April 29, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services (CMS)
200 Independence Avenue, SW
Washington, DC 20201

Mr. Russell Vought
Director
U.S. Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Re: CY2026 Home Health Proposed Rule

Dear Administrator Oz and Director Vought,

On behalf of LeadingAge, I am writing to raise our concerns regarding the future of the Medicare Home Health Benefit. LeadingAge represents more than 5,400 nonprofit and mission-driven aging services providers across the country and along with a full spectrum of services and supports, such as senior housing including affordable housing, assisted living and memory care, skilled nursing, home health, and hospice, and life plan communities that offer a continuum of housing and services to their residents.

The Medicare Home Health Benefit, which has been in place since 1965, has gone through many iterations and the payment system has been updated a number of times to address concerns with excessive services in the name of profits. In recent years, however, the changes in fee-for-service payment methodology, the national implementation of the Expanded Home Health Value Based Purchasing model, along with the growth of Medicare Advantage plans and their unwillingness to fairly negotiate, have led to significant closures of home health agencies across the country, decreasing access to services for older adults.

Between 2019 and 2023, the number of skilled home health agencies that treated more than 10 fee-for-service patients annually decreased or remained the same in 94.1% of U.S. counties.[1] Half of U.S. counties have five or fewer home health agencies per 1,000 square miles, with many rural areas having access to only one agency or no agencies serving more than 10 patients. These are concerning statistics considering the growth in the older adult population and the focus on receiving care in the home. We believe there are opportunities for this Administration to ensure that access to critical home health services is not lost.

[1] Trella Health Special Report: HOME HEALTH ACCESSIBILITY AMONG MEDICARE FEE-FOR-SERVICE (FFS) BENEFICIARIES. (December 2024).

Patient-Driven Groupings Model

The Patient Driven Groupings Model (PDGM) was developed in an effort to better align patient characteristics to how home health agencies were paid. In previous iterations of the payment methodology for home health providers, certain services took priority in payments and led to overutilization of physical therapy visits in pursuit of maximizing profits. PDGM attempts to move home health away from this payment practice and focus on matching payment to clinical characteristics of the actual patient. We would argue PDGM's focus on patient characteristics is crucial to the future of home health care.

While we support the development of a payment methodology based on clinical characteristics, the accompanying legislative requirements regarding budget neutrality raises significant concerns. The previous Administration first implemented permanent and temporary adjustments to provider payments and we strongly believe the interpretation of the adjustments was incorrect. We ask that your staff review the previous Administration's interpretation of the required adjustments and use your congressionally mandated authority to not implement the temporary adjustments under the budget neutrality clause.

Home Health Value Based Purchasing

The original demonstration of the Home Health Value Based Purchasing (HHVBP) model, which occurred in only nine states was highly positive and correlated with considerable savings and improved quality of services. In 2021, the demonstration was expanded nationally. Data from the first year of quality related payment adjustments was released in January 2025. This data raises some concerns regarding the design of the program and, specifically, to how it is incentivizing non-compliance with quality reporting requirements and inequity based on cohorts and lack of risk adjustment. We ask that you look closely at the structure and results of the HHVBP and make important adjustments to the program to ensure it is working as intended.

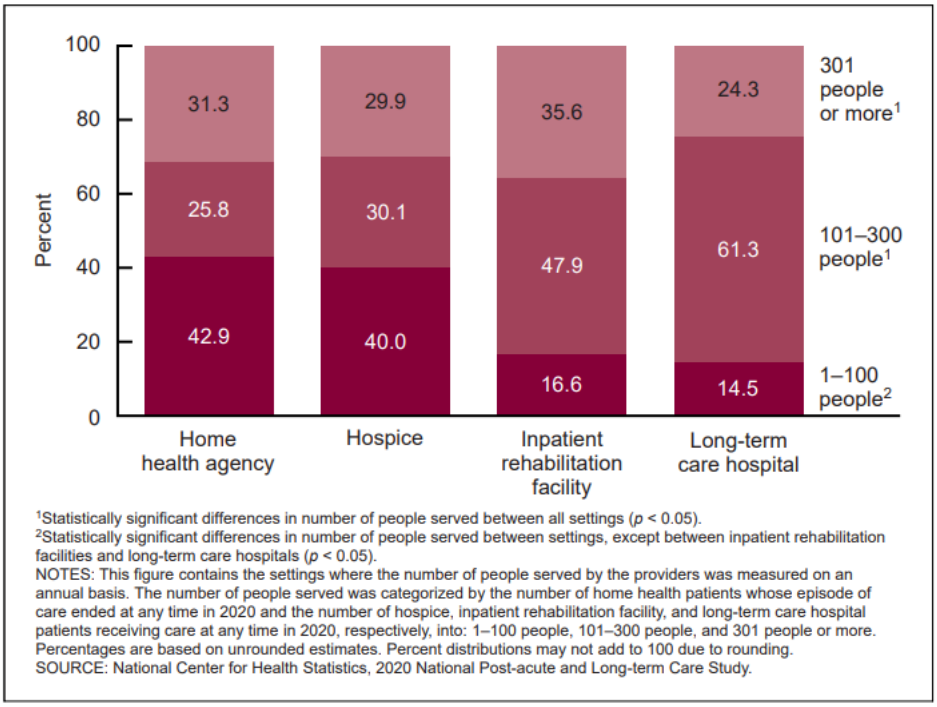
Expand Number of Cohorts Based on Size

In the initial demonstration, cohorts were organized by states, not sizes of agencies. Generally, this allowed participants to compare themselves against agencies with similar client populations, regulatory burden from states, and allowed for a fair distribution of sizes. The expanded model created two simple cohort sizes: the small-volume cohort, which includes agencies with fewer than 60 unique beneficiaries in the baseline year, and the large-volume cohort, which includes agencies with 60 or more unique beneficiaries in the baseline year.

In our review of the data published from the first year of payment adjustment, we found that 54% of home health agencies fell into the large cohort, only 5.7% fell into the small cohort, and 40% of agencies did not participate due to size and newness. That means that while the majority of agencies were compared to each other in the large cohort. The small cohort had a cap on the number of beneficiaries an agency had while the large cohort had no cap on the volume of patients. In the most recently

available federal data on the size of home health agencies, 42.9% served 100 or fewer people annually, 25.8% served between 101 and 300, and 31.3% served 300 or more people annually.[2]

Figure 4. Percent distribution of number of people served annually by post-acute and long-term care services providers, by setting: United States, 2020



[1]Statistically significant differences in number of people served between all settings ($p < 0.05$).
[2]Statistically significant differences in number of people served between settings, except between inpatient rehabilitation facilities and long-term care hospitals ($p < 0.05$).
NOTES: This figure contains the settings where the number of people served by the providers was measured on an annual basis. The number of people served was categorized by the number of home health patients whose episode of care ended at any time in 2020 and the number of hospice, inpatient rehabilitation facility, and long-term care hospital patients receiving care at any time in 2020, respectively, into: 1–100 people, 101–300 people, and 301 people or more. Percentages are based on unrounded estimates. Percent distributions may not add to 100 due to rounding.
SOURCE: National Center for Health Statistics, 2020 National Post-acute and Long-term Care Study.

This means that relatively small agencies with just 60 beneficiaries could be compared to large agencies, which can have up to 300 patients. We believe this structure within the large cohort significantly disadvantages smaller agencies when the model was explicitly designed to accommodate differences in agency size. We request CMS redesign the cohort distribution based on average daily census of home health agencies or on their number of OASIS episodes during the baseline year.

Establish Penalties for Agencies who Fail to Meet Basic HHQRP Reporting Requirements

We are concerned that certain agencies are manipulating the program by simply bypassing their home health quality reporting program (HHQRP) requirements. This is highly evident in the number of agencies which received significant increases in their payment, despite not complying with HHQRP requirements and receiving a 2% annual payment update (APU) reduction for that non-compliance.

Part of the reason for CMS to define cohorts by the 60 patient threshold is due to the requirement that agencies participate in the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS), which requires a patient count of 60 or more. However, when we look at the first year of data on performance of large cohort agencies in the HHCAHPS measures, there were 254 out of 401 top performing agencies – those that received the highest possible payment adjustment of +5% – that had no HHCAHPS data used in their total performance score calculations. When we reached out to CMS

[2] https://www.cdc.gov/nchs/data/nhsr/nhsr208.pdf

regarding this lack of data, it was explained that 40 completed surveys for agencies in the larger-volume cohort is the minimum threshold of data an agency must have for *each applicable* HHCAHPS measure to receive a measure score. However, CMS did not delineate between agencies that had no HHCAHPS, meaning they did not participate in the requirement, and too few HHCAHPS responses to calculate a score. CMS stated that for the purposes of the expanded HHVBP model, having insufficient HHCAHPS data and having no HHCAHPS data have the same results in CMS' calculations and therefore these differences are not delineated in the model.

Given this insight, we reviewed the top performing home health agencies which did not have HHCAHPS scores to calculate and compared them to the list of agencies which received a reduction in their APU for not publicly reporting data in CY2023, the first performance year for HHVBP.[3] This identified 36 agencies, or roughly 14% of top earners without HHCAHPS scores, which received the highest payment increase of +5% despite not complying with HHQRP requirements. All told, 75% of these non-reporting agencies were located in California, and mostly in Los Angeles County.

This does not account for the potentially countless other agencies at other performance thresholds who earned an increase despite not fully complying with basic HHQRP requirements. This cannot be allowed to continue. We request CMS update the program requirements to state that agencies who are not in compliance with the HHQRP reporting requirements during the performance year will not be eligible to receive a payment increase due to their non-compliance.

Explore Further Risk Adjustment

We remain concerned that the current HHVBP model does not appropriately adjust for agencies that serve high need, complex populations – both based on clinical characteristics and also based on factors effecting well-being and nutrition that contribute to making a population harder to serve effectively. Part of the goal of value-based care is to ensure that providers can spend their dollars on what would be most effective to improve quality and control costs. In the final report on the original HHVBP model, CMS acknowledged needing to continue monitoring patient selection by agencies and its potential impact on access to home health care for medically complex patients. While nearly all the measures used for the program are risk adjusted, it is unclear if the risk adjustment of these model measures adequately mitigates incentives that agencies may face to avoid patients for whom a goal of stabilizing function may be more appropriate than a goal of improving function.

We believe there is a tendency for agencies to "cherry-pick" patients who will do well on the quality measures of the program, the majority of which look at functional improvement and not maintenance of function. There are clinical characteristics regarding the complexity of an individual's medical needs that agencies look at before admitting someone to service.

We therefore believe CMS should review the current data for those types of patients and determine a risk adjustment methodology based on the patients who may not see improved function. This approach

[3] We reached out to CMS again to confirm if there was a list of agencies by reason for non-compliance, be it not fully participating in HHCAHPS, as the numbers above might suggest, or not meeting the 90% threshold for reporting for OASIS assessments. CMS stated this information was not available.

does not bias the payment system in favor of one demographic group but ensures that providers cannot ignore patient populations with clinical characteristics that may lower their scores in the program due to lack of improvement.

We believe that a strong home health provider base will further the Administration's goal around promoting improved health and well-being. But without consideration to adequately funding and supporting these critical providers, home health providers will not be in business to do that work. We thank you for your consideration of these issues and are happy to meet to discuss any of them further.

Katy Barnett

Katy Barnett
Director, Home Care and Hospice Operations and Policy
LeadingAge

CC: Kimberly Brandt, Deputy Administrator and Chief Operating Officer, Centers for Medicare and Medicaid Services
John Brooks, Deputy Administrator and Chief Policy and Regulatory Officer, Centers for Medicare and Medicaid Services
Chris Klomp, Director, Center for Medicare, Centers for Medicare and Medicaid Services
Don Dempsey, Associate Director, Human Resources Programs, Office of Management and Budget

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.