requiring home health services. For example, the physician must sign and date the encounter documentation, and the encounter must occur within a specific time frame. However, sub-regulatory guidance issued by Medicare Administrative Contractors (MACs) has added excessive and inconsistent layers of

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scrutiny to this process. Claims are often denied for technical issues—such as the date not appearing on the exact "date" line or the physician's signature being deemed

illegible—even though such specifications are not included in the actual regulation. These arbitrary denials result in providers losing payment for valid, medically necessary care due to minor formatting or stylistic preferences. We recommend that sub-regulatory guidance be revised to ensure that compliance with the face-to-face requirement is based solely on the criteria explicitly stated in the regulation.

Additionally, Home health agencies frequently identify new or evolving care needs upon a patient's discharge from an inpatient facility, needs that may become the primary reason for initiating home health services. Current requirements that hospital documentation must precisely match the reason for home health services can prevent timely and appropriate care from being provided. We recommend allowing a waiver of the face-to-face documentation requirement in cases where patients are discharged directly from an inpatient stay to home health care, and where the primary reason for home health services emerges post-discharge. This flexibility would better reflect the real-world care trajectory of patients and support continuity of care.

- **All payer OASIS reporting requirement** 42 CFR 484.285
  The requirement to collect data on all patients, regardless of payer source, is set to take effect on July 1, 2025. However, CMS has not provided additional funding to support the increased administrative burden on home health agencies, particularly the added staff hours needed to complete these assessments. Additionally, the clinical profiles of patients covered by commercial payers often differ significantly from those of the Medicare population. Including this data without appropriate contextualization risks producing skewed or misleading results.

- **Social Determinants of Health for the Home Health Quality Reporting Program (HHQRP)** 42 CFR 484.245
  This newly introduced measure under the Home Health Quality Reporting Program (HHQRP) presents additional challenges for agency providers. Issues include the lack of consistent standards, mismatched coding requirements, and the need to screen patients for health-related social needs rather than clinical indicators. Furthermore, the measure is duplicative of the comprehensive assessment already mandated by the Home Health Conditions of Participation. We recommend that this requirement is removed.

- **COVID-19 vaccination reporting for the HHQRP** 42 CFR 484.245
  The COVID-19 vaccination reporting requirements under the Quality Reporting Program (QRP), while well-intentioned in promoting transparency, impose significant burdens on already short-staffed healthcare providers. These mandates divert critical staff time and resources away from direct patient care at a time when the workforce is already under extreme strain. We urge reconsideration of this requirement or the implementation of streamlined reporting mechanisms to reduce administrative burden and allow providers to focus on delivering high-

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quality care.

- **Admission to service policy:** 42 CFR 484.105 (i)
  The 2025 Medicare admission-to-service policy seeks to standardize how home health providers accept patients and communicate their services, with the goal of reducing access barriers. However, this policy largely codifies practices that are already in place and does little to address the underlying issue: limited provider capacity driven by persistent staffing shortages. Without meaningful strategies to support workforce recruitment and retention, standardizing admission processes will have minimal impact on improving access to care. We recommend that CMS pair any procedural changes with targeted efforts to strengthen the home health workforce.

- **OSHA General Duty Clause (OSH Act §5(a)(1)):**
  Even in the absence of specific standards, employers are required to maintain workplaces "free from recognized hazards" (e.g., workplace violence or trip/fall hazards in cluttered homes). OSHA has issued voluntary guidelines for preventing violence against healthcare workers, including those in home health, and agencies are still obligated to address such risks under the General Duty Clause. However, this regulation is overly broad, as employers cannot reasonably ensure that a home environment is free from hazards. We recommend revising this regulation to exclude workers in home settings.

We appreciate the opportunity to submit feedback on behalf of our members. Should you have any questions, please do not hesitate to contact me.

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