August 28, 2025
Electronic Submission via Regulations.gov

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1828-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1828-P, Medicare Program; CY 2026 Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates

Dear Administrator Oz:

Well Care Health ("Well Care") thanks the Centers for Medicare & Medicaid Services ("CMS") for the opportunity to respond to the CY 2026 Proposed Rule ("Proposed Rule") and respectfully submits the following information regarding the impact of the Proposed Rule on Well Care Health and the communities we serve. Based on Well Care's extensive experience delivering home health services with industry-leading quality of care, we express our **significant and urgent concerns** about the Proposed Rule and urge CMS not to finalize the proposed permanent and temporary adjustments. In addition to these comments, Well Care fully supports the detailed comments submitted by the National Alliance for Care at Home (the Alliance) and Homecare Homebase (HCHB). The Proposed Rule's nearly 9% reimbursement cut is the largest single-year cut in recent memory and would negatively impact the larger US healthcare system by further destabilizing a home health care delivery system that is already fragile and strained. **In a real-world operating environment that features pervasive cost inflation along with tight and compressing margins, cuts of this magnitude are not sustainable. These proposed cuts, following nearly 9% in funding cuts from CMS from 2023 to 2025, would impact not only Well Care and home health providers across the country, but also, unmistakably and directly, the patients and communities we serve.**

Specifically, we seek to emphasize the following summary points for 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 drive operational uncertainty and contribute to the destabilization of the home health benefit.
3. The Proposed Rule threatens to diminish essential patient access to home health services, especially for already-underserved populations such as rural and higher-acuity patients;
4. The Proposed Rule's payment cuts would foreseeably have the counterproductive and negative impact of increasing overall Medicare program expenditures;
5. The Proposed Rule suffers from significant flaws in its methodology; and
6. Well Care has multiple points of feedback in relation to the Proposed Rule's updates to the HHVBP, HHQRP, and other proposed regulatory changes.

As background, Well Care Health is a family-owned and operated home health and hospice home care provider that currently serves a home health patient census of over 5,000 patients across more than 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 over 38 years of experience in home-based care, including more than 25 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 Alliance for Care at Home (the Alliance) and the Association for Home and Hospice Care of North Carolina (AHHCNC).

The home health benefit is a vital component of the healthcare continuum, directly addressing patient care needs through services such as nursing and therapy in a low-cost care setting, where patients overwhelmingly prefer to receive care. Home health 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 serves as an instrumental value-based care driver for the Medicare program and other payers – supporting the clear need for legislation that strengthens and reinforces home-based care, rather than destabilizing it.**

For the following reasons, Well Care expresses its **deep and urgent concerns** 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.

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 from 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 and sweeping cost inflation in recent years across a wide range of expense categories:

- **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.
    - 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.
    - **Exacerbating the overall shortage of healthcare workers** is that Well Care and other home health agencies compete not only with other home health providers for the same clinical professional pool, but also with sectors such as hospitals, facility-based providers, physician practices, hospice agencies, and health insurers.

- Many of these sectors can generally offer more attractive wage and benefit packages compared to home health providers due to their higher revenue and profit profiles.
- **Wage pressure continues to impact home health providers' ability to recruit and retain workforce.** Costs associated with recruiting (e.g., digital marketing, sign-on bonuses, referral bonuses) and onboarding have all increased significantly as the pool of available candidates increasingly lags behind staffing needs.
- Nurses seeking additional flexibility, pay, and benefits have trended towards joining contract staffing agencies offering more competitive pay in addition to travel and housing reimbursements. Increased need for contract staff accentuates cost inflation pressure on providers because **contract staff often cost 30%+ more than employed staff.**
- These pervasive **workforce shortages increase pressure on existing staff to see additional patients**, while continuing to achieve clinical outcomes with fewer visits. For example, industry-wide data from Homecare Homebase (HCHB) shows that compared to pre-pandemic levels, clinicians are experiencing **both substantial increases in patient load per clinician (21%) and reductions in the number of patient visits per care episode (13%).**[1]

- **Administrative workforce**: administrative personnel within home health agencies have also experienced wage inflation in line with broader market trends, reflecting an average increase of more than 4% annually over the last four years.
- **Operating expenses**: based on Well Care's operating experience, inflationary cost pressures have further extended to wide-ranging operating expenses such as:
  - Non-labor costs have also increased nearly 6% over the past twelve months.
  - Costs of medical supplies, which home health agencies are responsible for providing, have increased materially in recent years.
  - Employee health insurance premiums have risen 6% per year, and general and professional liability insurance has grown by an average of 10% annually in recent years.
- **Regulatory Compliance:** To maintain compliance in an increasingly complex and robust regulatory environment, Well Care, like many home health providers, has recently had to make numerous sizable investments in infrastructure and resources. For example, the recently implemented Home Health Review Choice Demonstration (RCD) Program has increased the administrative burden on agencies to submit additional documentation to Medicare Administrative Contractors to ensure payment. For Well Care, the administrative burden associated with making 10,385 RCD-related submissions and subsequent approvals since the beginning of 2023 has required nearly 2,100 administrative personnel hours, requiring the added cost of multiple dedicated staff resources.[2]
- **Impact of Managed Care Plans:** This financial pressure is further exacerbated by the economic reality that Well Care, along with many other home health providers, regularly and increasingly accept

[1] Home Health Care News, "Executive Report: Metrics, Margins, and Market: Data Trends in Home Health and Hospice." Released July 22, 2025.
[2] Based on conservative assumption of 10 minutes per submission, which does not account for MAC website/technical issues, denial determinations in error, etc.

Medicare Advantage and Medicaid patients with significantly higher administrative requirements and reimbursement rates that fall short of the costs of delivering such care.

Given the widespread inflationary forces outlined above, it would be reasonable for home health agencies to expect corresponding reimbursement increases similar to adjustments CMS has afforded other health service segments with similar market dynamics (e.g., Medicare Advantage plans, skilled nursing facilities, inpatient rehabilitation facilities, and hospice home care) in order to account for the increasing costs associated with delivering home health services.

2. Significant continued shifts in wage index values drive operational uncertainty and contribute to the destabilization of the home health benefit.

Apart from reimbursement considerations, the Proposed Rule model contributes to staggering impacts on Well Care's branches at a local level through its significant year-over-year fluctuations in county-level wage indexes. 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 have been reduced significantly in the same counties over the last three years.

This level of yearly local branch reimbursement uncertainty makes it highly challenging for home health agencies to plan for the future and make resource investments, forcing agencies to manage staffing allocations and implement wage strategies amongst substantial payment variability. Confusingly, the markets proposed to suffer significant reductions in wage index are often the areas with the greatest staffing shortages, the highest wage inflation factors, and the most underserved patient populations. These dynamics are confusing and disconnected from operational reality, as agencies do not and cannot fluctuate staff wages up and down to mirror wage index variations.

Moreover, regional and national averages often mask far more impactful market-level variations. For example, CMS assumes an average impact of wage index changes to be -0.3% in the Mid-Atlantic Region, yet Well Care will see significant local market variations from this regional average. For example, Well Care's Greater Mecklenburg, Triad, Raleigh-Durham, and Myrtle Beach markets sustained significant 2025 decreases in the Wage Index by -1.56%, -3.51%, -2.17%, and -1.74% respectively, while suffering -1.73%, -0.11%, -2.03%, and -2.52% respective decreases under the proposed 2026 Wage Index changes. Conversely, in our operating experience, these markets face fierce labor market competition with hospital systems and other healthcare segments, exacerbated by the limited supply of clinical workforce residing in these 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, demanding schedules related to travel, and decreased ability to pay higher wages to compensate for long travel distances, these policies exacerbate existing financial pressures to scale back services in these areas and therefore further diminish existing access-to-care challenges.

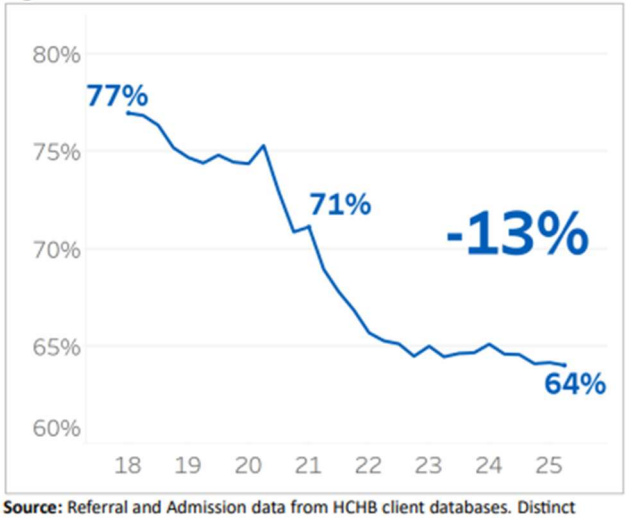
We ask that CMS consider the impact of this type of volatility of wage index variation in further destabilizing agencies, in addition to the impact of the proposed rate cuts on patient access to care.

3. The Proposed Rule threatens to diminish essential patient access to home health services, especially for already-vulnerable populations such as rural and higher-acuity patients.

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.[3] This rate has grown by 13% since 2018 and HCHB estimates that 4.2 million beneficiaries have been impacted by access to home health services challenges – a trend that correlates directly with CMS payment rate reductions.[4] Driven by structural shortages of clinical workforce and a pressing need to make continued investments in workforce and care delivery, home health agencies such as Well Care do not currently have the clinical capacity to admit all patients needing home health services. **This reality can be deeply frustrating and impactful 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 receiving care at home.** These more costly alternatives both raise the overall cost of care and strain limited clinical resources and available beds in those facilities. In addition, many patients are discharged home without receiving needed home health care, who then often experience worse clinical outcomes and a higher likelihood of readmission to acute care facilities. These access to home health care barriers contribute to an overall increase in Medicare spending, in addition to a very real negative 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 have been experiencing increasing referral rejection rates for prospective home health patients since 2020. **This trend aligns with concerns shared by Well Care's referral source partners who have experienced worsening challenges securing placement for patients in need of home health services.**

Industry analysis from Homecare Homebase (HCHB), the largest home health EMR platform, similarly shows decreasing patient acceptance rates (referral conversion) under recent PDGM reimbursement trends:

Figure 3: Distinct referral conversion rate from 2018 to 2025-Q2



Source: Referral and Admission data from HCHB client databases. Distinct referrals are identified across databases and not counted more than once.

Source: HCHB 2025 Comments on Home Health Proposed Rule

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

Well Care's experience is consistent with this national industry data. Since 2020, Well Care has faced limitations in our capacity to serve home health patients. While several factors have contributed to these limitations, reimbursement pressure under PDGM has undoubtedly been a major factor. Other factors include staffing shortages, challenges in competing for staff with other healthcare sectors, and increased prevalence of Managed Medicaid and Medicare Advantage plans with substandard reimbursement rates that fall considerably below the cost of care delivery.

Despite substantially increased demand for home health services nationwide, patient access has declined in recent years, with industry data showing 13% fewer patients receiving care over the last few years since 2018.[5] These patient access issues are particularly challenging for higher-acuity patients and rural populations. Since its inception, PDGM has driven payment based on patient acuity. Higher acuity patients require increased home health utilization (i.e., more care) to address their needs and ensure they can remain safely at home. While patient acuity continues to trend higher across the industry, reimbursement cuts force home health providers with constrained clinical capacity to accept patient referrals to make difficult decisions about the types of patients for which they can adequately care. This access to care dynamic puts the most vulnerable populations, such as rural communities and high-acuity patients, 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, leaving communities with more limited home health provider options and access to care.

In responding to this apparent disconnect between Medicare payment trends and cost inflation, Well Care, like many providers nationwide, has had to implement wide-ranging measures to scale back services and reduce costs, including:

a. **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 that they must drive an average of 9 miles farther[6] to access health services compared to those in urban areas. Given the operational reality that delivering care in rural communities is often more costly, the combined impact of the proposed payment cuts and wage index adjustments, Well Care would be reluctantly forced to more selectively allocate its already-limited clinical capacity.

b. **Delaying and limiting admissions of patients into care.** Well Care's Charlotte-Mecklenburg, Triad, Raleigh-Durham, and Myrtle Beach markets are poised to suffer significant decreases in Wage Index under the Proposed Rule. Meanwhile, we have experienced substantial wage pressure in these same markets as labor supply has not kept pace with demand and competing healthcare providers have regularly increased wages to maintain their own workforce.[7]

c. **Increasing selectivity on the types of referrals we accept into our care.** The North Carolina Healthcare Association (NCHA) released its latest Critical Needs Assessment in March of 2024,

[5] See Comments submitted by HCHB

[6] RHIhub Barriers to Transportation in Rural Areas; https://www.ruralhealthinfo.org/toolkits/transportation/1/barriers

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

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. 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 reluctantly had to make strategic decisions to decline certain referrals. If the proposed rate reductions are implemented for 2026, Well Care will be forced to reluctantly make exceedingly difficult decisions to remain operational in its current service areas, especially given that our projected payment cut impact is substantially greater than the national average.

d. **Halting or reducing acceptance of certain Medicare Advantage or Medicaid patients.** Medicare Advantage payment is on average 27% less than Medicare and represents a negative operating margin (-11.62%) for home health providers, according to industry-wide data from Homecare Homebase (HCHB).[9] Therefore, reducing Medicare payments has a much greater impact on agencies than can be accounted for by CMS's impact analysis of the Proposed Rule's reimbursement cuts. Medicare Advantage patient visits have surged over the last decade and now account for a higher patient volume (44.1%) than Traditional Medicare (43.4%).[10] Because Medicare Advantage plans often reimburse home health providers at a percentage discount level to Medicare rates, the Proposed Rule's payment cuts would cascade to impact other payer rates as well.

e. **Discontinuing specialized clinical programs (e.g., cardiac-focused remote patient monitoring and telehealth), 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, like many other providers, to cut these programs, further limiting access to care.[11]

f. **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 service areas and programs. Additionally, patients per clinician ratios continue to rise, with data from Homecare Homebase showing that **clinicians now care for an**

[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] Home Health Care News, "Executive Report: Metrics, Margins, and Market: Data Trends in Home Health and Hospice." Released July 22, 2025.

[10] Home Health Care News, "Executive Report: Metrics, Margins, and Market: Data Trends in Home Health and Hospice." Released July 22, 2025.

[11] NAHC Reimbursement for Home Health Telehealth Services; https://nahc.org/wp-content/uploads/2020/10/FactSheet_HHTelehealth_.pdf

average of more than 1.5 more patients than pre-pandemic, further straining already extended clinical staff.[12]

Based on Well Care's direct experience as described above, the proposed payment cut fails to account for the realities faced by home health providers delivering essential patient care and misses an opportunity to support providers in an increasingly complex and challenging operating environment.

4. The Proposed Rule's payment cuts would foreseeably have the counterproductive 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 counterproductive 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. These conclusions are supported by the successful results of CMS's Value-Based Purchasing Model for Home Health, representing a cumulative Medicare cost savings of $1.38 billion. If home health is where CMS realizes the most value and patients overwhelmingly prefer to receive care, then the Proposed Rule's foreseeable impact of destabilizing home health seems incongruent with these overarching objectives.

5. The Proposed Rule suffers from significant 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 -- representing an inflated, siloed, and incomplete analysis that does not reflect the reality of home health providers' financial condition**. Medicare cost report data over-inflates HHA profitability by accounting for neither all reimbursements nor costs, excluding key financial drivers such as: (1) Medicare Advantage and Managed Medicaid reimbursement data; (2) non-reimbursable services and community investments (e.g., charity care, infrastructure for rural access); and (3) administrative and infrastructure costs (e.g., compliance, technology, leadership support). Medicare typically represents only one of the prominent payers of home health services, apart from 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 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. Given the high stakes involved, margin estimates should seek a fuller and more accurate picture, while accounting for factors such as inflation and reduced managed care plan payment rates. Perhaps most concerning, when industry data shows that many home health agencies nationwide are in jeopardy of bankruptcy or closure with the implementation of the proposed payment cuts[13], the significant risks of destabilizing the home health benefit based on flawed and incomplete margin assumptions are alarming.

[12] Home Health Care News, "Executive Report: Metrics, Margins, and Market: Data Trends in Home Health and Hospice." Released July 22, 2025.

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 behavioral change 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, and have been 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 Clinical Groupings and Therapy Utilization. Providers have not systematically shifted coding or therapy to optimize payment, as evidenced by the decrease in Wound and MMTA Clinical Groups from 2016 to 2024 and the growth of therapy utilization over the same time period.[14] Both examples further highlight material flaws in CMS's behavioral assumptions. Well Care requests that CMS provide a clear and transparent methodology and supporting data describing how CMS calculates behavioral assumptions. 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 such as 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 points of feedback in relation to the Proposed Rule's updates to the HHVBP, HHQRP, and other proposed regulatory changes.

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 positions:

a. **Proposed OASIS assessment removals:**

- We **support** the removal of the 'COVID-19 Vaccine: Percentage of Patients Who Are Up to Date' measure and the corresponding OASIS data element.
- We **support** the removal of the 4 social determinants of health questions from the standardized patient assessment.
- We **urge** CMS to take further steps to decrease the frequently changing OASIS assessment by limiting the frequency with which OASIS updates can be made.
- We **urge** CMS to place a hard cap on the number of assessment items that can be included for each assessment type, so that no additional assessment items can be added without removing an equal number of assessment items.

[14] See pages 5-7 of HCHB Comments

b. **Proposed changes to the Face-to-Face encounter policy:**

- We **support** the efforts of CMS to broaden the types of practitioners who can perform the Face-to-Face requirement to include community providers and specialist physicians who follow patients in the community.
- We **encourage** continued review and update of Face-to-Face policy, including but not limited to:
    - Increasing the permitted timeframe for Face-to-Face visits to occur beyond 30 days after the start-of-care date.
    - Making permanent the current allowance for audio and visual telehealth encounters to satisfy the Face-to-Face requirement.
    - Removing the requirement that certifying providers must attest to the date that the Face-to-Face encounter occurred when another provider performed the encounter.

c. Proposed HHCAHPS changes:

- We **support** the proposed **addition and removal** of questions from the HHCAHPS survey.
- We **ask** that CMS continue identifying ways to **reduce** the survey length for patients and caregivers.
- We **encourage** CMS to continue exploring alternative methods to administer the survey to patients and their caregivers so that CMS can more accurately gauge the beneficiary experience. Solutions could include sending surveys via email or conducting online surveys that can be completed through links sent via email or text message.

d. Proposed changes to the HHVBP program:

- We **support** the proposal to remove the three composite measures from the HHVBP program scoring model.
- We **support** CMS's efforts to expand the number of measures that address functional improvement, but **urge** CMS to consider using the "**GG items**" that address the same functional domains instead of using the "M-items" on the OASIS.
- We **support** the measure weight changes that CMS has proposed to address the addition and removal of measures covered in the Proposed Rule.
- We **encourage** CMS to evaluate ways to more tightly **align Star Rating** performance measures with HHVBP measures so that patients and CMS can more clearly evaluate care performance.

Summary

Well Care Health reiterates the comprehensive and serious concerns expressed in the comments submitted by the National Alliance for Care at Home (the Alliance) and Homecare Homebase (HCHB). **In turn, we offer the perspective of an independent, family-owned and operated home health provider that delivers direct patient care to thousands of patients across the Carolinas. We hope this viewpoint is informative and valuable – and that it helps avert a dangerous and potentially damaging payment direction in the Final Rule.**

Home-based care offers high-quality and essential healthcare services to millions of Medicare beneficiaries, providing tremendous value to the Medicare program through healthcare cost savings that far exceed those of any other Medicare benefit. Implementation of the Proposed Rule threatens the financial sustainability of home health providers like Well Care Health across the country and endangers patient access to vital home health services. CMS has the authority and 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 expressed in these comments, we invite CMS to join us in advancing this mission and avoiding any negative impact on the home health benefit and home health providers across the country.

Well Care joins the National Alliance for Care at Home (the Alliance) 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 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.

Well Care Health 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