July 28, 2023

Submitted via regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
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: Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update Proposed Rule

Dear Administrator Brooks-LaSure,

With urgency, the National Association for Home Care & Hospice (NAHC) and the Partnership for Quality Home Healthcare (the Partnership) submit this initial comment letter to highlight the major threat that the Centers for Medicare & Medicaid Services (CMS) CY 2024 reimbursement proposals for Medicare home health agencies (HHAs) pose to beneficiary access to the Medicare home health benefit. We urge corrective action in the final rule to avoid substantial harm to the delivery of skilled care in patients' homes.

NAHC was established in 1982 and is the largest trade association representing the interests of HHAs and hospices nationwide, including nonprofit, proprietary, urban and rural based, hospital affiliated, public and private corporate entities, and government providers of home care. NAHC members provide most Medicare home care services throughout the U.S. The Partnership was established in 2010 to work in concert with government officials to ensure access to quality home healthcare services. The Partnership is dedicated to developing innovative reforms to improve the program integrity, quality, and efficiency of home healthcare for our nation's seniors.

The purpose of this letter is to sound the alarm for CMS, which bears critical responsibility for overseeing the Medicare program. The cuts proposed by CMS in the CY 2024 HH PPS Proposed Rule ("the Rule") must not be finalized. Doing so risks irreparable fracturing of the foundation of skilled home health care in America and the erosion of seniors' ability to receive care in their home. Irrespective of our long-standing opposition to the methodological approach that CMS is using to calculate these home health cuts – with which we continue to vehemently disagree – we now urgently ask you to evaluate the impact that your decisions in the final rule will have on beneficiaries and on the Medicare program itself, and we request that you take steps to reverse course before these cuts create a fully unsustainable future for Medicare home health.

I. Overview of CMS' Proposal

In the CY 2024 Home Health Proposed Rule, CMS is proposing to apply an additional -5.653% permanent cut to Medicare's HHA rates, which already reflect a -3.925% reduction put in place for CY 2023. This amounts to a -9.356% cut that would apply in perpetuity. In 2024 alone, by CMS's own calculations, the -5.653% cut would remove $870 million from the home health benefit. On top of these permanent cuts, CMS is also proposing that an additional $3.44 billion in cuts be levied under the "temporary adjustment" authority at some point in the near future. Medicare's home health benefit in Parts A and B totaled approximately $16.1 billion in annual spending in 2022, meaning temporary cuts to claw back that amount will have severe and longstanding consequences, no matter how CMS moves forward.

II. The Proposed Rate Cuts Are a Threat to Home Health Access

Reducing reimbursement rates causes reduced access, particularly when an aggregate rate cut is significant. For Medicare home health, cuts (actual and proposed) would total nearly 10% over a period of two years if the CY 2024 HHA rate is finalized as proposed.

CMS already recognizes the clear connection between rate reductions and access reductions. In CMS' recent proposed rule on Medicaid home and community-based services (HCBS), the Agency is proposing that States must conduct thorough access analyses when proposing "rate reductions or payment restructurings" in order to assure that such proposed rate reductions will not hinder access to care.[1] Specifically, CMS proposes in the HCBS rule that a State's proposals to reduce rates or restructure payments for HCBS services must not result in more than a 4 percent aggregate reduction to any particular benefit category.[2] Under CMS's own terms for HCBS, it should be abundantly clear that a -5.653% cut to the Medicare home health (on top of a nearly 4% cut in the prior year) is too deep and will jeopardize access to HHA services.

The cost of delivering care in the home – like everything else in the American economy – has increased far faster in recent years than historical averages. Inflation and documented work shortages following the COVID public health emergency have pushed key cost inputs, primarily nursing and clinician wages, higher – sometimes precipitously. In many places, the salaries for skilled clinical workers have increased by double digit percentages year-over-year. At the same time, the U.S. Treasury has repeatedly increased borrowing rates. Supplies, including fuel, cost more than they used to. Yet, CMS is choosing to propose massive cuts that would put the Medicare home health benefit at grave risk.

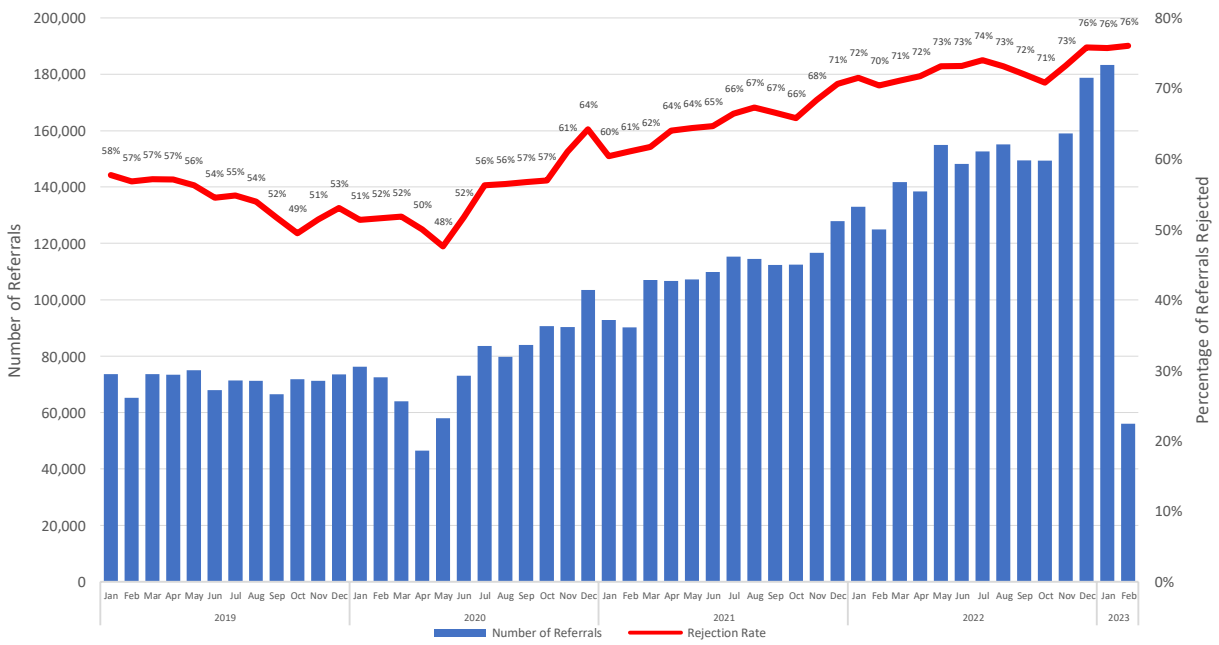
In this environment, access to home health care is already falling at an alarming rate in wake of the initial cuts from CMS' implementation of the Patient Drive Groupings Model (PDGM). According to a CarePort survey of HHA referral data from more than 2000 hospitals and health systems across the country, HHA referrals for Medicare beneficiaries are increasingly being rejected by HHAs, rising to an

[1] CMS "Medicaid Program; Ensuring Access to Medicaid Services" 88 Fed. Reg. 27960, 28025-28036 (May 3, 2023) and proposed 42 CFR § 447.203(c) at 88 Fed. Reg. 28087. Specifically 42 CFR § 447.203(c)(1)(ii) mandates that a state's rate reduction proposal must not reduce rates for any benefit category by more than 4% total in any given fiscal year.

[2] *Id*. at 28088, proposed 42 CFR § 447.203(c)(1)(ii).

all-time high at an average of 76% in December 2022, up from 54% in 2019 (chart 1).[3] This comports with reports from hospitals that indicate that referrals to home health, in order to successfully transition patients from hospital to home, are increasingly problematic, impeding the discharge process.

Chart 1: Average Referral Rejection Rate to HHA



At the same time, survey data from Homecare Homebase indicates that the percentage of rejections due to staffing shortages have risen too – from 3.8% at the beginning of 2020 (when the PDGM was first implemented) to 12.1% at the beginning of 2023 (chart 2).

Chart 2: Percentage of Rejected Referrals due to Staffing

[3] CarePort®, 2023 Evolution of Care Report, released July 25, 2023.

Together, these trends indicate that patients referred to HHAs are now less able to receive HHA care. Importantly, these patients who are not taken into the care of an HHA do not simply disappear. Rather, they often are instead directed to institutional settings that cost far more and are typically a non-preferred care setting. Patients who cannot access home health may also go home without adequate support, leading to grave outcomes discussed below.

Indeed, CMS reports that in 2019 there were 3,281,493 Medicare enrollees that used home health services with a total of 100,229,366 visits at 30.54 visits per person. In 2021, there were 3,018,466 Medicare enrollees that used home health services with a total of 76,785,088 visits at 25.44 visits per person. This represents a decline of 263,027 Medicare enrollees using home health services, with a total decline of 23,444,278 visits, or 5.10 visits per person. These trends reflect a number of factors, but CMS's implementation of PDGM and resulting rate cuts have undeniably contributed to declining access to home health services for Medicare beneficiaries.

III. The Impact of Reduced Access for Medicare

CMS must show concern for what happens to beneficiaries who are unable to access the HHA care to which they are directed. Using 2022 claims data from the Medicare program, the "cost" of reduced HHA access can be quantified. CareJourney analysis shows that approximately 20.5% of all short-term acute hospital discharges in 2022 were directed to HHA care as the discharge destination. However, of those beneficiaries directed to HHA care following their hospital stay, only 63% were successfully converted to HHA care within 7 days of discharge. It is also notable that, of these patients referred for HHA care, racial and ethnic minorities and dual eligible beneficiaries were far less likely to obtain HHA care than white patients. This points to a looming health equity imbalance in home health care that will only worsen with new cuts.

The disparity of quality and health outcomes is striking between the 63% of Medicare beneficiaries referred to HHAs who successfully converted versus those 37% that do not. CareJourney finds that, among the beneficiaries directed to HHAs following hospital discharge, those that received home health services within 7 days of discharge saw:

- substantially lower emergency department rates during the 90 days following discharge compared to those who went home without services: 24.3% versus 28.3%, respectively.
- substantially lower readmission rates in 90 days following discharge compared to those who went home without services: 29.2% versus 39.6%, respectively.
- substantially lower mortality rates in 90 days following discharge compared to those who went home without services: 8.1% versus 11.6%, respectively.

Home health saves lives while saving Medicare Trust Fund dollars, yet CMS's steep rate reductions have already produced a measurable decline in access to HHA care.

IV. Conclusion

Home health agencies face numerous challenges providing high quality care to their patients. The current economic environment for home health, with dramatically increased costs associated with clinical staff, medical supplies, fuel, and other inputs to care, is not reflected in CMS' payments. Rather, annual updates are simply used by CMS to show an offset for significant cuts in payments and, in any case, do not reflect real increases in providers' costs. CMS' own data shows a -5.2 percent error in the market basket updates for home health in 2021 and 2022. The long-term economic impact to the home health payment system of this forecast error alone will have reduced vital reimbursement to the Medicare home health program by $9 billion over a ten-year period. In addition, increasing enrollment in Medicare Advantage results in further reductions in payments for many providers.

More importantly, Medicare beneficiaries are harmed as access to care is further eroded as a result of the continued cuts to the Medicare home health benefit that have no foreseeable end due to the policies and approach CMS is pursuing. We plan to provide more data on how access has been eroded in our full comments to the final rule, however, the data provided above should be cause for concern.

NAHC and the Partnership strongly encourage CMS to exercise discretion to reverse, delay, or at the very least significantly moderate the cuts it has proposed for CY 2024 and to work together with providers to ensure access to a sustainable home health benefit for beneficiaries. The future viability of the Medicare Home Health Program depends on it.

Sincerely,

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