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August 16, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1766-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, Maryland 21244-8013

Submitted via: regulations.gov.

Re: CMS -1766-P Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements

87 Fed. Reg. 37600 (June 23, 2022)

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 home health agencies (HHAs) along with the CY 2023 payment rates in the Notice of Proposed Rulemaking (NPRM). 87 Fed. Reg. 376000 (June 23, 2022).

The National Association for Home Care & Hospice (NAHC) respectfully submits these comments regarding the proposals contained within the NPRM. NAHC 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. NAHC members provide most Medicare home care services throughout the U.S.

NAHC 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, NAHC 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 virtually all people.

These comments are also supported by many members of our Forum of State Associations. 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 impact of the proposed rules in their local settings. Their "on the ground" perspective deserves special attention.

PAYMENT REFORM: PATIENT DRIVEN GROUPINGS MODEL (PDGM)

General Comments

We greatly appreciate the efforts that CMS has employed over the years to modernize the Medicare home health payment model. Further, early on, the degree of transparency provided regarding the development of the Patient Driven Groupings Model (PDGM) has been crucial in permitting stakeholders to fully evaluate it and its potential impacts on patients and home health agencies. With the onset of PDGM on January 1, 2020, no one could have forecast the degree of disruption and impact that Covid-19 would bring in patient mix, significant alteration of the home health patient census, practice changes in all sectors of health care, and the response from patients and prospective patients. Yet, during this unprecedented health care crisis, the Medicare home health program underwent the transition to a wholly new, untested payment model. Now, based on the experiences in 2020 and 2021, CMS proposes to permanently reduce home health reimbursement rates by 7.69% while further proposing to collect over $2 billion in alleged overpayments at some future date. NAHC disputes the validity and logic of the proposed payment reductions and recommends that CMS withdraw its payment proposals and open discussions with stakeholders regarding the nature of appropriate and compliant methodologies for assessing the mandated budget neutral transition from the HHRG-HHPPS payment model to PDGM. The future of essential home health services is at stake.

In NAHC comments to the CY2021 NPRM, we indicated that "the PDGM model has been tested in a manner we all hope is not repeated in 2021. At this stage, it is doubtful that anyone can confidently say that it works or does not work." Unfortunately, the pandemic continues still, affect all of society and all of health care. Added to the health care crisis is the CMS payment rate proposal that fails tests of transparency and legal validity. That proposal also fails logically in that it puts care access in severe jeopardy in applying a budget neutrality reconciliation methodology that takes PDGM-induced behavior changes to assess what otherwise would have been expended by Medicare in the absence of PDGM. In doing so, CMS fully fails to meet its obligation to ensure that the transition to a new payment model is budget neutral.

As discussed in more detail below, NAHC strongly recommends that CMS withdraw any proposed permanent and temporary payment rate adjustments related to its budget neutrality assessment until such time that there is a full disclosure of the methodology and calculations used by CMS to reach the current proposal. Further, NAHC respectfully recommends that CMS present a comprehensive legal analysis of its obligations and authority under Section 1895 of the Social Security Act prior to initiating any such rate adjustments. As is indicated in these comments, NAHC views the CMS proposed action as outside of its authority and directly in violation of its statutory mandate. It is fully clear under Section 1895 that CMS is not obligated to initiate adjustments in 2023 as Section 1895 (b)(3)(D) authorizes CMS to institute permanent and temporary adjustments "at a time and in a manner determined appropriate." As is discussed

fully below, the risk of losing access to home health services is abundantly clear, which warrants great caution by CMS in its proposal to reduce payment rates at an unprecedented level during an ongoing Public Health Emergency.

Today, our entire economy is mired in high, cost inflation affecting all sectors. In the CY2021 rulemaking, NAHC recommended that CMS consider establishing a systemic methodology whereby future expedited adjustments can be made to accommodate impacts such as those triggered by the pandemic during a fiscal year so that access to care can continue for the usual population of home health patients while access can be established for a patient population that did not exist pre-pandemic. We repeat this recommendation this year as the continuation of the pandemic clearly demonstrates that expedited, temporary measures are essential to the continued provision of health care during a Public Health Emergency, including measures that ensure a fair level of payment from Medicare.

Similarly, the country is facing health care cost inflation that necessitates quick financial supports to maintain care access. Home health agencies have been hit with significantly rising labor costs as the nursing shortage has triggered wage increases, sign-on and retention bonuses, and other compensation cost increases not previously experienced in our economy. In addition, the $2 per gallon gas cost increase particularly affects the delivery of care to people in their homes. NAHC has conducted studies in the past on the number of miles travelled to provide care to the 12 million people that annually receive some form of health care at home. Our most recent analysis calculated an estimated 7.8 billion miles travelled each year to provide care. These and other cost increases must be addressed in the annual market basket index along with other measures that account for real-time changes in costs. The proposed inflation update does not come close.

Health care also faces a staffing crisis that has led to significant care access problems throughout the health care spectrum. Home health care is significantly affected by that shortage, particularly in its inability to compete for nursing staff with comparable wages. With indications that the current rate of refused admissions due to staff shortages at 35-40%, the depletion of revenues will only exacerbate the difficulties that HHAs face in recruiting and retaining staff when other health care sectors are often competing for the same staff with greater resources available.

RECOMMENDATIONS:

1. **CMS should withdraw its proposed BNA methodology**
2. **CMS should develop a compliant BNA methodology that applies pre-PDGM "estimated aggregate expenditures" based on the behaviors that would otherwise have occurred in the absence of PDGM**
3. **CMS should evaluate actual PDGM behavior changes by distinguishing between behavior changes and "real" changes in case mix**
4. **CMS should publicly disclose all data and analytical methodologies regarding any BNA**
5. **CMS should engage stakeholders by way of a Technical Expert Panel to devise a compliant methodology for determining any BNA**
6. **CMS should implement any temporary or permanent budget neutrality adjustments at a time and in a manner that is least disruptive and minimizes risks to access to care**

CMS Must Recognize that Payment Rate Cuts Inevitably Change the Home Health Benefit and Severely Reduce Access to Care: The Proposed Rate Cut is No Exception

It is commonplace that providers of care argue that rate cuts negatively impact access. That said, it is often difficult to determine what is factual and what is hyperbole. With home health there is no need for exaggeration, the facts presented in the history of the home health benefit offer indisputable proof that Medicare rate cuts directly translate to loss of care by hundreds of thousands of Medicare beneficiaries every time either Congress or CMS institute such cuts. The proposed 7.69% base rate cut for a 30-day payment period will be no exception. To avoid that consequence once again, CMS must withdraw its proposed rate actions, adopt a legally compliant and logical methodology for assessing whether PDGM is budget neutral in comparison to HHRG-HHPPS, and engage the home health community in its development and application in a manner that ensures continuity of care access. WE offer the following history of the impact of Medicare home health services rate cuts on care access in hopes that such context will help CMS recognize that its proposal will inflict great harm that is the opposite of what Congress expected in mandating a budget neutral transition to a new payment model.

The Evolution of Home Health Services Under Medicare

INTRODUCTION

The Medicare home health benefit has been in place since the beginning of Medicare in 1965. It is a unique benefit in that it is the only health care services that is covered in both Medicare Part A and Part B. Overall, it is a benefit without limits on the number of home health visits and no cost-sharing for beneficiaries. However, it is subject to strict conditions of coverage that require the beneficiary to establish a need for skilled nursing care on an intermittent basis or a need for physical therapy or speech-language pathology while confined to home. If these qualifying criteria are met, a host of services are covered, including part-time or intermittent skilled nursing care, physical therapy, speech-language pathology, occupational therapy, part-time or intermittent home health aide services, and medical social services.

Over the last 25 years, the benefit has been subject to numerous changes in payment, payment models, and scope of coverage. In addition, the environment of operations surrounding the benefit has not been stable with events such as the OIG Operation Restore Trust, the elimination of provider protections from retroactive claim denials, expanded claims audits and oversight, and a misperception by MedPAC and others that the benefit was becoming something akin to a "long term care" program because of extended services and patient length of stay. In addition, concerns have been raised at various points that the benefit wrongly has focused only on patients with a potential for functional restoration to the exclusion of patients whose needs are for care that maintains function or prevents accelerated deterioration in their condition.

The most notable area of change is the level of home health aide services provided to patients. Home health aides provide a combination of medically necessary personal care supports, assistance with oral medications and therapy programs, and simple wound care services. In the 1990s, Medicare beneficiaries gained access to a level of benefits that included 28-35 hours of medically necessary aide services weekly through litigation. *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988). That level of

care became inaccessible following numerous legislated changes in payment models and payment rates along with intensified scrutiny of home health claims. Since 2001, the average level of home health aide services has ranged from 1-3 visits over a 30-day period with visits usually 2 hours in length. The impact of payment model and rate changes on the amount of aide services provided is evident in the current Patient Driven Groupings Model (PDGM) wherein Medicare included 0.86 visits of a home health aide in a 30-day episodic payment to the providers. (See detail p. 18).

Notably, the outcome of numerous changes in Medicare payment models and rates is not a new phenomenon as the level of care provided under the benefits has remained stable since 2001 despite multiple payment rate reductions over that period. Accordingly, to the extent to which the Medicare home health benefit fails to deliver on its full scope of services today, one must look to the distant past to uncover causes and effects.

This analysis focuses on changes in the benefit structure and operations as such affects the level of care received by patients. Through a variety of legislative, regulatory, operational, and other changes, three distinct eras emerge in the past 25 years: Post-Balanced Budget Act of 1997 (1997-2000); Initial Prospective Payment System (2001-2009); and Post=Affordable Care Act of 2010 (2010-present). During these three eras, there has been a marked decline in the scope and level of care provided to beneficiaries. The data demonstrates that payment reforms combined with regulatory oversight are prime contributors to these changes. Ultimately, the outcome trend is fewer visits per patient and fewer patients accessing home health services along with a declining number of providers and reduced Medicare spending on care. Despite these developments, quality of care outcomes and patient satisfaction continues to improve and achieve positive results.

Home Health Payment Structure

Since the origin of the home health benefit, there have been numerous changes to payment models and changes within payment models.

Reasonable Cost Reimbursement (1965-1998)

As with other Medicare Part A benefits, the original payment model for home health services was based on the "reasonable cost" of care. Under that model, not all costs of operating a home health agency and delivering care was considered as an acceptable cost. Similarly, the full level of costs was not necessarily considered "reasonable." For example, the costs of marketing and taxes were not allowable. Also, owner and employee compensation cost were subject to "reasonable" limitations. Annual cost reports were required and were subject to audit.

With home health services, costs were also subject to discipline-specific "per visit" limits established by Medicare. Various formulae set by Congress and Medicare were used to calculate the limits. These limits were applied in the aggregate rather than on a visit-by-visit basis.

Model Risk: Under this payment model, HHAs were incentivized to provide the highest volume of visits possible. HHAS were also incentivized to incur cost up to but not above the aggregate limits. Otherwise, the HHAs would "leave money on the table."

Interim Payment System (1998-2000)

Out of concern that the incentives in the "reasonable cost" reimbursement model unnecessarily increased service volume and Medicare spending, Congress enacted (Balanced Budget Act of 1997) and Medicare implement the Interim Payment System (IPS) in 1998. IPS established a "per beneficiary limit" that set a maximum level of reimbursement paid to the HHA for its overall Medicare patient census. It was not applied to an individual Medicare beneficiary. Instead, it was applied in the aggregate.

IPS limits were calculated on an HHA-specific basis for providers that had been operating in 1995. Those HHAs had limits based on a blend of their utilization experience and national experience. For those that began operation after 1995, a limit was imputed based on national data. The end outcome was that both categories of HHAs had limits generally lower than their past level of visit utilization.

Model Risk: This payment model significantly penalized HHAs financially when serving patients with a high level of visits, even when such was necessary to meet their care needs. As such, this model incentivized reductions in visits to patients, early termination of care, and selective admission of patients. As a result, the Medicare patient population dropped by nearly 1 million beneficiaries, average visits per patient dropped from 73 to 37 and Medicare spending fell from $16.7B in 1997 to $7.2B in 2000. Those changes led to the closure 3817 HHAs in just 18 months.

Prospective Payment (2000-present)

HHRG Gen 1 (2000-2008)

The BBA 1997 also required the institution of a prospective payment system for HHAs. That model was based on the reduced utilization and spending from IPS. CMS implemented this model through a Home Health Resource Grouping that classified patients based on several measures. Initial payment rates were set at 11.57% lower than base year cost experiences to achieve budget neutrality with IPS. One impacting measure was that application of a payment adjustment tied to the number of therapy visits in a 60-day episode of care. HHAs received a flat episodic rate, adjusted up and down based on the case mix category of the patient. Further adjustment occurred based on the geographic location of the patient through a wage index that reflected variation in wage costs. Lastly, HHAs received a per visit reimbursement where the episode of care had 4 or fewer visits known as the Low Utilization Payment Adjustment. In the early stage of the HHRG-HHPPS, Congress reduced episodic payment through a 2003 adjustment that brought payments rates 7% lower than the initial IPS budget neutral cost experience.

Model Risks: This model financially incentivized high volume of therapy visits and low volume of other services. For example, HHAs were paid the same amount for a patient with 5 non-therapy visits in the episode as was paid with 10 visits. At the same time, an HHA was paid $1500-$2000 more for a patient with 10 therapy visits in the episode than a patient with 9 therapy visits. As discussed below, the outlier payment guaranteed financial losses to HHAs that grew as the visit volume increased thereby further discouraging an extended number of visits. HHAs responded to these risks with a reduction in average visits per patient and per episode.

HHRG Gen 2 (2008-2019)

CMS remodeled HHRG-HHPPS in 2008, replacing the 10-therapy visit threshold for increased payment with one that reflect the volume of individual therapy visits combined with high payment bumps at 14 and 20 visits. CMS also instituted a series of rate adjustments to address increases in average case mix weight that was unrelated to changes in patient severity. From 2008-2013, these adjustments reduced payment rates by 17.15%. In addition, congressionally mandated inflation rate adjustments were reduced by 3 points during that time.

In 2014, HHRG-PPS rates were subject to "rebasing" as required by the Affordable Care Act. This had the effect of reducing base payment rates by $80.65 per episode for each of 2014-2017, thereby permanently reducing overall rates by $322.60 through the 4-year phase in of rate rebasing.

Model Risks: The therapy volume incentive continuers, but with a somewhat modified strength. The payment rate adjustments, including the case mix weight and rebasing adjustments pushed HHAs to lower levels of visit volume in response.

PDGM (2020-present)

The Patient Driven Groupings Model (PDGM) began its application with periods of care that started January 1, 2020, or later. PDGM is a wholesale change from the previous payment models with a shift to a 30-day period of care/payment from the 60-day episodic model under HHRG. Further, a fully new case mix adjustment was instituted that has 432 case mix categories of patients and drops the problematic therapy volume measure that drove HHRG. Finally, the PDGM model replaces the 4-visit/60-day LUPA threshold with a set of thresholds ranging from 2-6 visits over 30 days. The base payment rate and case mix weights were set using a 4.36% "behavioral adjustment" that is intended to account for anticipated changes in diagnosis coding, secondary diagnosis data, and LUPA volume to achieve budget neutrality. CMS is authorized to institute further rate adjustments from 2021 through 2026 to achieve budget neutrality between an HHRG outcome under that model of payment and the PDGM payment outcome.

Model risks: The elimination of the therapy volume adjustment as a case mix measure will likely lead to a reduction in therapy services to patients. In fact, CMS (with the support of MedPAC) fully intended PDGM to trigger a reduction in therapy visits. Since PDGM favors patients discharged to home health from an inpatient hospital over a community admission, the model can create a barrier to community admissions. With the shift to a 30-day payment period, the scheduling of care may be affected. For example, rather than front-load a volume of service early in the care, visits may be extended into a second 30-period to maximize revenues. Finally, HHAs may be cautious in the delivery of visits as the threat of further behavioral and budget neutrality adjustments.

DATA REVIEW

MEDICARE HOME HEALTH SERVICES HAS BEEN UNSTABLE SINCE BBA 1997

An analysis of home health services utilization and spending data since 1990 depicts the three eras in the benefit set out above. In 1997, the year the Balanced Budget Act of 1997 was enacted, the Medicare home health benefits served nearly 3.6 million beneficiaries with an average of 73 visits person, Medicare spending was over $16.6B and $4,704 per person served. A precipitous drop began in 1998 and

dramatically declined to 2.4 million with an average of 37 visit of care in 2000. Medicare spending dropped to just over $7.2 billion and $2,935 person. These changes were driven by the institution of the Interim Payment System, which was included as part of the BBA 1997.

YEAR	Traditional Medicare Enrollment (thousands)	USERS (thousands)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (thousands)	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

The Congressional Budget Office evaluated that the BBA 1997 changes in the home health payment models would garner juts $16.2B in reduced Medicare spending from 1998-2002 and $49.7B from 1998-2007. In fact, it was expected that the changes would simply limit the growth in spending. Instead, over the 1998-2002 period, Medicare spending on home health services dropped by $43.7B in comparison to an annualized 1997 spending level and $67B from CBO projected spending in the absence of BBA 1997 changes.

> "Beginning in fiscal year 2000, the Secretary is required to provide for payments for home health services under a prospective payment system. Prospective rates will be based on the per-visit and per-beneficiary cost limits described above, decreased by 15 percent in the year of implementation, then updated by the home health market basket in future years. Periodic interim payments will be eliminated for home health agencies. Savings for the home health proposals total $16.2 billion over the 1998-2002 period. Although these proposals will limit the growth of spending per user of home health services, CBO assumes that some savings will be offset by the efforts of home health agencies to increase the number of beneficiaries who use home health services".
>
> bba-97 CBO projections.pdf

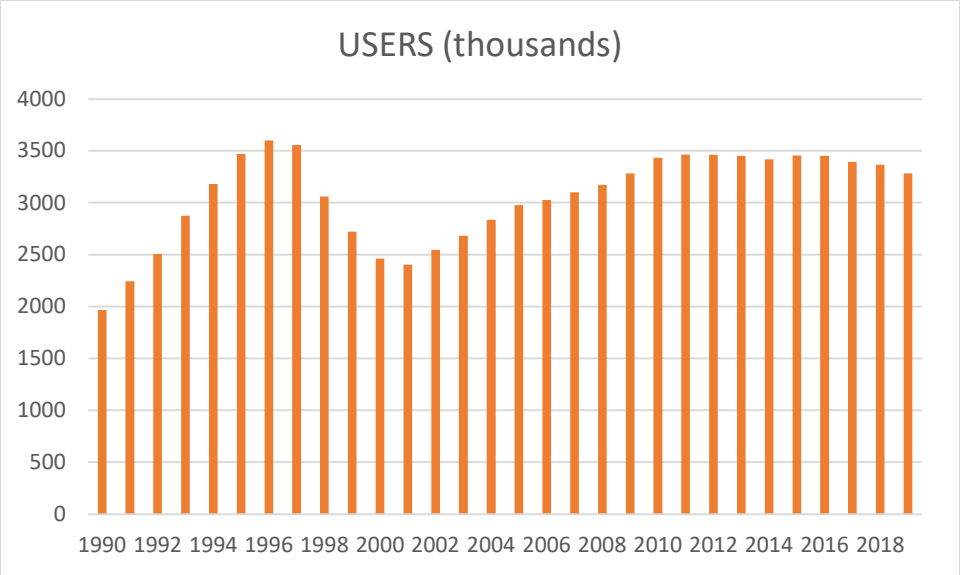
A display of CBO projections on spending post-BBA 1997 shows an ever-decreasing level of support for Medicare home health services.

	CBO Baseline												
YEAR	1997	98	99	00	01	02	03	04	05	06	07	08	09
1996	16.7												

1997	19.0	17.5											
1998	21.1	18.2	14.9										
1999	23.2	19.3	15.0	9.7									
2000	25.3	19.0	16.5	9.8	9.2								
2001	27.5	21.4	15.6	11.1	10.4	9.1							
2002	29.9	23.1	17.1	12.5	11.7	11.4	10						
2003	32.3	24.8	18.3	14.4	12.8	12.5	9.8	10.0					
2004	34.9	26.4	19.6	16.8	15.0	14.3	11.0	10.9	11.2				
2005	37.6	28.1	21.1	18.9	17.5	17.0	12.9	12.3	12.2	12.4			
2006	40.4	29.7	22.8	21.1	20.3	19.8	14.5	13.3	13.3	13.1	13.2		
2007	43.4	31.2	24.4	23.3	23.4	23.1	16.5	14.8	14.7	14.7	14.2	15.5	
2008		32.5	26.1	25.5	26.9	26.8	18.8	16.5	16.2	16.0	15.2	16.4	16.5
2009			27.8	28.0	30.7	30.7	21.1	18.3	17.8	17.7	16.6	17.3	17.8
2010				30.7	35.1	35.0	23.7	20.2	19.6	19.5	18.1	18.1	19.0
2011					40.4	39.9	26.4	22.3	21.5	21.5	19.8	19.2	21.1
2012						45.0	29.5	24.5	23.7	23.8	21.8	20.9	23.5
2013							32.9	27.0	26.2	26.4	24.1	23.2	26.2
2014								29.7	28.9	29.3	26.7	25.9	29.0
2015									32.0	32.5	29.7	28.9	32.2
2016										36.1	33.0	32.3	35.7
2017											36.7	36.0	39.7
2018												40.3	43.9
2019													47.9

It is very apparent that BBA 1997 started a series of actions that has led the home health benefit to a point where it is far short of the original design in terms of access, level of service, and Medicare spending. The payment model and payment rate changes have established a "slippery slope" that has resulted in a benefit that is in deep contrast to the one still in the law.

The initial Prospective Payment System began in fiscal year 2001 whereupon, a new era began that involved a steady increase utilization of home health services nearly returning to 1997 levels over the next 10 years. By 2010, Medicare home health utilization reached 3.4 million with $19.4 billion in spending at $5,688 per user. During that period, visits per user rose to a high of 40 in 2009 with 37 visits per patient in 2010. The spending change however was below the rate of change in health care costs between 1997 and 2010 and does not account for the nearly 3 million enrollees increase in overall traditional Medicare enrollment during that period. Further, it does not reflect that Congress intended that the BBA 1997 stem the growth in Medicare spending on home health services, not reduce it dramatically and leave 2010 spending barely above 1997 levels in 2010 dollars.

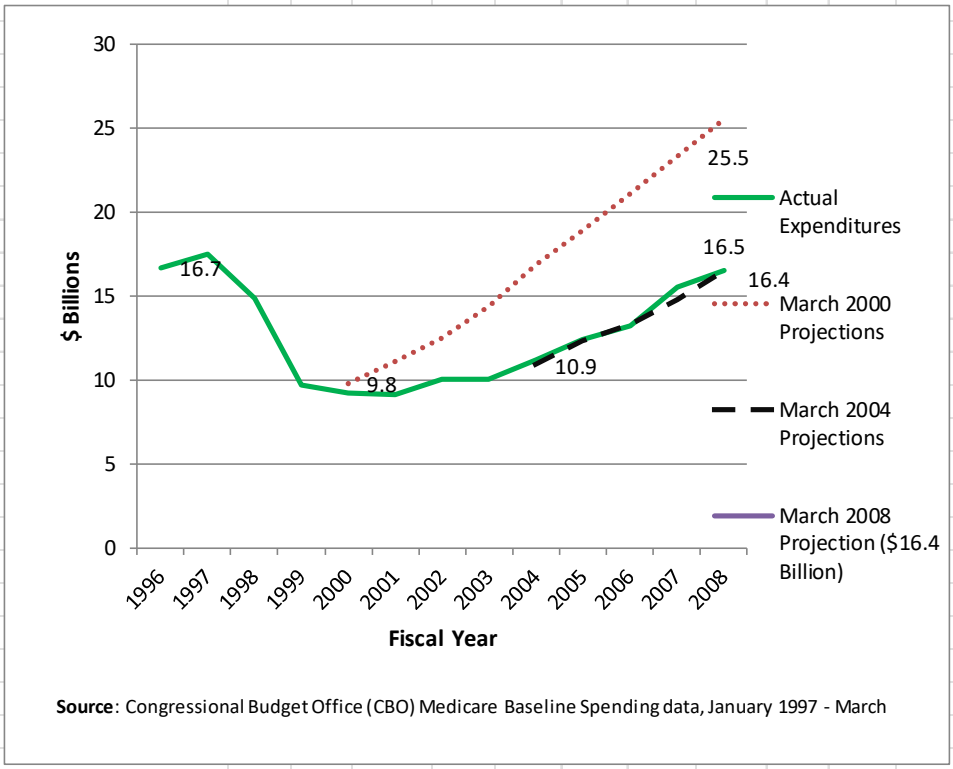


YEAR	Traditional Medicare Enrollment (thousands)	USERS (thousands)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (thousands)	PAYMENTS PER PERSON	PAYMENTS PER EPISODE
2001	33,860	2402.5	31	21.4*	8,513,702	3,545	N/A
2002	34,977	2544.4	31	20*	9,550,683	3,765	$2,329*
2003	35,815	2681.1	31	18.39**	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

Once again, the outcome in terms of Medicare spending on home health services fell far below the projections of CBO. For example, the post-Interim Payment System projections by CBO had home health spending at $25.5 B in 2008 while it ended up at $16.5 without further payment rate cuts or payment model changes by Congress.

CBO Baselines and Actual Spending, FY 1996 - FY 2008

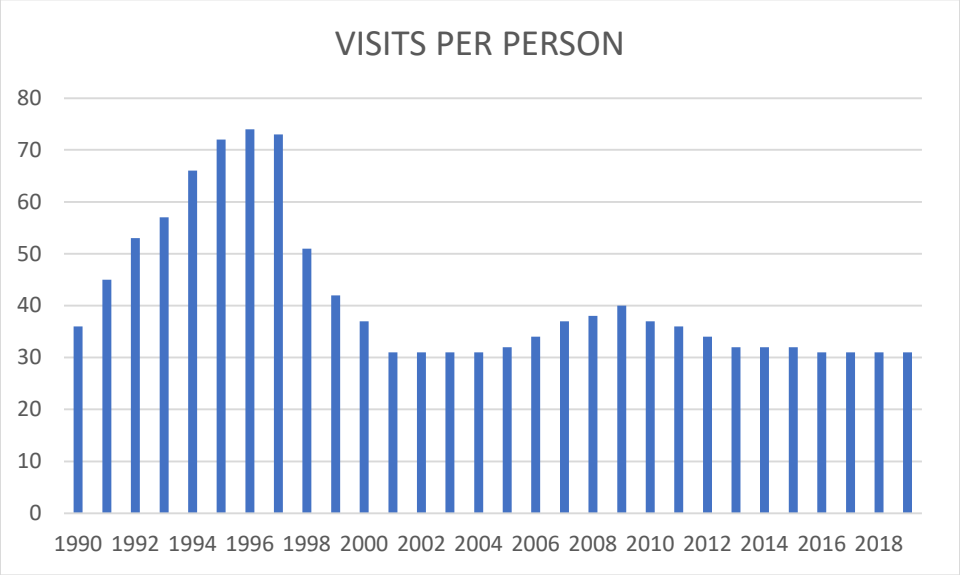
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Actual Expenditures	16.7	17.5	14.9	9.7	9.2	9.1	10.0	10.0	11.2	12.4	13.2	15.5	16.5
March 2000 Projections					9.8	11.1	12.5	14.4	16.8	18.9	21.1	23.3	25.5
March 2004 Projections									10.9	12.3	13.3	14.8	16.5
March 2008 Projection ($16.4 Billion)													16.4



Source: Congressional Budget Office (CBO) Medicare Baseline Spending data, January 1997 - March

The third era of payment rate reductions began in 2011 with the passage of the Affordable Care Act. With it came a combination of limits on annual Market Basket Index increases, rate rebasing, and the institution of the annual productivity adjustment. As a result of the rate cuts. this period (2011-2019) experienced a decline in home health utilization (3.46M-3.28M), services provided (37-31 visits), Medicare spending ($18.36B-17.85B), and per patient payment amounts ($5,357-5,440), all while Medicare enrollment grew. Notably, the visits per person further declined from 36 to 31. Visit per episode numbers also show a decline. The most significant change showing a decrease in access to care

was in the number of patients served with a reduction of nearly 200,000 users annually between 2011 and 2019.



YEAR	Traditional Medicare Enrollment (thousands)	USERS (thousands)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (thousands)	PAYMENTS PER PERSON	PAYMENTS PER EPISODE
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		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

Overall, the Medicare home health benefit evinces a program with limited periods of stability, inconsistent utilization of care, fluctuations in service levels, and prone to significant swings driven by payment models and payment rates. While very little change has been legislated regarding the scope of the benefit, the level of care and access to services has been significantly influenced by the payment model in place and its resulting payment rates.

Home Health Benefit by the Numbers: 1990-2019

YEAR	Traditional Medicare Enrollment (thousands)	USERS (thousands)	VISITS PER PERSON	VISITS PER EPISODE	MEDICARE HH PAYMENTS (thousands)	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

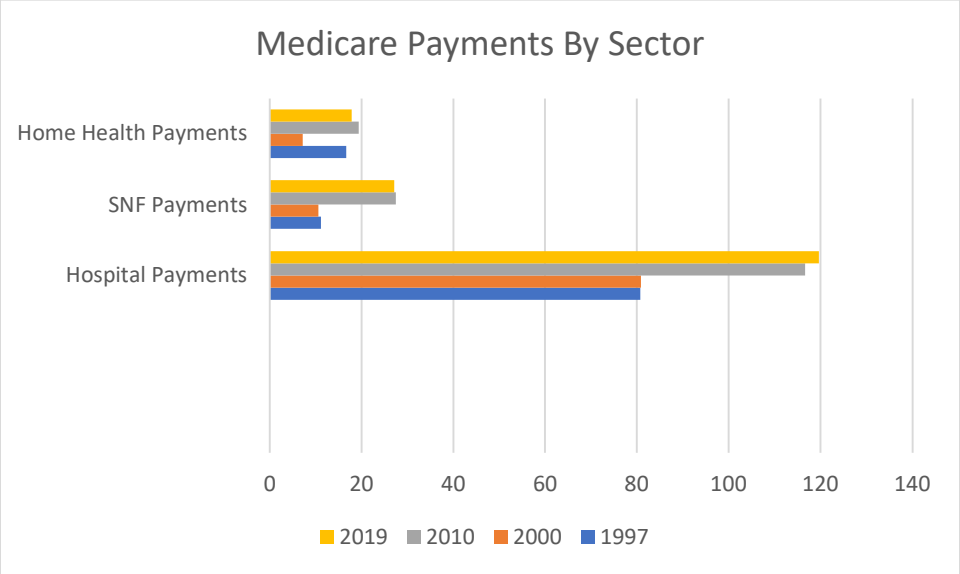
Sources: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cmsprogramstatistics ; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS

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

** Data from CMS HHA cost reports

HOME HEALTH SERVICES HAVE SHRUNK SINCE BBA 1997 WHILE THERE HAS BEEN HIGH GROWTH IN INSTITUTIONAL CARE

The home health services path between 1997 and 2019 contrasts with that of other health care sectors. While Medicare spending for home health services is a roller coaster ride from 1997 through 2019, spending significantly increased for inpatient, short-term hospitals, skilled nursing facilities, and hospices. Of those settings, hospice care is a substitute for inpatient, SNF, and home health services at end-of-life. Hospice has well established itself as a modality of care that brings savings to Medicare. However, it is notable that the greatest spending growth is in SNF care, a setting that home health has the clinical ability to be a viable substitute for many of the SNF patients. There, Medicare spending has increased 242% since 1997 while the number of unduplicated users has deceased (1.9M-1.6M). Further, SNF per patient payment grew from $5,077 in 1999 to $12, 123 in 2019 while home health services per patient payment grew only from $4,704 to $5,440 between 1997 and 2019.



Sources: See, Sources, Comparison of Short-Term Acute Care Hospital, Skilled Nursing Facility, and Home Health Services 1997-2019

Comparison of Short-Term Acute Care Hospital, Skilled Nursing Facility, and Home Health Services 1997-2019

	1997	2000	2010	2019
Hospital-Facilities		4647	3510	3283
Hospital-Users (discharges)	11.527M	11.581M	12.290M	9,280,388
Hospital-Payments	$80.725B	$80.849B	$116.643B	$119.620B
Hospital-Per Patient Payment (per discharge)	$7,021	$7,021	$9,611	$12,890
SNF-Facilities		14,841	15,084	15,109
SNF-Users	1.902M	1.936M	2.543M	1.624M
SNF-Payments	$11.199B	$10.651B	$27.454B	$27.13B
SNF-Per Patient Payment	$5,077 (1999)	$5511	$10,808	$12,123
HHA-Facilities	10.917*	7,100	10,914	11,157
HHA-Users	3557.5	2461.2	3434.4	3281.4
HHA-Payments	$16,718,263	$7,215,958	$19,407,218	$17,850,864
HHA-Per Patient Payment	$4,704	$2,936	$5,688	$5,440
Hospice-Facilities	2344	2267	3509	4970
Hospice-Users	383,071	534,408	1,163,037	1,622420
Hospice-Payments	$2.206B	$3.105B	$12.084B	$20.899B
Hospice-Per Patient Payment	$5242	$5476	$11,175	$12,881

Sources: CMS Program Statistics, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cmsprogramstatistics; CMS Medicare and Medicaid Statistical Supplement, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS; *MedPAC 2017 Report https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar17_medpac_ch9.pdf

MEDICARE PAYMENTS RATES HAVE BEEN CUT SIGNIFICANTLY NEARLY EVERY YEAR SINCE 1998

While payment rates and payment methods 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.

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				
CY2021		-0.3%		
CY2022		-0.5%		
TOTAL REDUCTIONS	-7.7%	-2.8%	-40.327%	-$322.60 (14.0%)

Sources:

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

MEDICARE'S PAYMENT MODEL REFLECTS AN EXTREMELY LIMITED LEVEL OF CARE, WELL LESS THAN THE SCOPE OF BENEFITS

One consequence of these changes and reductions in most noted in the CY2020 institution of the new Patient Driven Groupings Model (PDGM) that included a shift from a 60-day episodic payment to a 30-day period payment and a change from 153 case mix categories under the Home Health Resource Groupings Model (HHGM) to 432 categories under PDGM. With the new 2020 rates, reimbursement was tied to the level of service volume that represents the significant reductions triggered by the Interim Payment System in 1998-2000. The Tables 2 and 4 below are from the CY2020 rulemaking found at https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf.

Note that the current payment system reflects 0.86 home health aide visits in a 30-day period along with 4.88 visits of skilled nursing care and a total average of 10.5 visits of all disciplines combined. Table 4. The 60-day episode equivalent is 1.63 home health aide visits along with 8.59 visits of skilled nursing care and a total average of 18.19 visits of all disciplines combined.

TABLE 2: ESTIMATED COSTS FOR 60-DAY EPISODES IN CY 2017

Discipline	FY2017 Cost Per Visit [1]	Average # Total Visits [2]	60-Day Episode Costs [3]	NRS Cost Per Visit	60-Day Episode Costs with NRS
Skilled Nursing	$135.93	8.59	$1,167.64	$3.58	$1,198.39
Physical Therapy	$156.59	5.78	$905.09	$3.58	$925.78
Occupational Therapy	$153.13	1.7	$260.32	$3.58	$266.41
Speech Pathology	$169.89	0.35	$59.46	$3.58	$60.71
Medical Social Services	$223.96	0.14	$31.35	$3.58	$31.85
Home Health Aides	$61.83	1.63	$100.78	$3.58	$106.62
Total			**$2,524.64**		**$2,589.76**

[1] **Source:** Updated methodology described in the 2013 Rebasing Report (Analyses in Support of Rebasing & Updating Medicare Home Health Payment Rates. June 21, 2013. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Analyses-in-Support-of-Rebasing-and-Updating-the-Medicare-Home-Health-Payment-Rates-Technical-Report.pdf.) using cost reports accessed in January 2019 and claims data from 2016 and 2017.
[2] **Source:** Home health episode data linked to OASIS assessments for episodes ending in CY 2017. PEP and LUPA episodes were excluded.
[3] **Source:** Calculated by multiplying Average Cost per Visit by Average Number of Total Visits.

TABLE 4: ESTIMATED COSTS FOR 30-DAY PERIODS IN CY 2017

Discipline	2017 Average Costs per Visit (without NRS)	2017 Average Number of Visits	2017 30-Day Period Costs (without NRS)	2017 Average NRS Costs per Visit	2017 Average Cost+NRS per Visit	2017 30-Day Period Costs with NRS
Skilled Nursing	$135.93	4.88	$663.34	$3.58	$139.51	$680.81
Physical Therapy	$156.59	3.45	$540.24	$3.58	$160.17	$552.59
Occupational Therapy	$153.13	1.03	$157.72	$3.58	$156.71	$161.41
Speech Pathology	$169.89	0.21	$35.68	$3.58	$173.47	$36.43
Medical Social Services	$223.96	0.08	$17.92	$3.58	$227.54	$18.20
Home Health Aides	$61.83	0.86	$53.17	$3.58	$65.41	$56.25
Total		10.50	**$1,468.07**			**$1,505.69**

Source: Medicare cost reports were pulled in January 2019. Medicare claims data from 2017 was pulled from the CCW in August 2018. The 30-day periods were simulated from 60-day episodes and excluded low-utilization payment adjusted episodes and partial-episode-payment adjusted episodes. The 30-day periods were linked to OASIS assessments and covered the 60-day episodes ending in CY 2017.

Data from the Medicare Payment Advisory Commission (MedPAC) indicates that in 1998, Medicare home health patients received an average of 31.6 visits in a 60-day episode of care. That is 1.737 times the number of visits credited in PDGM. With respect to concerns on the changed volume of care in home health services, PDGM has established a payment model that cements this changed volume in the Medicare benefit without any change in the statutory scope of the benefit.

OUTLIER PAYMENTS FALL FAR SHORT OF PAYMENT FOR EXTENSIVE SERVICES

To the extent that the outlier component of PDGM is available to support the provision of the full scope of the home health benefit, one example presented by CMS in CY2019 rulemaking demonstrates that the outlier payment model falls far short of sufficient to cover the costs of extensive care. Notably, the example applies a plan of care with 28 hours per week of home health aide services, the level of care ostensibly available under the "part-time or intermittent" scope of coverage of that disciple. CMS notes that the imputed costs of the home health aide services are $13,852 over a 60-day episode. Overall costs of the entire plan of care are $25,575.80. However, payment to the provider would be only $20,478.07. This produces a payment to cost shortfall of $5,097.73. It can be expected that the financial outcomes would pose a significant barrier to providing such care to the patient.

In pertinent part, here is the CMS outlier example:

TABLE 28—CLINICAL SCENARIO CALCULATION: EPISODES 3 AND 4

HH outlier—CY 2018 illustrative values Value Operation Adjuster Equals Output

National Per-Unit Payment Amount—Home Health Aide.....	
Number of 15-minute units (28 hours per week = 112 units per week for 8 weeks)	
Imputed Home Health Aide Costs (National Per-Unit Payment Amount * Number of Units)	13,852.16
Total Wage-Adjusted Imputed Cost Amount-- Outlier Threshold Amount (Total Wage-Adjusted Fixed Dollar Loss Amount + Total Case-Mix and Wage-Adjusted Episode Payment Amount)	25,575.80
Total Payment Per 60-Day Episode = Total Case-Mix and Wage-Adjusted Episode Payment Amount + Outlier Payment	20,478.07

Source: https://www.govinfo.gov/content/pkg/FR-2018-07-12/pdf/2018-14443.pdf pp 32379-32380

QUALTY OF CARE IS HIGH AND CONTINUES TO IMPROVE

While the level of care is significantly different than it was in 1997, quality outcomes remain high with continuing improvements in multiple areas of performance. Using uniform reports submitted by HHAs to CMS, MedPAC reports show that performance improvement has been steady since the early stages of the prospective payment system both in self-reported measures, e.g., walking, as well as the objective measure of hospitalizations. Below are several of the MedPAC Tables on select quality measures.

TABLE 9–8 **Average home health agency performance on select quality measures**

	2003	2006	2010	2012	2013
Share of an agency's beneficiaries with improvement in:					
Walking	34.8%	41.2%	53.5%	58.3%	58.5%
Transferring	49.1	52.7	52.7	54.6	53.8
Hospitalization	27.5	28.1	28.4	27.5	N/A

Note: N/A (not available). Data are risk adjusted for differences in patient condition among home health patients; includes fee-for-service beneficiaries only. The measures for walking and transferring changed in 2011 and are not comparable to data from prior years.

Source: MedPAC analysis of data provided by the University of Colorado.

Source: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-9-home-health-care-services-march-2015-report-.pdf

TABLE 9–9 **Average home health agency performance on select quality measures**

	2004	2008	2012	2013	2014	2015
Rate of hospitalization	27.7%	28.8%	27.5%	26.5%	27.8%	25.4%
Share of an agency's beneficiaries with improvement in:						
Walking	35.9%	41.9%	52.5%	54.4%	56.0%	66.9%
Transferring	49.2	48.1	48.9	50.5	51.3	63.3

Note: All data are for fee-for-service beneficiaries only and are risk adjusted for differences in patient condition among home health patients.

Source: MedPAC analysis of data provided by the University of Colorado.

Source: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar17_medpac_ch9.pdf

TABLE 9–5 **Average home health agency performance on select quality measures**

	2014	2015	2016	2017	2018
During an episode, the share of an agency's beneficiaries who:					
Used emergency department care	12.0%	12.2%	12.1%	12.7%	12.8%
Had to be admitted to the hospital	15.4	15.5	16.2	15.4	15.4
Share of an agency's beneficiaries who improved in:					
Transferring	55%	59%	65%	72%	77%
Walking	61	63	69	74	77

Note: All data are for fee-for-service beneficiaries only and are risk adjusted for differences in patient condition among home health patients.

Source: MedPAC analysis of data provided by the University of Colorado.

Source: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch9_sec.pdf

TABLE 8–5 **Since 2015, HHAs have reported a modest improvement in the rate of successful discharge from home health care to the community, but the rate of hospitalization during care has increased**

	2015	2016	2017	2018	2019
Successful discharge to the community	68.3%	69.2%	69.6%	70.4%	72.2%
Hospitalization during home health care	20.6	20.8	21.4	21.5	21.4

Note: HHA (home health agency). "Successful discharge to the community" includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytical files from CMS.

Source: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch8_sec.pdf

Patient improvements are notable in relation to the reduced services provided:

- Walking improved for 38.3% of patients in 2003 to 77% of patients in 2018.
- Transferring improved for 49.1% of patients in 2003, increasing to 77% of patient in 2018
- The rate of hospitalizations dropped from 27.5% in 2003 to 21.4% in 2018

MEDICARE CLAIMS COMPLIANCE HAS SIGNIFICANTLY IMPROVED

In 2015, the Medicare claims error rate as report through the Comprehensive Error Rate Testing audits reached an unacceptable highpoint of 59.9%. Since 94.8% of those "errors" were determined to be

related to “Insufficient documentation,” with just 4.1% related to the medical necessity of services, measures were readily available to return to a solid state of compliance.

CMS employed a combination of a demonstration project, Pre-Claim Review/Review Choice Demonstration and Probe and Educate audits along with industry-led efforts in provider education and support resulting dramatic reduction in errors. While there remains work to be done, the progress is significant.

REPORT YEAR	IMPROPER PAYMENT RATE	INSUFFICIENT DOCUMENTATION	MEDICAL NECESSITY
2015	59.9%	94.8%	4.1%
2016	42.0%	96.4%	2.3%
2017	32.3%	89.0%	4.3%
2020	9.3%	68.7%	16.0%
2021	10.3%	59.1%	27.1%

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports

OVERALL FINANCIAL MARGINS Of HHAs ARE THE TRUE INDICATOR OF CARE ACCESS STABILITY

Any business must balance all business operations and revenue sources to achieve an overall bottom-line that keeps the business in existence. A reasonable margin is essential as all business must have cashflow to meet expenses such as payroll and have sufficient capital to address unexpected expenses and to continually modernize. HHAs, like most other health care entities have been investing is technology for years without reimbursement or financial supports for clinical technologies or operational improvements such as EMR that other provider sectors received.

HHAs are far different than some other health care sectors in terms of revenue sources. By and large, HHA revenue comes from Medicare and Medicaid with a small addition from the VA health program and commercial insurance. In contrast, hospitals have significant revenues from commercial insurance that offsets any shortfalls from government payers.

In addition, the Medicare margin for home health services as presented by MedPAC is a misleading indicator of home health services costs. First, there are common business costs that are excluded from the calculation such as marketing and taxes. Second, cost reporting requirements allow an HHA to report telehealth-related costs, but only in a non-reimbursable cost center thereby inflating the Medicare margin calculation. Third, relying on average margins fails to indicate that there is a wide range in Medicare margins across the diverse universe of HHAs. The average is not the norm.

The **overall** financial margins of HHAs offer a better picture of a provider sector that is fully dependent on traditional fee-for-service Medicare to effectively subsidize “less-than-cost payment from Medicaid and Medicare Advantage (MA). While traditional Medicare margins have average around 15%

over the last 15 years, HHA overall margins are far less at an average of near 4%. HHAs have shown no leverage in negotiating payment rates with MA plans and low Medicaid rates are standard throughout the states in virtually all health care sectors. It should also be noted that margins in traditional Medicare are calculated without consideration of all costs of operation such as taxes, marketing, and telehealth services that became a significant clinical practice during the pandemic.

While not a preferred business approach, HHAs provide care to Medicare Advantage and Medicaid patient because their referral sources need the HHAs to take these patients as a trade-off to getting traditional Medicare patients as referral sources also bear a financial burden with these payers. Notably, hospitals receive added payments from traditional Medicare when they have a high proportion of Medicaid inpatients. HHAs do not have a "disproportionate share" payment add-on. Also, SNFs have only a small percentage of revenue from traditional Medicare and gain a high degree of financial support from private pay services prior to Medicaid eligibility.

Accordingly, to determine whether a payment rate change will affect care access, it is essential that the overall business be the focus, not a single revenue stream. For example, with inpatient hospital services, the average Medicare margin may be -7%, the overall margin is usually +7-8%. In that sector, hospitals have the benefit of commercial payers to subsidize Medicare shortfalls. HHAs have the opposite financial circumstance where the non-Medicare payers are generally limited to Medicare Advantage and Medicaid. The outcome is that a Medicare rate reduction triggers risk for all patients as the stability of the whole operation is put at risk. This may not be the optimal circumstance from a Medicare perspective, but it is reality when it comes to evaluating the impact of a Medicare rate reduction on care access. Further, the outcome is not speculative. Instead, it is proven through years of experience with other rate reductions.

HHA Margins 2005-2019

Year	MedPAC margin Freestanding HHAs*	Medicare CR freestanding HHA margin**	Medicare CR hospital-based HHA margin**	Medicare CR all HHA margin**	Overall Freestanding Margin**	Public Company EBITDA margins***
2005	17.3	20.12	(4.76)	12.98	4.18	9.8
2006	15.9	20.54	(5.37)	15.80	5.53	11.1
2007	16.5	17.48	(6.19)	13.83	8.60	12.4
2008	17.4	17.59	(6.06)	13.17	6.21	13.0
2009	18.2	17.89	(7.82)	14.71	5.54	14.0
2010	19.4	17.88	(5.04)	15.00	3.71	14.7
2011	14.8	18.8	(6.29)	16.12	3.15	10.3
2012	14.5	14.74	(17.23)	11.70	2.98	8.9
2013	12.7	14.71	(16.64)	11.65	3.98	6.4
2014	10.8	13.38	(22.21)	9.83	4.98	6.8
2015	15.6	17.82	(13.51)	14.75	4.78	8.4

Sources: * MedPAC March Reports to Congress; ** CMS Cost Report data; ***Bank of America Merrill Lynch Equity Research Report on Home Health Care

Some parties have argued that HHAs can and should use their margins under traditional Medicare to extend the volume of services to patients. However, those margins, if available to spend rather than used to fill financial shortfalls with other patients, would only cover the cost of a few extra hours of service. For example, with a typical skilled nursing visit costing $165, an entire 15% traditional Medicare margin would be exhausted in less than 2 visits. Likewise, with a home health aide visit costing nearly $75 for two hours of care, use of an entire 15% margin would allow for 8 hours of care in contrast to the 28-35 hours permitted in the scope of benefits. It is crucial to understand also that such action would necessitate a rejection of Medicare Advantage and Medicaid patients, assuming referral source would continue to refer traditional Medicare patients, to stay solvent. HHA cannot operate in revenue silos. HHAs must respect its marketplace.

To assess the potential impact of the proposed 7.69% base rate cut in PDGM, NAHC analyzed the Fiscal Year End (FYE) 2020 cost reports available from CMS. As anticipated, the findings are consistent with MedPAC calculations of Medicare margins. Likewise, the findings on overall margins are consistent with past analyses relative to overall financial margins too. That means that most of any Medicare margin is used to subsidize other government payers, particularly Medicare Advantage and Medicaid. Further, the margins vary widely between providers and provider types.

Ultimately, the key factor in determining risks of negative impacts on Medicare enrollees is the degree to which HHAS are threatened with closure due to overall costs exceeding overall revenue. In that respect, the impact of the proposed 7.69% rate cut is frightening. **With freestanding HHAs, the incidence of providers estimated to experience overall negative margins nationwide is 51.5%.**

26 states and territories are projected to have more than half of their HHAs with overall margins below zero with the proposed cut. In contrast, only 7 states and territories show 50% or more HHAs with net overall negative margins without the proposed cut.

Note that this analysis does not include "institution-based" HHAs as their cost reports do not allow for an overall margin calculation. However, for these HHAs, the Medicare margin itself is 22.67%. Assumedly, the overall margins are even worse given the consistent finding that other payers fall short of the cost of care.

State	% Of HHAs Margins Below ZERO
Alabama	33.3%
Alaska	33.3%
Arizona	46.2%
Arkansas	34.8%
California	53.3%

Colorado	61.0%
Connecticut	73.1%
Delaware	25.0%
District of Columbia	42.9%
Florida	54.1%
Georgia	45.2%
Guam	0.0%
Hawaii	37.5%
Idaho	51.4%
Illinois	53.0%
Indiana	56.1%
Iowa	65.1%
Kansas	70.5%
Kentucky	46.2%
Louisiana	45.0%
Maine	52.6%
Maryland	47.1%
Massachusetts	40.7%
Michigan	62.0%
Minnesota	59.6%
Mississippi	29.4%
Missouri	71.6%
Montana	54.5%
Nebraska	48.1%
Nevada	44.6%
New Hampshire	75.0%
New Jersey	50.0%
New Mexico	43.2%
New York	54.8%
North Carolina	42.9%
North Dakota	50.0%
Ohio	60.8%
Oklahoma	41.5%
Oregon	59.3%
Pennsylvania	45.2%
Puerto Rico	28.0%
Rhode Island	64.3%
South Carolina	52.6%
South Dakota	33.3%
Tennessee	50.5%
Texas	51.8%
Utah	43.4%

Vermont	80.0%
Virgin Islands	0.0%
Virginia	50.0%
Washington	38.1%
West Virginia	36.1%
Wisconsin	46.8%
Wyoming	38.5%

The consequences stemming from reimbursements falling below the cost of care can certainly include the closure of HHAs. Notably, that consequence is already underway with 1,140 fewer HHAs today than in 2015. In fact, if California was excluded from the calculation, the remaining states lost 1,638 HHAs over that period.

Active Provider and Supplier Counts Report

Region	Active Providers and Suppliers							
	2015	2016	2017	2018	2019	2020	2021	2022
(I) Boston	429	475	484	480	462	448	442	437
(II) New York	245	241	222	210	203	200	197	196
(III) Philadelphia	842	860	867	863	869	860	855	837
(IV) Atlanta	2,049	1,978	1,875	1,805	1,754	1,762	1,764	1,758
(V) Chicago	2,900	2,827	2,719	2,626	2,511	2,445	2,384	2,345
(VI) Dallas	3,384	3,290	3,075	2,917	2,818	2,723	2,710	2,686
(VII) Kansas City	547	535	536	522	502	485	467	459
(VIII) Denver	399	397	402	408	400	400	405	400
(IX) San Francisco	1,670	1,727	1,761	1,852	2,022	2,215	2,220	2,203
(X) Seattle	181	184	187	186	191	187	185	185
National Total	**12,646**	**12,514**	**12,128**	**11,869**	**11,732**	**11,725**	**11,629**	**11,506**

- Source: https://qcor.cms.gov/active.jsp?which=1&report=active.jsp&jumpfrom=

All told, there are:

- Nearly 300,000 fewer Medicare beneficiaries using home health services annually than in 2015
- Fewer services provided during episodes of care in response to rate cuts historically
- Medicare annual spending on home health services has dropped by nearly $2 billion since 2015
- More than half of all HHAs are at risk of experiencing overall costs exceeding overall revenue if the CMS proposal is implemented

It defies logic for CMS to believe that HHAs have been overpaid under PDGM and that a 7.69% rate cut is needed to end that overpayment when HHAs are financially at such risk with the proposal.

However, that is the foreseeable outcome when CMS applies the HHRG-HHPPS payment model to the outcome of a PDGM-induced care universe, an approach wholly outside the statutory mandate as is discussed in depth below along with the detailed analysis attached as Appendix A. The concept of a budget neutral transition from HHRG-HHPPS to PDGM should result in no relative change in the financial stability of the home health services delivery system. That is the essential purpose of the budget neutrality requirement that Congress mandated for the transition to the new payment model, to protect against unintended disruptions in care access.

While HHA closure is one option for HHAS that are paid less than their overall cost of care, service reduction has been a regular response for HHAs to stay accessible for some patients. Still, the evidence is quite strong that the proposed rate cuts will fall far short of the Congressional intent of stability in care access during the transition to the PDGM payment system. This proposal can be fully expected to lead to a combination of closures, service area reductions, and service reductions.

SPECIFIC COMMENTS ON PROPOSED PDGM BUDGET NEUTRALITY ADJUSTMENT

The Proposed Methodology for Assessing Budget Neutrality Is Counter to the Plain Language of Section 1895 of the Social Security Act

Attached to these comments as Appendix A is a detailed legal analysis of the requirements of Section 1895 of the Social Security Act as it relates to the compliance of the CMS proposed rule provided by the Foley Hoag law firm on behalf of NAHC. That analysis firmly establishes that CMS's proposal fails to adhere to the law in several respects. NAHC fully adopts that analysis as part of it comments herein.

Notably, the Foley Hoag analysis is highly consistent with separate analysis presented by the law firm, King & Spalding, on behalf of the Partnership for Quality Home Health care (PQHH). (Appendix B).

First, the Medicare statute requires CMS to evaluate whether actual provider behavior changes under PDGM lead to a determination that the PDGM payment rate based on assumed behavior changes has led to an overpayment or underpayment to HHAs. That analysis is predicated on an estimate of aggregate expenditures under the HHRG-HHPPS payment model for a budget neutral comparison. In no way does that permit CMS to do what it has done in its proposal—to reassess the estimated expenditures under an HHRG-HHPPS payment model in the context of the impact of PDGM on HHA behavior, a world that would not exist in the absence of PDGM. On this basis alone, CMS must withdraw its proposed rate adjustment.

Second, among other flaws, CMS relies upon the reduction in therapy visits to justify its proposal while recognizing that the reduction was a behavior change, one that would not have occurred under HHRG-HHPPS. Under PDGM, the volume of therapy is not a measure within the payment model that affects the level of payment. As such, it is not a behavior change that matters in the CMS responsibility to compare assumed and actual behavior changes on PDGM estimated aggregate expenditures.

Third, CMS has failed to provide essential information for stakeholders such as NAHC to evaluate the legal and logical appropriateness of the proposed PDGM evaluation and resulting alleged overpayment to HHAs. For example, NAHC submitted a simple data request to CMS stemming from the inability to replicate the various calculations that CMS made to conclude that a 7.69% rate reduction was necessary to achieve budget neutrality prospectively under PDGM. That request was presented by way of an email to Brian Slater on June 20, 2022, and July 7, 2022. The text of the July 7 message is below:

> Thanks for your response. I understand your uncertainty as to what I am looking for**.**
>
> As you note, the NPRM provides significant information as to the calculation of estimated aggregate expenditures. Still, here are my questions/data needs:
>
> 1. Table B13 indicates that "aggregate expenditures" for the Budget-neutral 30-day Payment Rate with Assumed Behavior Changes is $15,170,223,126. Can you provide the inputs for that calculation? It does not appear to be based on the2020 final dataset of actual 30-day periods of care (7,618,061) or the 2020 analytic file number of 8,423,688 at $1864.03. It also must not be based on the original 2018 final analytic file of 9,336,898 30-day periods. $15,170,223,126/$1854.03 = 8,138,400 30-day periods. My apologies if I missed something.
>
> 2. The Budget-neutral 30-day payment rate with actual Behavior Changes is listed in Table B13 at $1742.52 with aggregate expenditures of $14,297,150,00. If that calculation is based on 4,463,549 simulated 60-day episodes at $3,284.88, it does not result in the expenditure amount listed. Likewise, the expenditure listed is not the result from 7,618,061 actual 30-day periods X $1742.52. (Actual outcome of such would be $13,274,623,653).
>
> Please provide the basis of the calculations used to reach each of the numbers set out in Table B13 other than $1864.03 as that is known.
>
> Further, it appears that CMS concluded that all changes occurring in 2020 were behavior changes, thereby leading CMS to apply the HHRG payment model within that outcome. Can you confirm that no separate calculations on actual behavior changes were done in any of the following areas:
>
> LUPA
> Primary diagnosis
> Comorbidities
> Functional status assessment
> Source of admission
> 30-day periods vs 60-day episodes
> HHGM service domain factors, e.g., Therapy visit volume HHGM clinical domain factors
> HHGM functional domain factors

As of the date of the submission of these comments, there has been no response to this request. However, the request goes to the core of CMS calculations leading to the 7.69% rate reduction in the NPRM. The alleged overpayment and resulting proposed rate adjustment is not derived from the various numbers displayed by CMS in the NPRM. As such, it is impossible to reasonably review and provide comment on that calculation. The essence of APA rulemaking is that CMS must disclose not just what it

is proposing, but why it is proposing to take certain action. With the proposed rate cut and its likely devastating effect, all details matter.

All told, the CMS budget neutrality methodology fails to comply with unambiguous obligations under section 1895 of the Social Security Act. That failure warrants a full withdrawal of the proposal to institute permanent and temporary adjustments to payment rates.

The Budget Neutrality Adjustment Proposed is Inconsistent with the Concept of Budget Neutrality

NAHC's evaluation as to whether the PDGM system has achieved budget neutrality using the original rate setting method employed by CMS in setting the PDGM rate shows an underpayment of 3.22% in 2020. A separate analysis by the renowned health economics firm Dobson-Davanzo, using the parity adjustment methodology employed under the SNF benefit shows a 2020 underpayment of 2.5%.[1] In contrast, CMS calculates that HHAs were overpaid by 6.52% in 2020. This radical difference is explained in the fatally flawed methodology employed by CMS that applies the HHRG-HHPPS payment system to the PDGM-induced 2020 home health care delivery, a universe that would not exist in the absence of PDGM.[2]

While the proposed methodology for determining the impact of actual behavior changes on the budget neutrality of the PDGM base 30-day period rate is noncompliant with statutory mandates, it is also fails to achieve the goal of budget neutrality with the expenditures that otherwise would have occurred in the absence of the new payment model. By definition "budget neutrality" means that Medicare spending under the PDGM system must be equal to the level of spending that would have been made under HHRG-HHPPS.

In its original rate setting, CMS determined that HHRG-HHPPS estimated aggregate expenditures would be based on the actual 2020 60-day episode base rate translated to a 30-day period base rate at $1908.18 prior to the annual inflation update. That set the target for PDGM budget neutrality for 2020. CMS did not offer an "estimated aggregate expenditure" for 2020 under an HHRG-HHPPS payment model. Instead, it represented that amount through a simulated 30-day base rate relying upon HHRG-HHPPS data on expenditures, 60-day episodes, and simulated 30-day payment periods. In setting the

[1] *Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2023 HH PPS Proposed Rule,* Dobson Davanzo. April 12, 2022 (Appendix C)

[2] NAHC is aware of the comments submit by the Medicare Payment Advisory Commission (MedPAC) on this proposed rule. https://www.medpac.gov/wp-content/uploads/2022/08/08152022_HomeHealth_MedPAC_COMMENT_SEC.pdf. MedPAC expresses support for the proposed 7.69% rate adjust. However, that support appears to be an "any means to the end" support. Notably. MedPAC offers no evaluation of the legitimacy, rationality, and accuracy of the budget neutrality methodology or outcome of the CMS proposal. Instead, MedPAC's support is centered around its previous recommendations that payment rates be reduced. NAHC recommends that CMS consider these comments from MedPAC for what they are, a support for rate cuts no matter how they come about.

$1908.18 30-day simulated rate, CMS reached the final target rate for its later budget neutrality analysis that is subject to the current NPRM. While the aggregate expenditure outcome would change based on patient volume, the CMS's approach avoided that complication by boiling the methodology down to the base rate.

To establish the PDGM 30-day base rate, CMS then considered the potential impact of HHA behavior changes that PDGM would trigger with respect to operating elements of that payment model. Three measures that would affect PDGM payment determinations were chosen by CMS for "assumed" behavior changes that could increase PDGM expenditures about the budget neutral target that was set through the $1908.18 base rate. Those measures were primary diagnosis, LUPA proportion, and comorbidities. Based on consideration of assumed HHA behavior changes on these factors and the timing of assumed changes, CMS reduced the base 30-day rate by 4.36% to $1824.99. When a 1.5% inflation update was added to that rate, the final rate for 2020 was $1864.03. To the extent that CMS accurately estimated the impact of PDGM-induced and payment level-affecting behavior changes, the 2020 outcome of the $1864.03 rate should have been $1936.80 in average 30-day period expenditures.

The question to be resolved by CMS in its budget neutrality analysis is whether actual PDGM-induced behavior changes led to an average 30-day period expenditure higher or lower than $1936.80 ($1908.18 + $1908.18). Factors such as patient acuity or changes in clinical practice that are not behavior changes that affect PDGM payment are not to be included in the calculation.

In the NPRM, CMS offers two data points that are essential to the calculation of 30-day period average expenditures: 2020 PDGM 30-day period aggregate expenditures ($14,297,150,005) and the number of 30-day periods that make up those expenditures (7,618,061). That data result in an average expenditure of $1876.74 ($14,297,150,005/7,618,061). At that level, CMS should determine that HHAs were underpaid by $60.06 per 30-day period to achieve budget neutrality with estimated expenditures under HHRG-HHPPS. Accordingly, the base 30-day rate should be increased for 2020 by $60.06 or 3.22%.

That calculation preserves the intended budget neutral transition mandate established by Congress. Further, it is a simple formula based on CMS reported data sources that are the same that CMS used to establish the original 2020 base rate. It also avoids the use of a methodology that warps the budget neutrality calculation by applying the HHRG=HHPPS payment method to a PDGM modified universe of care and services which ignores the concepts inherent to a budget neutrality assessment along with the clear mandate that the assessment is based on what would have been expended if PDGM never existed, including any behaviors that would not have changed otherwise.

As an alternative, NAHC suggests that CMS employ a methodology comparable to that used to determine the "parity adjustment" in the FY 2023 SNF payment rate. That approach is fully set out in the Dobson Davanzo report attached in Appendix C. That methodology achieves the goal of budget neutrality in that it fully recognizes that PDGM drover changes in therapy utilization that would not have occurred if the HHRG-HHPPS remained in operation in 2020.

The Proposed Rate Reduction and Cost Increases Jeopardizes Care and Will Lead to the Failure of the Expanded HHVBP

It takes financial resources to deliver health care services. As discussed above, the depletion in financial resources to HHAs over the years has depleted home health services to patients and erected barriers to care. That depletion of support will also affect innovations in health intended to reduce overall costs. One of the few successful Value-Based Purchasing experiments in Medicare has been the Home Health Value-Based Purchasing (HHVBP) demonstration program with hundreds of millions in savings to Medicare, primarily through reduced use of inpatient hospitalization.

The planned expansion of HHVBP nationwide is a policy action that NAHC supports as it definitively establishes that home health services bring dynamic value to Medicare, not only through reduced costs of care on a per diem basis, but through cost avoidance mainly stemming from reduced risk of patient hospitalization. CMS has estimated that the nationwide expansion of HHVBP will garner nearly $3.4 billion in Medic are savings during it course of operation.

However, it is readily apparent that the success of HHVBP is at risk if CMS reduces revenues to HHAs through the proposed 7.69% rate cut. It is unfathomable that HHAs provide the same level of patient support and operational performance with a $1.3 billion revenue reduction. The impact of that revenue reduction is combined with an unfunded $267 million cost increase stemming from the proposal to require OASIS on all patients and the annual Market Basket Index update that is far below actual cost inflation. It is highly unlikely that the non-Medicare payers of home health services will increase payment rates to HHAs to accommodate the added $267 million in costs for expanded OASIS. The discussion above on HHA overall margins makes it abundantly clear that those payers currently pay less than the cost of care on average. The proposed OASIS expansion comes at a cots equivalent to 1.7% of Medicare home health services revenues. Ultimately, the expansion of OASIS costs will be an unfunded mandate that will have the natural and foreseeable impact of reducing resources and services to patients.

The added OASIS costs are not only financial. Health care providers of all types are struggling with the shortage of nursing staff to perform essential patient services. As recognized by CMS in the proposed rule, expanded OASIS not only comes with a financial cost, but it also draws on the limited availability of nursing staff. As a result, it can be expected that the OASIS expansion will lead to a reduction in two resources that will affect HHVBP performance: financial supports and staffing supports for direct patient care.

CMS has not demonstrated the need for the OASIS expansion for purposes of improving patient care, enhancing patient safety, or improving its HHA performance quality assessment process. Further, CMS has not explained what, if any, patients, would continue to be excluded from OASIS. Fort example, OASIS was not designed for or serve any purpose with respect to pediatric patients and patients whose sole services are personal care or home health aide service. There are also serious questions as to whether the OASIS expansion is within the statutory authority of CMS as there has been no justification presented that the expansion is necessary for the health and safety of patients as required under Section 1861(o)(8) of the Social Security Act.

The proposed update of 3.3% reduced by 0.2% productivity adjustment falls short of real-life cost inflation. Notably, cost inflation is at a 40-year high regardless of which index is considered. HHAs report continuing labor cost increases in 2022 Q2 and Q3 that range from 7-12%. A recent survey conducted by Dobson Davanzo found much high-cost inflation relative to labor costs than is reflected in the proposed

Market Basket Index along with a significantly great nurse labor cost increase determined by the U.S. Department of Labor, Bureau of Labor Statistics.[3]

With labor representing 75% of home health costs, the proposed 3.1% market basket index is less than half of actual labor cost increases. In addition, HHAs, unlike many other health care sectors, are hard hit with transportation cost increases both in terms of vehicle acquisition and gasoline. With an estimated 7.8 billion miles driven each year, HHAs face transportation cost increases alone that may exceed the proposed Market Basket Index increase.

CMS has the authority to modify its MBI calculation methodology. Section 1895(b)(3)(B)(iii) provides:

> Home health market basket percentage increase.—For purposes of this subsection, the term home health market basket percentage increase means, with respect to a fiscal year or year, a percentage (estimated by the Secretary before the beginning of the fiscal year or year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year or year.

This provision offers significant discretion to the Secretary to account for cost increases specifically related to "the mix of goods and services included in home health service." The labor and transportation costs are certainly within home health services.

The recent MBI increases for hospitals, SNFs, and hospices is a positive indication that CMS will raises the Market Basket Index in the final rule. However, the increases seen in the other sectors remain short of what HHAs report as actual cost increases in 2022.

NAHC estimates that that the overall impact of the changes set out in the NPRM will be over $2 billion in 2023 alone through a combination of lost revenue ($1.3 billion), added costs ($267 million), and the shortfall in the inflation update ($500 million). With an estimated $16-$17 billion in Medicare home health revenues in 2023, a $2 billion negative impact clearly creates an insurmountable barrier to the success of HHVBP. In fact, it would not be surprising to see a deterioration in HHA performance leading to higher overall Medicare costs.

To achieve success with HHVBP, HHAs must invest in performance improvements that come at a financial cost. In the absence of such, performance will be no better than in the past. The outcome will be that half of the HHAs will pay for the bonus payments made to the other half. Medicare will gain nothing as, at best, the HHA performance will be at status quo. It is axiomatic that reduced resources will reduce performance.

Success with HHVBP might occur with "smarter" allocation of resources by HHAs. However, it stretches credulity to a breaking point to believe that even the smartest operational changes can offset the lost revenue through the 7.69% rate cut, added OASIS costs, and inadequate inflation update. The

[3] *Home Health Labor Cost Survey,* Inflationary wage impacts on home health agency labor costs as of 2022 with implications for the future, Dobson Davanzo, August 16, 2022 (Appendix D).

dynamic value of home health services that is intended to fuel the Medicare savings expected through HHVBP will be lost.

RECOMMENDATIONS:

1. **CMS must use most recent BLS data; where sector specific data is not recent, use CPI data**
2. **CMS should adjust 2022 base rates to conform to actual cost inflation in 2022 that exceeds the 2022 MBI as was done for SNFs**
3. **Withdraw the proposal to expand OASIS**
4. **Include exemptions for personal care and pediatric patients in any consideration of expansion**
5. **Fund any OASIS expansion through an increase in Medicare payment rates as the purpose is to address a Medicare mandate**

The 2023 Wage Index Continues to Discriminate Against Certain HHAs in a Manner that Favors Hospitals that Employ Staff from the Same Geographic Area

CMS proposes to establish a budget-neutral 5% cap on future negative adjustments in the wage index as applied to HHAs. CMS has proposed and finalized that same policy already for inpatient hospital services, Skilled Nursing Facility services, hospice care, and other provider sectors. NAHC supports that policy.

At the same time, CMS proposes no action to address the unfair discriminatory action it took in 2022 in extending the original wage index transitional 5% negative change cap for hospitals, but not other health care providers. CMS had rebuffed calls for an extension for HHAs on the basis that it was not a subject of the CY 2022 proposed rule. CMS did not address the merits of the NAHC request to extend the transitional cap to HHAs.

NAHC disagrees that CMS had no authority to address the request to extend the 5% transitional cap on negative wage index adjustments to HHAs. The wage index without a cap was proposed by CMS for CY 2022. That put the cap issue very much a part of the CY2022 NRPM. With the CMS standard as to which matters are subject to the public comment opportunity under the Administrative Procedures Act, commenters could only address the specific proposal and not alternatives to that proposal. Such an approach essentially guts the purpose and intent of the APA. It also ignores the longstanding authority of federal agencies to promulgate policies that are "natural outgrowth" of a proposed policy extending the 2021 cap is such a "natural outgrowth" of a policy proposal to end the cap, particularly in the context of extending it for one other provider sector.

Likewise, it is open to comment and consideration by CMS with respect to the present proposal to institute a permanent cap on negative wage index changes, particularly since it significantly departs from the CMS practice of applying the hospital w age index as a base for the home health wage index. While CMS deviates from the hospital wage index by using a pre-area reclassification, pre-rural floor hospital wage index for home health services, CMS has continually applied the hospital wage index in all other

respects. With hospitals subject to a wage index with a 5% negative adjustment cap since 2021 and HHAs subject to an index that is significant different as a result having no cap in effect in 2022, HHAs will permanently have a markedly different wage index that hospitals while competing with hospitals for the same type of staff. The unfairness and predictable impact of that inconsistent action is readily apparent.

In CY2021, CMS modified the wage index area designations for all providers subject to wage index adjustments in payment rates. In doing so, CMS reset the Core-Based Statistical Areas (CBSA) in a manner that reflects findings of the Office of Management and Budget (OMB) relative to economic marketplaces for labor. As some of the modified CBSA designations led to significant reduction of wage index values in certain areas of the country, CMS implemented a budget neutral cap on negative adjustments set at 5%.

To illustrate the depth of the potential reduction in wage index values, the example of CBSAs 35614 and 35154 standout. CBSA 35614 generally encompasses the New York City metropolitan area including parts of New Jersey. The revised CBSA designation maintained an application to some New Jersey counties but excluded several previously included New Jersey counties. Those excluded New Jersey counties include Monmouth, Middlesex, and Ocean. The excluded counties had been included in the New York City CBSA for at least a decade. The redesignation has a dramatic effect on the applicable wage index for those excluded counties, reducing the CY2022 wage index from 1.3389 to 1.0578.

CMS has not proposed any method of reconciling the inequities attendant to the application of a protective 5% cap on negative wage index changes for hospitals one year earlier than for HHAs or other Medicare providers. There is no basis for concluding that hospitals deserve special protection from the effects of the CBSA redesignations, but that HHAs, hospices, SNFs, and rehabilitation facilities do not. In fact, since all these providers compete for the same labor pool they warrant equal treatment, not discrimination. At the same time, due to the likely unprecedented reduction in wage index values triggered by the CBSA redesignation, all providers warrant a cap on any negative adjustment on the same basis and at the same time. A payment rate reduction over two years of nearly 15% and a 2022 reduction over 11% is not sustainable without access to care consequences.

NAHC suggests that CMS has options to reconcile the inconsistent treatment of hospitals and HHAs. One approach would be to calculate the 2023 HHA wage index as if the 5% cap had applied in CY 2022. A second would be to retroactively institute the cap for all affected areas for CY2022 and to modify the proposed CY 2023 wage index applying any applicable other wage index changes.

RECOMMENDATIONS:

1. **CMS should apply the 5% wage index reduction cap in 2023 as if it had been applied in 2022 without regard to budget neutrality as it relates to the limited geographic areas affected.**
2. **CMS should otherwise finalize the 5% negative adjustment cap on a permanent basis prospectively**

The Proposal to End the Suspension of OASIS Data Collection on Non-Medicare/Medicaid HHA Patients to Require HHAs To Submit All-Payer OASIS Data for Purposes of the HH QRP, Beginning with the CY 2025 Program Year

CMS is proposing to require the collection and reporting of the OASIS data set on all home health patients receiving skilled services regardless of payer. Specifically, CMS is proposing that for the CY 2025 HH QRP, the expanded reporting would be required for patients discharged between January 1, 2024, and June 30, 2024. Beginning with the CY 2026 HH QRP, HHAs would be required to report assessment-based quality measure data and standardized patient assessment data on all patients, regardless of payer, for the applicable 12-month performance period.

The proposal as written requires HHAs to collect and report the OASIS data set on all patients receiving skilled services regardless of payer. It is unclear whether CMS intends to require OASIS collection on all patients without any exceptions. Therefore, without further clarification or qualification, this proposal would include the collection and reporting of the OASIS data set on pediatric and maternity patients, categories of patients that are currently excepted from the OASIS collection. Because the Report to Congress cms-oasis-study-all-payer-data-submission-2006.pdf that is referenced in the proposal is limited to adult, non-maternity patients, it is difficult to know the patient population CMS intends to apply the collection and reporting of the OASIS data.

An expectation that HHAs collect and report OASIS data on all patients without exception would create an untenable burden for agencies and result in erroneous quality measure data for agencies with pediatric and maternal-child programs.

NAHC surveyed home health agencies on whether they supported either proposal. If the response was not to support, the respondents were requested to provide the reason(s) for not supporting the proposals. A large majority of respondents (>80%) do not support collection and reporting the OASIS data set on all patients without exceptions. A smaller majority, (65%), do not support collecting and reporting the OASIS data set for the adult, non-maternity patients.

Reasons for not supporting the collection and reporting OASIS data, even on the limited number of non-Medicare/Medicaid patients (adult, non-maternity), were related to burden and concerns with including private pay patients in the home health quality reporting program. The burden is associated with both financial and opportunity costs for agencies, with no additional reimbursement from payers. Agencies are struggling with workforce shortages, devastating payment rate cuts. and raising inflation. Rural providers are particularly impacted by these challenges. Efficiencies of scale are different for these providers. Agencies in rural areas travel long distances, operate in underserved areas, and have even more challenges recruiting qualified staff.

Even by CMS' estimates the proposal would result in HHAs having to increase by 30 percent the number of assessments they complete at each timepoint, with a corresponding 30 percent increase in their estimated hourly burden and estimated clinical cost. Additionally, CMS has consistently under reported the burden estimate for the OASIS completion.

Quality reporting concerns also revolve around the varied patient profiles for private pay patients served by HHAs. This population is typically younger with shorter lengths of stay, have a healthier baseline, and have more acute care needs. Therefore, they are discharged from home health services earlier into their recovery phase with more varied outcomes than the Medicare/Medicaid population.

Additionally, CMS aims to ensure quality care is provided to all patients served by the HHA, including private pay patients. However, it is unclear how the impact on private pay patients will be determined since quality measure reports are not stratified by payer type. The home health industry has been requesting that CMS provide agencies with this information but have been unsuccessful in obtaining this level of detail in the home health quality reports.

Lastly, CMS proposes to begin collecting OASIS data on all patients beginning January 1, 2024. The implementation date for the all-payer collection of the OASIS data causes concerns for several reasons. The OASIS-E will be implemented January 1, 2023, and it contains several new complex assessment items. Collection of the OASIS-E on all patients will be burdensome even for those agencies that already collect OASIS on all adult, non-maternity patients. There will be a long learning curve for clinical staff to become adept at completing the OASIS-E and agencies will likely still be struggling with OASIS accuracy well into 2024. This is compounded by the above noted ongoing work force shortages and significant rate cuts to HHAs along with rising inflation.

Recommendations:

1. **Withdraw its proposal to require the collection and reporting of OASIS data on all patients regardless of payer.**
2. **Prior to finalizing a proposal to collect and report OASIS data on all patients CMS should:**
    a. **Clarify which patients the OASIS collection and reporting requirements apply.**
    b. **Delay the implementation date until CMS has provided sufficient reimbursement to cover the additional costs for HHAs to collect and report the OASIS data on all patients.**
    c. **Ascertain the impact of including Non-Medicare/Medicaid patients in the HH QRP**
    d. **Examine the burden impact on HHAs in rural areas to collect and report OASIS data on all patients.**
    e. **Ensure quality measures can be stratified by payer and reported on the agency's quality measures report.**

Comment Solicitation on the Collection of Data on the Use of Telecommunications Technology Under the Medicare Home Health Benefit

CMS proposes to develop three new G-codes to identify when home health services are furnished using telecommunications rendered via a real-time two-way audio-video telecommunications system; audio only technology such as telephone or other real-time interactive audio-only telecommunications; and the collection of remote patient monitoring. Voluntary reporting for the G-codes on claims would begin January 1, 2023, with mandatory reporting beginning July1, 2023.

CMS is also soliciting comments on future refinement of these G-codes. Specifically whether the codes should differentiate the type of clinician performing the service via telecommunications

technology, such as a therapist versus therapist assistant; and whether new G-codes should differentiate the type of service being performed through the use of telecommunications technology, such as: skilled nursing services performed for care plan oversight (for example, management and evaluation or observation and assessment) versus teaching; or physical therapy services performed for the establishment or performance of a maintenance program versus other restorative physical therapy services.

NAHC supports collecting telecommunication services on home health claims and supports developing a mechanism to refine collecting visit details for the type of clinician and service provided. Capturing telecommunication visits on home health claims will greatly assist with accurate cost reporting for the use of telecommunication technologies. However, there are concerns with future refinements of the G- codes that specify the type of clinician and service provided as proposed. The creation of multiple G-codes may lead to confusion and result in inappropriate assignment of the G-codes on claims.

CMS could use a similar approach to identify telecommunication visits on home health claims as was done for physician services during the COVID-19 public health emergency. Appending a modifier to existing G-codes on claims would be a less cumbersome approach to reporting detailed information around telecommunication visits.

Recommendation: **Rather than create individual G-codes that identifies each type of telecommunications technology by clinician and service provided, CMS should consider using modifiers to identify the specific telecommunications technology that can be appended to existing G-codes that identify the clinician and type of service provided.**

Expanded HHVBP Program

The HHVBP program is to be implemented nationwide January 1, 2023. Although, in general, NAHC supports the expansion, HHAs have expressed concern with the negative impact payer changes have on the OASIS based outcome quality measures.

When a Medicare beneficiary switches from a Medicare Advantage (MA) plan to Fee-for-Service Medicare, CMS requires the agency complete a new Start of Care (SOC) OASIS. Although CMS' policy does not require a discharge OASIS from the previous payer, without completing the discharge OASIS, the SOC OASIS for the MA plan does not have an assessment necessary to complete the quality episode. Failure to discharge from the MA plan could negatively impact the agency's Quality Assessment Only metric. Therefore, HHAs will complete a discharge OASIS assessment with payer changes, creating a premature discharge from the agency, with a resulting artificial quality episode.

Because of the premature discharge, the resulting quality measures for the artificial quality episode typically reflects little or no improvement in the outcome measures; negatively impacting the agency's overall quality measure scores. HHAs increasingly have had concerns with how this has negatively impacted their star ratings and HH QRP program. However, with the nationwide implementation of the HHVBP program, agencies that have high numbers of patients in MA plans, and subsequent payer changes, are at greater risk for negative impacts.

High occurrences of beneficiary payer changes from one MA plan to another MA plan demonstrates an additional area of ongoing concern by many agencies. In these situations, agencies are

faced with varying plan guidance for submission of start of care and discharge assessments. Often, agencies must unwillingly utilize the Discharge/Readmit process to meet the plan requirements when switching from one MA plan to another. This creates an even larger number of artificial quality episodes, therefore, creating additional negative impact on star ratings and HHVBP measures.

Because there is great variation in the saturation of MA plans in states, and areas within states, nationwide cohorts in the Expanded HHVBP program could place agencies in high MA saturation areas at an unfair disadvantage. NAHC is not aware if this effect was noted in the nine states under the original HHVBP program. However, it is important to note that there may have been less variation within those state cohorts than will be seen in a nationwide cohort for comparison.

NAHC also repeats its position from the CY 2022 NPRM with respect to its recommendation that CMS modify the HHVBP design to provide a "shared savings: element where in HHAs that reduce Medicare spending through performance improvement share in the estimated $3.4 billion in expected savings to the Medicare program. Doing so would further incentivize performance improvement as well as fairly address the weakness in the HHVBP model that leads to financial penalties to HHAs that contribute to Medicare savings, but still fall in the bottom half of performance in comparison to other HHAs. In the CY 2022 rulemaking, CMS chose not to address this recommendation on the basis that it had not proposed a "shared savings" element to the design. However, proposed rulemaking is intended to refine and improve policy proposals. The NAHC recommendation was offered for that purpose.

Recommendation:

1. **CMS should consider applying the same exception for the OASIS based outcome measures within the HHVBP model that is applied to the acute care hospitalization and emergency department use within 60 days measure. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 60 days following the start of the home health stay or until death should be excluded from the HHVBP OASIS-based outcome measures calculations.**
2. **CMS should include a "shared savings" element to the HHVBP design**

Request for Comment on a Future Approach to Health Equity in the Expanded HHVBP Model

CMS is requesting comments on whether they should consider incorporating adjustments into the expanded HHVBP Model to reflect the varied patient populations that HHAs serve around the country and to tie health equity outcomes to the payment adjustments based on HHA performance under the Model. Recommendations include adjustments made at the measure level such as stratification based on dual status or other metrics or adopt new measures of social determinants of health (SDOH). These adjustments could also be incorporated at the scoring level in forms such as modified benchmarks, points adjustments, or modified payment adjustment percentages (for example, peer comparison groups based on whether the HHA includes a high proportion of dual eligible beneficiaries or other metrics).

NAHC supports the concept of capturing and incorporating elements around health equity into the HHVBP program and appreciates CMS' considering an approach to the Expanded HHVBP program that captures the diverse populations that HHAs serve. As noted in the *Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model Fifth Annual Report*, there were disparities among the Medicaid population for acute care hospitalizations and functional measures. This is particularly

important to rural providers in underserved areas who have a disproportionate share of patients with social and economic challenges.

HHAs serving higher numbers of dual eligible, for example, should be given consideration where risk adjustment falls short on the measures. Additionally, incorporating health equity adjustments into the Expanded HHVBP may provide better access to home health services for patients with complex needs. However, any approach to incorporating a health equity into the Expanded HHVBP program must be implemented in a manner that does not unfairly penalize agencies and does not increase burden for HHAs to collect and report the data necessary to incorporate health equity adjustments.

With a nationwide VBP program the degree of diversity of patients served by HHAs will be magnified. CMS should consider that there are varying intensities of racial, ethnic, and cultural diversity in communities and ensure incorporating health equity into the HHVBP program does not unintentionally disadvantage any HHAs serving communities with particularly low levels of diversity.

Measuring health equity will require the collection and reporting of data items that are not yet standardized in home health both in terms of the data to be collected and how that data will be captured. Although the OASIS-E has several new items aimed at social determinants of health, they are only a few, and may not provide sufficient data to support modifying the HHVBP program. Additionally, although it is generally accepted that certain social determents of health (SDOH) contribute to health equity gaps, it is unclear if there are any evidence-based studies that supports incorporating SDOH or health equity considerations into healthcare payment models.

Recommendations: CMS should:

1. **Examine strategies to reduce the risks for unintended consequence prior to implementing health equity adjustments to the HHVBP program.**
    a. **Convene a Technical Expert Panel for stakeholder input**
    b. **Ensure that metrics for health equity and the application to the HHVBP are determined through evidence-based research.**
2. **Use existing data sources for data collection and not require HHAs collect additional data to support incorporating health equity into the HHVBP.**

Request For Information Related to the HH QRP Health Equity Initiative

In this proposed rule, CMS is requesting feedback on the following questions and a structural composite measure. NAHC applauds CMS for the continued focus on health equity in this proposed rule and strongly supports embedding the principles of health equity in the design, implementation, and operationalizing of policies and programs to improve health and reduce disparities for all people served by the Medicare program and stand ready to assist and partner in this endeavor.

Soliciting comment on the following questions:
1. What efforts does HHA employ to recruit staff, volunteers, and board members from diverse populations to represent and serve underserved populations? How does your HHA attempt to bridge any cultural gaps between your personnel and beneficiaries/clients? How does HHA measure whether this has an impact on health equity?
2. How does your HHA currently identify barriers to access in your community or service area?
3. What are barriers to collecting data related to disparities, social determinants of health, and equity? What steps does HHA address these barriers?

4. How does your HHA collect self-reported demographic data such as information on race/ethnicity, disability, sexual orientation, gender identity, veteran status, socioeconomic status, and language preference?
5. How is your HHA using collected information such as housing, food security, access to interpreter services, caregiving status, and marital status to inform its health equity initiatives?

HHA readiness to develop and implement health equity initiatives varies greatly. Some agencies report that health equity concepts are new to their organization while others report collecting and analyzing data related to health equity for some time and using it as part of their performance improvement program. Consistent feedback from members indicates that there are HHAs operating all along this spectrum. Primary factors impacting readiness level include workforce shortages and financial constraints. Many agencies report that the COVID-19 pandemic required a shift in priorities prohibiting them from focusing on any priorities other than the most urgent ones. It has only been recently that some HHAs have been able to dive deeper into health equity concepts and plan for adoption or expansion in their organizations. Those HHAs that are hospital-based or part of hospital-based systems have had earlier, steady, and greater exposure to health equity concepts primarily due to CMS' introduction of these concepts to hospital providers over the course of years. These HHAs also have access to more resources to learn about and address health equity and disparities. Therefore, their knowledge and experience has evolved over time, and they tend to have more advanced health equity programming. **CMS should allow for adoption of health equity initiatives with HHAs in a manner like that utilized with hospitals – slowly and over the course of years.** This allows for those HHAs that have not had the exposure and experience to build their knowledge and level the industry's baseline.

There is a learning and implementation curve for all provider types relative to health equity initiatives, and these initiatives are critical to quality care. Therefore, CMS should consider that staggered implementation across provider types (e.g., hospitals, hospice, primary care, etc.) limits the synchronization, synergy and compatibility of the improvements that all sectors are being encouraged (and on their own commit) to undertake.

Relative to recruitment and employment of staff and volunteers including board members, many NAHC members reported that financial constraints prevent them from utilizing recruitment strategies targeted to diverse populations. Many HHAs are facing significant workforce shortages and do not have the option of creating or accessing more diverse applicant pools from which to hire staff.

Some HHAs are reporting progress in recruiting and employing a diverse workforce representative of their population served. More advanced programs are partnering with local colleges and universities to recruit diverse staff. Some are partnering with elders of the diverse cultures in their area to teach the staff the culture and for the HHAs to share employment opportunities with the various communities. Other partnerships include those with local community organizations in underserved areas. However, these HHAs also reported that these programs take a significant amount of time as well as human and financial resources. Providers need time and additional financial resources to continue such efforts. Likewise, additional educational resources are needed for these types of partnerships and for HHAs to advance their basic knowledge of equity and inclusion. These resources are needed to focus efforts on learning what data should be used to drive recruiting strategies and employment decisions and to support implementation.

Those HHAs reporting that they would like to gather data related to disparities, social determinants of health, and equity indicated this would need to be done manually. The ability of EHR systems to capture this type of data is inconsistent due, in part, to not having standardized determinants of health and agreement in the industry on what data should be captured related to disparities and equity. Furthermore, there is no central repository for the data, so its value is minimal currently. It can only be

used internally, preventing true comparisons and benchmarks and subsequent performance improvement. The cost of collecting data, especially if there is a change in software required, is often a barrier. EMR systems may not be well suited to collect accurate information on gender, sexual orientation, race/ethnicity identities. For example, most ask participants to choose "one" option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Gender is also still binary, disregarding patients who may identify as non-binary. Expansion of demographic categories to capture more detailed information (e.g., Asian Americans broken down by region of national origin (East, Southeast, South, and other Asians) and Pacific Islanders broken down to four groups (Melanesians, Micronesians, Polynesians, and other Pacific Islanders)) would be helpful as would including measures of socio-economic status – income and education and insurance status. Perhaps some of these are part of the anticipated Hospice Outcomes & Patient Evaluation (HOPE) tool.

NAHC encourages CMS to expand its systems to allow for the submission of such data and for CMS to develop and share meaningful reports with this information for HHAs that will help them move forward or expand.

When barriers to care have been identified HHAs started their efforts with training their own staff on the concepts of health equity. HHAs more advanced in this area are working on approaching all care and administering the program with a health equity lens.
NAHC is pleased that the OASIS E includes some SDOH. Regardless of available resources and where they fall on the spectrum of adopting health equity initiatives, HHAs shared a desire to learn and improve their efforts in this arena.

Soliciting comment on a structural composite measure

NAHC supports introducing a structural composite measure on health equity into the home health quality reporting program provided the burden of doing so is reasonable under the current environment. We believe such a measure is a good starting point for the HH QRP and will help HHAs learn what is expected and best practices. Agencies reported to NAHC after reviewing the structural measure details that they are concerned about the burden on home health agencies that a structural measure would create. Agencies are struggling with the workforce shortage and will be adding the implementation of OASIS E in 2023. This version of OASIS is significantly different than previous versions requiring significantly more resources from agencies. These factors combined with the proposed devastating financial cuts to Medicare payments in 2023 make it near impossible for home health agencies to adequately focus on the implementation of a health equity structural measure in the same year. If any action on health equity is undertaken for home health agencies in 2023, it is important that CMS begin with education and providing resources for home health agencies to increase their knowledge of health equity initiatives.

It is also critical that when a structure measure is adopted the measure not be publicly reported until there have been learning opportunities for HHAs including the sharing of best practices. Doing so earlier would minimize the learning opportunities that are available with a structural measure and that are necessary for agencies. NAHC encourages dialogue with stakeholders about the development of a structural composite measure to ensure all components are included and the reporting of such a measure is meaningful while not being overly burdensome to providers, so we are pleased that a Technical Expert Panel is being utilized. We believe home health agencies must learn how to incorporate much of the health equity framework into their daily practice before data collection for a structural composite measure is considered.

We also recommend that as the home health measure is developed, data be gathered from agencies with feedback and learning opportunities provided to them before any public reporting is considered.

CMS has asked for information on the possible scoring of a structural measure, and NAHC asks CMS to consider the scoring of such a measure considering the broad spectrum of understanding health equity and the broad spectrum of readiness existing in home health. Perhaps a period of voluntary reporting is implemented as was done with the inception of the Hospice Quality Reporting Program before mandatory reporting is implemented. CMS should also consider that there are varying intensities of racial, ethnic, and cultural diversity in communities and ensure scoring of any health equity measures do not unintentionally disadvantage any HHAs serving communities with particularly low or high levels of diversity. And, again, public reporting is not considered until sufficient feedback and learning opportunities are shared with agencies.

We note the three domains identified as components of the structural composite measure do not adequately address social determinants of health, which must be considered as the focus on health equity increases. Social determinants are the conditions in which people are born, grow, live, work, and age. Some examples of SDOH include access to healthcare, neighborhood safety, housing stability and income level. Research estimates up to 80% of health outcomes are impacted by social determinants of health. SDOH have been shown to impact healthcare utilization and cost, health disparities, and health outcomes. Research has shown social interventions targeted at beneficiaries can result in improved health outcomes and significant savings to the health care sector (Lipson, 2017). We provide the following feedback on each domain:

- **Domain 1: HHA commitment to reducing disparities is strengthened when equity is a key organizational priority.**

  This is a great starting point for CMS to employ with agencies as it communicates expectations and guidance regarding how to begin work in health equity.

- **Domain 2: Training HHA board members, HHA leaders, and other HHA staff in culturally and linguistically appropriate services (CLAS),48 health equity, and implicit bias is an important step the HHA can take to provide quality care to diverse populations**

  We appreciate the CMS discussion of staff training needed for culturally and linguistically appropriate services (CLAS) and culturally sensitive care mindful of social determinants of health (SDOH). However, we ask CMS to also stress that efforts to improve cultural sensitivity will be different from efforts to improve SDOH. While both are very important, it is important to remember race/ethnicity should not be considered a SDOH as there is nothing inherent in being Black, or part of another racially minoritized group which contributes to poorer health outcomes. We know race and ethnicity play a significant role in understanding the distribution of social determination of health. It is however important to understand *racism* is a SDOH. Better measures of SDOH can assist agencies with targeting social problems that can be changed to improve health equity. Targeted social interventions can help prevent or delay beneficiaries needing high cost in patient care and can facilitate community integration while receiving home health care.

  Common examples of SDOH which are often used as data points in research include: access to healthy foods, neighborhood safety, housing stability, Income level, education quality, transportation availability. These circumstances are mostly determined by a distribution of

money, power, and resources. Many of these circumstances are not fair, and the unjust differences in the social determinants of health lead to poorer health. As recommended by the Institute for Healthcare Improvement1, each HHA should collect, at a minimum, race/ethnicity, socioeconomic status, gender, and a measure of geography such as zip code or US Census tract. These are important concepts to distinguish to better guide collection of data and plan for interventions to improve health equity.

- **Domain 3: HHA leaders and staff could improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity.**

NAHC agrees that health equity should be a strategic priority for HHAs, and organizational cultures should reflect this priority in hiring practices for senior leadership, as well as clinical and administrative positions. There is no doubt that doing so is of benefit to patients, their families, and those in the community served by the HHA. However, a domain comparing capacity over time should be withheld until a leveling of the state of readiness across HHAs has occurred.

Two resources have been suggested as being of help to hospices in setting an organizational culture of equity. The Augustus A. White Institute for Healthcare Equity[4] has useful resources to address implicit bias. The book *Doorway Thoughts: Cross-Cultural Health Care for Older Adults*[5] has a cultural assessment tool that has been valuable in board staff and volunteer education.

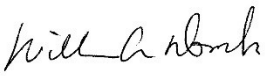
[4] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

[5] Augustus A. White III Institute for Healthcare Equity, https://aawinstitute.org

CONCLUSION

Thank you for the opportunity to submit these comments on behalf of the National Association for Home Care & Hospice along with the listed state home care associations.

Very truly yours,



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These comments are also submitted on behalf of the following organizations:

HomeCare Association of Arkansas

California Association for Health Services at Home

California Hospice and Palliative Care Association

Home Care and Hospice Association of Colorado

Connecticut Association for Healthcare at Home

Home Care Association of Florida

Georgia Association for Home Health Agencies

Illinois Homecare & Hospice Council

Indiana Association for Home and Hospice Care

Iowa Center for Home Care

Kansas Home Care & Hospice Association

Kentucky Home Care Association

HomeCare Association of Louisiana

Home Care & Hospice Alliance of Maine

Maryland-National Capital Homecare Association

Home Care Alliance of Massachusetts

Michigan HomeCare & Hospice Association

Minnesota Home Care Association

Mississippi Association for Home Care

Missouri Alliance for Home Care

Nebraska Association for Home Healthcare and Hospice

Granite State Home Health & Hospice Association (NH)

Home Care & Hospice Association of New Jersey

New Mexico Association for Home & Hospice Care

Home Care Association of New York State

New York State Association of Health Care Providers

Association for Home and Hospice Care of North Carolina

Ohio Council for Home Care & Hospice

Ohio Health Care Association

Oklahoma Association for Home Care & Hospice

Oregon Association for Home Care

Pennsylvania Homecare Association

Rhode Island Partnership for Home Care

South Carolina Home Care and Hospice Association

Texas Association for Home Care & Hospice

Homecare and Hospice Association of Utah

VNAs of Vermont

Virginia Association for Home Care and Hospice

Home Care Association of Washington

West Virginia Council of Home Care Agencies

Wisconsin Association for Home Health Care