August 16, 2022

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1766-P

P.O Box 8013

Baltimore, MD 21244-8013

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

Dear Administrator Brooks-LaSure,

The Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services have proposed several reforms affecting the Medicare home health benefit along with setting CY 2023 payment rates in the Notice of Proposed Rulemaking (NPRM).

The Minnesota Home Care Association (MHCA) respectfully submits these comments regarding the proposals contained within the NPRM. MHCA is a non-profit trade association representing home care agencies across Minnesota, with over 80% of our members being Medicare Certified.

**Rate adjustments**

**MHCA strongly urges CMS not to impose this cut on providers due to provider behavior changes.** The landscape of patients that are entering home health systems has changed due to the COVID pandemic, but this change is not unique to home care. This is a systemic issue, not a homecare issue. Patients are coming to homecare with a higher acuity because either no one else will accept them or hospitals are pushing patients out quicker to open beds. CMS should be increasing funding to agencies for stepping up during this time, not implementing payment cuts that would exacerbate the already dire situation by weakening the ability of home health providers to meet the health care needs of post-acute patients.

**Instead, MHCA strongly urges CMS to take action in addressing the root issue at hand: the workforce shortage.** To provide accurate data for this letter, MHCA surveyed its members, all of which have a different patient landscape and area of service (urban vs rural). The results showed the following:

1. On average, 23% of agencies’ staff positions are unfilled, leading to, on average, over 25% of patients being turned away from the care they desperately need. This results in longer hospital/TCU stays and higher expenditures of Medicare funds. If patients return home following inpatient stays and cannot secure the care they require, the risk of re-hospitalization increases, which again results in worsened patient outcomes and higher Medicare spending. Being forced to turn down referrals has a negative impact on agencies’ financials, leaving them losing out on an average of $300 thousand per month in revenue.

* Agencies are forced to have clinicians work below their license type just to provide the care their patients need. A common example of this is an LPN or COTA working as an HHA to provide those services because they cannot fill these positions at their agency. This trend is worse at rural agencies where clinicians are more limited. It leads to higher costs for the agency (paying a higher wage for the care) in order to provide the quality of care that is expected and deserved. Making more payment cuts will not financially allow agencies to do this, further impacting patient care and access.

1. Agencies in MN are closing due to the workforce challenges, and the increased cost of doing business without the necessary reimbursement will lead to more closures. Three Medicare-certified agencies have closed their doors in MN this year alone, all of which cited workforce challenges as the main contributor. MHCA’s survey of members shows an average increase in wages of over 5% in the last year. Agencies cannot keep up with the rising costs as is; let alone if CMS cuts rates even further. Additionally, staff burnout is high due to COVID-19 and the demands it has taken on employees. Agencies are paying incentives to keep staff working and that has still not proved to be enough to retain staff. Agencies are paying an average of $11,500 in additional costs each month this year to keep staff working and to provide the care patients so desperately need.
2. **MHCA suggests that CMS reimburse home health agencies for telehealth to address the workforce shortage.** Agencies have successfully used telehealth services throughout the COVID-19 PHE to monitor and care for patients but have done so without being fully reimbursed for these services. Telehealth has great potential to assist with caring for a growing population of patients that require more care, while at the same time dealing with the ongoing workforce shortage issues.

**Market Basket Index**

**MHCA asks CMS to increase the proposed market basket index rate to one that truly reflects the increase in the cost of doing business that is occurring.** BLS data on labor cost increases in home health show a greater than 5% increase between 2021 Q2 and 2022 Q1. As stated earlier, a survey of our members shows the same increase. Labor represents over 75% of home health costs. Other costs of doing business have also increased, most notably among them are PPE costs that have risen to unprecedented rates as a result of the COVID-19 PHE. **The rates must reflect these increased costs if agencies are to survive and provide care to all who need it.** Travel cost increases alone are greater than the 3.3% proposed rate increase, and inflation is currently playing a large role in this. This should be reflected in the market basket rate as well.

**Home Health Quality Reporting Program (HH QRP)**

**MHCA asks CMS to keep the current OASIS submission requirements as is and not require it to be submitted for all payers.** OASIS expansion will reduce the availability of clinical staff to provide direct patient care. 2023 will bring OASIS E, which will be even longer than the current version and will be very time-consuming for agencies that are already overstretched. Agencies will need to provide more OASIS training for staff, taking nurses and qualified therapists out of the field and away from patients. With more OASIS comes the need for additional staff to conduct OASIS reviews and submissions to ensure financial and quality ratings are not impacted. With HHVBP around the corner, this practice will be crucial, placing another financial burden on agencies during a time that CMS is proposing to cut rates. Adding unnecessary costs and staff burden during this time of increased workforce staffing issues is not beneficial to the patients served.

At this time, it is unclear what benefit of collecting this additional data will be. COVID-19 has brought an increase in higher acuity patients to homecare, adding to the time that it takes to develop the OASIS and all the interventions across all payers. OASIS collection for purposes of payment and quality reporting does not fit for all patients served by home health agencies. This is particularly true for patients whose goal of care is stabilization, and not improvement, as well as for agencies limited in the services they are allowed to provide based on non-Medicare payer requirements and limitations.

**Wage Index**

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

**Expanded Home Health Value-Based Purchasing Model**

**MHCA would like CMS to return to its original plan of using 2019 as the baseline performance year or release the 2022 baseline performance standards prior to the end of 2023 Q1.** MHCA is concerned that CMS will be unable to inform HHAs as to the baseline performance targets prior to January 1, 2023 start of nationwide HHVBP. Such targets are important to HHAs by providing guidance as to the performance measures that HHAs need to prioritize for improvement to achieve outcomes warranting bonus payments. Agencies have already started to prepare based on the 2019 data, and this preparation would not be of great use if last-minute changes are required. Agencies are struggling to keep up as is, and do not have the resources to start over with the preparation for this proposed change.

**Health Equity**

**MHCA respectfully asks that when considering policies around health equity after receiving the data from the requested questions, CMS considers our environment and realizes that it is different than every other health care setting.** There is not a difference in care provided between two individuals but a difference in how someone’s cultural differences and practices in their home impact their willingness to engage with the care interventions. Examples of the differences include:

1. Hospital space vs someone’s private home. There are more cultural and environmental variables to consider when in someone’s home vs in the hospital.
2. Care happens on providers’ time when making rounds at the hospital, and care happens on patients’ time in the home. For example, home care staff could be limited to the times the patient is willing to accept someone in their home due to cultural beliefs.

**Conclusion**

CMS’s proposed payment cuts will result in financial harm for home health providers and undercut patient care and quality at a time when in-home care is an essential option for many patients due to the ongoing COVID-19 pandemic. Home health is preferred over institutional care by many patients and families and can deliver significant value to the Medicare program. We urge CMS not to finalize severe rate reductions for home health. We hope CMS will work with the home health community to support continued access to care for beneficiaries.

Sincerely,

Kathy Messerli

Executive Director