August 29, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1780–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: CMS–1780–P; RIN 0938–AV03

Thank you for the opportunity to provide comments on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). MHCA is a non-profit trade association representing home care agencies across Minnesota, with over 80% of our members being Medicare Certified.

Payment Provisions

MHCA strongly urges CMS not to impose the payment cut of 5.653% to the CY 2023 base payment rate. We firmly believe that CMS has failed to provide evidence as to why this is warranted. First, industry data does not support the behavioral adjustment assumptions made by CMS related to clinical grouping since the start of PDGM. One example of this is data shared by Homecare Homebase (HCHB), a leading software vendor for home-based care, which represents almost 50% of all Medicare home-based visits. The data they published do not support the assumption that agencies are upcoding comorbid conditions to increase reimbursement, nor do the data show a significant shift in additional diagnoses codes added to claims to increase likelihood of a higher comorbidity adjustment. Second, these cuts do not consider the increase in expenses that home care agencies have had to endure since the pandemic and the beginning of PDGM. Some of these expenses include:

- Increases in recruiting and retaining quality workers in a challenging/complex industry. We will address the increase in these costs later in our letter.
- The landscape of patients that are entering home health systems has changed due to the COVID-19 pandemic. Patients are coming to home care with a higher acuity because other health care entities will not accept them, or hospitals are discharging patients quicker due to capacity issues. Higher acuity patients leave agencies with a higher cost to safely care for them. Because these patients are sicker, they require more visits than most home health patients. In addition to more face-to-face visits with the patient, agencies are spending additional time coordinating care amongst all care providers for that specific patient. This ensures the patient has quality care and all parties involved are up to date with the patient's condition. Unlike other care settings, this coordination is not something agencies can bill for even though it is an essential part of case management.
- Due to the staffing challenges HHAs are facing, current clinical staff are forced to work outside their usual "territory." This means that clinicians are driving farther distances to get

to each patient, increasing the mileage workers must be reimbursed for. MHCA members stated this mileage increase, on average, has been close to 15%.

- The market basket update has not kept up with the rising inflation. The data used by CMS lag behind actualized impact. In 2021-22, the impact to the home health industry was about 5.2%, yet providers were given a market basket update of less than 3%. MHCA believes that CMS should adjust the market basket based on actual impact using forecast correction.
- HHAs were hit hard with PPE costs in the height of the pandemic, with agencies seeing over a 20% increase in costs. Many are still trying to recover from this. Cutting payment makes this recovery even harder, forcing numerous agencies to close their doors.
- Regulatory oversight continues to grow. Electronic Visit Verification is a new expense that agencies now must comply with, with no increase in payment to offset this mandate. Even if agencies choose to use the free system provided by the state, they still need an employee to assist with the logistics of the new requirement.

We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Agencies in MN are closing due to the workforce and financial challenges and the increased cost of doing business without the necessary reimbursement will lead to more closures. **Seven Medicare-certified agencies have closed their doors in MN in the past 18 months, all of which cited workforce and financial challenges as the main contributors.** The cuts that CMS is proposing cuts would only exacerbate the already dire situation by weakening the ability of home health providers to meet the health care needs of patients.

In addition to increasing funding, MHCA urges CMS to act in addressing the root issue at hand: the workforce shortage. To provide accurate data for this letter, MHCA surveyed its provider members, which included HHAs with a variety of patient landscapes and areas of service (urban vs rural). The results showed the following:

- On average, 23% of Minnesota home care agencies' staff positions are unfilled. The inability to staff has impacted the ability of home health agencies to accept referrals, leading to increasing referral rejections and higher lengths of stay in the hospital, which has detrimental impacts to financial stability for HHA's and hospitals as well as patient outcomes. According to a study by Strata Decision Technology, the average length of stay in a hospital has increased by 12.6% in 2022 from 2019 levels for patients being discharged to a home health agency. Once a patient is deemed ready for discharge in a hospital, they no longer receive reimbursement for their care, leaving a financial burden for hospitals. At the same time, in Minnesota, the rejection of referrals in MN has resulted in, on average, a loss of $300,000 in revenue.
- In addition to having to turn down referrals due to staffing challenges, HHAs in Minnesota have reported that clinicians need to work below their license just to provide the care their patients need. A common example of this is an OT or RN working as a home health aide 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) to provide the quality of care that is expected and deserved. The payment cuts that CMS is proposing will add another layer of financial burden to home health agencies that are already struggling with unpredictable staffing challenges.

- Staff burnout is at an all-time high. Clinicians are being asked to see more patients due to the workforce shortage and documentation standards keep increasing each year. This is causing clinicians to work well beyond a normal 8-hour day, and many clinicians are leaving for healthcare industries that can provide a more stable work routine (and most often, higher wages). In attempts to retain staff, agencies have reported having increased wages by over 5% in the last year and many are paying high incentives. In Minnesota, agencies reported 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. Unfortunately, these tactics have not proved to be enough to retain staff.

In addition to the proposed rate cuts, MHCA and its members continue to be disheartened by the yearly changes to the case mix weight recalibration. Due to the complexity of the way these items are calculated, it is difficult for an agency to determine expected payment and costs associated with providing care. Once agencies get a handle on the changes, it is changed again, creating instability for home health agencies as they work to ensure they are providing the care each patient needs but also not operating with negative profit margins.

From what we can tell on this recalibration, it appears that there would be a reduction in reimbursement for the highest acuity patients and we question the reasoning behind this as this will limit an agency's ability to care for them. For example, a patient who depends entirely on another person to assist with dressing and bathing will be given a lower functional score, likely resulting in a decreased functional impairment level for reimbursement purposes. We respectfully asked that this be reconsidered.

Home Health Quality Reporting System

MHCA is in support of removing the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, M0110: Episode Timing, and M2220: Therapy Needs. We do not agree with the two items that are proposed to replace these items.

We firmly believe that the COVID:19 Vaccine: Percent of Patients/Residents Who Are Up to Date tracking should not fall upon home health providers. Immunization tracking is the responsibility of a primary care physician and not home health who is typically only involved in patient care for acute episodes of care. In Minnesota, there is an immunization tracking system in place called Minnesota Immunization Information Connection (MIIC). Making another party responsible for tracking this would duplicate work that is already done when the benefit of adding this additional burden has not been identified.

Minnesota Home Care Association

The addition to discharge function makes sense but we respectfully suggest waiting to add this until other items are removed. Currently, there are multiple approaches (the GG's and the M1800s) used to measure someone's functional status. This creates confusion and frustration with field staff which is contributing to inconsistent data, which ultimately leads to lower payments and star ratings. We propose the removal of the M1800 functional items.

Once removed, the discharge function addition is something we would be in support of, if there were adjustments made to how the score is calculated. If a clinician scores a GG item as ANA (Activity Not Attempted either due to patient refusal, not applicable, not attempted for environmental or safety reasons, or not assessed) for the observed functional score, CMS is proposing to use statistical imputation to allow NAs to take any value from 1 to 6, based on patient clinical characteristics and codes assigned to other GG items. The variables and statistical imputation models are complicated. We are concerned with CMS disregarding/changing functional status information assessed by the skilled professional in the patient's home. We feel it would be more appropriate to exclude ANA responses from the calculation.

In addition to adjustments on how the score in constructed, we believe HHA's should have access to this measured data for an adequate time before it is included in HHQRP.

Home Health Value Based Purchasing (HHVBP)

MHCA does not support changing the baseline year to 2023 for the 2025 performance year. Home health agencies have spent significant resources on quality improvement efforts using 2022 data. Switching the data to 2023 could set agencies up for failure and will have caused them a whole year in wasted time and resources. We strongly urge CMS to keep the baseline year as is to allow some stability for agencies.

In addition to the proposal to change the baseline year, MHCA does not support changing the quality measures used in HHVBP, which includes the usage of the proposed discharge function measure. Agencies have spent significant resources on quality improvement, working to improve the items currently in the HHVBP model. As we alluded to in the quality reporting section of our letter, we feel there are issues with the proposed discharge function measure that need to be addressed before being used in the home health setting.

Continually moving the goal post adds a significant administrative burden for agencies and making an astronomical amount of changes at one time is simply setting agencies up for failure. We respectfully request that CMS and MACs establish reasonable enhancements and work collaboratively with the agencies to ensure quality of care for clients.

Lymphedema

MHCA is in support of the new lymphedema benefit being proposed. We would like to ask for confirmation in the final rule that items and services under this new Part B benefit are not subject to the home health consolidated billing rules.

Access to Home Health Aide Services RFI

MHCA greatly appreciated the opportunity to provide feedback on the decrease in utilization for home health aide services. We surveyed our membership to provide feedback on all the questions CMS is seeking for information on. Below are summaries of the responses we received.

1. ***Why is utilization of home health aides continuing to decline as shown in Figure B4 if the need for these services remains strong?***

Much of this decline has to do with staffing issues at agencies. Many of our member agencies in Minnesota have had aide positions open for multiple years without a qualified applicant. The decrease in available home health aides has left these agencies cutting those services down altogether. For example, a typical home health patient used to receive aide services 2-3 times a week. Due to the staffing issues, many agencies reported that they are lucky to be able to staff these visits once a week, if at all, even resorting to turning down referrals simply because they cannot staff the home health aide services. To get around this, agencies have also stated that many of their referral sources will drop the home health aide services from their referral if it means the patient will get the other services needed.

Many times, agencies use their professional staff to cover these visits to ensure the patients are still receiving the care they need.

2. ***To what extent are higher acuity individuals eligible for Medicare (for example, individuals with multiple co-morbidities or impairments of multiple activities of daily living) having more difficulty accessing home health care services, specifically home health aide services?***

We believe that eligible Medicare beneficiaries with co-morbidities are in a crisis trying to find agencies to provide qualified home health services. Home health agencies are seeing an increase in referrals for higher acuity patients due to difficulty getting placement in other settings, such as ALFs and nursing homes, as well as the increased interest in being cared for at home that was a result of the Covid pandemic. Higher acuity patients require more visits than someone with a lower acuity, and with staffing challenges with all disciplines, this is hard for an agency to take on and provide a safe plan of care. In addition to this, higher acuity individuals have a greater risk for hospitalization. Hospitalization now impacts home health payments. Even if a home health agency has the staff to take on this individual, they run a greater financial risk of doing so.

3. ***What are notable barriers or obstacles that home health agencies experience relating to recruiting and retaining home health aides? What steps could home health agencies take to improve the recruitment and retention of home health aides?***

There were a few notable barriers and obstacles all agencies cited in our survey. These included:

- Pay – agencies are not able to pay home health aides the wages they deserve for this position. Often, aides can get the same or better pay in less stressful positions (food service, retail, etc.). Many industries are using sign on bonuses as a way of attracting eligible workers, in upwards of $2,000 for entry level positions at fast food restaurants. With the current reimbursement rates

(agencies must account for all payers – not just Medicare), it is impossible to financially offer this for a home health aide.

- Vehicle use – this position requires a lot of wear and tear on an aide's vehicle. Even though they get reimbursed for mileage (most MN agencies pay the Federal IRS rate), this is not sufficient to cover the added expenses one incurs by sometimes driving 100+ miles a day.
- Job stigma – Generally, home health aides are not respected to the same degree as professional roles at home health agencies. These roles get looked down upon, making it harder to attract employees.

Home Health agencies are doing all they can do in Minnesota to recruit and retain these valuable employees. The most significant change they could make would be to provide a better wage, but the reimbursement for all payers needs to keep up with this. Our members believe Medicare Advantage and Medicaid plans should be required to pay reimbursement rates that are much closer to the Medicare rates. Agencies report these rates are nowhere near the Medicare rate, leaving agencies struggling to ensure they have a viable payer mix to even meet payroll obligations. If these rates were higher, agencies would be able to pay higher rates, offer sign-on bonuses, and provide better benefits. All these things would make this role more attractive.

4. ***Are HHAs paying home health aides less than equivalent positions in other care settings (for example, are aides in the inpatient hospital setting or nursing home setting paid more than in home health)? What are the reasons for the disparity in hourly wages or total pay for equivalent services?***

Almost all agencies in our survey cited having to pay less than equivalent positions within the industry. One main reason for this was the mileage cost that agencies need to pay on top of a home health aides wages. This was especially prevalent in rural areas. Facilities and hospital settings do not have this expense, allowing them to add this addition to one's wages.

5. ***In what ways could HHAs ensure that home health aides are consistently paid wages that are commensurate with the impact they have on patient care that they provide to Medicare beneficiaries?***

MHCA firmly believes that the inconsistency amongst payer reimbursements leads to a difficulty in paying reasonable wages. Employee wages need to be set at a level that aligns with the average reimbursement. If all payer reimbursement rates were at sustainable rates, agencies would be able to pay all staff (including nursing, which is also paid less than hospital/nursing homes) the rates they deserve.

A few suggestions to accomplish this from our members included reimbursement studies amount the Medicare Advantage plans and an add-on payment for home health aide services.

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6. ***Are physicians' plans of care less reliant on home health aide services in the past, or are HHAs less willing/able to provide these services? If so, what are the primary reasons why such services are not provided?***

No, physicians' plans of care are not less reliant on home health services than in the past. The issue stems from agencies being able to staff these visits. As stated in earlier responses, agencies often decline a referral because they cannot staff the home health aide visits. Referral sources will drop the home health aide services from their referral if it means the patient will get the other services needed due to the industry-wide nature of this issue.

7. What are the consequences of beneficiary difficulty in accessing home health aide services?

MHCA believes there are many detrimental consequences of the current difficulty in accessing home health aide services. These consequences include:

- Individuals must resort to more expensive care settings such as hospitals or nursing homes. Home Health is a far more cost-effective option for taxpayers, and it increases the quality of life of beneficiaries.
- Increase in falls during showers/ADLs due to not having the help they need. This unsafe environment often leads to greater hospitalization rates.

Increase burden on the patient and their family. Often this care need is left unmet and the individual's quality of life declines.

<u>Hospice</u>

MHCA understands CMS's reasoning behind the Special Focus Program (SFP) but believe the SFP is punitive to hospices and that in some cases, the intense oversight and financial burden of hospices included in the SFP would lead to agency closure. As an industry, we believe there are many hospices that struggle to keep up with the overly burdensome regulations that CMS requires. In some cases, the hospice may be excellent at providing care, but may struggle with regulatory compliance. These hospices would benefit from guidance and help from CMS and/or their MAC, but the enforcement remedies in this proposal are not sustainable for the average hospice.

We recognize there are hospices engaging in fraudulent behavior. However, we respectfully suggest CMS focus energy on identifying fraudulent activities and those agencies, while providing more education and support to the Hospice industry in general to promote safe, quality end-of-life care.

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Conclusion

Thank you again for the opportunity to provide our comments. CMS's proposed payment cuts will result in financial harm for home health providers, impacting access to care, and undercut patient care and quality. We urge CMS not to finalize severe rate reductions for home health and to work with the home health community to support continued access to care for beneficiaries.

Sincerely,

Kathy Messerli

Kathy Messerli, Executive Director

Minnesota Home Care Association