Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

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

Submitted electronically via https://www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers from across the continuum of aging services, including home health and hospice, and our 36 state partners in 41 states, LeadingAge is pleased to offer the following comments in response to the CY2025 Home Health Prospective Payment System Proposed Rule.

Since President Biden took office, and even before in the early days of his campaign, LeadingAge applauded his strong stand on ensuring quality in long-term care services and particularly for promoting services in home and community settings. However, for the last three consecutive rulemaking cycles the articulation of this vision has fallen desperately short, impeded by the Administration's proposed 1.7% cut to home health services in this proposed rule. If implemented, CMS will have cut home health payment permanently by nearly 9% in three years (-8.989%) only two short years after the COVID-19 pandemic dismantled health care as we know it.

As we detail below, these cuts are coming at times when our members' costs and demand for services are rising and cannot be met. Continuing to implement these cuts will have a devastating effect on older adults who rely on these services. Further, it runs counter to the Administration's stated goals of promoting equity and the use of home and community-based care. From our vantage point, the combined impact of the proposed payment changes and current workforce and inflationary pressures will lead to more closures and the inability of providers that remain to take on new referrals.

Let us be clear, the workforce crisis remains unresolved. All LeadingAge provider members, across settings, are experiencing workforce shortages. Unlike retail or other business sectors, aging services providers cannot raise their prices. They are reliant on Medicare and Medicaid dollars to provide high-quality care. Health care workforce pressures will only be exacerbated by the finalized nursing home staffing mandate. From LeadingAge's unique position, representing aging services providers across the continuum, we see the forthcoming results of these policies –the competition for nurses and certified nursing assistants will become even more dire than it is today. Taken as a whole, CMS' proposals in the Medicare space are going to hurt the Administration's mission to create a strong long-term care system rather than help it.

We should take what we have learned from these past four and a half years and put more money into the system so that providers can modify, adapt, and grow rather than struggle to figure out where they can cut costs and ultimately, cut services. The impact could be even more devastating than service

cutbacks -- because of the proposed payment cuts, coupled with the first year of reductions resulting from value-based purchasing, we are hearing from several of our members that they are seriously considering reducing or ceasing to offer home health services. Others have already sold their home health business. This will only create more access issues.

LeadingAge and our members strive to provide the highest quality, person-centered care across the entire continuum. We want to take the lessons learned from this pandemic and work with CMS to envision and enact a future where high-quality long-term care is accessible and affordable for all. Many of the Administration's bold statements about long-term care and home and community-based care point to historic support to accomplish this high standard. Cutting the funding for essential services makes it impossible to turn that vision into reality.

Proposed CY2025 Home Health Payment Rate Updates

LeadingAge remains gravely concerned with the continued proposed decreases associated with the Patient-Driven Groupings Model (PDGM). In the CY2025 Home Health Proposed Rule, CMS is proposing to apply an additional -4.067% negative adjustment leading to a -1.7% adjustment to the base rate. A number of our members have already started looking at shutting down their home health lines of service or selling them – these cuts will accelerate that trend.

CMS has been abundantly clear that they are legally required to make these adjustments based on statutory language and clearly stated in the proposed rule, "…we believe that CMS has been clear through notice and comment rulemaking that the remainder of these permanent adjustments would be applied, thereby giving HHAs adequate notice to prepare for this year's proposed rate reduction. Accordingly, we are proposing to apply the full remaining permanent adjustment of −4.067 percent to the CY 2025 home health base payment rate, noting that we will update this percentage using more complete claims data in the final rule."

Preparing for a payment cut in theory is different than being able to manage it in reality. Agencies do not live in a vacuum of only fee-for-service payments and are experiencing reductions from multiple sides of the payment equation; having to absorb all of them at the same time threatens provider viability for these reasons:

1. **CY2025 Home Health Value-Based Purchasing (HHVBP):** While agencies have known that CY2025 would be their first year of rate adjustments based on their performance in the HHVBP program, they were not provided the final calculation until August 2024.[1] Agencies could guess where within their cohort they would land however, they could not begin to budget for the reduction in CY2025 without these final reports. Additionally, in July 2024, many home health agencies found that their scores were altered due to a miscalculation in the data around hospitalization measures that included the Medicare Advantage population, giving an inconsistent update to their status in the program and their potential for decreased payment. Every single nonprofit and mission driven member we have spoken to has stated they are anticipating a reduction in payment from HHVBP in CY2025. We believe the current program measures disproportionately impact our members as there are no payment-based risk adjustments on certain populations our agencies serve that require more resources. Additionally, nonprofit and government-based agencies, which make up only 21% of HHVBP participants combined, will share in a disproportionately high percentage of HHVBP reductions.

[1] https://www.cms.gov/priorities/innovation/media/document/hhvbp-exp-ipr-quick-ref-guide

Organizational Type	# of HHAs	Average Payment Adjustment (%)	10%	20%	30%	40%	50%	60%	70%	80%	90%
Religious affiliation	289	0.085	(2.658)	(1.807)	(1.294)	(0.794)	(0.252)	0.465	1.123	2.062	3.232
Private not-for-profit	579	(0.010)	(2.961)	(2.053)	(1.432)	(0.891)	(0.262)	0.422	1.098	2.055	3.562
Other not-for-profit	478	0.230	(2.618)	(1.812)	(1.144)	(0.470)	0.160	0.752	1.314	2.296	3.280
Private for-profit	5,869	0.459	(2.913)	(1.997)	(1.271)	(0.500)	0.278	1.044	1.918	3.039	4.677
State	186	0.548	(3.244)	(1.790)	(0.699)	(0.225)	0.441	1.317	2.151	3.047	4.263
Gov't & voluntary	10	1.059	(0.356)	(0.171)	0.073	0.322	0.879	1.395	1.565	1.618	3.134
Local	96	0.583	(2.604)	(1.584)	(0.797)	(0.102)	0.507	1.361	1.834	2.749	3.799
Note: The total number of HHAs differ by category due to missing HHAs in some data sources.											

One member shared that they are anticipating the full 5% reduction in their small rural agency with $2 million in revenue, meaning a $100,000 reduction in payments for CY2025. If the proposed permanent adjustment is enacted it will be an additional $34,000. This reduction could mean loss of staff positions leading to reduced services and access. This rural member is strongly committed to retaining staff – however, due to other cuts from previous years, they could not afford to increase wages which hurts recruitment, retention, and ultimately access. This member is committed to absorbing as many of the cuts as possible in the executive team by taking on more work and reducing executive compensation – but that only goes so far.

2. **Core Based Statistical Areas (CBSAs) Changes:** In the CY2024 Home Health Proposed Rule and Final Rule, CMS gave no indication that in CY2025 new CBSAs would be proposed. Agencies serving counties which have moved CBSAs based on the 2020 census, had no prior notice to prepare for these changes. Many agencies will see a reduction in payment based on these changes on top of the proposed -1.7% base cut.

3. **Fraudulent Agencies in Los Angeles, California:** It has come to our attention that some of the same fraudulent practices experienced in hospice are occurring in home health, particularly in California.[2] Much like the hospice fraud reported on in 2022, California, and specifically Los Angeles County, appear to be at the center of exponential home health enrollments.[3] This is of grave concern and we hope that CMS takes action quickly to curb the abuse. According to MedPAC's 2024 Health Care Spending and the Medicare Program Databook, much of the growth in home health agencies since 2018 has been concentrated in California and when the state is excluded from overall industry growth, the supply of agencies actually declined by about 2 percent between 2018 and 2023.[4] We believe that this growth could be disproportionately impacting the assessment of payments and behavioral adjustments for the entire industry, leading to the needless closure of many agencies serving communities across the country. Individual home health agencies have no control over fraudulent actors and their impact on the overall payment system. **LeadingAge requests CMS to immediately investigate the exponential growth of agencies in Los Angeles County, CA.**

All combined, payment impacts could contribute to the closure of agencies serving vulnerable populations.

[2] https://homehealthcarenews.com/2024/01/hospice-fraud-back-in-the-spotlight-with-new-data-also-raising-questions-about-home-health-care/
[3] https://www.newyorker.com/magazine/2022/12/05/how-hospice-became-a-for-profit-hustle
[4] https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf

LeadingAge requests CMS delay the proposed payment reduction for the third year, with the recognition that it will contribute to the growth of the temporary payment adjustments. LeadingAge also implores CMS to conduct analysis into the home health agency growth in Los Angeles County, California, assessing and publicly reporting the real and ongoing potential impacts on the aggregate adjustments since the implementation of PDGM and HHVBP.

Proposed CY2025 Home Health Wage Index

LeadingAge understands the need for Core Based Statistical Areas (CBSAs) and wage index information to be accurate. However, the significant number of changes established in the rule may lead to unintended consequences for populations impacted by health equity issues especially those in urban and rural areas. LeadingAge thanks CMS again for the implementation of the 5% cap to wage index reductions as a policy to combat ongoing wage index inequities. However, with CMS' proposal to adjust Labor Market Delineations based on the 2020 census, we reiterate that 5% remains a considerably high cap, especially as nearly 10% of counties in the country will be impacted by these CBSA changes.

Based on feedback from LeadingAge members, which we presented in our comments on the CY2023 Home Health Proposed Rule, we also found that most wage indices do not swing by 5% but even a 2% wage decrease impacts operations. Due to the home-based nature of home health, we also found agencies can serve multiple CBSAs, and while a 5% cap is helpful to maintain payment stability, agencies serving multiple CBSAs will find it difficult to consistently account for differences across their service area. Home health agencies are especially vulnerable in the transition CMS is proposing in CY2025. For example, one member that serves the greater Atlanta, Georgia CBSA will not simply contend with a small CBSA change, but potentially 26 different counties being added or removed from the CBSA, which will have significant impacts on the final wage index for their area. Providing a lower cap on decreases will allow agencies serving multiple CBSAs to better predict costs. **We urge CMS to reduce the permanent cap on home health wage index decreases to 2% during the CBSA transition year of CY2025.**

Home Health Quality Reporting Program (HH QRP)

OASIS Additions and Modifications

LeadingAge supports CMS' work on eliminating health disparities and the collection of data could contribute to better understanding the social determinants of health (SDOH) for the home health population as well as future risk adjustments for payment. LeadingAge and its members have a long history of engaging on these issues and are leading advocates for affordable seniors housing funding, programs, and policies. We work to expand, preserve, and improve the supply of affordable senior housing and better connect residents to the services and supports they need to age in community. We are grateful to CMS for acknowledging the critical importance of housing in health care.

While we know that CMS must collect standardized patient assessment data elements (SPADEs) across all post-acute providers, we want to emphasize that CMS needs to consider the data from home health agencies differently than skilled nursing, inpatient rehabilitation facilities, and long-term care hospitals. All of these post-acute settings are institutional based settings and are required to plan for the safe discharge to the community where the majority of these questions apply and impact the safety of the transition back to the community.[5] The staff social worker can prepare information and attempt to

[5] Skilled Nursing Facility Safe discharge requirement: https://www.ecfr.gov/current/title-42/part-483/subpart-B#p-483.15(c)(2)(iii)(F)

establish needed services prior to the individual returning home. Additionally, patients may feel safer to respond to questions like these when they are in a stable environment which is required to house and feed them for the duration of their stay.

In contrast, home health agencies often walk into the home where these SDOH situations are currently happening and may be at a crisis level not addressed by the system upstream before discharge. Not only is there no guarantee that the home health agency would be able to mitigate the existing issue for the patient and their family, but there may also be a risk for the individual and their caregivers in responding such as risk of mandatory reporting to adult protective services or risk of condemning their current living space with no alternative – outcomes that would violate the trust the home health agency is trying to establish through its services. Any of these circumstances could jeopardize the ability of the individual to access services for which they need and are eligible.

At this time, home health agencies do not necessarily have the capacity to help remediate many of the experiences captured in the items proposed for inclusion. There are no action steps for providers after these questions are asked. Presumably, one would not be asking questions if one was not able to intervene in some way to help address problems identified. A recently published study of a health care program that screened patients for housing instability in Boston, Massachusetts, saw marked improvements in health care utilization for individuals enrolled in the program and received housing interventions based on their screenings.[6] If a home health agency were to undertake information gathering and referral for ancillary services such as organizing home delivered meals or housing stability supports, this would surely take significantly more time than simply conducting the assessment-- more commitment from the agency, at a time when their base rates in fee for service and contracted rates in Medicare Advantage are being depleted.

We caution that these items are not used as process or outcome measures unless CMS is prepared to support home health providers in offering paid, agency-based resources for housing, utility, food assistance, and transportation referrals and interventions on behalf of patients. Until such a time, these questions should simply be an opportunity to gather more information on populations accessing home health services.

Additionally, we have concerns with increasing the burden to clinicians if these questions are added to the already complex and time-consuming OASIS. While CMS estimates these questions will take less than one additional minute, the reality of these conversations is much more serious and could take much longer to understand the true situation of the patient. Additionally, the best qualified team member to engage in these discussions is the social worker who is not typically responsible for completing the OASIS. Medicare regulations clearly define medical social services as the correct discipline to support "social and emotional problems":

[6] Primary Care–Based Housing Program Reduced Outpatient Visits; Patients Reported Mental And Physical Health Benefits
Mary Catherine Arbour, Placidina Fico, Sidney Atwood, Na Yu, Lynn Hur, Maahika Srinivasan, and Richard Gitomer
Health Affairs 2024 43:2, 200-208

42 CFR 409.45(c)

Medical social services. *Medical social services may be covered if the following requirements are met:*
(1) The services are ordered by a physician or allowed practitioner and included in the plan of care.
(2)

(i) The services are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the beneficiary's medical condition or to his or her rate of recovery.
(ii) If these services are furnished to a beneficiary's family member or caregiver, they are furnished on a short-term basis, and it can be demonstrated that the service is necessary to resolve a clear and direct impediment to the effective treatment of the beneficiary's medical condition or to his or her rate of recovery.

(3) The frequency and nature of the medical social services are reasonable and necessary to the treatment of the beneficiary's condition.
(4) The medical social services are furnished by a qualified social worker or qualified social work assistant under the supervision of a social worker as defined in § 484.115 of this chapter.
(5) The services needed to resolve the problems that are impeding the beneficiary's recovery require the skills of a social worker or a social work assistant under the supervision of a social worker to be performed safely and effectively.

To this end, LeadingAge makes the following recommendations to support these OASIS items collection:

- Clarify at which timepoints the revised A1250 Transportation will be required. The current version of the item is required at start of care (SOC), resumption of care (ROC), and discharge (DC), however in the draft HHQRP New and Modified Items document[7], the timepoints references are only SOC and ROC.
- Expand the role and billing for medical social work services to ensure the right member of the team is assessing and addressing the needs of patients:
    - The current OASIS manual clearly states that medical social workers are not discipline authorized to complete the comprehensive assessment or collect OASIS data.[8] CMS should allow medical social workers to collect OASIS data elements. While they do not need the authority to conduct the initial or comprehensive assessment, allowing medical social workers to collect data on behalf of the team is essential to getting the most accurate SDOH data while also alleviating the burden of more data items on RNs.
    - 42 CFR 484.60(a)(2)(xiii) establishes that training of caregivers is a required element of the home health care plan but does not specify which professionals are allowed to conduct this training. However, the Medicare Claims Processing Manual restricts training to only RNs and LPNs.[9] A clinical social worker is the appropriate staff to train and/or educate a patient or family member on accessing services to support SDOH especially in the context of discharge planning. Therefore, CMS should add a G-Code for medical social services to provide training to patients and families within the context of 42 CFR 409.45(c).
    - In combination, LeadingAge strongly encourages CMS to allow home health agencies to bill for social worker phone calls consistent with the billing requirements established in

[7] https://www.cms.gov/files/document/proposed-hhqrp-sdoh-item-mockup-june-2024.pdf.
[8] https://www.cms.gov/files/document/draft-oasis-e1-manual-04-28-2024.pdf
[9] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c10.pdf

hospice: *Social worker phone calls made to the patient or the patient's family should be reported using revenue code 0569, and HCPCS G-code G0155 for the length of the call, with each call being a separate line item…Report only social worker phone calls related to providing and or coordinating care to the patient and family and documented as such in the clinical records."* [10]

Proposal to Update OASIS All-Payer Data Collection

When CMS first proposed to end the temporary suspension of OASIS data collection on non-Medicare/non-Medicaid home health patients in CY2023 proposed rule, LeadingAge stated "**Without more concrete details on the how this data will be used to positively impact additional patient populations and the private insurers who are responsible for their care, LeadingAge cannot support this proposal to end the suspension of OASIS collection on all patients regardless of payer...[11]"**

While an informal survey of LeadingAge members in 2022 found that many do collect OASIS data on all patients regardless of payer, members still have many outstanding questions which remain unanswered from the CY2023 Final Home Health Rule including:

- Will agencies be required to conduct OASIS for charity patients who have no payer source to link to the data?
- Would patient level affirmation such as consent, or release forms be necessary to submit data to CMS?
- Has CMS assessed the burden of this type of patient-level authorization?
- How would CMS account for many private insurers not requiring homebound status as part of their home health eligibility?

In addition to the number of outstanding questions, we reiterate our concerns from our CY2023 comments regarding the collection of OASIS on all payers including the financial burden it will cause agencies who are not properly reimbursed for conducting the assessment by other payer sources. The burden of collection remains high in a time when Medicare Advantage plans continue to underpay home health agencies for services and workforce shortages remain severe.

According to the information collection requirements for this proposed rule, nurses continue to be the professional completing nearly 77% of the OASIS documentation – an increase since the reinstatement of all-payer OASIS collection finalized in the CY2023 final rule. Any increased need for nursing is challenging – especially in light of the forthcoming nursing home staffing mandate, which will only enhance competition for this valued workforce already in short supply.

Finally, we continue to be concerned about the future calculation of measures based on the full population of home health users. We agree with the commenter in the CY2023 Final Home Health Rule concerned, "that this proposal could result in HHAs limiting their care to non-Medicare/non-Medicaid patients to limit the potential impact on their HHA." Especially now that OASIS measures are part of payment calculations for home health value-based purchasing, agencies may see a benefit to provide more services to non-Medicare/non-Medicaid patients to improve their scores.

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[10] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c11.pdf

[11] https://leadingage.org/wp-content/uploads/drupal/LeadingAge%20Comment%20Letter%20CY2023%20Home%20Health%20Proposed%20Rule%208.16.22.pdf

LeadingAge recommends CMS reconsider the expanded collection of OASIS data and push back the voluntary and mandatory collection timelines.

Request for Information (RFI) HH QRP Quality Measure Concepts under Consideration for Future Years

LeadingAge is supportive of additional measure concepts to maintain measures that are meaningful and relevant. LeadingAge agrees that information on vaccination, depression, pain management, and substance use disorders could be useful in understanding the global perspective of patients across settings. However, we cannot support inclusion in the HHQRP program without measure specifications. A composite vaccination measure could be meaningful or convoluted, depending on the vaccinations included in the measure. Any measure that requires a change to the plan of care for clinician referral or pharmaceutical intervention is outside the scope of home health and relies on the overseeing physician. Unlike hospitals, skilled nursing facilities, and hospices, home health agencies do not have a medical director on staff to oversee and amend the plan of care as necessary. Finally, LeadingAge feels that any measures proposed for adoption should be endorsed by the consensus-based entity prior to proposal. Below are our responses to the specific domains suggested for future adoption.

A composite of vaccinations which could represent overall immunization status of patients such as the Adult Immunization Status measure in the Universal Foundation.

- Similar to the concerns around the SDOH questions, many of these immunizations could be delivered in facility settings due to access to refrigeration and proper storage. However, some of the immunizations listed are not realistic for a home health agency to offer due to the cost of doses and storage requirements.
- Home health agencies are only allowed to bill for pneumococcal pneumonia, influenza virus, and hepatitis B vaccines.[12] The ordering of these vaccines is also outside the scope of the home health agency and requires the referring physician to change the plan of care.
    - Is CMS prepared to pay agencies for the administration of tetanus and diphtheria or tetanus, diphtheria and acellular pertussis or zoster?
    - What will be the expectation for a home health agency if they cannot reasonably provide a vaccination due to either cost not being covered or inability to store the vaccination?

The concept of depression for the HH QRP, similar to the Clinical Screening for Depression and Follow-up measure in the Universal Foundation.

- LeadingAge strongly supports additional services for individuals experiencing depression and behavioral health issues in general. The Universal Foundation measure referenced in the rule is currently implemented as part of the Medicaid Home Health Services measure set but includes populations 12 years and older as well as an age-appropriate standardized screening tool, and a follow-up plan. This raises concerns about access to treatments especially in underserved communities both in rural and urban areas as home health agencies are currently not reimbursed to support mental and behavioral health issues beyond a social worker identifying additional, external resources. Again, any ordering for pharmacological interventions is outside the scope of the home health agency and requires the referring physician to change the plan of care.
    - How this measure differs from the current PHQ-2 to 9 questions which were implemented with OASIS-E and across other post-acute settings?

[12] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c10.pdf

- Will CMS support home health agencies through additional payments to conduct depression interventions?
- What will be the expectation for a home health agency if they cannot reasonably provide update the plan of care or find resources for the patient?

The concept of pain management.

- While we wholeheartedly agree pain management is incredibly important to track for home health patients, especially with the goals of home health being rehabilitative and maintenance of conditions, the concept is exceedingly vague. In the rehabilitative settings, truly pushing patients in a rehabilitative sense should produce pain, not torturous pain, but discomfort that could fall on a pain scale- none the less. We would argue again that aligning measures across multiple settings is not an apples-to-apples comparison and the information could become convoluted. Home health agencies currently track pain through a comprehensive pain interview and the guidance document clearly states, "Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does."[13] Our members also noted that for many patients the exhaustion that comes after being discharged from an acute or post-acute setting can intensify their response to pain questions. It is then very difficult to develop a pain measure beyond those available in hospice which are simple process measures of whether a pain assessment was completed and, with the newly finalized measures, if that symptom was moderate to severe, did the individual receive a follow-up visit in two calendar days. While these could be a positive addition, incentivizing additional visits, there is no way of knowing if the visit effectuated any change in the patient's pain. Again, any ordering or increasing of pharmacological interventions for pain management is outside the scope of the home health agency and requires the referring physician to change the plan of care.
    - How would CMS plan to measure something that is so subjective and individualized?
    - Would CMS be looking to utilize existing OASIS items to create this measure, or would they be looking to develop a cross setting SPADE?
    - How would agencies be held accountable to the measure if pain were not reduced?

A measure concept relating to substance use disorders, such as the Initiation and Engagement of Substance Use Disorder Treatment measure included in the Universal Foundation of Quality Measures.

- LeadingAge strongly supports additional services for individuals experiencing substance use disorders and behavioral health issues in general. The Universal Foundation measure referenced in the rule is currently implemented as part of the Medicaid Home Health Services measure set but includes populations 6 years and older as well as tracking the initiation of treatment and engagement in treatment for 34 days, which is longer than the Medicare home health episode. This again raises concerns about access to treatments especially in underserved communities both in rural and urban areas as home health agencies are currently not reimbursed to support mental and behavioral health issues beyond a social worker identifying additional, external resources. Additionally, for homebound individuals, a requirement of the Medicare home health benefit, it may be exceedingly difficult to access substance use treatment since little of it is home-based. In fact, results of a recent study focused on social worker interviews in New York City stated, "Results indicate social workers believe substance use and abuse occurs frequently among Medicare home health patients; substance use and abuse is not assessed and treated professionally in Medicare home health; the lack of coverage in Medicare home health results in exacerbation of existing patient physical and mental health conditions, which, in turn, worsen

[13] https://www.cms.gov/files/document/draft-oasis-e1-manual-04-28-2024.pdf

substance use and abuse conditions; the homebound requirement and lack of coverage of transportation and personal care assistants limits home care patients ability to obtain outpatient substance use and abuse treatment; and lack of home-based assessment and treatment contributes to increased home care readmissions, re-hospitalizations, and increased caregiver burden." [14] Home health agencies would need additional payment, training, and other resources to appropriately and holistically address substance use disorders.

The Expanded Home Health Value Based Purchasing (HHVBP) Model

LeadingAge appreciates the detailed review of potential future approaches to health equity in the HHVBP model. We would like to express our concerns about health equity adjustments in the form of quality measurement instead of meaningful payment adjustments for the populations themselves such as by dual eligible status (DES), Area Deprivation Index (ADI), or other metrics. We understand measures go hand in hand with payment adjustments, however, for many of our nonprofit, mission driven members who historically serve individuals in rural and underserved communities attaining the quality expectations of the program with no adjustments for the vulnerability of their populations has made it impossible to achieve a positive score. In many communities served by our members, hospitals and emergency departments are the only source of health care access, making it difficult to control for current claims-based emergency room and hospital utilization measures. In speaking with our members, only one agency has stated that they will not receive a reduction in payment, and even that they will be neutral, with no change to current payment. If this trend continues and no changes are made in the methodology to risk adjust payment based on factors like DES and ADI of an agency, we fear many agencies will be forced to close or drastically reduce services in their already disadvantaged communities.

Request for Information: Future Performance Measure Concepts for the Expanded HHVBP Model

With the recognition that quality measures need to be paired with a robust risk adjustment methodology for disadvantaged populations, we provide the following comments on future performance measure concepts.

- **Family Caregiver Measure**
    - The proposed caregiver assessment measure for the Guiding an Improved Dementia Experience (GUIDE) Model is not yet public; we would be concerned about utilizing it in home health without knowing how the measure is being defined. Ideally, we would wait to see its impact and be able to comment on the measure through notice and comment rulemaking. As it stands, it is difficult to comment on whether a patient-reported outcome performance measure (PRO-PM) on caregiver burden would be applicable to home health. We have multiple members who were accepted into the first cohort of the model. In the coming years we will continue to stay abreast of the development of these tools and how implementation and performance is going for our membership. With that in mind, we want to strongly encourage CMS to look at caregiving broadly in the context of home health and consider further identification of individuals who lack a caregiver. Our members find those patients to be the most challenging to serve because they have no social network to rely on for support and thus require more resources from agencies.
- **Falls with Injury (claims-based)**
    - LeadingAge strongly agrees with the technical expert panel on the need for a measure that assesses falls with injury based on claims and not OASIS data. In 2023, the Office of

[14] Cabin, W. (2021). Painful Places: Medicare Fails Homebound Patients with Substance Abuse Disorders. Journal of Health and Human Services Administration, 43(4), 406-419. https://doi.org/10.37808/jhhsa.43.4.5

Inspector General's report on the subject found that over half of falls were not reported on the OASIS as required.[15] Additionally, reporting was also lower among for profit agencies as compared to nonprofit and government-owned agencies and this led to misinformation for consumers on Care Compare since agencies which had the lowest major injury fall rates reported falls less often than HHAs with higher Care Compare fall rates.

- **Medicare Spending per Beneficiary (MSPB)**
  - LeadingAge cannot support the inclusion of this measure in HHVBP without understanding how this will be applied and its impact on the overall score for claims-based measures. Unfortunately, the TEP report and proposed rule provide little insight into how the measure would be applied leaving several questions:
    - If a home health agency spends above the national average of MSPB, which is how the measure is currently reported publicly, will they receive a lower score?
    - Alternatively, if they are above their cohort in MSPB will that have a negative impact on their score?
    - Will this be risk adjusted to the patient populations served by the particular provider?

    The lack of detail provided along with the focus on savings over the quality of care leave us concerned that this is not the correct direction for the program.
- **Function Measures to Complement Existing Cross-Setting Discharge Function Measure**
  - LeadingAge would support the expansion of the Discharge Function measure to include GG0130D-GG0130G for dressing and bathing functions. Many of our members take explicit time in providing these supports and education for these activities of daily living. Especially for individuals without family caregivers, being able to complete these more physically demanding tasks without support is essential for their success post-discharge.

Home Health CoP Changes

Proposed Updates to the Home Health Agency CoPs to Require HHAs to Establish an Acceptance to Service Policy

LeadingAge adamantly opposes the addition of a condition of participation for home health agencies to establish an acceptance to service policy.

LeadingAge agrees with the research cited by CMS on the positive patient outcomes associated with timely initiation of home health care. This is born out not only in the literature but in the day-to-day work of our membership. LeadingAge also agrees there are growing concerns with the timely initiation of care. Our members' nonprofit, mission driven work includes support of unfunded patients which fewer agencies are willing to take. Certainly, there are agencies that take patients they are unable to serve. Given the role of our members in their communities, those individuals often get referred to nonprofits from home health agencies who took the patient without the ability to support their extensive needs, especially if the reimbursement will be lower.

While LeadingAge generally supports transparency, we disagree with CMS that this purported lack of transparency is the root cause of the delay in access. Over the last several years, LeadingAge relayed concerns to CMS and MedPAC about the referral rejection rate in home health including extensive documentation in our CY2024 Home Health Proposed Rule comments. We are extremely disappointed

[15] https://oig.hhs.gov/oei/reports/OEI-05-22-00290.asp

with the resulting proposal. Without an RFI first to understand the problem further or any analysis of CMS data to identify the root cause, CMS is proposing additional administrative burdens to home health agencies instead of effectuating true changes in access.

Inconsistency in the Proposed Rule and Current Regulations
Leading Age is concerned about several inconsistencies between the proposal and the current conditions of participation.

First, timely initiation of care is not singularly defined in regulation, it is a quality measure developed from OASIS assessment data which looks at the percentage of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC/ROC date (if provided), otherwise was within 2 days of the referral date or inpatient discharge date, whichever is later.[16] This is consistent with the current CoP on the initial assessment visit:

> *42 CFR 484.55(a)(1): The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner-ordered start of care date.*

And to be abundantly clear, this data can be manipulated because it is not claims based just like we stated in our earlier comments with regards to OIG's findings on OASIS reported falls. The current national average for the timely initiation of care measure on Care Compare is 96.1%.[17] This is in direct contradiction to the research cited by CMS.

Second, there is no data to confirm CMS' observation that self-referrals are common, indeed, they should be completely irrelevant since a physician or allowed practitioner is required to make a referral to the agency as part of the existing CoPs:

> *42 CFR 484.60(a)(1): Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry or allowed practitioner acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan.*

A patient or family caregiver could certainly identify an agency that may be able to support their loved one, but that does not then mean they can bypass the requirement to be referred by a physician or allowable practitioner.

Third, the requirement that providers publicly post their caseload and case mix seems counter to how CMS has prioritized data reporting in the past. CMS strives, through Care Compare, to provide a comprehensive accessible place for individuals seeking services to find the appropriate match for their needs. As evidenced by Section II. 1. B. C. Clinical Groupings and Comorbidities, CMS can track clinical groupings and their percent of patient 30-day periods. Additionally, CMS posts similar data for hospice providers which looks at the percentage of patients with cancer, dementia, stroke, circulatory,

[16] https://www.cms.gov/files/document/home-health-process-measures-tableoasis-e2024.pdf
[17] https://www.medicare.gov/care-compare/?providerType=HomeHealth

respiratory and other conditions as well as average daily census. Why does CMS need agencies to self-report on data that CMS has?

Fourth, CMS' cost estimates are entirely unrealistic given the complexity of the proposal's requirements. CMS states in the ICR for the acceptance to service policy states, "We also estimate the HHA nurse would review the acceptance to service policy on an annual basis. This annual review would take 5 minutes for an HHA nurse…" If annual review is intended to keep the policy fresh and aligned with the actual service area, clinical acumen, or capacity, updating a plan should and would take significantly more time than 5 minutes a year.

Fifth, there are no standards or requirements, in the CoPs, State Operations Manual, or Medicare Claims Processing Manual for documenting referrals rejections and reasons for rejection. In the CY2024 Home Health Final Rule, CMS echoed this point in their refutation of industry concerns about referral rejections in CY2024:

> "In addition, the proportion of hospital referrals rejected by HHAs does not equate to the proportion of qualifying beneficiaries who are denied care. The data fails to capture why the beneficiary was rejected—for example, because the analysis focuses on numbers of referrals denied rather than numbers of beneficiaries denied care, the rejection referral proportion could be inflated by a small number of beneficiaries rejected from multiple HHAs, or by beneficiaries rejected from one HHA but who ultimately received care from another HHA. It also fails to indicate that the HHA did in fact reject the referral and why it was rejected (for example, payment or staff related), or whether there was another reason the patient did not receive home health services, such as patient refusal or readmission to an inpatient facility."

As a practical matter, agencies have no claims data or OASIS for individuals they reject since care was never initiated. It is concerning, that given there is no requirement for tracking referral rejections, that CMS would propose a policy that would penalize an agency based on their acceptance to service policy for rejecting a referral that they were never required to track.

Finally, there is a considerable lack of transparency in this proposal to improve "transparency." There is nothing in the rule that discusses how this CoP may be audited or surveyed. It is unclear from the proposal how a home health agency would be compliant. LeadingAge fears the opposite of expediting access to services is likely to happen- a provider could create very narrow policies that they post publicly, then make exceptions for individuals based on referral or payer source. The rule seems to say they expect providers to develop broad and adaptable plans that accommodate flexibility in staffing changes, among others. This is not realistic to offer a real-time snapshot of when a provider has the capacity to accept a new referral. Creating a requirement which could be used punitively against a provider that turns down a referral because of clinical indications that are not within their publicly posted scope of acceptance to service is not going to further or expedite service availability.

Staffing Challenges Remain

In general, most LeadingAge members confirmed they have acceptance to service policies that are broad with statements like "cannot accept patients to service we are not able to serve." This is aimed to allow flexibility to admit as staff turns over and new skills are available. In the proposal, CMS underestimates how often staffing and ability to accept new referrals changes. It is not simply a yearly basis but can be daily, if a policy were updated that frequently it would only lead to more confusion for referral sources, especially patients and caregivers.

Requiring posting of acceptance policies does not solve the issue causing most home health providers to turn away referrals: lack of adequate home health staff. As mentioned earlier in our comments, according to the information collection requirements for this proposed rule, nurses continue to be the professional completing nearly 77% of the OASIS documentation. Lack of nurses delays care initiation.

In the final CY2024 Home Health Final Rule, CMS responded to concerns from commenters about referral rejection rates being caused by staffing by stating:

> "We do not believe that the percentage of "referral rejections" attributable to staffing issues requires a different policy. Commenters did not submit any evidence that staffing shortages are due to changes in the payment rate or case-mix adjustment rather than the widespread staffing shortages that exist across the spectrum of health care, and in the general labor market. While we recognize the staffing challenges faced by HHAs and other health care providers, we are accounting for those staffing challenges in other ways, such as the market basket increase (which includes labor costs), as explained in section II.C.3 of this final rule."

We believe this is incredibly shortsighted of CMS given the Health Resources and Services Administration's continued projections that, nationally, there will be a shortage of 78,610 full-time equivalent (FTE) RNs in 2025 and a shortage of 63,720 FTE RNs in 2030.[18] This proposed CoP would add more administrative burden with no additional investment in rates to compete with hospitals, and soon nursing homes, for staffing. Additionally, there are operational barriers with increased staffing including wage compression, regulatory and legislated state wage increases, and falling or stagnant reimbursement rates from FFS, MA, and Medicaid while health care inflation outpaces consumer inflation.

Relation to Medicaid Access

LeadingAge disagrees with CMS that this proposal is consistent with the "Ensuring Access to Medicaid Services" (the Access Rule). That final rule requires states to report how they establish and maintain Home and Community Based Services (HCBS) wait lists, assess wait times, and report on quality measures. That final rule aims to increase transparency and accountability and standardize data and monitoring, with the goal of improving access to care based on state collected and reported data, not individual providers.

Perhaps CMS is attempting to solve for Medicaid access to home health services and providers' ability to make financial decisions about acceptable reimbursement rates and patient payer mix. The fact that Medicaid is a loss-leader is not the fault of providers, nor should be they penalized for their inability to serve additional Medicaid participants simply because they can serve some. Maintaining adequately trained staff and compensating them appropriately is costly. Creating CoPs in the Medicare program that overreach on behalf of Medicaid, where neither the federal government nor the provider have the ability to increase Medicaid rates is inappropriate. When challenges with adequate payments and staffing challenges are met by regulators with additional requirements on providers that do not correlate with the reasons Medicaid participants struggle to access home health services, providers self-select out of Medicaid service provision.

[18] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Nursing-Workforce-Projections-Factsheet.pdf

Additionally, maintenance of these kinds of administrative burdens are EXACTLY the kinds of overhead and costs that providers incur in complying with regulations that do not support the direct care workforce. The Access Rule codified a requirement that 80% of Medicaid rates for three waiver services, one of which was home health, be passed on to workers in the form of compensation. Maintaining a public posting of a policy on staff acumen and specialization, along with capacity would be another unfunded requirement on Medicaid providers to fit into an already impossible 20% administrative, management, and capital budget.

Acceptance Regardless of Payment Source

LeadingAge believes CMS is potentially setting dangerous precedent in this proposal and not fully evaluating all the unintended consequences of these proposed CoPs. The CoP proposal states:

> "It is our position that HHAs should accept or decline patient referrals based solely on clinical considerations and the capacity of the HHA to safely and effectively deliver care to meet patient needs, rather than on financial factors related to the perceived adequacy of the payment rate that the HHA has already voluntarily agreed to accept upon establishment of relationships with its payment sources."

Just like any business, some products or services are more lucrative and others are taken at lesser margins or losses. The government making a broad-brush business decision for a provider based on a provider's willingness to take a loss on a portion of their products and services because it supports their mission does not induce them to serve every Medicare Advantage (MA) patient to which they have a clinical capacity to serve. Indeed, providers have no choice but to make complicated financial decisions to keep an agency running or risk financial ruin and closure. For many of our nonprofit, mission driven providers, it is not about profitability but sustainablity. What patient *AND* payer mix is necessary to ensure that an agency can support uncompensated cases or more complicated patients while maintaining stability and operation for their community?

Current dynamics with MA plans and rates that are simply not covering costs make it difficult to accept someone you cannot afford to deliver services to, MA beneficiary or not. It is possible that implementing this "regardless of payment source" approach would either force providers to no longer accept contracts with plans that underpay or worse: bankrupt the provider. In both instances, we surely are neither increasing access nor transparency.

Additionally, we are concerned CMS is anticipating providers would be required to accept patients with payers with which they did not have an explicit contract since the language states "voluntarily agreed" not "contractually agreed." Does this mean if an agency voluntarily accepts an out of network patient from an MA plan once they must always accept those patients? Many MA plans pay well below Medicare fee-for-service rates, making it nearly impossible to take their contracts and therefore their patients. Very rarely do plans send patients outside of network. And while some MA plans may pay 100% of the Medicare FFS rate if there is no contracted agency, other plans will simply pass on the cost to patients in the form of out of network fees which negates any improvement in the access issues this proposal is attempting to address.

An additional factor not considered in this proposal is the impact of plan policies on access for patients. For plans that an agency is contracted with, we maintain that more often than not, it is the plan reducing access to services through prior authorization and other utilization management efforts, not the provider. Several of the academic research papers cited by CMS to establish credibility for this

proposal included both fee-for-service and Medicare Advantage patient populations. Looking closer at the studies, researchers indicated that there were more access issues for MA populations than FFS:

- Among the patients who did not receive home health services, there were higher proportions of Medicare Advantage beneficiaries ... [19]
- [Researchers] did not account for differences between Medicare Advantage plans, some of which have copays or more extensive prior authorization procedures associated with reduced utilization of home health care services, and potential delays to start of care.
- Initial home health visit rates were higher among fee-for-service Medicare beneficiaries compared with those enrolled in Medicare Advantage…[20]

This proposal does not address home health access issues for Medicare Advantage patients, who are now 51% of enrollees. This proposed acceptance to service would not help those individuals as a provider may or may not be in network with their MA plan or there may be additional burdens like prior authorization before an individual can actually access these services. LeadingAge is currently collecting data from our membership on the burdens associated with MA prior authorizations which consistently slow down the admissions process and will share the results with CMS.

Referral Source Responsibility

Throughout this section of the rule, CMS firmly positions the responsibility for timely initiation of care on home health agencies. However, it is rarely the case that one entity contributed to the failure of a transition of care. Referral sources need to have more skin in the game.

CMS cited only one academic research paper to establish credibility for this proposal related to community admissions, despite the fact that the majority of home health episodes now are community admissions. That study specifically stated, "Results suggest that recent changes in Medicare reimbursement for home health that reduce payment for episodes without a preceding hospitalization may threaten access to care for older adults with greater social vulnerability, ongoing functional needs, and/or clinical severity."[21] Home health agencies should not face a reduced rate for community admissions when the ordering of home health services have occurred without a preceding hospitalization. This is counterintuitive; these home health services were ordered because without the services of a HHA, the person could further deteriorate leading to a hospitalization. HHA services from community admissions likely reduce unnecessary hospitalizations and agencies should not be incentivized to admit patients after a hospitalization because of more adequate payment.

Additionally, we have heard from members that community-based patients looking for home health placement will delay their ordered start of care date to accommodate home health agency scheduling which leads to a skewed view of timely initiation of care on OASIS data.

For individuals accessing home health after an acute hospitalization, the evidence is more readily available and clear that an access issue is occurring. Our provider members shared that their hospital partners are desperate for support in discharge, asking for agencies to "save spots" and will work with

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8197411/

[20] Li J, Qi M, Werner RM. Assessment of Receipt of the First Home Health Care Visit After Hospital Discharge Among Older Adults. *JAMA Netw Open.* 2020;3(9):e2015470. doi:10.1001/jamanetworkopen.2020.15470

[21] Burgdorf JG, Mroz TM, Wolff JL. Social Vulnerability and Medical Complexity Among Medicare Beneficiaries Receiving Home Health Without Prior Hospitalization. Innov Aging. 2020 Oct 3;4(6):igaa049. doi: 10.1093/geroni/igaa049. PMID: 33241125; PMCID: PMC7672253.

home health agencies to postpone hospital discharge dates to meet expected timelines to be able to serve a patient.

Initial assessments take a lot of time. Members have repeatedly made us aware of the practices of many hospitals to refer patients needing services to multiple agencies at once. Agencies will electronically accept the referral, dispatch a nurse to begin the assessment only to find another agency had also accepted the referral and was completing the initial assessment when staff arrived. This is simply a waste of resources and a mismanagement of referral resources on the part of hospitals. Without requirements for similarly regulated entities, how could a home health agency hope to improve timely initiation of care?

In other situations, agencies will call patients prior to sending staff out and they have been sent to a skilled nursing facility, but the referral source did not cancel the referral wasting more time for the home health agency. In the same vein, there is a general concern that hospitals do not refer patients to the appropriate post-acute providers but rather rely on already established relationships. Members affiliated with hospital systems felt a burden to take any discharge regardless of the patient's readiness for the home environment. As the Office of Inspector General (OIG) estimated in a 2020 report, Medicare improperly paid $267 million during a 2- year period for hospital services that should have been paid a graduated per diem payment rather than the full payment because of improper coding related to home health discharge destination coding.[22] These types of practices are of growing concern and are a result of misaligned incentives for hospitals to reduce the length of patient stays to maximize reimbursement. Despite this very clear issue, CMS did not purpose similar requirements for hospitals in this year's proposed rule.

These first-hand experiences of our members in addition to misaligned incentives, does not indicate that the lack of transparency on the part of a home health provider is to blame for the delay in care initiation, or that the proposed CoPs would improve timely access to care.

Additional questions from CMS:

We strongly believe the issue of timely access to home health services warrants further review and we want to engage meaningfully with CMS on the issue. We acknowledge and share CMS' concerns regarding poor outcomes for individuals that do not access home health services timely. However, policy solutions should address all the factors we have outlined above, a blanket policy will not solve the access crisis.

First and foremost, we strongly recommend CMS establish a technical expert panel (TEP), including all referral stakeholders, to review all available data and research on timely access to home health services and conduct a thorough root cause analysis. Based on this review, the TEP can make recommendations on payment, additional CoPs, and referral requirements that are necessary to truly address access to services.

Alternative ways to address the delay of home health care initiation.

- More Patient Education by Referral Sources: Multiple studies of both FFS and MA populations found that delayed care is often due to patient preferences or conflicting appointments beyond HHA

[22] https://oig.hhs.gov/oas/reports/region4/41804067.pdf

control.[23] In one study, one-third of home health care episodes had delayed SOC nursing visits. The most prevalent identified category of reasons for delayed start-of-care nursing visits was no answer at the door or phone (46.3%), followed by patient/family request to postpone or refuse some services (35.5%), and administrative or scheduling issues such as staffing issues (18.2%). Another study found, in 40% home health episodes, 2 or more reasons were documented for missed visits.[24] This research is replicated for MA beneficiaries in another recent study that found 32% of patients refused service and another 19% could not be located or contacted by the accepting agency.[25] Referral sources have a responsibility to ensure patients understand the discharge planning and referral process and why a home health agency will be contacting them.

- Expand Clinician Roles: Home health is at its core a multidisciplinary service. However, the burden of completing timely assessments falls predominately to RNs as we discussed in the OASIS section of this comment letter. Allowing other clinicians on the interdisciplinary team to conduct assessments and collect OASIS data could significantly elevate the burden on nurses and provide more timely admission to services for patients.

Barriers for patients with complex needs to find and access HHAs.

- Address Payment Barriers: While CMS attempted to address inappropriate incentives around therapy utilization with the implementation of PDGM, it simply created other incentives and continued existing cultures of cherry-picking patients. We would argue the patients most likely to be delayed in finding care and accessing care are those with high SDOH issues, those who will not achieve improvement on home health value-based purchasing, and those with clinical groupings that pay the least.

Other opportunities to improve transparency regarding home health patient acceptance policies to better inform referral sources.

- Noninterference Clause Authority: The noninterference clause restricts CMS' ability to ensure payments are adequate for services offered by MA plans. While this may be outside the scope of this payment policy group, what happens in other payment sources impacts FFS. CMS needs additional authority to ensure rates for providers are adequate to serve MA beneficiaries.
- Enforce Network Adequacy: An audit or review of current MA home health agency networks and their ability to accept patients is needed. Over the last 5 years we have seen increasing beneficiary access issues for MA beneficiaries. Additionally, the MA network adequacy rules need to be reviewed. This could include assuring that all network providers remain open, are accepting new MA patients over the course of a predetermined period of time and have submitted MA claims in a specific time period.

Other ways to improve the referral process for referral sources, patients, and home health agencies.

- Referral Metrics: We believe both community and institutional referral sources are well informed regarding available agencies to serve their patients. However, there are clear incentives to adjust timing of admissions to be conducive for the agency, and their referral partners. To get a true sense of the magnitude, and the population, impacted by the delays in care, metrics and data collection standards should be developed to assess referral acceptance.

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[23] Zolnoori, M., Song, J., McDonald, M., Barrón, Y., Cato, K., Sockolow, P., Sridharan, S., Onorato, N., Bowles, K., Topaz, M. (2021) *Exploring reasons for delayed start-of-care nursing visits in home health care: Algorithm development and data science study*. The Journal of Medical Internet Research Nursing. 4(4):e31038.

[24] Song, J., Zolnoori, M., McDonald, M., Barrón, Y., Cato, K., Sockolow, P., Sridharan, S., Onorato, N., Bowles, K., Topaz, M. (2021). *Factors associated with timing of the start-of-care nursing visits in home health care.* Journal of the American Medical Directors Association. S1525-8610(21)00301-7.

[25] *Am J Manag Care. 2024;30(7):310-314. https://doi.org/10.37765/ajmc.2024.89579*

A number of the articles cited by CMS use MedPAR discharge destination coding from acute care and skilled nursing as a surrogate for referral to home health care. CMS could fashion a metric similar to a number of hospitalizations metrics available to identify how many of those MedPAR discharge destinations to home health ended up having a billable home health visit or episode. For referrals from community providers, CMS could institute a referral claims code for Part B physicians that would then be tracked against home health billable claim dates.

- Standardization of Service Rejection: In addition, there should be some consistent way to track service rejections on the side of the patient. Consistently the literature identifies patient choice to not receive services, or the inability to contact the patient, as a significant barrier in timely initiation of care. An inability to contact a patient in the community or the patient declining services could be for any number of reasons including embarrassment about their living conditions, feeling like home health is an invasion of their privacy, forgetting they were to receive home health and concerns around scammers, among others. Providers should not be held accountable for the decisions of possible referral patients to decline services or not answer outreach from HHAs. Collecting data on the patients who are not reachable or reject services in their home through the OASIS and connecting that with claims from the referral source could shed more light on education needed for patients. In the recently finalized Hospice Outcomes and Patient Evaluation tool, CMS included responses to items for the new symptom reassessment measures which identified when a patient refused services:

  Reason SRA Visit Not Completed.
  1. Patient and/or caregiver declined an in-person visit.
  2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).
  3. Attempts to contact patient and/or caregiver were unsuccessful.
  9. None of the above.

Request for Information on Rehabilitative Therapists and HHAs Scope of Services

LeadingAge has long supported the expanded ability of therapy providers to conduct initial and comprehensive assessments. During the pandemic this was an invaluable tool to support patients and staff alike. CMS asked for data, detailed analysis, academic studies, or any other information to support our response.

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

Occupational therapists are qualified to perform the start of care and already do in therapy-only cases and cases where Medicare is not the payer, such as Medicaid, as well as if they are in as a continuing need or for resumption of care. The comprehensive assessment is the same, the difference is the OASIS documentation. Every therapist should be able to do a comprehensive assessment based on the education and training they have received, they have the skills; the need for additional training would be for completing the OASIS.

The standardized PT curriculum provides graduates with appropriate foundational knowledge that should be supplemented with routine, discipline-agnostic training and preceptorship (when available) through the home health agency. PTs are trained to complete examinations and screenings to inform patient and client management, including comprehensive subjective examination, systems review, tests and measures covering the major biologic systems.

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

Home health agencies often employ admissions nurses, if possible given staffing constraints, whose role it is to complete the initial and comprehensive assessments to admit new patients. While this is not an absolute in every agency, it often allows that nurse to specialize in proper completion of the complex documentation requirements in the OASIS. While there may be special certifications available for nursing staff to complete to better understand OASIS, there is not necessarily a required competency.

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

We do not believe there are any training gaps that are greater for therapists than they are for entry level nurses. From a clinical standpoint, therapists are just as educated as nurses. Entry-level PTs for example are subject to rigorous doctoral-level education, the content of which is standardized based on curricular requirements set via the Commission on Accreditation in Physical Therapy Education. Comparatively, the minimum requirement for an RN is an associate's degree, though baccalaureate and hospital diploma programs are also available. However, the wide range of options and limited rigor for associate's degree RNs has been debated within the nursing community, with stakeholders raising concerns around outcomes and consistency when comparing the associates and baccalaureate-level nursing-degree holders. Regardless, the educational standards for nursing are more variable compared to PTs given the multiple pathways available to become an RN.

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

We do not believe there is a skill gap related to rehabilitation therapy and the initial and comprehensive assessments. For the comprehensive assessement, both nurses and therapists have to learn how to perform the OASIS – CMS should not have additional restrictions for therapists. CMS should see the use of the COVID-19 PHE flexibility as a 2.5-year test of rehabilitation therapy to conduct these visits.

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

As we have stated throughout our comments here today, staffing remains a significant concern of our home health membership. While extending this COVID-19 waiver could help reduce the burden to nursing staff, recruiting and retaining rehabilitation staff is not without its own challenges especially in rural and underserved communities. Regardless of the staffing challenge, distributing work evenly amongst the interdisciplinary team will help support more timely access for patients.

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

During discussions with LeadingAge members there was incredible support for the ability of rehabilitation staff to complete the initial and comprehensive assessments. Many providers felt the ability to utilize these staff in those roles allowed them to initiate care sooner for many patients. During these discussions we were not made aware of any unintended consequences of rehabilitation staff conducting either assessment.

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

For rural agencies with limited staff deploying a nurse for admissions could require a full day due to travel.

- A systematic review article of urban vs rural home health agencies found rural beneficiaries, compared with urban, had lower home health care utilization (4 of 5 studies) and fewer visits for physical therapy and/or rehabilitation (3 of 5 studies).[26]

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

We appreciate the opportunity to provide feedback on the current practices of home health agencies and provide CMS more information regarding the practices of nonprofit, mission driven agencies.

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

There are many factors that determine the service mix of an agency including the current staff knowledge and expertise. Agencies will also adapt their case mix to the needs of acute care partners e.g. hospitals accredited for joint replacement need skilled therapy partners. Payers including MA can also have an impact on service mix based on their patient case mix and referral patterns e.g. some plans may prefer to send certain patients to home health and others to skilled nursing based on their population and contracted post-acute capacity. In the complex payer and referral source environment, home health agencies must be nimble in order to sustain relationships.

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

In discussions with LeadingAge members, most EMR vendors have coding available to agencies to track rejection reasons, but they are not standardized across the industry. Often referral rejections relate to uncontracted insurance plans, the home health agency does not provide a certain type of service, behavioral health needs are present, or the patient requires infusion therapy which is not provided by the agency due to the separate payment system. Often our members will reject a referral and subsequently accept the rejected referral once they have capacity again. Finally, some patients who are referred do not meet the definition of homebound which puts an agency at risk of audit and payment recoupments.

- One industry analysis we would like to draw CMS' attention to is a review of the referral documentation. it can take intake coordinators up to 70 minutes to fully review an average referral packet to make an informed admit or rejection decision.[27] On average, each patient admission packet totals approximately 35 pages across two documents. In some extreme there can be 25 documents with nearly 300 pages of clinical information.

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

The experience of our members in communicating with referring physicians and allowed practitioners was varied. Many who worked with acute care providers or practitioners who were part of Accountable

[26] https://www.sciencedirect.com/science/article/abs/pii/S1525861022006454
[27] https://medalogix.com/solving-the-home-health-maze-referral-intake/

Care Organizations found communications much easier. But those working with referring providers found it difficult to keep up communications.

- A survey of home health agencies found nearly 40% of agency clinicians report never or rarely being able to reach a physician. The research also found the odds of a home health clinician sending someone to the emergency department were increased for those who never or rarely reached a physician.[28]
- Another survey of certifying providers found nearly half of the providers who had certified at least 1 plan of care in the past year had spent less than 1 minute reviewing the CMS-485, HOME HEALTH CERTIFICATION AND PLAN OF CARE. An additional 21% said they spent at least 2 minutes reviewing the documentation. The survey also found 80% rarely or never changed an order and 78% rarely or never contacted the home health agency clinicians with questions.[29]

To what extent do physicians rely on HHA clinician evaluations and reports in establishing the mix of services, service frequency, and service duration included in the plan of care?
Based on our members' experience and academic literature, home health staff are deeply involved in the creation of personalized plans of care, which significantly impact the quality of care received and the associated outcomes.

- In a study exploring how home health nurses develop personalized visit plans for patients with diverse needs, researchers interviewed 26 nurses from three agencies. Nurses used a combination of patient assessments, personal experience, and agency protocols to create and adjust these plans based on patient condition, engagement, and caregiver support. The findings highlight the different strategies taken to determine visit planning and improve patient outcomes in home health care.[30]
- Another study examined how home health nurses make decisions during the hospital-to-home care admission process, focusing on a home health agency in Pennsylvania and how they gather and use information. Through a focus group with six admitting nurses, the researchers identified key themes and relationships between decision-making tasks using thematic analysis and a custom visual tool. Since it is not clear how nurses get and use information to support decision-making, the visualizations highlight the relationships between decisions, tasks, and information themes and sub-themes.[31]
- One study analyzed Medicare data to explore the relationship between the length of home health care and skilled nursing visits with hospitalization rates among Medicare recipients. It found that patients who received home health care for at least 22 days or had at least four skilled nursing visits were less likely to be hospitalized within 90 days of discharge. The findings

[28] https://pubmed.ncbi.nlm.nih.gov/34599759/
[29] https://pubmed.ncbi.nlm.nih.gov/29610828/
[30] Irani, E., Hirschman, K.B., Cacchione, P.Z., Bowles, K.H., 2018. Home health nurse decision-making regarding visit intensity planning for newly admitted patients: a qualitative descriptive study. Home Health Care Services Quarterly 37, 211–231. https://doi.org/10.1080/01621424.2018.1456997
[31] Sockolow PS, Yang Y, Bass EJ, Bowles KH, Holmberg A, Sheryl P. Data Visualization of Home Care Admission Nurses' Decision-Making. AMIA Annu Symp Proc. 2018 Apr 16;2017:1597-1606. PMID: 29854230; PMCID: PMC5977644

suggest that extending the duration of home health services and increasing skilled nursing visits may reduce hospitalization rates for chronically ill patients.[32]

What are the patient and caregiver experiences in receiving nursing, aide, and therapy services when under the care of a home health agency?
The role of the family caregiver in home health care cannot be overstated.

- A key informant study found that caregiver training is currently integrated into clinician workflows in home health care, but conversations lack structure. There are no valid assessment instruments or training materials. The informal conversations with caregivers help determine visit intensity and discharge timing.[33]
- Another qualitative analysis found, in addition to training materials, the most salient factors to effective caregiver training included clinician–caregiver communication and rapport, accuracy of hospital discharge information, and access to resources such as additional visits and social work consultation.[34]
- A qualitative descriptive study looked at family caregiver and patient perceptions of readiness for discharge and identified nine themes: self-care ability, functional status, status of condition(s) and symptoms, presence of a caregiver, support for the caregiver, connection to community resources/support, safety needs of the home environment addressed, adherence to the prescribed regimen, and care coordination.[35]

What additional evidence is available regarding negative outcomes or adverse events that may be attributable to the mix, duration, and service frequency provided by HHAs, including, but not limited to, avoidable hospitalizations?
Our members recognize that there are adverse events associated with their care choices. For many, that is the primary reason for rejecting referrals, an understanding that they cannot properly serve a patient and could potentially cause more harm.

- One systematic review of 54 studies found that about half of older adult patients transitioning from the hospital to community settings were affected by at least one medical error and 20% were affected by one or more adverse events.[36]
- One study found that home health agencies that failed to provide required family caregiver training resulted in almost twice the number of acute care hospitalizations.[37]
- Another study echoed caregiver education needs in its findings that patients with caregivers who needed training in providing medical procedure or treatment were at higher risk for wound-site infections. A caregiver's lack of training places patients at high risk for infection. The study also suggested that education for patients and caregivers should be tailored based on their health literacy level to ensure complete understanding.[38]

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[32] O'Connor M, Hanlon A, Naylor MD, Bowles KH. The impact of home health length of stay and number of skilled nursing visits on hospitalization among Medicare-reimbursed skilled home health beneficiaries. Res Nurs Health. 2015 Aug;38(4):257-67. doi: 10.1002/nur.21665. Epub 2015 May 19. PMID: 25990046; PMCID: PMC4503505.
[33] https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.17492
[34] https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.17762
[35] https://www.sciencedirect.com/science/article/abs/pii/S0197457220303840
[36] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7235049/
[37] Burgdorf JG, Arbaje AI, Stuart EA, et al. Unmet family caregiver training needs associated with acute care utilization during home health care. J Am Geriatr Soc. 2021;69(7):1887-1895.
[38] https://onlinelibrary.wiley.com/doi/abs/10.1002/nur.22053

- Yet another systematic review which aimed to identify diabetes specific patient safety domains that need to be addressed to improve home care of older people, found that risk and adverse events were dependent on four domains related predominantly to the home health agency's actions: home care services support, the informal caregiver's knowledge skills, motivation and judgment and communications within the team across staff.[39]
- Finally, a study of acute care hospitalizations and emergency department use found that for each unit increase in the number of skilled nursing visits, the odds of an acute care hospitalization increased by 0.02.[40]

In what ways can referring providers and HHAs improve the referral process?
As we stated in our response to the proposed CoPs, there are many practices used by acute care hospitals right now that put a strain on the home health system, including referring to multiple providers at once which causes scheduling delays. Additionally, the lack of follow-up in communication after the patient is admitted to a skilled nursing facility instead of the referred home health agency. Requirements on referring providers to conduct in-home assessments to facilitate understanding of the home environment and patients' understanding of the need for ongoing care. This assessment would also assist the acute care provider in better understanding home-based risk factors such as falls, unsanitary conditions, or physical features of the home that may make the person's recovery more limited such as stairs to enter or narrow doors.

What other factors may influence the provision of services that impact the timeliness of services and service initiation?
In our response to the proposed CoPs we outlined many factors that impact the timeliness of services and service initiation including staffing, payer prior authorization and utilization management efforts, referral source communications, and lack of patient communication or response.

What additional areas should CMS consider to address HHA patient health and safety concerns?
Based on the evidence presented in one of the previous questions regarding adverse events, CMS could consider looking at claims-based measures to ensure agencies are utilizing caregiver training and medication reconciliation.

Long-Term Care Requirements for Acute Respiratory Illness Reporting

CMS proposes to extend requirements for nursing homes to report COVID data to the Centers for Disease Control & Prevention (CDC) through the National Healthcare Safety Network (NHSN) system. These reporting requirements were first implemented through an interim final rule in May 2020, then extended through December 31, 2024 in the CY '22 Home Health payment rule.

LeadingAge previously advocated for these requirements to be allowed to expire but CMS now proposes to make these requirements permanent. CMS also proposes to expand these requirements from reporting solely on COVID-19 to include data on other respiratory viruses including, at a minimum, influenza and respiratory syncytial virus (RSV). CMS further proposes to give the Secretary unmitigated authority to expand reporting requirements, including increasing the frequency of reporting up to daily, in the event of a public health emergency or significant threat of a public health emergency. LeadingAge opposes all provisions and advocates that NHSN reporting requirements for nursing homes be allowed to

[39] https://eprints.whiterose.ac.uk/143961/3/Haltbakk_et_al-2019-Journal_of_Advanced_Nursing.pdf
[40] https://pubmed.ncbi.nlm.nih.gov/32134817/

expire on December 31, 2024. Reporting requirements are unnecessary, duplicative, and result in no direct benefit to nursing home residents, the staff who care for them, nor the community at large.

When NHSN reporting was first required for nursing homes, we were in a very different place. It was the beginning of the COVID-19 public health emergency (PHE), when COVID was still new, unpredictable and not well understood. We were learning every day. Because of the unique setting and populations most often served by nursing homes, NHSN data provided rich opportunities to examine the impact of COVID on specific groups, such as older adults with comorbidities, older adults in residential settings, and health care workers with occupational exposure. The data helped guide response efforts, informing both CDC and HHS in recommending mitigation strategies and allocating essential supplies and resources such as personal protective equipment (PPE), test kits, and mobile strike teams, and later, vaccination support. Since then, things have changed.

In the proposed rule, CMS states, "Ultimately, access to this information proved critical to providing resources and supporting coordinated action by facilities, health systems, communities and jurisdictions in responding to the PHE and protecting the health, safety and lives of LTC facility residents." That *was* true during the early years of the PHE, but is no longer the case. The PHE ended more than a year ago and the federal government is no longer involved in large-scale efforts to provide resources and support coordinated response to long-term care. Allocations of PPE from HHS ended mid-way through the PHE, and strike teams are also a relic of the early days. HHS continues to send test kits to nursing homes, but test kit allocations are based on nursing home requests, not NHSN data.

LeadingAge acknowledges that nursing homes continue to receive support from public health. CMS states in the rule, "Data collected from LTC facilities is used by local health departments to provide specific outreach to individual facilities. This can include interventions such as site visits from health departments, providing additional supplies such as PPE and/or testing supplies, recommendations for testing protocols and individualized advice for infection prevention and control practices to protect the health and safety of residents within individual facilities." We note, however, that public health activities are local activities, not federal response efforts, and these public health entities would continue to have access to data on respiratory illness outbreaks, even without NHSN data, due to separate existing requirements to report outbreaks to public health authorities. Even without NHSN reporting requirements, nursing homes would continue to report clusters of respiratory virus symptoms and confirmed cases to public health, allowing for continued support and outreach.

CMS also states that "LTC facilities, hospitals, and other health care partners also use the information for planning purposes, identifying how their facility may be impacted and preparing accordingly." First, even without NHSN data reporting requirements, nursing homes will continue to track and monitor respiratory illness data as part of infection control requirements and this data will be used in both the required Infection Prevention and Control program and the required Quality Assurance and Performance Improvement program. Further, LeadingAge notes that while CMS alleges, "Information sharing across the health care ecosystem helps the health care community to prepare for, and effectively respond to, respiratory illness surges in ways that maintain the safety and availability of critical care services," NHSN data could not be supporting this information sharing across the health care ecosystem, since nursing homes are the only setting that continues to be required to report such data. While CMS proposes that nursing homes would continue to report at pandemic-level frequencies, reporting requirements ended completely for hospitals on May 1, 2024, and dialysis centers have not been required to report since end of the PHE in May 2023.

CMS has been unable to adequately justify the continued reporting of respiratory illness data by nursing homes to NHSN on a weekly basis and LeadingAge advocates that these reporting requirements be allowed to expire on December 31, 2024.

Provider Enrollment--Provisional Period of Enhanced Oversight (PPEO)

LeadingAge supports the proposed changes to CMS' provisional period of enhanced oversight (PPEO) authority which will ensure that providers or suppliers returning to service are not doing so for unscrupulous reasons. In the CY2024 Home Health Proposed Rule, LeadingAge supported CMS' provider enrollment changes for both hospice and more broadly. LeadingAge continues to advocate for transparency and program integrity in all Medicare benefits and provided 34 recommendations to CMS in 2023 regarding hospice program integrity actions.[41]

Conclusion

In sum, LeadingAge appreciates the opportunity to provide comments on the proposed payment cuts and conditions of participation, along with offering insights on the requests for information. We have concerns that implementing payment cuts will further strain home health providers' tenuous financial position. Additionally, impositions of additional administrative burden in additional OASIS reporting domains and development and posting of an acceptance to service policy fails to address the root causes of service access limitations and delays in initiation of services. Similarly, we oppose extension of NHSN COVID reporting for nursing homes, as these requirements are duplicative with no obvious community benefits. We hope CMS continue the dialogue with stakeholders to fully understand the effects of proposed changes while also accepting additional information on factors outside of the provider's purview limiting service start. LeadingAge along with our members stand ready to be a resource for CMS as the programs and payer supports continue to evolve.

Sincerely,

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About LeadingAge: *We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.*

[41] https://leadingage.org/leadingage-provides-hospice-program-integrity-recommendations-to-congress-and-cms/