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August 26, 2024

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1803-P

P.O Box 8013

Baltimore, MD 21244-8013

Re: **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**

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 and the CY 2025 payment rates in the Notice of Proposed Rulemaking (NPRM). 89 Fed. Reg. 55312 (July 3, 2023).

The ALLIANCE-NHPCO Alliance (formerly the National Association for Home Care & Hospice), hereinafter “Alliance”, respectfully submits these comments regarding the proposals contained within the NPRM. The Alliance is the largest trade association representing the interests of Medicare home health agencies (HHAs) and hospices nationwide including nonprofit, proprietary, urban, and rural based, hospital affiliated, public and private corporate entities, and government run providers of home care since 1982. Alliance members provide most Medicare home care services throughout the U.S.

The Alliance is also an original provider-member of the Leadership Council of Aging Organizations (LCAO) as it has put patients first in its health policy and advocacy positions since its inception. Each year, Alliance members serve millions of patients of all ages, infirmities, and disabilities, providing an opportunity for individuals to be cared for in their own homes, the care setting preferred by most people.

Many members of our Forum of State Associations also support these comments. We are specifically joined on this letter by numerous state home care associations listed on the final page. Many others are filing their own comments too. State associations are an important voice in understanding the impact of the proposed rules in their local settings. Their “on the ground” perspective deserves special attention.

We are aware that numerous other organization and representatives of the HHA community have submitted comments as well We especially recommend that CMS provide thoughtful consideration to those comments submitted by the Partnership for Quality Home Health along with those submitted by several by our the EMR/IT business partner members that offer extensive “real-time” data analysis.

At the outset, we respectfully express that the existing and newly proposed payment rate cuts will continue to serve to significantly reduce access to essential home health services throughout the country and set the stage for further annual rate cuts that will dismantle this crucial benefit. That outcome stems from the application of a budget neutrality adjustment methodology that will perpetually rebase payment rates reflecting the natural and foreseeable reaction of home health agencies (hereinafter “HHAs”) to reduced reimbursement. CMS understands HHAs, like all health services providers, will reduce costs in reaction to payment reductions. Cost reductions often can include service reductions involving the admission of patients, the scope of services offered, and the extent of services provided. Consequently, the CMS budget neutrality methodology will continue to trigger further payment rate reductions that will eventually destroy the value of the home health services benefit.

CMS has the authority and the responsibility to prevent such an outcome under 42 USC 1395fff to determine the “time and manner” of applying any rate adjustments under PDGM. CMS has the full discretionary power to go forward with the 2025 rate setting without the proposed 4.067% rate cut.

While we once again will not relitigate here our position that the budget neutrality methodology fails to conform with statutory mandates, CMS does have the clear authority to determine the time and manner of any permanent and temporary adjustments under the payment model and has used that power in past rulemakings. **We once again strongly recommend that CMS use that authority to withhold any such adjustments in 2025 to provide the opportunity for a full and deep review of the direction of the home health benefit, its impact on access to care, and options to preserve a longstanding benefit that has brought high quality of care and essential health care services to millions of Medicare beneficiaries since 1965, along with great value to the Medicare program through expenditure savings far in excess of any other Medicare benefit. Since the initiation of PDGNM in CY2020, CMS’s own data shows the significant deterioration of the home health benefit and the increasing reduction in access across the country. AS detailed below, fewer and fewer Medicare beneficiaries have access to the home health benefit and those that do face a significantly reduced scope and depth of care.**

Specific comments on all elements of the NPRM are below. We offer the following summary of our overall recommendations:

**OVERALL RECOMMENDATIONS**

1. **Home Health Services Payment Rates**

* CMS should postpone application of any further permanent adjustments related to PDGM budget neutrality to preserve current access to home health services and the scope of care available.
* CMS should maintain its position to withhold any part of the PDGM budget neutrality temporary adjustments in 2025.
* CMS should recognize the disruptive, continuing, and permanent financial impact of its forecasting error with respect to the annual Market Basket Index updates from 2021 and 2022 and implement a one-time adjustment to account for the 5.2% forecasting error.
* CMS should consider the negative and disruptive financial impacts of its proposed wage index changes and case mix weight recalibrations on care access as it finalizes the 2025 payment rates and any systemic reforms.

**B.**

**C.**

**D.**

**SPECIFIC COMMENTS ON PROPOSED RULE AND POLICY CHANGES**

**The Proposed Payment Rate Cuts Further Exacerbate Significant Care Access Barriers for Patients and Will Bring the Home Health Benefit to a Point of Crisis**

For several years, Medicare payment policies have seriously diminished the Medicare home health benefit. Concurrent with rate reductions, payment model changes, case mix weight recalibrations, and inaccurate cost inflation forecasts there continues to be a corresponding dilution of the home health benefit resulting in a significant, negative impact on care access. The Alliance forecast this outcome in it CY2020 comments with added support for the contention each year thereafter. While CMS thankfully responded to those concerns by withholding any application of the growing temporary adjustments along with a reduced permanent adjustment in CY 2023 and CY 2024, the deterioration of the benefit and access to it still continues. The outcome has been startling with several hundred thousand less Medicare beneficiaries annually using home health services, less care provided to patients, and fewer provider options. Such dramatic changes cannot be accounted for because of oversight activities, marketplace changes, or the increased enrollment in Medicare Advantage plans as an alternative to traditional Medicare enrollment. This deterioration is clearly displayed even in the limited data offered by MedPAC and data routinely available to CMS.

The 2023 MedPAC data analysis shows a decline of 400,000 home health users between 2017 and 2021. In-person visits per user declined by over 17% from 30.7 to 25.4. Active HHAs fell by 1,232 from 2016-2021. The active provider numbers continue to decline to date, except for California where program integrity issues have been raised. **This data does not depict a stable home health benefit in any form.**

As predicted by the Alliance in its earlier PDGM comments, the data analysis shows a continuing decline in home health users, in-person visits per user, and active HHAs. **An ongoing pattern of loss of access to care cannot be ignored by CMS, particularly when the obvious cause is the flawed payment model established and introduced by CMS in 2020.** An alternative explanation does not lie in increased Medicare Advantage enrollment as the percentage of Medicare Fee-for-Service enrollees using home health services is declining, not just the gross number of users. Similarly, the explanation does not lie in a reduced inpatient population as the majority of HHA admissions is from the community and those enrollees that would have come from an inpatient stay to home health in the past still have health care needs even if they are no going to inpatient care. Finally, CMS cannot reasonably adopt the MedPAC view that there has been a reduction in use of home health along with a declining number of HHAs since 2013 as the explanation. The institution of PDGM re-triggered the benefit deterioration that began with the Affordable Care Act’s rate rebasing mandate after just two years of a modicum of “stability.”

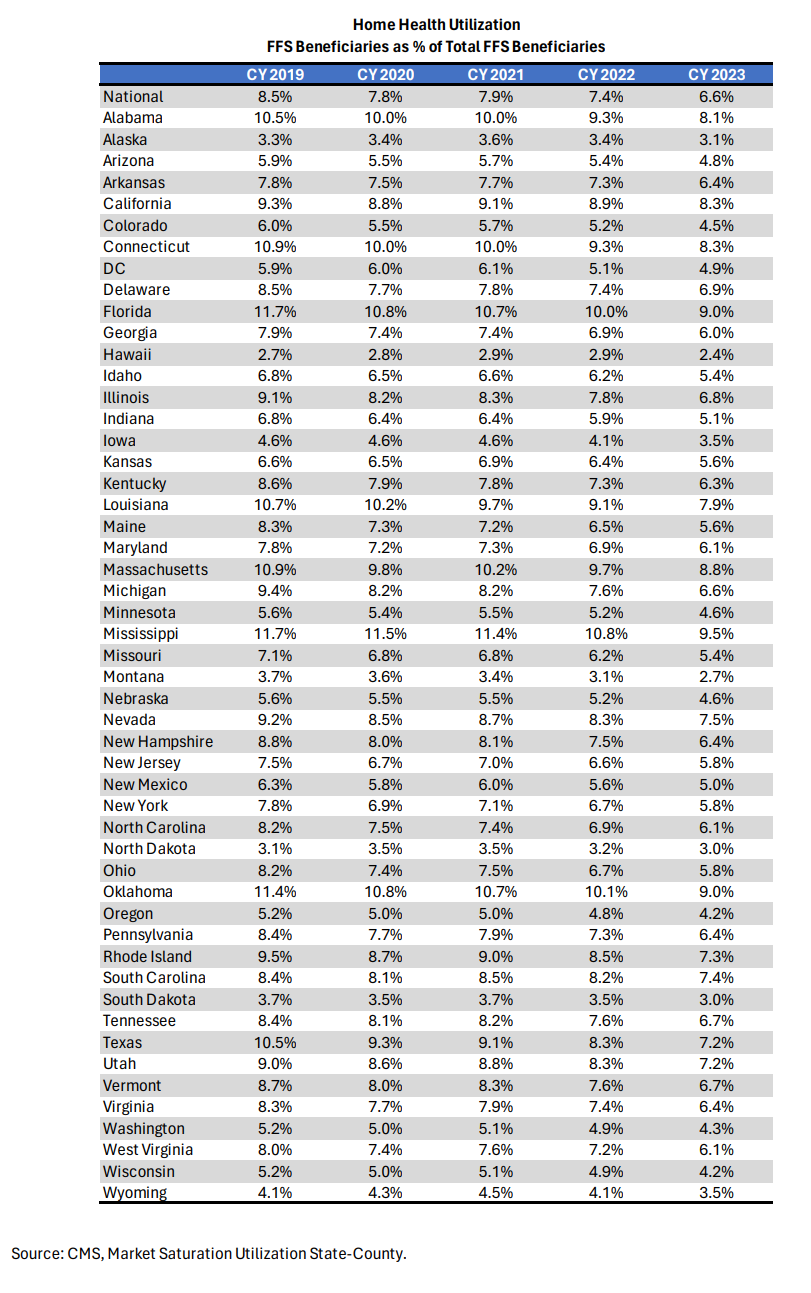
All told, the PDGM era to date has shown a combination of:

* Nearly 500,000 fewer Medicare beneficiaries accessing home health services
* A 22,4% decline in the proportion of Medicare fee-for-service beneficiaries accessing home health services
* A 9% nationwide reduction in active HHAs accessible to beneficiaries
* A 15.6% reduction in the number of clinical visits in a 30-day period

These data do not portray a budget neutral transition to PDGM. Instead, these data depict a crucial an essential benefit in the Medicare program, one that has demonstrated dynamic positive impact through cost and care avoidance, that is on a continuing downward path to being effectively dismantled.

The chart that follows shows that fewer beneficiaries as a percentage of enrollees have accessed home health services in all 50 states since the initiation of PDGM in 2020. This should concern every Medicare enrollee, particularly as the US population ages overall while consumers increasingly express a very strong desire to age in place with health care services in their own homes. It should also concern CMS as Medicare heads towards significant financial challenges with its ongoing reliance on inpatient and institutional care. It is time for CMS to recognize, in its practices, what it has conveyed regarding the Home health Value Based Purchasing demonstration program—home health services reduce overall Medicare expenditures—when used.

The following data from the CMS Market Saturation Report details the decline in home health utilization. CMS cannot ignore its own data and the obvious impact of PDGM during the period involved. Coincidences are not simply happenstance. Notably, both CMS and Congress recognized that Medicare payment changes lead to provider behavior changes. These data support that assumption. Reduced payment rates have led to reduced care access and usage. Correspondingly, the proposed further reductions in payment rates for CY2025 will lead to further reductions in care access and usage.



<https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county>

While the Alliance does consider the below MedPAC analyses to be wholly accurate in comparison to the CMS Market Saturation Reports, those analyses are categorically consistent with the downward trends displayed in the CMS data. Nearly 600,000 fewer users of home health services, a 6% decline in the proportion of FFS beneficiaries utilizing home health services between 2019 and 2022, reduced lengths of stay receiving home health services, and a significant decline in the number of in-person clinical visits to patients are all consistent with the Market Saturation Report data compiled by CMS.

**MedPAC March 2023 Report to Congress**

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**MedPAC March 2024 Report to Congress**

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**MedPAC March 2023 Report to Congress**

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**MedPAC March 2024 Report to Congress**

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CMS also offers important data on the level of care provided under the home health benefit in the NPRM that shows the continuing decline is services provided as each year of PDGM advances.

A close-up of a chart

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89 Fed. Reg. 55312, 55318 (July 3, 2024).

The pattern is clear and unambiguous. Rate cuts under PDGM lead to care cuts.

The decline in the number of active, billing HHAs continues to plummet nationwide, with very frwe states excepted. Notably, California is the unicorn among the states with 534 active HHAs added between 2019 and 2023. Active is defined as billing for Medicare homne health services during that calenadr year. Active is contrasted with simply existing as a certified HHA as that status does not help define care access.

The data from the CMS Market Saturation Reports shows a 9% decline in the number of active HHAs since prior to PDGM. All but six states (AZ, CA, ME, NV, RI, and WA) show a sizeable decline in the number of HHAs that are activre. California is suspected to have seen growth with a large number of new HHAs raising program integrity concerns. With California excepted, thre decline in active HHAs during PDGM is in excess of 17%

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **2019** | **2020** | **2021** | **2022** | **2023** | **2019-2023** | |
| Alabama | 129 | 119 | 120 | 113 | 114 | -15 | -12% |
| Alaska | 16 | 14 | 15 | 14 | 13 | -3 | -19% |
| Arizona | 135 | 135 | 136 | 137 | 135 | 0 | 0% |
| Arkansas | 101 | 98 | 94 | 96 | 93 | -8 | -8% |
| California | 1,343 | 1,417 | 1,546 | 1,743 | 1,877 | 534 | 40% |
| Colorado | 114 | 112 | 109 | 102 | 101 | -13 | -11% |
| Connecticut | 84 | 80 | 68 | 67 | 65 | -19 | -23% |
| DC | 26 | 26 | 26 | 25 | 22 | -4 | -15% |
| Delaware | 25 | 21 | 24 | 21 | 21 | -4 | -16% |
| Florida | 815 | 800 | 812 | 781 | 742 | -73 | -9% |
| Georgia | 109 | 111 | 112 | 105 | 106 | -3 | -3% |
| Hawaii | 14 | 12 | 13 | 12 | 10 | -4 | -29% |
| Idaho | 53 | 53 | 51 | 47 | 49 | -4 | -8% |
| Illinois | 597 | 532 | 527 | 498 | 482 | -115 | -19% |
| Indiana | 171 | 160 | 152 | 140 | 133 | -38 | -22% |
| Iowa | 128 | 123 | 117 | 113 | 110 | -18 | -14% |
| Kansas | 112 | 106 | 104 | 98 | 96 | -16 | -14% |
| Kentucky | 102 | 94 | 90 | 87 | 86 | -16 | -16% |
| Louisiana | 175 | 173 | 171 | 170 | 165 | -10 | -6% |
| Maine | 25 | 24 | 28 | 27 | 26 | 1 | 4% |
| Maryland | 63 | 64 | 62 | 63 | 61 | -2 | -3% |
| Massachusetts | 147 | 137 | 142 | 130 | 114 | -33 | -22% |
| Michigan | 398 | 353 | 340 | 311 | 279 | -119 | -30% |
| Minnesota | 111 | 111 | 107 | 94 | 86 | -25 | -23% |
| Mississippi | 48 | 47 | 46 | 46 | 45 | -3 | -6% |
| Missouri | 153 | 145 | 144 | 136 | 128 | -25 | -16% |
| Montana | 26 | 25 | 24 | 23 | 23 | -3 | -12% |
| Nebraska | 66 | 65 | 62 | 60 | 57 | -9 | -14% |
| Nevada | 143 | 147 | 146 | 160 | 157 | 14 | 10% |
| New Hampshire | 39 | 35 | 37 | 37 | 35 | -4 | -10% |
| New Jersey | 52 | 49 | 52 | 49 | 46 | -6 | -12% |
| New Mexico | 66 | 67 | 69 | 68 | 63 | -3 | -5% |
| New York | 142 | 135 | 132 | 131 | 123 | -19 | -13% |
| North Carolina | 173 | 166 | 166 | 160 | 157 | -16 | -9% |
| North Dakota | 18 | 17 | 18 | 16 | 16 | -2 | -11% |
| Ohio | 321 | 285 | 268 | 251 | 230 | -91 | -28% |
| Oklahoma | 232 | 226 | 220 | 215 | 205 | -27 | -12% |
| Oregon | 61 | 55 | 59 | 57 | 58 | -3 | -5% |
| Pennsylvania | 274 | 246 | 244 | 226 | 209 | -65 | -24% |
| Rhode Island | 22 | 24 | 24 | 22 | 22 | 0 | 0% |
| South Carolina | 85 | 85 | 85 | 82 | 75 | -10 | -12% |
| South Dakota | 28 | 24 | 26 | 25 | 24 | -4 | -14% |
| Tennessee | 136 | 128 | 129 | 127 | 126 | -10 | -7% |
| Texas | 1,490 | 1,346 | 1,242 | 1,138 | 1,056 | -434 | -29% |
| Utah | 82 | 79 | 79 | 76 | 71 | -11 | -13% |
| Vermont | 14 | 14 | 14 | 13 | 12 | -2 | -14% |
| Virginia | 220 | 210 | 202 | 199 | 196 | -24 | -11% |
| Washington | 63 | 64 | 68 | 67 | 68 | 5 | 8% |
| West Virginia | 62 | 57 | 58 | 53 | 50 | -12 | -19% |
| Wisconsin | 97 | 84 | 84 | 84 | 81 | -16 | -16% |
| Wyoming | 30 | 29 | 32 | 28 | 26 | -4 | -13% |
| **Total** | **9,136** | **8,729** | **8,696** | **8,543** | **8,345** | **-791** | **-9%** |

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| **Total w/o CA** | **7,793** | | **7,312** | | **7,150** | | **6,800** | | **6,468** | | **-1,325** | | | **-17%** |
|  | |  | |  | |  | |  | |  | |  |  | |

Source: CMS Market Saturation Reports, <https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county>

The Alliance also considers the CMS Market Saturation Reports a superior data source on access to HHAs to that displayed by MedPAC as it relies on robust claims data analyzed by CMS itself. Nevertheless, even the MedPAC analyses in 2023 and 2024 depict a continuiing decline in available HHAs. Such a finding supports the concerns voiced by the Alliance over the past PDGM yearsthat the access to care has been materially diminished and is facing an ongoing threat to a complete loss in some parts of the country due to the continuing PDGM rate cuts based on the flawed budget neutrality assessment methodology applied by CMS.

**MedPAC March 2023 Report to Congress**

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**MedPAC March 2024 Report to Congress**A screenshot of a document

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Sources: March 2023 Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission, Chapter 8, Pages 242, 243, 245. <https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/>

March 2024 Report to Congress: Medicare Payment Policy. Medicare Payment Advisory Commission, Chapter 7, Pages 206-211. <https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/>

MedPAC’s mischaracterization of the data trends as sufficient access to care should be given no weight as the numbers speak for themselves—care utilization is significantly down, less care is provided today than in prior years, and there are fewer HHA choices for beneficiaries. While full data is not yet available, there are clear indications that the reduction in patients using home health services and the volume of in-person visits continue to decline post-2021 along with the number of active HHAs.

Further indications of the fragility of the financial status of HHAs are found in cost report data from calendar year 2022. The ALLIANCE analyzed cost reports for all HHAs with a fiscal year end of 12/31/22 to evaluate the impact of CY2022 payment rates, cost inflation, service changes, and other factors related to 2022 influences and behavior in a consistent manner. The ALLIANCE methodology trimmed out reports with no data on revenue and/or costs along with an application of the common 90/10 natural log trim. The ALLIANCE evaluated both “Medicare margins” (the difference between reported fee-for-service Medicare revenue and reported fee-for-service Medicare costs) as well as “Overall Margins” (total home health revenue compared to total home health costs).

The ALLIANCE notes the following regarding the cost report data analysis:

1. Cost report data came from CMS at <https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports/cost-reports-by-fiscal-year>
2. Cost reports used were limited to those with 12/31/22 fiscal year ends. An estimated 30% of HHAs use alternative fiscal years.
3. Cost report inputs were used as reported.
4. CMS cost reporting standards do not consider certain usual and ordinary business costs, such as marketing, telehealth services and equipment, and certain taxes as “allowable” thereby depressing the amount of costs in the margin analysis.
5. The wide range in margins makes the nature of the cost report trimming affect the margin calculation.

Most notable from the cost report analysis is that HHAs experience a wide range of financial outcomes in both the “Medicare Margin” and the “Overall Margin.” This outcome occurs regardless of HHA geographic location, urban or rural service area, tax status, or size. The wide range of financial outcomes of a payment model set out below itself demonstrates current fragility and uncertainty in the financial status of the organization along with the impact of any future rate changes. Most importantly, it demonstrates that relying upon averages is a high risk undertaking when setting or evaluating payment rates and any changes in payment rates, particularly as it relates to the impact on care access as averaging masks the impact that comes from losing those providers with margins below the average.

|  |  |  |
| --- | --- | --- |
| **Cost Reports FYE 12/31/22** |  |  |
|  |  |  |
| **Region** | **Total Medicare FFS Reimbursement** | **Number of HHAs** |
| **National** | $11,625,894,736 | 5,639 |
|  |  |  |
|  |  |  |
| **Medicare Margin** | **Number of HHAs** | **Percentage of HHAs** |
|  |  |  |
| Greater than 20% | 2,958 | 52.6% |
| Between 0% and 20% | 1,479 | 26.2% |
| Less than 0% | 2,681 | 21.2% |
|  |  |  |

It should be apparent that HHAs with current negative Medicare Margins would face significant financial difficulties in absorbing the proposed additional 5.653% rate cut for 2024 based on FYE 2022 data alone. With those providers, serious negative impact on patients can be fully expected if the affected HHA is to continue operations.

For HHAs with Medicare Margins above zero percent, those difficulties are also serious and insurmountable without negative impacts on patients. As we have seen over the years, rate cuts have reduced access in several ways, including HHA closures, reduced service areas, reduced admissions, and reduced scope of services.

However, we advise CMS not to confine its access impact analysis to a silo built on Medicare Margins data. While payers may prefer to limit their rate impact evaluation to the relationship of its rate to provider cost, the economic model of HHAs necessitates a view consistent with the HHAs’ evaluation of its overall financial condition. HHAs do not have the luxury of confining its evaluation to a payer-centered one. Instead, it must look at the overall combination of payers to determine the impact of any single payer change on its operations because HHAs’ business is a variety of government or quasi-government-based payers where payment rates are assigned by the payer, not determined by the provider. For HHAs, most payments come from traditional Medicare, Medicare Advantage, Medicaid, the VA, and Tricare. Most HHAs have little or no commercial insurance or private pay home health services, unlike most other health care sectors.

HHAs serve patients and do not distinguish between traditional Medicare patients and those patients covered by Medicare Advantage, Medicaid, the VA, or other payers. HHA nurses, therapists, and home health aides provide patient care, not Medicare patient care, Medicare Advantage patient care. Medicaid patient care, or care that is different based on payer source. Professional standards of care make home health services payer-agnostic. The Medicare Conditions of Participation apply equally to all payers too.

It is notable that MedPAC evaluates the full financial outcome for inpatient hospital services and SNF services in its consideration of the impact of Medicare rates of payment on access to care. Such makes sense as health care providers do not operate in payer-related silos. AS previously stated, the Medicare Conditions of Participation apply equally to all patients without regard to payer source. In home health services, all patients are subject to the OASIS patient assessment and quality of care measures along with public quality data reporting do not distinguish patients by payer source. The Medicare cost report does require delineation by Medicare and “Other,” but cost calculations blend all costs without regard to payer source.

The ALLIANCE recognizes that, based on cost report data and inputs from The ALLIANCE members, traditional Medicare payments may subsidize other payers such as Medicare Advantage or Medicaid. In some respects that is the reality that HHAs must deal with every year. In other respects, which may be a creature of cost reporting weaknesses. Either way, HHAs operate as an HHA, not a Medicare Fee-for-Service HHA. It is not unusual for one payer’s revenue to be needed to subsize a shortfall from another payer.

While it may not be the best Medicare payment policy, currently it must be recognized as a central impacting feature of the financial status of HHAs. Changing payment rates in traditional Medicare has a ripple effect on the entire patient population of an HHA. That is particularly the case when the other payers are highly unlikely to step up and improve their payment rates as we have here in home health with Medicare Advantage and Medicaid, both having rate setting power that is sanctioned by CMS. Accordingly, CMS must recognize the need to apply its discretion on the application of PDGM permanent adjustments taking into consideration the overall impact of rate cuts on the ability of HHAs to maintain full access to care. Here the proposed rate cuts are clearly highly disruptive in relation to continued care access. The “Overall Margins” of HHAs, as discussed below, demonstrates that the level of disruption is monumental.

The projected national Overall Margin for 2024 with the proposed base rate cut would show that 52.7% of freestanding HHAs would be “underwater” with overall margins below 0% assuming no change in costs compared to 2022. The analysis is limited to freestanding HHAs due to the unavailability of such data from cost reports submitted by institution based HHAs. However, it can be safely assumed that the percentage would increase if those HHAs were capable of being included since the Medicare-related margins tend to be lower than freestanding HHAs as a starting point.

These data depict a substantial risk that a majority of HHAs would be in jeopardy of bankruptcy or closure with the proposed rate cut. Those HHAs’ options to avoid that risk are highly limited, none of which would be good for the patient population and most have already been employed with the CY2023 rate cut. Those options include:

* Reducing the volume of visits in the episode of care. More than a full visit reduction on average would be needed to stay financially even.
* Reducing costs by narrowing the geographic scope of the service area to reduce travel time between visits or the need for a branch office. That action would effectively “close” the provider for a portion of previously served patients.
* Eliminate services to Medicare Advantage and Medicaid patients. This would require an HHA to address fixed and semi-variable costs that would remain through such a census reduction.
* Refocus Medicare home health services on certain patient populations that would not trigger financial losses in a manner consistent with nondiscrimination requirements.

Such changes in service are easy to predict since they are already ongoing due to the initial 4.36% rate cut at the start of PDGM, shortfalls triggered by inflation rate forecasting errors, and the 3.925% rate cut in 2023. Compounding the risk is the 5.2% forecast error in 2021 and 2022 as it relates to cost inflation and the resulting Market Basket Index (discussed further below). The proposed 4.067% rate reduction will send the overall financial status of HHAs into the world of closures, bankruptcies, and patient service roadblocks and reductions. The data earlier presented and as further set out below shows that such a crisis has begun and will continue to grow nationwide. .



Source: FYE12/31/2022 Freestanding HHA cost reports, <https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports/cost-reports-by-fiscal-year>. The forecast is based on 2022 data trended forward with the 9.36% base rate cuts in 2023 and proposed for 2024 without regard to any cost changes that are greater than the 2023 MBI and proposed 2024 MBI. If cost to revenue changes were considered, it is expected that the number of HHAs with overall margins below zero would increase.

Most states are already in trouble with the existing 2024 rate cut. Extending a further cut of 4.067% in 2025 is bound to accelerate the decline in care access. Most geographic areas within each state are at risk of losing HHAs. In some areas, all HHAs are forecast to be faced with a negative net financial margin. The risk to access to care for Medicare beneficiaries and all others that need home health services is acute and undeniable. CMS cannot let that happen.

**The Home Health Benefit Has Been Shrinking with Each Rate Cut: The Proposed 2025 Rate Cut Will Only Bring Further Shrinkage**

In 1996, the number of visits per user of home health services was 74. By 2021 it had shrunk to 25.44. That shrinking occurred at various stages of payment model changes and payment rate reductions. The first generation of benefit shrinkage was in 1998, the first year of the ill-designed Interim Payment System (IPS), where average visits dropped to 51. With the onset of the Prospective Payment System in October 2000, the CY2001 average number of visits dropped to 31. With a few years of stability in the payment rates, visit volume per patient stabilized and rose slightly. However, within a six-year series of rate cuts, visits per patient dropped back down to an average of 31. With the additional rate cuts that began in 2014 and continued to 2017, per patient visit volume stayed steady, but by 2018 the number of patients served dropped by over 100,000 despite the growth in Medicare enrollment of more than 1.4 million.

With the onset of the PDGM system in CY2020, another drop in per patient visits occurred, reducing the average to 27.57. The second year of PDGM saw more of the same with the average reduced to 25.44 visits. While the level of services lost has been significant, the reduction in Medicare beneficiaries that use home health services has been even more dramatic, dropping from 3.6 million in 1996 to 3.02 million in 2021 despite a 2.7 million increase in traditional Medicare enrollees.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| YEAR | Traditional Medicare Enrollees | USERS (1000s) | VISITS PER PERSON | VISITS PER EPISODE | MEDICARE HH PAYMENTS (1000s) | PAYMENTS PER PERSON | PAYMENTS PER EPISODE |
| 1990 | N/A | 1967.1 | 36 | N/A | $3,713,652 | $1,892 | N/A |
| 1991 | N/A | 2242.9 | 45 | N/A | 5,369,051 | 2,397 | N/A |
| 1992 | N/A | 2506.2 | 53 | N/A | 7,396,822 | 2,955 | N/A |
| 1993 | N/A | 2874.1 | 57 | N/A | 9,726,444 | 3,389 | N/A |
| 1994 | 34,076 | 3179.2 | 66 | N/A | 12,660,526 | 3,987 | N/A |
| 1995 | 34,062 | 3469.4 | 72 | N/A | 15,391,094 | 4,441 | N/A |
| 1996 | 33,704 | 3599.7 | 74 | N/A | 16,756,767 | 4,660 | N/A |
| 1997 | 33,009 | 3557.5 | 73 | N/A | 16,718,263 | 4,704 | N/A |
| 1998 | 32,349 | 3061.6 | 51 | 31.6\* | 10,456,908 | 3,420 | N/A |
| 1999 | 32,179 | 2719.7 | 42 | N/A | 7,936,513 | 2,921 | N/A |
| 2000 | 32,740 | 2461.2 | 37 | N/A | 7,215,958 | 2.936 | N/A |
| 2001 | 33,860 | 2402.5 | 31 | 21.4\* | 8,513,702 | 3,545 | N/A |
| 2002 | 34,977 | 2544.4 | 31 | 20\* | 9,550,683 | 3,765 | $2,329\* |
| 2003 | 35,815 | 2681.1 | 31 | 18.39\*\* | 10,069,628 | 3,770 | N/A |
| 2004 | 36,345 | 2835.6 | 31 | 18.0\*\* | 11,402,560 | 4,039 | N/A |
| 2005 | 36,685 | 2975.6 | 32 | 18.21\*\* | 12,779,158 | 4,314 | $2,366\* |
| 2006 | 35,647 | 3026.2 | 34 | 18.45\*\* | 13,912,750 | 4,619 | N/A |
| 2007 | 35,490 | 3099.5 | 37 | 18.19\*\* | 15,565,441 | 5,046 | $2,566\* |
| 2008 | 35,320 | 3171.6 | 38 | 19.1\*\* | 16,872,735 | 5,361 | $2,705\* |
| 2009 | 35,360 | 3281.1 | 40 | 18.7\*\* | 18,733,108 | 5,747 | N/A |
| 2010 | 35,910 | 3434.4 | 37 | 18.0\*\* | 19,407,218 | 5,688 | N/A |
| 2011 | 36,458 | 3463.9 | 36 | 17.0\*\* | 18,362,264 | 5,357 | $2,916\* |
| 2012 | 37,214 | 3459.6 | 34 | 17.0\*\* | 18,025,554 | 5,256 | N/A |
| 2013 | 37,613 | 3452.0 | 32 | 16.79 | 17,924,989 | 5,193 | $2,687 |
| 2014 | 37,790 | 3417.2 | 32 | 16.66 | 17,736,862 | 5,190 | 2,703 |
| 2015 | 38,025 | 3454.4 | 32 | 16.60 | 18,203,863 | 5,280 | 2,762 |
| 2016 | 38,610 | 3451.5 | 31 | 16.63 | 18,117,018 | 5,249 | 2,780 |
| 2017 | 38,668 | 3392.9 | 31 | 16.60 | 17,830,844 | 5,255 | 2,823 |
| 2018 | 38,665 | 3365.9 | 31 | 16.67 | 17,934,054 | 5,328 | 2,876 |
| 2019 | 38,577 | 3281.4 | 31 | 16.57 | 17,850,864 | 5,440 | 2,952 |
| 2020\*\*\* | 37.776 | 3054.5 | 27.57 | 9.27 | 17,082,332 | 5,592 | 1881 |
| 2021\*\*\* | 36.356 | 3018.5 | 25.44 | 8.27 | 16.872,835 | 5.590 | 1.818 |

Sources: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cmsprogramstatistics> ; <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS>

\*Data from Medicare Payment Advisory Commission (MedPAC) various March Reports to Congress

\*\* Data from CMS HHA cost reports

\*\*\*The payment model shifted to a 30-day episode

**Medicare Home Health Services and Use Reductions Coincided with Payment Rate Reductions: The Proposed PDGM Cut Will Bring More**

While payment rate and payment method are not the only contributing factors to service access and level of care changes in home health services, their impacts are natural and foreseeable. Since BBA 1997, home health services PPS episodic rates have been subject to numerous negative adjustments that began with the initial rate setting for FY2001. Due to the dramatic impact of the Interim Payment System in 1998-2000 and the BBA 1997 requirement that PPS be set in a budget neutral manner, the FY2001 payment rates were set at a level that was over $300 lower than provider costs $2115.50 versus $2416.01) due to a .88423 budget neutrality adjustment. <https://www.govinfo.gov/content/pkg/FR-2000-07-03/pdf/00-16432.pdf>. Thereafter, the episodic rates have been hit with multiple legislated and regulatory reductions. The table below sets out those reductions. The PDGM rate reductions have and will continue to have the same reduction in care access and level of services.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YEAR | MBI REDUCTION | PRODUCTIVITY ADJUSTMENT | BUDGET NEUTRALITY and CASE MIX WEIGHT ADJUSTMENT\*\* | REBASING REDUCTION |
| FY2001 |  |  | 11.577% |  |
| FY2002 |  |  |  |  |
| FY2003 | 1.1% |  | 7% |  |
| FY2004 |  |  |  |  |
| CY2005 | 0.8% |  |  |  |
| CY2006 | 0.8% |  |  |  |
| CY2007 |  |  |  |  |
| CY2008 |  |  | 2.75% |  |
| CY2009 |  |  | 2.75% |  |
| CY2010 |  |  | 2.75% |  |
| CY2011 | 1.0% |  | 3.79% |  |
| CY2012 | 1.0% |  | 3.79% |  |
| CY2013 | 1.0% |  | 1.32% |  |
| CY2014 |  |  |  | $80.65 (3.5%) |
| CY2015 |  | 0.5% |  | $80.65 (3.5%) |
| CY2016 |  | 0.4% | 0.97% | $80.65 (3.5%) |
| CY2017 |  | 0.3% | 0.97% | $80.65 (3.5%) |
| CY2018 | 2.0% |  | 0.97% |  |
| CY2019 |  | 0.8% | 1.69% |  |
| CY2020 PDGM begins |  |  | 4.36% |  |
| CY2021 |  | 0.3% |  |  |
| CY2022 |  | 0.5% |  |  |
| CY2023 | 5.2% forecast error | 0.20% | 3.925% |  |
| CY2024 |  | 0.30% | 2.89% |  |
| CY2025 (proposed) |  | 0.50% | 4.067% |  |
| TOTAL REDUCTIONS\* | 12.9% | 3.8% | 55.569% | $322.60 (14.0%) |

Sources:

\*This represents the sum of the cuts. However, the cumulative impact is much greater as each cut affects the base rate on a permanent basis.

\*\* Reductions unrelated to adjustments made to achieve budget neutrality with case mix weight or wage index recalibrations

FY2001: <https://www.govinfo.gov/content/pkg/FR-2000-07-03/pdf/00-16432.pdf>

FY2002: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CMS-1147-NC.pdf>

FY2003: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1198nc.pdf>

FY2004: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/cms1473nc.pdf>

CY 2005: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1265f.pdf>

CY2006: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1301f.pdf>

CY2007: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/cms1304f.pdf>

CY2008: <https://www.govinfo.gov/content/pkg/FR-2007-08-29/pdf/07-4184.pdf>

CY2009: <https://www.govinfo.gov/content/pkg/FR-2008-11-03/pdf/E8-26142.pdf>

CY2010: <https://www.govinfo.gov/content/pkg/FR-2009-11-10/pdf/E9-26503.pdf>

CY2011: <https://www.govinfo.gov/content/pkg/FR-2010-11-17/pdf/2010-27778.pdf>

CY2012: <https://www.govinfo.gov/content/pkg/FR-2011-11-04/pdf/2011-28416.pdf>

CY2013: <https://www.govinfo.gov/content/pkg/FR-2012-11-08/pdf/2012-26904.pdf>

CY2014: <https://www.govinfo.gov/content/pkg/FR-2013-12-02/pdf/2013-28457.pdf>

CY2015: <https://www.govinfo.gov/content/pkg/FR-2014-11-06/pdf/2014-26057.pdf>

CY2016: <https://www.govinfo.gov/content/pkg/FR-2015-11-05/pdf/2015-27931.pdf>

CY2017: <https://www.govinfo.gov/content/pkg/FR-2016-11-03/pdf/2016-26290.pdf>

CY2018: <https://www.govinfo.gov/content/pkg/FR-2017-11-07/pdf/2017-23935.pdf>

CY2019: <https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf>

CY2020: <https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf>

CY2021: <https://www.govinfo.gov/content/pkg/FR-2020-11-04/pdf/2020-24146.pdf>

CY2022: <https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf>

CY2023: https://www.govinfo.gov/content/pkg/FR-2022-11-04/pdf/2022-23722.pdf

CY2024: <https://www.govinfo.gov/content/pkg/FR-2023-07-10/pdf/2023-14044.pdf>

CY2025: https://www.govinfo.gov/content/pkg/FR-2024-07-03/pdf/2024-14254.pdf

**Current Care Access Problems Are Expected to Significantly Increase with the Proposed Rate Cut**

In the CY 2024 rulemaking, the Alliance and others presented stunning evidence about the growing barriers to care access faced by Medicare beneficiaries since the onset of PDGM. This evidence was dismissed by CMS in its rulemaking responses for a variety of reasons including that causation was not established, the data analysis may have relied on duplication of patients, and that the rejection of a patient by one HHA did not automatically translate to rejection by all HHAs.

Such a position begs for something more than a dismissal of concerns. Instead, CMS, with its ability to evaluate global data on home health care access, must take steps to answer the questions posed through the analyses presented by HHAs and their representatives. CMS is best positioned to undertake that analysis. Something more from CMS than a casual dismissal of relevant data analysis is a CMS responsibility.

One of the CY 2024 rulemaking commenters, Homecare Homebase, took added steps for its CY2025 rulemaking comments on the extraordinarily relevant question as to what becomes of patients that are rejected for admission by an HHA. In using its vast database of Medicare claims and other data, the recent comments submitted by Homecare Homebase confirm the concerns that have been previously voiced. Its data analysis shows that 35% of referrals to its clients are rejected and do not find access with any other of its clients. Given the significant market share for Homecare Homebase, at a minimum this outcome warrants a deeper dive by CMS. Even if one-half of those referrals find an alternative HHA, the impact on patients and Medicare of the remaining half finding no care is unacceptable. When combined with the continuing reduction in the number of home health users annually since PDGM, an investigation is the duty of CMS.

Here are several previously referenced signs of the existing difficulties in care access:

Hospital discharge data shows that hospitals are facing a growing level of patient referral rejections for prospective home health patients. This has led to delays in discharging patients to their homes, and extending costly inpatient stays as reported by the American Hospital Association. <file:///C:/Users/wad/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/L69H8U3R/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf>

The delays in hospitals discharging patients to home health services is certain to create a significant cost to the hospitals, but also to Medicare.

A graph of a graph with a line

Description automatically generated with medium confidence

Source: July 25, 2023, WellSky Evolution of Care report, available at: https://careporthealth.com/about/results/the-evolution-of-care-2023/

Home Care Home Base, a large provider of EMR and billing services to HHAs further reports decreasing patient acceptance rates under the current PDGM payment rates.

A graph showing the number of covid-19

Description automatically generated

Source: HCHB data, as presented in HCHB comments on this Proposed Rule.

Finally, data analytics company, Care Journey explains that only 63% of inpatient discharges are securing and initiating home health services within 7 days.

A graph of blue and white text

Description automatically generated

We characterized this data as “scary” in our CY 2024 comments. It has gotten worse and all trends point o the decline to continue. HHAs routinely express to the ALLIANCE that nurses are rejecting home health care employment every day due to compensation offers that fall short of what they can earn in other care sectors. Reducing payment rates at this time will certainly make care access even worse.

**Additional Proposed Changes Affecting Medicare Payment Rate Will Greatly Increase the Disruptive Nature of the CY2024 Payment Rule Creating Further Risks to Care**

The above analysis fully substantiates THE ALLIANCE’s concerns that the proposed rate cut in 2024 will be a disaster for home health services patients and HHAs. However, there are additional elements of the proposed rule that affect payment that can be fully expected to compound the negative impact of that rate cut. These other proposals include:

* The failure to correct the unprecedented error level in the forecast of HHA cost changes in 2021-2022.
* Significant shifts in the wage index values.
* Recalibration of the 432 case mix weights.
* Market Basket Index rebasing and revision of input weights.

**The Financial Shortfall in the Market Basket Index Will Continue to Disrupt**

**the Financial Stability of HHAs**

CMS has confirmed that its modeling led to a Market Basket Index forecasting error for CY2021 through CY 2022. The Alliance previously estimated that error to be 1.8 and 3.2 points in 2021 and 2022 respectively. In previous rulemaking, CMS declined to correct the error indicating it did not have such authority.

As submitted in the Alliance’s CY 2024 NPRM comments, the estimated impact of that errorcast error is expected to result in an approximately $11 billion underpayment by Medicare over a ten-year period.

**Projected Impact of 5.2 Forecast Market Basket Error in CY 2021 through CY 2030**

|  |  |
| --- | --- |
| **Total Payments** | **Impact of CY 2021 and CY 2022 Forecast Error** |
| 2021 | -$285,512,085 |
| 2022 | -$867,452,091 |
| 2023 | -$871,874,624 |
| 2024 | -$1,115,186,361 |
| 2025 | -$1,161,316,235 |
| 2026 | -$1,225,352,343 |
| 2027 | -$1,273,931,221 |
| 2028 | -$1,342,554,653 |
| 2029 | -$1,394,931,985 |
| 2030 | -$1,449,139,655 |
| **Total** | **-$10,987,251,254** |

*Source: Dobson | Davanzo*

While CMS has not and is not likely to correct the error, the impact is nonetheless real for HHAs, creating another destabilizing force within the HHA community. When combined with the proposed rate reduction, the impact of significant swings in wage index values, and the recalibration of the 4432 case mix weights and resetting of the universe of LUPA thresholds, HHAs face multiple disruptions in operations that will affect patient access to care and the level of services available. The impact is not conjecture. Instead, it is a prognosis based on over a decade of experiences since 2011.

**Significant Shifts in Wage Index Values Add to the Destabilization**

**of the Home Health Benefit**

Once again, the changes in wage index values significantly contribute to the instability on access to the home health benefit. As CMS well knows, HHAs are relegated to the pre-rural floor, pre-geographic reclassification inpatient hospital wage index while HHAs compete with hospitals that are subject to a different wage index for the same clinical and administrative staff. For 2024, CMS implemented a recalibration of the assigned wage index values, but also a resetting of the labor percentage of payment rates affected by the wage index. For 2025, in addition to the usual swings in the wage index for HHAs, CMS proposes to modify the county-level designations in CBSAs and rural areas. Since the home health NPRM was issued, CMS finalized these changes for other health care sectors operating on a federal fiscal year basis. As such, the disruptive effect of the proposed wage index changes for home health can reasonably be presumed to be the reality for 2025 in home health services. These changes add to the complications wrought by the proposed rate reduction and other payment-affecting proposals.

The ALLIANCE compared the current 2024 wage index values with the proposed values post-5% cap, See, Appendix A attached).

**Home Health Providers Significantly Impacted by Wage Index Change in CY 2025**

|  |  |
| --- | --- |
| **Count** | **Number** |
| Counties with wage index value change >/= -0.02 | 597 |
| Counties with wage index value change >/= -0.03 | 370 |
| Counties with wage index value change >/= -0.04 | 246 |
| Counties with wage index value change >/= -0.05 | 71 |
| Counties with wage index value change >/= -0.06 | 27 |
| Counties with wage index value change >/= -0.07 | 9 |
| Counties with wage index value change >/= -0.08 | 5 |
| Counties with wage index value change >/= -0.09 | 2 |

The ALLIANCE recommends that CMS consider the impact of the wage index changes in determining whether to use its authority to postpone the proposed PDGM rate cuts to mitigate the expected overall access and care impacts already underway with home health services that will expand in 2025 with all these changes.

**Medicare Stands to Lose Out in the HHVBP Demonstration as a Result of Expected Care Changes Triggered by the Proposed Rate Cuts**

It was just two years ago that CMS moved to expand the successful Home Health Value Based Purchasing demonstration program from nine states to nationwide application. The ALLIANCE had been a supporter of the program in its initial design and fully supported the expansion. The program stood as one of the few value-based payment experiments to date with Medicare savings millions annually through reduced hospital admissions and more brought about through high quality home health services. CMS estimated that the nationwide expansion would reduce Medicare expenditures by nearly $3.4 billion over five years.

To get that savings takes dedication and innovation by HHAs. That effort also comes with a cost in resources. The proposed rule reducing payment rates by 4.067% and the combined effect of a 5.2% shortfall in the annual inflation update, a modified wage index, and the instabilities coming through case mix weight recalibrations are certain to diminish needed resources to succeed in HHVBP. There is only so much an HHA can do to produce the highest quality of care when the resources needed to deliver care are reduced. While we expect that HHAs will continue to provide an incredibly high quality of care as they have done following other rate reductions, we believe that they have reached a breaking point financially. As noted above, as rates of payment are decreased, access to care and the level of care available also decrease. These changes are bound to affect patient outcomes and the success of HHVBP.

The proposed rate reduction may be viewed by some as CMS’s lack of respect for the value of home health services, which is at odds with the objective evidence in HHVBP that home health care brings a dynamic value to Medicare and the patients its serves. The ALLIANCE believes that CMS maintains an understanding of the value of home health services and will recognize the need to preserve that value by postponing the proposed rate cut in 2025.

**The ALLIANCE Maintains That the Methodology Applied by CMS to Determine Whether PDGM Is Budget Neutral Is Noncompliant with the Statutory Mandate**

In the 2022 and 2023 HHPPS rulemaking, THE ALLIANCE strenuously expressed its view that the budget neutrality assessment methodology used by CMS was fatally flawed both logically and under Medicare law. That view was supported by two independent legal analyses from highly respected law firms that included attorneys formerly with the CMS/HHS Office of General Counsel. The ALLIANCE will not repeat all the arguments presented to support that position.

While the U.S. District Court for the District of Columbia dismissed the case on the basis of failure to exhaust the remedy of seeking expedited judicial review, the matter will be eventually refiled once that administrative step concludes. However, it is clear that with the normal time involved in administrative appeals and the normal pace of litigation, it is unexpected that the matter will be resolved prior to January 1. 2025 effective date of the Final Rule that comes out of the pending proposed rule. For that reason, The ALLIANCE respectfully requests that CMS use its authority under 42 USC 1395fff to postpone the proposed 4.067% rate cut as the great harm outlined above must be avoided.

**RECOMMENDATIONS:**

1. **CMS should postpone application of any permanent adjustments related to PDGM budget neutrality to preserve current access to home health services and the scope of care available.**
2. **CMS should maintain its proposed position to withhold any part of the PDGM budget neutrality temporary adjustments in 2025.**
3. **CMS should recognize the disruptive and permanent financial impact of its forecasting error with respect to the annual Market Basket Index updates from 2021 and 2022 and implement a one-time adjustment to account for the 5.2% forecasting error.**
4. **CMS should consider the negative and disruptive financial impacts of its proposed wage index changes and case mix weight recalibrations on care access as it finalizes the 2025 payment rates and any systemic reforms.**

**ADD OTHER COMMENTS**

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

**D. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning With the CY 2027 HH QRP.**

CMS proposes collecting one item that addresses living situation, two food items, and one for utilities, along with a proposal to modify the currently collected transportation assessment item using the Outcome and Assessment Information Set (OASIS) data set. The Alliance supports collecting these additional social determinants of health (SDOH) data items. Although HHAs consider these SDOH for effective care planning, there is no standardized mechanism for collecting and reporting the data, which could provide valuable information for HH QRP and other federal programs. CMS might want to consider in future rulemaking to include the AHC HRSN core questions screening tool within the post-acute care (PAC) assessment instruments if there are plans to continue to propose and adopt items from the tool.

However, we have concerns with the frequency that CMS has modified the HH QRP necessitating updates to the OASIS data set over the last several years. The addition of the proposed new and modified items will require yet another revision of the OASIS data set to be issued sometime in 2026 to accommodate the January 1, 2027, proposed collection date.

Since the implementation of the Improving Medicare Post - Acute Care Transformation (IMPACT) Act there have been multiple revisions to the OASIS data set to accommodate the development of standardized assessment items and cross setting measures as required by the Act. HHAs have had to adjust to a revised OASIS data set and instructions in 2019, 2020, and 2023[[1]](#footnote-1). The last revision related to the IMPACT Act requirements was implemented in 2023 (OASIS E). However, CMS continued to implement additional changes to the HH QRP requiring another revision to the OASIS data set, effective January 1, 2025. CMS, again, is proposing additional changes to be implemented in 2027.

Changes to the OASIS data set, even small changes, increase resource use for agencies in terms of staff training, coordination with vendors, and altered productivity associated with the learning curve required for collecting new material. The burden is magnified by increased rate cuts and a protracted workforce shortage. Also, the addition of assessment items without modifications to reduce the data set could result in a very lengthy assessment tool.

An additional concern with frequent changes to the HH QRP is the delay in data reporting for HHAs. HHAs have consistently been the last of the PAC settings subject to the IMPACT Act to have their data set modified for cross setting assessment items and quality measures.  CMS has convened technical expert panels to address inclusion/exclusion of cross setting assessment items and measures based on data derived from the other PAC settings without the home health data being accessible to the participants or the home health agencies themselves.

**Recommendations:** CMS should:

1. Limit revisions to the OASIS data set to intervals no less than 4 years from the last revision.
2. Considered imbedding the AHC-HRSN core question screening tool into the PAC assessments if feasible.
3. Monitor additions to the OASIS data set to ensure that the tool is manageable for HHAs.
4. Provide sufficient data on HHA quality measures and assessment items prior to implementing any changes in the OASIS data set.

**G. HH QRP Quality Measure Concepts Under Consideration for Future Years— Request for Information (RFI)**

CMS is seeking feedback on four measure concepts that are part of the “Universal Foundation” of quality measures. The measures include immunizations (i.e. Adult Immunization Status measure); depression (i.e. Clinical Screening for Depression and Follow-up measure); pain management; and substance use disorder (i.e. Initiation and Engagement of Substance Use Disorder Treatment measure).

**Immunization - Adult Immunization Status measure:**

The recommended measure for the immunization concept includes the following vaccine rates and reasons for not receiving the vaccine.

Four individual vaccine rates: 1. Influenza rate: Beneficiaries who received an influenza vaccine on or between July 1 of the year prior to the Measurement Period and June 30 of the Measurement Period. 2. Td/Tdap rate: a. Beneficiaries who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the Measurement Period and the end of the Measurement Period, or b. Members with a history of at least one of the following contraindications any time before or during the Measurement Period: i. Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine. ii. Encephalitis due to the diphtheria, tetanus, or pertussis vaccine. 3. Zoster rate: Beneficiaries who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, anytime on or after the beneficiary's 50th birthday and before or during the Measurement Period, or beneficiaries with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period. 4. Pneumococcal rate. Beneficiaries who were administered at least one dose of adult pneumococcal vaccine on or after their 19th birthday and before or during the measurement period, or beneficiaries with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.

HHAs would not have access to information on the multiple vaccination status of patients without a tremendous amount of research across a patient’s medical records and /or interviews with practitioners familiar with the patient. HHAs will likely have to rely on the patient’s recall of their vaccination status, leading to inaccurate or misleading responses. The burden for HHAs to collect multiple vaccine rates far out weights any benefit that could be derived from collecting the information. Additionally, many of the provider representatives on thePost-Acute Care (PAC) and Hospice Quality Reporting Program Cross-Setting Technical Expert Panel[[2]](#footnote-2) did not support the measure for the reasons associated with the burden to collect the information. Therefore, we believe that the measure concept, as proposed, is not appropriate for the home health setting from a practicable standpoint.

**Recommendation:** CMS should not consider including in the HH QRP the “Adult Immunization Status” measure, or any similar measure related to vaccinations that requires extensive review of data sources.

**Depression- (i.e. Clinical Screening for Depression and Follow-up measure)**

The typical HHA is not set up to treat patients presenting with depression. Interventions to address a positive depression screen would not be within the HHAs control to facilitate without significant resources and an infrastructure to address a depression diagnosis. Additionally, home health patients are often discharged from services before any outcomes through community referrals can be realized.

If CMS were to include a measure for depression screening and follow-up, the follow-up would need to be limited to a referral to the patient’s PCP for further interventions. HHAs cannot be expected to provide intervention aimed directly at treating depression such as pharmacological interventions or other follow-up that involves long term planning.

**Recommendation**: CMS must consider the limitations for HHAs to address a depression diagnosis when considering the measure concept for the HH QRP

**Substance use disorder ( i.e. Initiation and Engagement of Substance Use Disorder Treatment measure).**

Like the depression diagnosis, HHAs are not set up to address patients with a substance use disorders (SUD), either as a primary or secondary diagnosis. HHAs are even less likely to accept a patient onto service with an active SUD due to their inability to effectively provide interventions or ensure that community support is available for the treatment of the disorder. Patients with a SUD require interventions provided by specially trained clinicians to treat SUD, along with intensive therapies. There is a known shortage of these clinicians and programs within most communities, and the typical HHA does not have specialty trained clinicians on staff. A HHAs would have limited control over the availability of such programs much less the interventions provided. Additionally, there is no data source currently available that captures SUD and interventions for home health patients, therefore, an added burden will be created for agencies to collect and report data needed for the measure concept.

As such, a measure concept for patients with SUD in the home health setting is not appropriate, particularly as described in the suggested measure for this concept.

**Initiation and Engagement of Substance Use Disorder Treatment -measure description**

1. Percentage of patients 13 years of age and older with a new substance use disorder (SUD) episode who received the following (Two rates are reported):
   1. Percentage of patients who initiated treatment, including either an intervention or medication for the treatment of SUD, within 14 days of the new SUD episode.
   2. Percentage of patients who engaged in ongoing treatment, including two additional interventions or short-term medications, or one long-term medication for the treatment of SUD, within 34 days of the initiation.

**Recommendation:** CMS should not move forward with a measure concept related to SUD for inclusion in the HH QRP.

**Pain management**

The Alliance supports performance measures around pain management and has relevance for home health patients. However, CMS removed the improvement in pain management measure from the HH QRP in 2020 due to the opioid crisis. Therefore, it is unclear what CMS is seeking in terms of a pain management performance measure in the current environment.

**IV. The Expanded Home Health Value Based Purchasing (HHVBP) Model**

**B. Request for Information on Future Performance Measure Concepts for the Expanded HHVBP Model**

CMS is seeking information on four measure concepts for inclusion in the HHVBP: family caregiver measure; falls with injury (claims-based) measure; Medicare Spending per Beneficiary measure; and function measures to complement existing cross-setting Discharge (DC) Function measure:

**Family Caregiver Measure**

The measure would address whether the needs of caregivers for home health patients have been met. CMS does not provide much information on exactly what is to be measured and how this measure would be constructed. Therefore, it is difficult to comment in support of the measure concept. The immediate concern is the additional burden around data collection for the measure. CMS would likely need to revise the standardized assessment tool or modify the HH CAHPs survey, which are already lengthy tools, for collecting and reporting of the data. Additionally, an HHA’s focus is on the care of patient and not the needs of the caregiver. Further, it is unknown if a measure can be developed that accurately reflects whether a caregiver’s needs have been met. It is also questionable whether a measure can be developed that will allow for accurate comparisons among HHAs.

**Recommendation:** CMS must consider the complexity and potential burden for data collection when developing a measure to address the needs of the family caregivers for home health patients.

**Fall with injury (Claims Based) measure**

The Alliance has the same concern with a potential claims-based measure for falls as it does with the OASIS based measure. The falls with injury measure (claims or OASIS based) does not take into consideration the nature of home health services. Care is provided on an intermittent basis with the focus on the home environment. The measure will capture a fall with injury anytime during the home health episode irrespective of whether the HHA had any control over the patient’s movements. For example, the patient falls while outside the home, such as on the way to the physician’s office. Fall prevention programs aimed at safety in the home for a particular patient might not be transferable to the general community setting.

**Recommendation.** CMS should not include the falls with injury measure into the HHVBP

**Medicare Spending per Beneficiary (MSPB)**

It is unclear how CMS intends to use the MSPB measure in the HHVBP. It is important to note that the MSPB measure is not a quality measure but a measure for Medicare spending. The measure is assumed to be a measure of efficiency if the HHA’s MSPB is less than the Medicare spending of the national median home health agency’s MSPB. However, a lower spend on care does not necessarily translate into efficient provision of services, it could, in fact, reflect that a there is stinting on care.

**Recommendation:** CMS should not include the MSPB measure in the HHVBP.

**Function measures to complement existing cross-setting Discharge (DC) Function measure:**

**Recommendation:** The Alliance supports the inclusion of additional function measures in the HHVBP that complement the DC Function measure.

**3. Requests for Information**

**a. RFI Regarding Rehabilitative Therapists Conducting the Initial and Comprehensive Assessment**

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

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

The clinical professionals (therapist and registered nurses) would be expected to have the skills necessary to conduct an initial and comprehensive assessment of a patient, and therefore when permitted by regulation, be able to conduct the assessments as needed. HHAs provide all professional staff with additional training specific to the agency policies and procedures, completing the OASIS data set, and the home health setting. Additionally, new hires to HHAs are typically expected to go through some type of orientation and period of supervision to determine their readiness for providing home health services. The orientation and supervision would be tailored to the individual’s clinical skills and needs.

**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?**

In discussion with representatives from the profession associations for physical therapy, occupational therapy, and speech language pathologist (American Physical Therapy Association (APTA), American Occupational Therapy Association, (AOTA) and the American Speech-Language Hearing Association (ASHA)) all concurred that the education and training prepare the respective therapists adequately to conduct an initial and comprehensive assessments on home health patients. CMS notes in the proposed rule the specific training required by each discipline.

PTs must hold a Doctor of Physical Therapy. The curriculum includes the general clinical skills required to conduct the initial and comprehensive assessments, 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, and clinical experience.

SLPs must obtain a Certificate of Clinical Competence in Speech-Language Pathology as well as state licensure. SLP must obtain a master’s, doctoral, or other recognized post-baccalaureate degree. Once students complete all academic coursework and a graduate student clinical practicum, they must also complete a clinical fellow.

OTs must hold either a master’s degree or Doctorate of Occupational Therapy. Education programs are accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the AOTA. The ACOTE establishes, approves, and administers educational standards to evaluate occupational therapy educational programs. Graduates of ACOTE accredited programs are eligible to take the National Board for Certification in Occupational Therapy (NBCOT) certification exam and apply for State licensure

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

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

Home health agencies did not report any challenges with exercising that waiver that expanded the role of therapists in conducting the initial and comprehensive assessments. Nor was there any evidence that quality of care for patients was impacted, suggesting that assessments conducted by therapist were assessment were completed accurately.

**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?**

Because the regulations permit a therapist to conduct the initial and comprehensive assessments if therapy is the only discipline ordered, there has always been precedent for a therapist to conduct the assessments. Long before the PHE, we had advocated for a change in the regulations at §484.55 that provides a similar flexibility as the PHE waiver.

HHAs have overwhelmingly reported that this flexibility was most beneficial during the PHE in their ability to provide care to patients requiring home health services and was the most widely used of all the PHE waivers. The application of that waiver into HHA operations during the PHE had the same effect as a three-year demonstration project.

During that time there were no adverse effects on the quality of care for home health patients, with many agencies reporting that the waiver allowed them to maintain timely initiation of care. The waiver was particularly beneficial for patients in rural areas where workforce shortages were, and remain, the most profound.

**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?**

The recent Medicare payment cuts to HHAs and the workforce shortages have significantly impacted HHAs in rural areas. Rural providers have unique challenges that include longer travel distances between visits and greater competition for qualified workers. Additionally, home health therapists and nurses often serve as the primary source for health evaluations and care delivery in underserved areas. Rural agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and integrate the use of technologies in agency operations. As a result, agencies have been forced to reduce service areas and refuse admission to patients whose care costs would place an agency at financial risk.

Reports from our rural provider members have sounded the alarm with closures and service area reductions. For example, one agency in rural Nebraska reported having to downsize from serving 13 counties (60-mile radius) to serving only one county (25- mile radius) with a drop in the average daily census (ADC) by 60% since 2020. An agency in rural Vermont has reduced its service area by a third with ADC down by nearly 50% over the past year. The state of Missouri alone has lost 56 home health agencies to closure since August 2017, and 14 of those just in the last 18 months. Sixty-six percent of these closures were in rural areas. It is reasonable to believe that this pattern of care delivery reductions and HHA closures is being repeated throughout rural America.

**b. Plan of Care Development and Scope of Services Home Health Patients Receive**

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

Most HHAs do, or strive to, provide all services permitted under the home health benefit. Limitations to the services an agency provides is usually driven by available staff. Agencies report having difficulty recruiting and retaining nurses and home health aides, although we are also hearing of reports of difficulty in recruiting and retaining all discipline types, particularly in rural areas. Therefore, the change in services provided is often dictated by market forces and the availability of certain categories of staff.

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

HHAs currently report that the most common reason for having to turn down referrals is because of workforce shortages particularly for nurses and home health aides, although HHAs also report difficulty in recruiting all disciplines to some degree. Home health patients are being referred to home health with more complex conditions requiring multiple disciplines and front loading of visits that the HHA may not be able to provide. Home health is experiencing a perfect storm of challenges whereby patients have greater needs, but the workforce is at critical low.

Other reasons include incomplete referrals, particularly where the referral sources is not able to identify a community provider to follow the patient or have the wrong provider listed. If the HHA cannot locate a practitioner to follow the patient timely, it places both the patient and agency at risk.

Discharge planners in acute/post-acute care facilities often routinely refer beneficiaries to home health care, irrespective of whether the beneficiary meets coverage criteria. It is not uncommon for inpatient referral sources to include a multitude of services on a referral respective of the needs of the patient. The HHA must explain to the beneficiary why they do not meet coverage criteria for some, or all, of the services.

**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?** Stil thinking about this one, varies by practitioner

**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?**

Community practitioners rely on the HHAs evaluation and reports to inform the plan of care. If a patient is being referred to home health from an acute/post-acute care facility the patient will have been followed by a hospitalist and/or a skilled nursing facility Medical Director who refers the patient to home health. The patient’s primary care practitioner (PCP) resumes care only upon the patient’s return home. The HHA is usually the first contact the patient has with a community healthcare provider. Therefore, the HHA’s evaluation of the patient’s condition and care needs relative to the home setting is necessary for effective care planning by the community practitioner. Even when a referral is received from the community PCP, the HHA provides a unique perspective for care planning in the individual’s home.

**What are the patient and caregiver experiences in receiving nursing, aide, and therapy services when under the care of a home health agency?**

Sources for this information include the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey and the HHA complaint logs.

**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?**

CMS’ discussion on negative outcomes for patients largely addressed those patients who were unable to access home health services timely. CMS cited several publications that addressed the workforce shortages related to the COVID-19 PHE. It is unclear what additional evidence CMS is seeking.

**In what ways can referring providers and HHAs improve the referral process?**

Improved communication between referral sources and HHAs with consistent feedback regarding necessary information needed for a complete referral, coverage criteria for beneficiaries to receive Medicare covered home health services, and the HHAs capacity for acceptance with anticipated referrals.

CMS should support and encourage interoperability of health care information across providers. Interoperability will help facilitate the referral process by allowing HHAs to obtain the necessary information regarding the patient’s current condition and care needs along with the past medical history and any social determinants of health that might impact care planning and delivery

**What other factors may influence the provision of services that impact the timeliness of services and service initiation**? Still thinking about this one.

**What additional areas should CMS consider addressing HHA patient health and safety concerns?**

Still thinking about this one

**VI. Home Health CoP Changes and Long Term (LTC) Requirements for Acute Respiratory Illness Reporting**

1. **Home Health CoP Changes**

CMS claims they have received an increasing number of beneficiary complaints related to the difficulty finding a HHA to accept them for service. Beneficiaries complain that in some instances, HHA services are being altered or diminished from the original plan of care without an accompanying reduction in patient needs or achievement of the measurable outcomes and goals set forth in the plan of care.

In addition to the challenges of finding the right HHA and resultant potential delays in the timely initiation of home health care, CMS also expressed concerned that HHAs are at higher risk of overextending their available resources when accepting new patients to HHA services. Delays in service initiation may indicate not only that referral sources have difficulty locating an appropriate HHA, but also that HHAs are accepting patients when and for whom they are not capable of delivering timely care

To this end, CMS is proposing at § 484.105(i)(1)(i) through (iv), that HHAs would be required to include information regarding the HHA’s case load and case mix (that is, the volume and complexity of the patients currently receiving care from the HHA), anticipated needs of the referred prospective patient, the HHA’s current staffing levels, and the skills and competencies of the HHA staff. These proposed elements are designed to inform an HHA’s assessment of its capacity and determine its suitability to meet the anticipated needs of the prospective patient that has been referred for HHA services.

CMS also proposes at § 484.105(i)(2), that HHAs make public accurate information regarding the services offered by the HHA and any limitations related to the types of specialty services, service duration, or service frequency, and that HHAs review that information annually or as necessary.

The Alliance has concerns with CMS’ proposal for the acceptance to service requirements, which include a prescribed acceptance to service policy and a requirement for HHAs to make publicly available information limitations on services, frequency and duration. The concerns CMS expresses around beneficiary access to home health services are not related to an agency’s process for accepting admissions. There are multiple reasons HHAs are not able to accept patients onto services, for example, available resources, an inability to identify a community practitioner, coverage criteria is not met, care needs are inappropriate for home setting, to name a few.

However, in the current environment, the main reason beneficiaries are not able access home health services is because HHAs do not have the capacity to accept all referrals. HHA capacity continues to shrink because of the increasing cost of providing services along with reduced reimbursement and an ongoing workforce shortage

Deep labor shortages, particularly in nurses and home health aides continue to be a challenge. HHAs are having an even greater time recruiting and retaining staff because of its precarious financial status that does not permit competitive compensation to clinician in comparison to hospitals and other care settings. HHAs are fully reliant on payments from Medicare, Medicaid, Medicare Advantage, and other government-based programs that have not raised reimbursements commensurate with labor. Resources are further strained by changes in operational policies.

For example, CMS’ policy for the collection and reporting of the OASIS data set on all patients beginning in 2025. This policy alone has an unfunded $267 million price tag for HHAs, and for some HHAs, will have a significant impact on the availability for staff to meet the expanded collection requirement. Additionally, the nationwide Home Health Valiue Based Purchasing program and the Review Choice Demonstration requires HHAs to expend additional resources and disrupts operations. CMS must be mindful of the impact policies implemented by federal agencies have on HHA resources and operations.

We are hearing increasing reports of HHAs receiving referrals for which there is not a community provider to follow the patient. The patient either has not identified a community practitioner or the referral source indicates an incorrect primary care practitioner. Referring patients to a HHA without identifying a community practitioner raises significant safety concerns for patients and liabilities for agencies. Because the HHA must conduct the initial evaluation visit within 48 hours of a patient’s return home or referral, many HHAs will not accept these patients even if they believe a practitioner can be identified readily.

CMS’ also expresses concern that “*delays in service initiation may indicate not only that referral sources have difficulty locating an appropriate HHA, but also that HHAs are accepting patients when and for whom they are not capable of delivering timely care*” CMS seems to be setting policy on an assumed effect of delays in services and does not provide any analysis on the scope of the problem or types of patients that have or maybe impacted. CMS only states that they are “..*aware of anecdotal reports of home care agencies not providing care to meet patient needs.”*

Although staffing changes can impact services provided and there will always be unforeseen circumstances, in any health care setting, that may alter capacity, HHAs do not routinely admit patients for which they cannot provide services. HHAs have admission policies in place that take into consideration the agency’s capacity and clinical skills of staff when determining whether to accept a patient onto services. Additionally, there are standards at §484.60 to ensure HHAs only accept those patients for whom there is a reasonable expectation that the agency will be able to meet the patient’s needs.

CMS proposals for an acceptance to service policy and requiring HHAs make publicly available information on the HHA’s service, duration and frequency, do not address the root causes around beneficiary access to home health services, and therefore, will not likely help to mitigate the problem. An acceptance to service policy as proposed will not increase an agency’s capacity or help to address many of the other reasons for non-acceptance onto services. In terms of transparency and HHAs making publicly available information on services offered, many agencies list on their website the services they provide. This information is also available on the CMS Care Compare website. Perhaps referral sources are not consulting these resources. Also, there is confusion around what CMS expects regarding the HHA’s listing limitations on frequency and duration of services that is to be made publicly available.

Furthermore, we have concerns with CMS’ following stated position.

“…*if an HHA accepts payment from both Medicare and another payment source, ‘‘source X,’’ the HHA’s referral policy should be applied consistently to referrals for patients having Medicare or ‘‘source X’’ as a payment source. 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*.”

Bill is to develop comments on this piece

Recommendations: CMS should:

* Withdrawal its proposal at § 484.105(i)(1)(i) through (iv), for an acceptance to service policy and to require HHAs make publicly available information on services, and limitations on frequency and duration.
* Continue to seek feedback from stakeholders to determine the root cause for the decreases in patient access to home health services.

**Conclusion**

Thank you for the opportunity to submit these comments. As you will note from our comments, we take this process very seriously and we are confident that CMS will give our comments thoughtful consideration as well. The contents of the proposed rule will have a significant impact on the abilities of HHAs to serve individuals in need of essential home health services.

Very truly yours,

A close-up of a signature

Description automatically generated

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**2023 State Association Co-signers**

**Arizona Association for Home Care**

**HomeCare Association of Arkansas**

**California Association for Health Services at Home**

**California Hospice and Palliative Care Association**

**Home Care Association of Colorado**

**Connecticut Association for Healthcare at Home**

**Home Care Association of Florida**

**Healthcare Association of Hawaii**

**Idaho Health Care Association**

**Illinois Homecare & Hospice Council**

**Indiana Association for Home and Hospice Care**

**Iowa Center for Home Care**

**Kansas Home Care & Hospice Association**

**Kentucky Home Care Association**

**Home Care Association of Louisianna**

**Home Care & Hospice Alliance of Maine**

**Maryland-National Capital Homecare Association.**

**Home Care Alliance of Massachusetts**

**Michigan HomeCare and Hospice Association**

**Minnesota Home Care Association**

**Mississippi Association for Home Care**

**Missouri Alliance for Home Care**

**Nebraska Association for Home Healthcare and Hospice**

**Home Care & Hospice Association of New Jersey**

**New Mexico Association for Home & Hospice Care**

**Home Care Association of New York State**

**Association for Home & Hospice Care of North Carolina**

**Granite State Home Health & Hospice Association (NH)**

**Ohio Health Care Association**

**Oregon Association for Home Care**

**Pennsylvania Homecare Association**

**Rhode Island Partnership for Home Care**

**South Carolina Home Care & Hospice Association**

**Tennessee Association for Home Care**

**Texas Association for Home Care and Hospice**

**Homecare and Hospice Association of Utah**

**VNAs of Vermont**

**Virginia Association for Home Care and Hospice**

**Wisconsin Association for Home Health Care**

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