Home Health: Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192) – Request for Information

June 2025

On January 31, 2025, President Trump issued Executive Order 14192 "Unleashing Prosperity Through Deregulation" that stated in part that for each new regulation introduced, federal agencies must identify at least 10 prior regulations to be eliminated. In response, the Centers for Medicare & Medicaid Services (CMS) issued a Request for Information on April 11 to assist in identifying regulations that could be considered for elimination from the Medicare Program.

LeadingAge submitted deregulation recommendations covering regulations for home health and hospice, Medicare Advantage, nursing homes, and Programs of All-Inclusive Care for the Elderly (PACE). What follows below are the LeadingAge recommendations for home health deregulation.

Streamline Regulatory Requirements

Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

Staffing Requirements for Home Health Initial and Comprehensive Assessment Visit. At the beginning of the COVID-19 Public Health Emergency (PHE), CMS waived the requirements at § 484.55(a)(2) and (b)(3) permitting rehabilitation professionals to perform the initial and comprehensive assessment in instances when both nursing and therapy services are ordered. This helped alleviate pressures on the nursing workforce during the PHE and allowed rehabilitation professionals to perform the initial and comprehensive assessment for patients receiving therapy services as part of the broader nursing and therapy care plan, to the extent permitted under State law, regardless of whether the therapy service established patient eligibility to receive home care. During the pandemic this was an invaluable tool to support patients and staff alike.

Additionally, Congress recognized the critical importance of all staff working to the top of their scope of practice when it incorporated the *Medicare Home Health Flexibility Act of 2019* into Division CC, section 115 of Continuing Appropriations Act of 2021, which established the

permanent ability of occupational therapists (OT) to conduct the initial and comprehensive assessments for HHAs when OT or other therapy services were part of the plan of care.

LeadingAge has reviewed the statutory language regarding home health and there is no foundation for nurses being the only professionals allowed to perform initial and comprehensive assessments when other therapy services are part of the plan of care. This creates an unnecessary burden to providers and can delay the start of care for patients due to continuing shortages in nursing staff. Home health is an interdisciplinary benefit and should rely on the full team to quickly initiate services and fully evaluate patients. All three categories of rehabilitation professionals -- OT, physical therapy, and speech language pathologists-- have curricular requirements which include in the general clinical skills required to conduct the initial and comprehensive assessments. These skills include both in the identification of immediate care and support needs, as well as the assessment of the patient's general health, psychosocial, functional, cognitive, and pharmacological status. These are qualified, experienced professionals who are trained in the skills needed to perform these assessments. In a time of clinical workforce shortage, HHAs and their clients will benefit from being able to utilize every team member at the top of their license.

LeadingAge believes this regulation must be replaced as it is inconsistent with statutory text, is outdated based on the experiences during the COVID-19 public health emergency which saw no adverse effects to a similar waiver, and generally is a burden to home health agencies by not allowing them to utilize their staff to the full scope of their professional abilities.

Supervision of Home Health Aides. LeadingAge believes that these regulations must be replaced by the original CY2022 Home Health Proposed Rule language, which allows visits to be completed via audio-visual communications "not to exceed 2 virtual supervisory assessments per HHA in a 60-day period" and the semi-annual on-site visit focus on "a" patient the aide is serving, not "each" patient served by that aide. These regulations are simply too burdensome for home health agencies to successfully comply with and places a burden on agencies when there is not a discernible public benefit as evidenced by the lack of quality concerns during the COVID-19 waiver period.

In the CY2022 Home Health Proposed Rule, CMS proposed requirements for supervision of aide services at § 484.80(h)(1) and (h)(2), which was supported by the home health community as it was initially believed to be a regulation applied at the agency level, i.e. the individual aide level. The proposed regulation also provided flexibility in these supervisory assessment visits by using two-way audio-video telecommunications not to exceed two virtual supervisory assessments per HHA in a 60-day period. However, CMS finalized the regulation not as initially proposed. Instead, CMS stated their intention to apply the changes at the patient-level rather than the agency-level. They modified the semi-annual onsite visit to require that this visit be conducted on "each" patient the aide is providing services to rather than "a" patient. Additionally, they determined to permit only one virtual supervisory visit per patient per 30-day

episode. Furthermore, CMS clarified a virtual visit must only be done in rare instances for circumstances outside the HHA's control and must have documentation in the medical record detailing such circumstances.

This change was unexpected by the provider community, which was not given an opportunity to comment on concerns with the ability to comply with the change. Since the final rule, agencies have struggled to comply with the requirement. While we strongly believe in the critical nature of supervision of aide services, the reality is there are simply not enough staff at agencies to consistently conduct a visit on "each" patient the aide is providing services to within the time frame dictated by the rule. During the COVID-19 PHE, the requirement for registered nurse supervision to home health aides was waived but virtual supervision was encouraged. There is no evidence that during this waiver period aide services were inappropriately performed and that care delivery suffered. In both the final and proposed rule, CMS stated that the regulatory impact is negligible. We do not believe that this assessment is accurate given the removal of additional flexibilities for audio-visual supervision and the change from agency to patient level semi-annual visits.

LeadingAge believes this regulation must be replaced as it is inconsistent with statutory text and generally is a burden to home health agencies by not allowing them to utilize NPPs to the full scope of their professional abilities based on the right of states to define those standards.

Who May Conduct the Face-To-Face Encounter and Certify Patients for Home Health Services. LeadingAge recommends the Administration replace the regulations to align with the flexibilities granted by the CARES Act and eliminate unnecessary barriers to Medicare home health certification. Specifically, CMS should modify §424.22(v)(A)(2) and §484.2 to allow NPPs to certify beneficiaries for home health services in accordance with state laws. Additionally, CMS should amend §424.22(a)(v)(C) to remove the requirement that the certifying practitioner must conduct the face-to-face (F2F) encounter. Instead, the regulations should permit the certifying practitioner to document that a physician or an allowed NPP has conducted the F2F encounter.

The CARES Act was signed into law on March 27, 2020, providing critical relief in response to the COVID-19 pandemic. Among its provisions, the Act included the bipartisan *Improving Care Planning for Medicare Home Health Services Act*, which expanded the authority of NPPs to certify eligibility and issue orders for Medicare home health services. Additionally, the Act introduced flexibility regarding who may conduct the F2F encounter, removing the requirement that only the certifying practitioner may perform this function.

On March 30, 2020, CMS issued an interim final rule with comment (IFC), Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency. This IFC included regulatory revisions under §424.22, granting NPPs the

authority to certify and order home health services. However, CMS has not yet issued conforming regulations to reflect statutory flexibility on who may conduct the F2F encounter.

Despite the statutory provisions, the revised regulations at §424.22(a)(v)(C) limit the F2F encounter to the certifying physician or practitioner for patients admitted from the community. Additionally, regulations at §424.22(v)(A)(2) and §484.2 retain a requirement for NPPs to collaborate with physicians when certifying and ordering home health services, even in states that permit independent practice for advanced practice registered nurses (APRNs). This contradicts the CARES Act, which explicitly allows NPPs to practice in accordance with state laws without requiring physician collaboration and provides flexibility regarding who may conduct the F2F encounter.

The CARES Act clearly reflects Congressional intent to authorize NPPs to certify and order home health services for Medicare beneficiaries in accordance with state laws. Furthermore, Congress explicitly granted flexibility regarding who may conduct the F2F encounter, ensuring greater access to care.

LeadingAge requests this regulation to allow home health agencies to utilize non-physician practitioners (NPPs) (nurse practitioners, physician assistants, and clinical nurse specialists) to the full scope of their professional abilities (consistent with applicable state law) which is inconsistent with Congressional intent and prevents interference with care delivery.

Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Home Health Agency Acceptance to Service. In the CY2025 Home Health Prospective Payment Final Rule published on November 7, 2024, CMS raised serious concerns about a lack of public transparency in Home Health Agency (HHA) acceptance to service policies and whether referral sources, including patients and caregivers searching for home health services, currently have access to sufficient and timely information necessary to locate an agency that is capable of meeting each specific patient's needs. CMS believes this lack of transparency is the root cause of delays in accessing services. Accordingly, CMS proposed and finalized the
§ 484.105(i) HHA acceptance-to-service policy.

This is an unnecessary and burdensome duplication of statutorily required information that predated the acceptance to service policy in Sec. 1891(a)(1)(E)(i-iv) as well as 42 CFR 484.60 – the part of the statute and regulations focused on patients' rights. CMS maintains that HHAs should leverage their partnerships throughout the stakeholder community to gain exposure to existing practices that could assist in minimizing facility burden associated with compliance. However, policies like these are often proprietary and inter-agency collaboration cannot be required. Further, CMS stated in the final rule that following the publication, interpretive guidance for the final policy would be released and will provide additional information regarding oversight and enforcement of the requirements. The requirements went into effect

January 1, 2025, and guidance is still not published regarding compliance leaving many HHAs potentially out of compliance at no fault of their own.

Finally, in the final rule, CMS did not appropriately update the Information Collection Requirements to account for additional language stating the public information would need to be "as frequently as services are changed." The language in the final rule only accounts for an update four to six times a year, however as outlined in numerous comments submitted to CMS, the availability of services changes on a weekly to daily basis, meaning the estimated cost to review and update public information would be significantly more than $41.70 per year or $398,860.50 a year for all agencies. If calculations incorporated the potential for services to change on a weekly or daily basis, the cost for the nation's 9,565 HHAs would be between
$3,456,791 and $24,264,013.75 per year.

LeadingAge recommends the rescission of this regulation because of its duplication of current regulatory requirements, its burdensome nature, and the costs it imposes on small entities.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

OASIS All-Payer Data Collection. When OASIS was initially implemented in 2000, it was intended for all patient populations despite the concerns of providers. Congress initially intervened to suspend this additional burden on HHAs with Section 704 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In 2006, the Secretary of the Department of Health and Human Services (HHS) submitted a report to Congress which evaluated the burden and utility of OASIS data collection on the non-Medicare/Medicaid patient population. Nearly two decades later, the suspension of data collection was rescinded by the previous Administration despite broad concerns from the home health community regarding burdens on providers to complete a lengthy assessment in addition to any assessments required by private insurers. The requirement will officially go into effect July 1, 2025. Removing this requirement would not endanger the program integrity of the Medicare home health benefit as patients receiving home health services through Medicare and Medicaid are already required to have this assessment.

If the requirement is allowed to move forward, providers will incur increased administrative costs without adequate compensation from non-Medicare/Medicaid payers. These costs are both for the expenses incurred through staff time completing the assessments and indirect costs associated with time lost on other patient-directed services. According to CMS projections in the CY2023 Home Health Proposed Rule, this policy will increase OASIS assessments by 30% at each assessment timepoint, increasing the hourly burden and clinical costs at a time when HHAs are still struggling to maintain adequate nursing staff to serve their existing populations.

Additionally, CMS has struggled to clearly articulate all of the populations which will, and will not be, subject to this requirement. This has left providers concerned that they may not be in compliance with the changes and the required 90 threshold for submission of OASIS data, putting their agencies at risk of a 2% reduction in annual payment updates.

LeadingAge requests CMS rescind the burdensome mandate to collect the Outcome and Assessment Information Set (OASIS) on all patients regardless of payer source.

Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.

OASIS-E1 Complexity and Potential Redundancy. LeadingAge supports the collection of assessment information for home health patients. However, over the last decade, the OASIS has ballooned into an expansive document with 200 data elements that takes almost an hour during the Start of Care assessment to complete according to the CY2024 Home Health Proposed Rule. Resumption of Care assessments take almost an equal amount of time to complete and has only 30 fewer items. The time spent by clinicians completing paperwork is time which providers could be supporting patients with clinical tasks, training and education, and observation and evaluation. We appreciate this Administration's focus on getting back to the core work of Medicare providers; serving patients and improving the health and wellbeing of the nation. We strongly encourage CMS to conduct a thorough evaluation of the current OASIS assessment, identifying items and removing which are not used to calculate quality measures, items that could be pulled automatically from other sources of information maintained by CMS, and items that are redundant to other items in the same assessment. This has the potential to reduce the burden of providers and clinicians significantly. Reevaluate the items included in the OASIS tool ensure the value of the items and reduce the redundancy of information collection and reporting.

Additional Recommendations

We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

Methodology for Evaluating Home Health Patient-Driven Grouping Model Budget Neutrality. In the CY2022 Home Health Final Rule, LeadingAge holds that CMS incorrectly interpreted federal statute. Under Section 1895(b)(3)(D)(i) of the Social Security Act, CMS is required to reconcile payment rates from the patient-driven grouping model (PDGM) to achieve budget neutrality in comparison to the former Home Health Prospective Payment System
(HHPPS) model through 2026. Section 1895(b)(3)(D)(i) states: *The Secretary shall annually determine the impact of differences between assumed behavior changes (as described in*

paragraph (3)(A)(iv)) and actual behavior changes on estimated aggregate expenditures under this subsection with respect to years beginning with 2020 and ending with 2026.

CMS' CY2022 finalized methodology for assessing whether actual PDGM aggregate expenditures in 2020 equaled a budget neutral level in relation to the level of expenditures is not limited to a focus on PDGM assumed behavior changes. Those assumed behavior changes were related to the primary diagnosis, LUPA volume, and incidence of comorbidities. However, CMS included considerations of volume of therapy visit changes, contrary to the requirement to eliminate therapy thresholds in 2019. This change in therapy thresholds occurred one year prior to the implementation of PDGM and violates paragraph (3)(A)(iv), which clearly states assumed behavior changes are those "that could occur as a result of the implementation of paragraph (2)(B) and the case-mix adjustment factors established under paragraph (4)(B) …." Paragraph (2)(B) refers to the establishment of a 30-day episode of payment that began in 2020 under PDGM.

CMS must utilize a PDGM budget neutrality methodology that is solely focused on assumed behavior changes that were incorporated into the original 2020 rate setting. As we shared in our CY2025 Home Health Proposed Rule Comment letter, some of the same fraudulent practices experienced in hospice are occurring in home health, particularly in California. Much like the hospice fraud reported on in 2022 by Pro Publica, California, and specifically Los Angeles County, appear to be at the center of exponential home health enrollments. 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.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 the rescission of this methodology as it is not based on the best reading of the underlying statutory authority. Further, CMS should use its authority to prevent the application of additional permanent or temporary payment adjustments to this sector, which has experienced significant reductions in access over the last decade and increasing vulnerability to fraud.