August 26, 2024
Electronic Submission via Regulations.gov

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1803-P
Re: CMS-1803-P, CY 2025 Home Health Prospective Payment System (PPS) Proposed Rule

Dear Administrator Brooks-LaSure,

Well Care Health ("Well Care") thanks the Centers for Medicare and Medicaid Services ("CMS") for the opportunity to respond to the CY 2025 Proposed Rule ("Proposed Rule") and respectfully submits the following information regarding the impact of the Proposed Rule. Based on Well Care's deep experience delivering home health services with industry-leading quality of care, we express our **significant concerns** about the Proposed Rule. In addition to these comments, Well Care fully supports the detailed responses submitted by the National Association for Home Care and Hospice (NAHC) and Home Care Home Base (HCHB).

Specifically, we seek to emphasize the following points for your consideration:

1. The Proposed Rule's substantial reimbursement cuts are disconnected from the reality of delivering home health services in the current operating environment;
2. Significant continued shifts in wage index values contribute to the destabilization of the home health benefit;
3. The Proposed Rule threatens to reduce much-needed access to home health services, especially for rural communities and higher-acuity patients;
4. The Proposed Rule's payment cuts would foreseeably have the counter-productive and negative impact of increasing overall Medicare program expenditures;
5. The Proposed Rule suffers from several notable flaws in its methodology; and
6. Well Care has multiple areas of feedback in relation to the Proposed Rule's updates to the HHVBP and HHQRP.

Well Care is **deeply concerned** about the negative impacts of the Proposed Rule's payment cuts on our ability to serve home health patients across the Carolinas, as well as its overarching impact on home health providers across the country.

As background, Well Care is a family-owned and operated Home Health and Hospice Home Care provider that currently serves a home health patient census of more than 4,000 patients across 40+ counties in North Carolina and South Carolina. Well Care has been repeatedly recognized as a national leader in quality

of care with a Five-Star rating in Quality of Patient Care by CMS, a designation that corresponds to the top 4-5% of home health providers nationwide. Our comprehensive service offerings provide critical support for patients in their path to independence and self-care in the comfort of their own homes, and our top priority is placing the needs of our patients first. With 37+ years of experience in home-based care, including 23+ years as a Medicare-participating provider, we are well-positioned to share valuable insights with CMS in relation to the foreseeable negative repercussions of the Proposed Rule on our organization, as well as the patients and communities we serve across North Carolina and South Carolina. Well Care is a proud member of the National Association for Home Care and Hospice (NAHC) and the Association for Home and Hospice Care of North Carolina (AHHC).

More broadly, the home health benefit is a vital component of the healthcare continuum, by directly addressing patient care needs through services like nursing and therapy in a low-cost care setting where patients overwhelmingly prefer to receive care. Home health also directly drives value-based outcomes by avoiding unnecessary utilization of costly institutional care settings such as skilled nursing facilities (SNFs), and hospital readmissions. Without adequate access to home health services, patients would alternatively be subjected to longer hospital length of stays, elevated hospital readmission rates, increased SNF utilization, and foregone needed care. For this reason, home health is uniquely positioned to serve as an instrumental value-based care driver for the Medicare program and other payers.

1. **The Proposed Rule's substantial reimbursement cuts are disconnected from the reality of delivering home health services in the current operating environment**

The Proposed Rule's payment cuts are strikingly disconnected with the real-world operating environment currently faced by home health providers like Well Care across the country. Reflecting the broader healthcare industry, Well Care has experienced substantial cost inflation in recent years across a wide range of expense categories:

a. **Clinical workforce**: stemming from challenging and worsening clinical workforce shortages, the home health industry has experienced significant wage increases for its clinical workforce in recent years, far exceeding historical inflation trends.
    i. Well Care has seen its labor costs rise at an unprecedented rate in recent years, with average wages for healthcare workers increasing more than 20% from the pre-pandemic levels of February 2020.
    ii. Exacerbating the overall shortage of healthcare workers is that Well Care competes with not only other home health providers for the same clinical professional pool, but also sectors such as hospitals, facility-based providers, physician practices, hospice agencies, and health insurers. Many of these

sectors can generally offer higher wages and benefits compared to home health providers due to their higher revenue and profit profiles.

iii. Nurses seeking additional flexibility, pay and benefits have also joined contract agencies offering more competitive pay in addition to travel and housing reimbursements. Increased need for contract staff accentuates cost inflation pressure on providers given that contract staff often cost 30%+ more than employed staff.

iv. Wage pressure continues to impact home health providers' ability to recruit and retain its workforce. Costs associated with recruiting (e.g., digital marketing, sign on bonuses, referral bonuses) and onboarding have all increased materially as the candidate pool increasingly lags behind staffing needs.

v. These pervasive workforce shortages increase pressure on existing staff to see additional patients, while continuing to reach clinical outcomes with fewer visits. Data gathered by Home Care Home Base shows a 21% increase in patient load per clinician from prior to 2020 and an 18% reduction in number of patient visits.[1]

b. **Administrative workforce**: administrative personnel within home health agencies have also experienced wage inflation in line with broader market trends of an average of more than 4% per year over the last four years.

c. **Operating expenses**: based on Well Care's operating experience, inflationary cost pressures have extended to wide-ranging operating expenses.

i. Non-labor costs have also increased nearly 6% over the past twelve months.

ii. Medical supplies home health agencies are responsible for providing have increased in line with inflation.

iii. Employee health insurance premiums rose 6% while general and professional liability insurance has increased by an average of 12% over the last year.

iv. Home health agencies are required to cover the expenses related to compensating clinicians for travel between patients' homes on a daily basis. There is a notable 23% rise in fuel expenses compared to the average industry fuel costs between 2018 and 2021, reflecting a collective industry expenditure increase of over $38 million over that period.

d. **Regulatory Compliance:** To maintain compliance in an increasingly complex and robust regulatory environment, Well Care, like many home health providers, has recently made numerous sizable investments in infrastructure and resources. For example, the Review Choice Demonstration has increased the administrative burden on agencies to submit documentation to Medicare Administrative Contractors to

[1] HCHB Comments on Proposed Rule.

ensure payment. For Well Care, the administrative burden for 7,290 submissions and subsequent approvals for pre-claim review since the beginning of 2023 equates to 1,215+ administrative hours (151+ workdays) solely dedicated to the submission of claims, a workload that requires a multitude of dedicated staff resources.[2]

Given the escalating expenses outlined above, one would reasonably anticipate a corresponding increase in reimbursement rates, similar to the adjustments CMS has made for Hospice, to account for the increasing costs associated with providers delivering home health services. Moreover, this financial strain is exacerbated by the economic reality that Well Care, along with many other home health providers, regularly accept Medicare Advantage and Medicaid patients at reimbursement that falls short of the costs of delivering such care.

2. **Significant continued shifts in wage index values contribute to the destabilization of the home health benefit**

The model CMS proposed this year has staggering impacts at the agency level, driven by significant fluctuations in the wage indexes year over year. HCHB's impact analysis indicates wage index adjustments between -9.67% and +12.95% throughout the three-year period. Providers located in single or contiguous states, such as Well Care, could experience a far different impact from agencies across the region. Specifically, North Carolina wage indexes over the three-year period in the current model yield a positive percentage change in 2023, negative percentage change in 2024, and another negative percentage change in 2025. In South Carolina, the result in 2023 is negative percentage change, positive percentage change in 2024, and negative percentage change in 2025. The swings range from 0.6% to -2.1% in single years.[3]

The model volatility forces agencies to manage staffing allocations and implement wage strategies amongst substantial payment variability. The same markets that are proposed to have significant reductions to wage index include many of the same areas experiencing the greatest staffing shortages, high wage inflation, and some of the most challenging patients. Agencies of course do not fluctuate staff wages up and down as the model does wage index.

CMS assumes an average impact of wage index changes to be -1.7%, yet Well Care will see significant variations from this assumption. Specifically, the Charlotte, Winston-Salem, Raleigh-Durham, and Myrtle Beach markets are proposed to see significant decreases in the Wage Index by -1.56%, -3.51%, -2.17%, and -1.74% respectively.

[2] Conservatively assuming 10 minutes for each submission, which does not count website/technical issues from the MAC, denial determinations in error, etc.)
[3] Figure 10 Comments submitted by HCHB

Our agencies in these markets face fierce competition with hospital systems and rural populations, exacerbated by the limited number of clinicians living in these rural areas. In addition to PDGM recalibration, the Proposed Rule's wage index decreases will have particularly damaging consequences for agencies serving rural areas. With fewer staff living in rural areas, undesirable schedules related to travel, and decreased ability to pay higher wages to compensate for long travel distances, agencies will have to consider scaling back services.

We ask that CMS consider the impact of this volatility in wage index due to its effect of further destabilizing agencies in addition to proposed rate cuts and resulting impacts patient access to care.

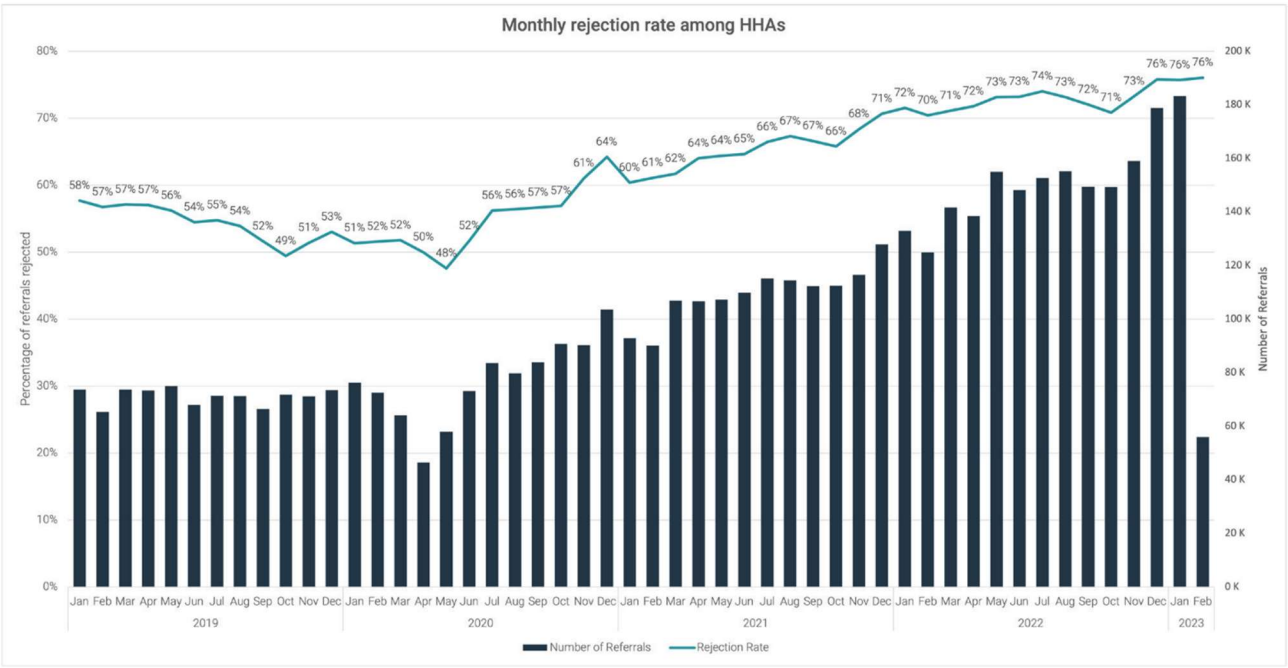
3. **<u>The Proposed Rule threatens to diminish much-needed patient access to home health services, especially in rural communities and higher-acuity patients.</u>**

Access to care is already a critical issue nationally across the home health industry, with 35% of all patients referred to home health being turned away from service.[4] This rate has grown by 12% in the last five years and HCHB estimates that 2.6 million beneficiaries have been impacted by access to home health services challenges – a trend that correlates directly with CMS payment rate reductions.[5] A primary cause of this dynamic is a shortage of clinical workforce, creating a situation where home health agencies such as Well Care Health do not have the clinical capacity to admit all the patients needing home health services.

This reality can be profoundly frustrating for patients who are denied care, as it often leads to worse health outcomes, extended acute stays, or admissions to skilled nursing or long-term care facilities rather than remaining at home. These costly alternatives not only raise the cost of care but also strain limited clinical resources and available beds in those facilities. Meanwhile, many patients return home without receiving needed care. Patients who return home without necessary care often experience poorer outcomes and a higher likelihood of readmission to acute care facilities. This, in turn, contributes to an overall increase in Medicare spending, alongside the human impact on patients and families. This worsening reality runs contrary to the very reason that home health providers exist – to help and care for the patients and communities we serve.

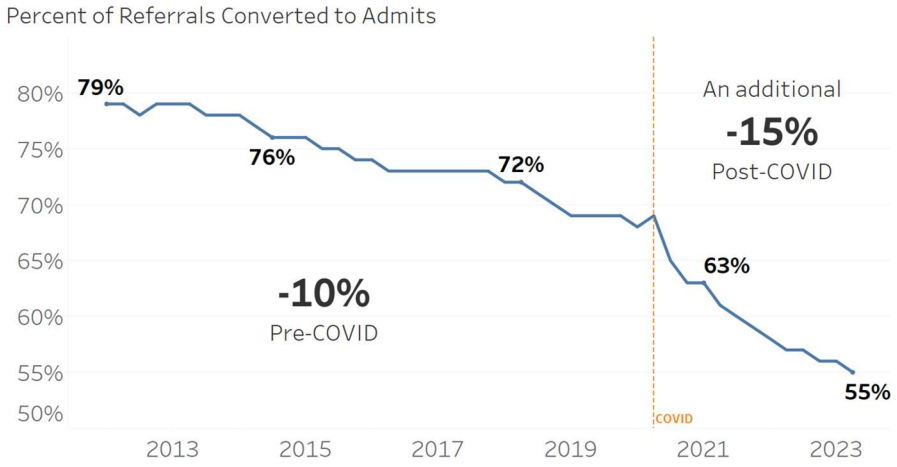
These concerns are echoed by industry data on referral rejection rates among home health providers. Hospital discharge data show that hospitals are experiencing increasing referral rejection rates for prospective home health patients since 2021. This trend aligns with feedback shared by referral source partners who have been experiencing worsening challenges securing placement for patients in need of home health services.

[4] See Figure 1 in Comments submitted by HCHB
[5] See Comments submitted by HCHB



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

Data from Home Care Home Base, the largest EMR and billing partner in home health similarly shows decreasing patient acceptance rates under current PDGM reimbursement trends:



Source: HCHB Comments on Proposed Rule

Well Care's experience is consistent with this national industry data. Since 2020, Well Care has experienced a reduction in our capacity to serve home health patients. While several factors have contributed to this decline, declining reimbursements under PDGM are a primary factor. Staff shortages have been a significant factor in that decline, with challenges in competing for staff with other healthcare sectors, which have also been greatly affected by reduced Medicare reimbursements.

These patient access issues are particularly challenging for higher-acuity patients and rural populations. Since its inception, PDGM has targeted payment based on patient acuity. Highly acute patients require increased home health utilization to address their needs and ensure they can remain safely at home. While acuity continues to climb, decreased reimbursement forces home health providers to make difficult decisions about the types of patients for which they can adequately care. This dynamic puts the most vulnerable populations at risk of either not receiving home health care or utilizing more costly care settings to meet their needs.

Well Care is not the only home health agency grappling with the financial pressures that have diminished access to care. In our service area, we are aware that other agencies have either ceased operations or curtailed services and in various regions in the Carolinas. In some instances, this creates a significant gap in access to care.

Despite increased demand for home health services, patient access is declining, with 500,000 few patients receiving care this year as compared to 2019. In order to respond to this apparent disconnect between Medicare payment trends and cost inflation, like many providers nation-wide, Well Care has had to implement wide-ranging measures to scale back services and reduce costs, including:

a. **Delaying and limiting admissions of patients into care.** Specifically, the Charlotte, Winston-Salem, Raleigh-Durham, and Myrtle Beach markets are proposed to see significant decreases in Wage Index. Concurrently, wages in these same markets have risen as supply has not kept pace with demand and competing healthcare providers have regularly increased wages to maintain their own workforce.[6]

b. **Reducing the volume of patients requiring intensive nursing care**. North and South Carolina have faced significant staffing shortages over the past several years. These shortages, combined with wage inflation and intense competition for a limited number of clinicians, have reduced the capacity of home health providers to care for patients. Consequently, agencies are forced to make tough decisions about managing their limited clinical capacity, often reducing services for patients with less favorable payers and in remote/rural locations. Additionally, patients per

[6] Atrium Health Implements Market-Leading Minimum Wage Increase; https://atriumhealth.org/about-us/newsroom/news/atrium-health-implements-market-leading-minimum-wage-increase

clinician ratios continue to rise, with HCHB estimating that clinicians now care for an average of 1.4 more patients than before 2020, further straining already extended clinical staff.[7]

c. **Increasing selectivity on the types of referrals we accept into our care.** The North Carolina Healthcare Association (NCHA) released their Critical Needs Assessment in March of 2024, highlighting the unique staffing challenges in North Carolina.[8] These include increased demand for nursing staff across all clinical settings and a minimal increase in nursing graduates to meet this demand. To address these challenges, home health agencies must compete with care settings such as hospitals, which generally have higher revenue and profit profiles, and more attractive benefit packages, to maintain current patient volumes. These factors continuously erode margins and limit opportunities to reinvest in improving patient care and access to care.

d. **Discontinuing specialized clinical programs**, such as cardiac-focused remote patient monitoring and telehealth, is necessary despite their proven value in providing clinicians with critical insights into chronically ill patients and keeping them safe at home. These tools do not qualify for Medicare reimbursement under the home health program forcing Well Care Health, like many other providers, to cut these resources, further limiting access to care.[9]

e. **Scaling back parts of our service area and limiting acceptance of patients, especially impacting rural service areas that require extended clinician drive times.** Patients qualifying for home health under CMS guidelines often face significant difficulty or a "taxing effort" to leave their homes. Rural communities are particularly challenged given they must drive an average of 9 miles farther[10] to access health services compared to those in urban areas. With proposed cuts to the wage index affecting much of the Well Care Health footprint, Well Care would be forced to more selectively allocate its limited clinical capacity.

f. **Halting or reducing acceptance of certain Medicare Advantage or Medicaid patients.** Medicare Advantage payment is on average 28% less than Medicare payments, according to Home Care Home Base (HCHB).[11] Therefore, reducing Medicare payments has a much greater impact on agencies than can be accounted for by CMS's impact analysis of the proposed Home Health cuts. Medicare Advantage patient visits have surged from 12.2% in 2012 to 43.7% in 2024, equaling the volume Traditional Medicare patient visits. Since Home Health providers are

[7] See Figure 2 of Comments submitted from HCHB
[8] North Carolina Healthcare Association Critical Workforce Needs Assessment; https://www.ncha.org/wp-content/uploads/2024/05/NCHA-2024-Workforce-Report-FINAL.pdf
[9] NAHC Reimbursement for Home Health Telehealth Services; https://nahc.org/wp-content/uploads/2020/10/FactSheet_HHTelehealth_.pdf
[10] RHIhub Barriers to Transportation in Rural Areas; https://www.ruralhealthinfo.org/toolkits/transportation/1/barriers
[11] See Figure 5 of Comments submitted by HCHB

typically paid a percentage of Medicare rates, decreasing Medicare payments further reduces many other payer rates as well.[12]

Like many home health providers across the nation, Well Care has experienced a higher demand for home health services than we can serve with our available clinical staff. As a result, we have had to make strategic decisions to decline some referrals. If the proposed rate reductions are implemented for 2025, Well Care will be forced to make exceedingly difficult decisions to remain operational in its current service areas, especially given that our projected payment cut impact is substantially greater than national average. The proposed payment cuts fail to reflect the realities faced by home health providers who deliver essential care. These cuts also represent a missed opportunity to support providers in an increasingly complex and challenging operating environment.

4. **The Proposed Rule's payment cuts would foreseeably have the counter-productive and negative impact of increasing overall Medicare program expenditures.**

Given the instrumental role that home health plays both in directly caring for patient needs and as a value-based care investment, the Proposed Rule's continued home health payment cuts and the resulting negative impact to patient access to care risks the counter-productive effect of higher overall Medicare program expenditures due to off-setting consequences on cost-drivers such as hospital length of stay, skilled nursing facility utilization, chronic disease management, and hospital admissions/readmissions.

5. **The Proposed Rule suffers from several notable flaws in its methodology.**

Well Care is deeply concerned about numerous meaningful flaws in the methodology of the Proposed Rule, including:

a. **The Proposed Rule relies on estimated "Medicare Margin" data in its supporting analysis, a siloed, incomplete analysis that does not reflect the reality of home health providers' financial condition**. Medicare typically represents only one of the prominent payers of home health services, alongside Medicare Advantage, the VA, Medicaid and Tricare. As home health providers, we do not operate in payer-specific siloes, thus it's unclear why CMS would limit its analysis of access impact to solely an incomplete Medicare Margin estimate. Moreover, it is unclear why MedPAC would evaluate the full financial outcome for inpatient hospital services and SNF services in its analysis of Medicare payment rates on access to care, while not adopting this approach for home health. Realistic margin estimates should account for factors such as inflation and reduced Medicare Advantage payment rates. Perhaps most

[12] See Figure 4 of Comments submitted by HCHB

concerning, when industry data shows that many home health agencies nationwide are in jeopardy of bankruptcy or closure with implementation of the proposed payment cuts[13], the significant risks of destabilizing the home health benefit based on incomplete margin assumptions are alarming.

b. **The Proposed Rule includes flawed and unfair behavioral assumptions**. When CMS changed to the PDGM payment model in 2020, CMS assumed several behavioral changes that agencies would undertake when under this new model. These assumptions were fundamental to CMS's argument that the shift to PDGM would be budget neutral, as required by the Bipartisan Budget Act of 2018.[14] These behavioral changes are central to CMS's annual updates. HCHB's modeling shows a significant gap between providers' *actual* performance to date under PDGM relative to CMS's behavioral assumptions, including vast differences in LUPA performance and coding practice. From 2018 to July 2024, LUPA rates have increased by 0.4% and overall net increase in coding practices from July of 2020 to July of 2024 is 3.4% (far from CMS's assumption of 100%).[15] Both examples further highlight material flaws in CMS's behavioral assumptions. Well Care requests that CMS provide clear and transparent methodology and supporting data describing how CMS calculates behavioral assumptions.[16] These discrepancies are a key ongoing reason why reimbursement has not kept pace with recent cost inflation.

The presence of these fundamental flaws in the Proposed Rule's methodology, in combination with the likelihood of significant harm to patient access and devastating financial blows to home health agencies across the country, justifies a CMS decision to not finalize the payment reductions in the Proposed Rule, and engage collaboratively with home health providers like Well Care to enhance the PDGM payment model in ways that avoid destabilizing the home health benefit and striking damaging blows to the home health providers who deliver needed care under it.

6. Well Care has multiple areas of feedback in relation to the Proposed Rule's updates to the HHVBP and HHQRP.

With respect to the proposed changes to the Home Health Quality Reporting Program (HHQRP) and the Home Health Value Based Purchasing (HHVBP) Program, Well Care expresses the following:

[14] See Comments submitted by NAHC.
[15] See Comments submitted by Home Care Home Base, Figure 12.
[16] See Comments submitted by HCHB

- **Proposed Oasis Assessment Additions:** Well Care supports the addition of 4 new Oasis items and the modification of 1 item designed to help improve insight into the Social Determinants of Health that may impact patient care. We further urge CMS to take steps to mitigate the impact of these new assessment items by removing an equal number of assessment items from the Oasis tool to offset these additions. We further propose that CMS take steps to limit the number of assessment items on the Oasis tool to reduce the already heavy documentation burden on Home Health clinical staff.
- **Proposed Home Health Conditions of Participation Addition:** Well Care opposes the creation of a new standard at 484.105(d) that would require Home Health Agencies to develop, implement, and maintain an acceptance to service policy. The information described in the Proposed Rule related to timely initiation of services seems to be an indicator of whether access to care issues exist with patients who need home health services. Delays that occur between the patient referral and admission to service are frequently due to staffing limitations, authorization difficulties, difficulty reaching patients, or patient preference. Adding the proposed regulatory burden would not alleviate **those** factors. Furthermore, the proposed regulation states that the policy must be applied consistently across all patients, including those with different payers. However, a significant cause of delays in the initiation of services lies with prior authorization processes for Medicare Advantage and Commercial payers. The Proposed Rule does nothing to address those potential issues and instead shifts the responsibility to Home Health agencies and adds administrative burden to already strained staff. Finally, this new proposed standard is vague and ambiguous, opening the possibility of wide variation in interpretations by surveying organizations.
- **Request for Information on Future HHVBP Measures:** Well Care supports the exploration and development of a claims-based measure that identifies falls with major injury leading to hospitalization, as well as the potential **inclusion** of this metric in the Value Based Purchasing Program. Well Care agrees that using the Oasis-based falls measure would not provide accurate information about the incidence of such falls.

Summary

In summary, Well Care reiterates the comprehensive concerns expressed in the comments submitted by the National Association of Home Care and Hospice (NAHC) and Home Care Home Base, and offers the above perspective of an independent, family-owned and operated home health provider delivering direct patient care. We hope this perspective is informative and useful – and that it helps avert a dangerous and damaging payment direction in the Final Rule.

Home based care offers high quality and essential health care services to millions of Medicare beneficiaries as well as great value to the Medicare program through health care costs savings far in excess of any other Medicare benefit. Implementation of the Proposed Rule threatens the financial sustainability of home health providers like Well Care across the country and endangers patient access to vital home health

services. CMS has the authority and the responsibility to prevent such a devastating outcome. As home health providers, our priority is delivering the best possible quality of care and access to care to the patients and communities we serve. Well Care's Mission Statement is *keeping our communities healthy, happy, and at home*. In consideration of the insights and concerns contained in these comments, we invite CMS to join us in advancing this mission and avoid negatively impacting the home health benefit and home health providers like Well Care across the country.

Well Care joins the National Association for Home Care and Hospice (NAHC) and the Association for Home Care & Hospice (AHHC), along with our partners in the home health provider community, to request that CMS withhold finalization of the payment reductions in the Proposed Rule, and work with the broader home health community to implement the PDGM payment model in a manner that aligns with the program's goal of increasing access to care for those patients that need home health services.

To summarize, Well Care strongly recommends that CMS:

1. **Postpone and not finalize any further permanent payment adjustments related to PDGM budget neutrality to preserve current levels of access to home health services; and**
2. **Consider the negative and disruptive financial impacts of its proposed wage index changes and case mix weight recalibrations on care access as it finalizes future payment rates and any systemic reforms**

Respectfully,

Zac Long, JD, MHA

CEO and General Counsel

Well Care Health