August 29, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1780-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1780-P - Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements; published at Vol. 88, No. 130 Federal Register 43654-43817 on July 10, 2023.

Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services’ (CMS) proposed Home Health rules for calendar year 2024. UnityPoint at Home is the Home Health Agency (HHA) affiliated with UnityPoint Health, one of the nation’s most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment, pharmacy, palliative care, hospice care, and (in certain locales) public health. In 2022, UnityPoint at Home provided nearly 340,000 visits to consumers in Iowa and Illinois. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in Medicare Shared Savings Program model, was an initial participant in the Home Health Value-Based Purchasing (HHVB) Model in Iowa and was a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. As a member of National Association for Home Care & Hospice (NAHC), UnityPoint at Home generally supports the formal comment letter submitted by NAHC to this proposed rule. In addition, UnityPoint at Home respectfully offers the following comments to the proposed regulatory framework.
GENERAL COMMENTS

Home Health is a community-based, low-cost setting of care that is preferred by patients. By offering a Home Health benefit, Medicare has the opportunity to reduce costs and improve outcomes. In a 60-day period, it is possible for a chronically ill patient with a progressive disease state to have four hospital stays or a Home Health episode with or without an initial hospital stay. This is the difference that Home Health can drive if guidelines appropriately incentivize these services.

As we review the proposed rule, CMS is eroding the traditional Home Health benefit, adversely affecting HHAs, and ultimately reducing access for Medicare beneficiaries. It is projected that 53% of HHAs will experience negative margins as a result of this proposed rule. This disproportionately impacts nonprofit HHAs, rural HHAs, and small HHAs. With health care consolidation being second-guessed by regulators, policymakers and the media, we question that these rules will not produce similar consolidation trends and disproportionately impact beneficiaries who may already have limited home health options.

In this rule, CMS is ringing the death knells on the traditional Home Health benefit, with decreased financial support and increased regulatory burden. With these constraints, it is increasingly challenging for HHAs to provide high quality care. It is also clear that the Home Health benefit is not available to all eligible Medicare beneficiaries due to HHA capacity limitations. The Home Health industry is at a juncture, and CMS can lead by establishing a sustainable high-quality Home Health model that takes care out of the hospital and into the home. UnityPoint at Home welcomes the opportunity to work with CMS on model development. Our experience in the value-based arena has spanned ACO models with benefit enhancements and innovations in care delivery, included participation as an early adopter of the Hospital At Home model, and developed epidodic At Home bundles (see Additional Input response at the end of this letter).

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

CMS proposes a 2.2% aggregate rate reduction for CY 2024 – a $375 million decrease from CY 2023. CMS also proposes to recalibrate the PDGM case-mix weights and update the LUPA (Low Utilization Payment Adjustment) thresholds functional impairment levels and comorbidity adjustment subgroups. The proposal rebases and revises the Home Health market basket, revises the labor-related share, and updates the fixed-dollar loss ratio (FDL) for outlier payments.

Comment: As stated by CMS, “we recognize that applying the full permanent and temporary adjustments to the CY 2024 payment rate may adversely affect HHAs, including small entities.” UnityPoint at Home opposes the continued erosion of Home Health episodic rates. This year’s proposed 2.2% aggregate reduction reflects an ongoing rate assault that is based on faulty assumptions, is not driven by actual data, and does not prioritize overall access to services, including residents in rural areas and those with Medicaid coverage. As more health care services are being pushed to the community and patients have expressed a desire for more home-based services, these rate reductions force HHAs to make unenviable decisions to close HHAs, reduce geographic service areas, and/or reduce overall services, which ultimately

1 Page 43811 of the proposed rule.
equates to less patients being served and poorer population health outcomes.

First, with inflationary pressures, **proposed rate reductions are tone-deaf to heightened costs attributable to labor, supplies, and mileage.** These financial pressures include:

- **Labor:** With a limited labor supply, the Home Health workforce is particularly sensitive to overall wage increases due to market conditions and the use of contracted labor. Capacity to provide Home Health services is in many cases restricted by staffing. Rate reductions negatively impact the Home Health workforce as cuts do not enable HHAs to attract and retain personnel with competitive compensation and raises. Home Health does not operate in a silo, and when other segments of healthcare or other non-healthcare industries increase wages, Home Health must compete or lose experienced team members from physicians, nurses, therapists, social workers and Home Health aides. These external pressures add to general Home Health recruitment challenges which are integral to this care setting – namely, Home Health combines a heightened critical thinking skillset with the ability to work independently. The conditions of participation (COPs) require Home Health to provide nursing services 24/7; however, other care settings do not require after-hours/holiday commitments. For this reason, other care settings are more desirable to workers when Home Health is not able to meet or exceed pay rates. So despite the fact that our Home Health compensation uses the same pay-scale as our inpatient providers, workforce continues to limit our service capacity.

- **Supplies:** The costs of nonroutine supplies (i.e. those outside the episodic payment) have not kept up with inflation. As for routine supplies (i.e. those covered in the episodic payment), CMS keeps expanding the list of included supplies without corresponding reimbursement attributable to the episode. HHAs are required to provide more service for less reimbursement.

- **Mileage:** For Home Health, particularly in rural areas, this reimbursement component is crucial. For HHAs from the organizational standpoint, it is impossible and unrealistic for our team members who cover multiple counties often on two-lane and gravel roads to serve the same caseloads as those in larger urban settings, like New York City. While advances in telehealth and remote monitoring have been useful, they cannot always substitute for an in-person visit. Smaller caseloads mean greater operational expense per patient. From a staff standpoint, team members in rural areas sometimes travel upwards of 600 miles per week for patient visits in addition to actual time and efforts spent on visits and documentation duties. Currently, mileage is set based on Internal Revenue Service rates and are established after the HHA budget is determined. Wear and tear on vehicles is another cost being absorbed by our personnel or the HHA and, as vehicle prices rise and gas prices skyrocket, mileage reimbursement does not cover costs and is seen as a decrease in wages. As noted above, the combination of cost of the employee given the lack of productivity and excessive mileage/reimbursement is driving HHAs to rethink the outlying territories they service, thus reducing overall access to Home Health.

This is the fourth consecutive year that the payment update does not reflect the actual cost increases experienced by HHAs, and UnityPoint at Home does not anticipate that cost pressures will revert to pre-pandemic levels. In the meantime, CMS continues on a path of rate reductions that undercut the financial
viability of a huge segment of the Home Health industry. In CY 2022, 37% (1,648) of freestanding HHAs nationwide posted a net overall negative margin; and the percentage of HHAs with a net overall negative margins is projected to increase to 53% (2,348) under current proposed cuts. Sustainability of freestanding HHAs will be futile and continue to lead to closures and acquisitions, further reducing the beneficiary’s choice of provider and access to providers. The proposed reimbursement cuts in Iowa and Illinois are projected to result in net overall negative margins for 39.3% and 53.2% of HHAs, respectively. Access to Home Health services will be reduced across these geographies, disproportionately impacting rural geographies and complex and/or high acuity patients.

Second, we implore CMS to re-evaluate the overly broad application of PDGM behavioral assumptions. The proposed permanent behavioral adjustment of -5.1% is not sustainable, but perhaps more worrisome is that CMS fails to recognize that its methodology does not reflect patient acuity and the changing nature of the patients being served versus those who are eligible for Home Health benefit. As payment rates are cut and expenses increase, our capacity to provide services is limited. At UnityPoint at Home, it is not the margins that drive patient selection but our capacity to staff – we can no longer take all referrals and, as a nonprofit HHA, we prioritize taking care of the sickest patients. We are frustrated that the CMS methodology does not account for the acuity shift within the entire population of those who are actually receiving the Home Health benefit.

- Decline in therapy visits – CMS attributes the decline in therapy visits to the removal of the threshold and adoption of the PDGM structure, and we would agree that payment policy impacts HHA financial stability and operational decisions. For UnityPoint at Home, a large contributor to this trend is workforce challenges. In one of our rural markets, we have had a physical therapist vacancy for 6 ½ years; so without the skilled therapy professionals, our capacity to provide therapy visits is limited. In the aftermath of the pandemic, workforce challenges are more pervasive and continue. Additionally, the PDGM structure disincentivizes patient referrals that require more therapy services. For high acuity patients requiring a lot of therapy, current methodology places these patients within the low or medium functional impairment level, which further erodes financial incentives to provide these services.

- Inaccurate functional impairment levels – CMS uses three functional impairment levels (i.e. low, medium, and high) to approximate resource usage. It should come as no surprise that high impairment level continues to predominate. The functional impairment methodology adjusts rates in a budget neutral fashion by total population served and associated coding; however, this methodology does not reflect the acuity of the patient, costs incurred, or eligible patients turned away. As stated above, our caseload is increasingly complex with higher acuity levels and heightened services. As artificial expectations divide the Home Health population into thirds, there is no recognition that each category/level is increasing in patient acuity and corresponding expense. We urge CMS to explore this patient acuity trend as well as the patient characteristics and acuity of those who were referred to Home Health but did not receive the Medicare benefit.

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2 National Association for Home Care and Hospice, files produced indicating “State Overall Margins by Category Free”.

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Third, **we are grateful for the rate increases, although minimal and not aligned with inflation, of low-utilization payment adjustment (LUPA) per visit payments.** The LUPA visit thresholds should remain static. CMS continues to move the needle upward on the LUPA visit thresholds from two and three visits to the current four and five visit thresholds. This narrows the gap between the LUPA visit threshold and the average visit per Home Health episode, which stands at 8.05 average visits per episode. As the gap narrows, LUPA payment no longer represent outlier episodes and CMS in essence is expanding services under the Home Health benefit. As a result, heightened scrutiny and compliance efforts focus on the number of visits, and Medicare intermediaries are engaging in targeted probes and education on this issue.

Fourth, **the further erosion of HHA funding undercuts the success of the Home Health Value-Based Purchasing (HHVPB) program.** We question the level of care that will result when HHAs are under-resourced and whether CMS financial bonuses will reflect similar outcomes.

Finally, **CMS reimbursement influences other payers.** For example, Medicare Advantage (MA) plans have historically adopted CMS rates in their contracts. As public payers comprise a majority of our payer mix, our financial margins continue to decrease with operational consequences.

For the reasons stated above, **UnityPoint at Home requests that CMS finalize a rate update that supports financial stability for HHAs and avoids industry-wide financial adversity impacting more than one-third of HHAs nationally.** Industry disruption, which significantly reduces health care access in a community-based and low-cost setting, is ill-timed, ill-advised and counterintuitive to serving patients where they are.

**DISPOSABLE NEGATIVE PRESSURE WOUND THERAPY**

*CMS codifies requirements for disposable negative pressure wound therapy (dNPWT). CMS proposes the payment amount for CY 2024 would be equal to the supply price of the applicable disposable device under the Medicare PFS (as of January 1, 2022) updated by the specified adjustment. Billing processes for the dNPWT device and services are changed and only Home Health services for the administration of the device would be geographically adjusted.*

**Comment:** UnityPoint at Home supports the proposed revision to dNPWT reimbursement. UnityPoint at Home encourages the swift release of guidance materials to enable HHAs and vendors sufficient time to adjust claims reporting processes accordingly.

**HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)**

*CMS proposes updated policies, the codification of the previously finalized 90 percent Outcome and Assessment Information Set (OASIS) data completion threshold policy in the Code of Federal Regulations (CFR) and the public reporting of four measures.*

**Comment:** The OASIS measure set is in a perpetual state of change. For CY 2025, changes in this rule for the HH QRP include adding two new measures and sunsetting three current measures. Changes to measure sets generally involve significant organizational time, effort and associated costs. While we appreciate the desire for program transparency and accountability and believe that quality is our north star, **we are concerned that CMS underestimates the amount of effort needed to collect and report**
quality measures. OASIS measures in particular demand significant documentation and administrative burden, even when “streamlining” two measures to one measure, this involves new EMR software (with associated costs), testing and go live intervals, and training on measure requirements and documentation.

Among the proposed measures, CMS proposes the adoption and public reporting of the measure, COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure. This assessment-based process measure reports the percent of Home Health patients that are up to date on their COVID–19 vaccinations per CDC’s latest guidance. The MAP Coordinating Committee reached 90 percent consensus on its recommendation of “do not support with potential for mitigation” when evaluating this proposed measure. Additionally, due to reporting lag, the recent roll-back of the federal mandate for vaccination of health care personnel, and the variance of state and local law governing vaccination requirements, we request that CMS continue to review this measure to determine whether to require public reporting and based quality scores on this measure which is subject to many external factors outside the control of the HHA.

HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

CMS proposes updated policies, including the codification of previously finalized measure removal factors, changes to the applicable measure set, updating the Model baseline year, and an amendment to the appeals process for the expanded HHVBP Model. The proposed rule includes updates on health equity and public reporting.

Comment: As an initial participant in the HHVBP Model in Iowa, UnityPoint at Home supports the concept of high-value care and value-base purchasing. For CY 2025, CMS is proposing to replace three OASIS-based and two claims-based measures finalized in the CY 2022 Home Health rule³ with one new OASIS-based measure and two claims-based measures. Only two out of seven total existing OASIS-based and claims-based measures are proposed to remain! The shift is significant and will undoubtedly alter the HHVBP model. Continual revisions to measures and the magnitude of changes to the measure set itself frustrates our providers and staff and undermines their confidence in Medicare quality programs particularly those tied to value and financial incentives. Upon each revision, EMR software is updated, tested, and implemented; policies, practices and decision support tools are reviewed and revised accordingly; and staff are trained and re-educated related to the new measure – for administrative staff this includes collection, management, and reporting; and for direct care staff this includes coaching on documentation of outcomes and demonstrating improved patient outcomes. We address specific measures below.

CMS proposes to replace both the OASIS-based Total Normalized Composite Change in Self-Care (TNC Self-Care) measure and the OASIS-based TNC Change in Mobility (TNC Mobility) measure with the OASIS-based Discharge Function Score (DC Function). DC Function measures Home Health episodes with an observed discharge function that is equal to or higher than the calculated expected discharge function. For this OASIS substitution, we applaud CMS for including maintaining as well as improving a patient’s functional status. For some conditions, it is not realistic to improve functional status. Additionally, the DC

³ These five measures had been piloted since CY 2020.
Function appears to shift function reporting emphasis from the M1800 series to the GG0130 and GG1070 series. For the GG series, function scores are calculated at the start of care and, in a substantial number of case (upwards of 20%), discharge function cannot be observed at that time, and we code as 88, 90 or blank. These often involve circumstances with high acuity patients or patients who refuse to engage. When coding is 88, 90 or blank, CMS will substitute its judgment, which may or may not reflect functional status. Naturally, we believe that CMS should defer to the judgment of HHA licensed professionals. Given that DC Function will be weighted at 20% for large-volume cohorts and 28.571 for smaller-volume cohorts, UnityPoint at Home requests clarification and guidance on how to better document functional status based on professional judgment when observations are not possible. UnityPoint at Home also suggests that CMS revisit the weight for the DC Function measure. This functional weighting seems extreme for patients that are often at a stage in disease progress but are not ready to elect Hospice. Ultimately, this measure may promote cherry-picking of patients, resulting in the Home Health benefit not being realized for highly acute and/or chronic patients that are extremely sick and in increased total cost of care as symptoms exacerbate requiring higher levels of care.

CMS proposes to replace two claims-based measures (the Acute Care Hospitalization During the First 60 Days of Home Health (ACH) Measure and the Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use) Measure) with the one claims-based Home Health Within Stay Potentially Preventable Hospitalization (PPH) Measure. UnityPoint at Home is concerned that the PPH measure will penalize HHAs for patients with progressive disease states and for outcomes that are beyond the control of the HHA. This measure targets patients with at least one potentially preventable hospitalization or observation stay during the Home Health stay. Although not a new measure, the PPH measure is challenging for patients with complex needs, who have chronic conditions that are subject to exacerbation. Because the PPH measure is weighted at 26% for large-volume cohorts and 37.143% for smaller-volume cohorts, it promotes cherry picking leaving patients with chronic conditions requiring monitoring and more intensive services without needed in-home support and services and forced to seek care in a high-cost setting, which elevate total cost of care.

CMS proposes to replace the OASIS-based Discharged to Community (DTC) measure with the claims-based Discharge to Community-Post Acute Care (DTC-PAC) measure. Instead of OASIS documentation, DTC-PAC involves as 31-day post-discharge observation window, monitors unplanned admissions into a hospital or LTCH, and is weighted at 9% for large-volume cohorts and 12.857% for smaller-volume cohorts. We support the exclusion of discharges to hospice without adversely impacting DTC-PAC; however, UnityPoint at Home is also concerned that the DTC-PAC measure will penalize HHAs for patients with progressive disease states and for outcomes that are beyond the control of the HHA. The 31-day lookback period is static regardless of the length of the Home Health stay and reason for discharge (i.e. no longer meeting homebound status). As with the previous measure, we believe DTC-ACP promotes cherry picking leaving patients with chronic conditions requiring monitoring and more intensive services without needed in-home support and services and forced to seek care in a high-cost setting, which elevate total cost of care.
**MEDICARE HOME INTRAVENOUS IMMUNE GLOBULIN (IVIG) ITEMS AND SERVICES**

CMS proposed regulations to implement coverage and payment of items and services related to administration of IVIG in a patient’s home for a patient with a diagnosed primary immune deficiency disease (PIDD). Permanent coverage and payment of the items and services needed for in-home administration will start beginning on January 1, 2024.

Comment: UnityPoint at Home supports this proposal as a first step to provide an alternative to outpatient services. This is a covered benefit under Home Health offered by many commercial health plans. While we appreciate the ability to be reimbursed for the drug, this is not enough to further encourage uptake of this service. To further promote this within the home setting, CMS should consider eliminating the beneficiary co-pay and to permit Home Health to bill for Part B pump, pole and supplies.

**HOSPICE INFORMAL DISPUTE RESOLUTION (IDR) AND SPECIAL FOCUS PROGRAM (SFP)**

CMS proposes to codify a SFP for poor performing hospices that includes the SFP algorithm (including data sources) to identify indicators of hospice poor performance, the criteria for selection and completion of the SFP, hospice termination from Medicare, and public reporting of the SFP. CMS also proposes an IDR process to provide hospice programs an informal opportunity to resolve disputes related to condition-level survey findings for those hospice programs that are seeking recertification for continued participation in Medicare.

Comment: UnityPoint at Home supports the adoption of IDR and applauds the use of targeted interventions for poor performing hospices. UnityPoint at Home has historically urged CMS to employ targeted mechanisms to address poor performance or fraud, abuse and waste so as not to hamper or place additional administrative burdens on hospices who perform well. While we are supportive of the direction, the devil is in the details of implementation. UnityPoint at Home reiterates the request of NAHC in relation to the proposed hospice changes:

- **SFP recommendations** - For CMS to work with the existing SFP Technical Expert Panel (TEP) to improve the SFP algorithm, pilot the new algorithm prior to its application to hospices, and implement an interim performance report where all providers are given reports of their performance ranking under the algorithm metrics.

- **IDR recommendations** – For CMS to institute a timeline for survey entities to complete the IDR process and only utilize condition-level deficiencies in the algorithm after the statement of deficiencies has been completed without any outstanding IDR requests and to conduct ongoing data collection on hospice utilization of the IDR process and its results and make refinements, as necessary.

**REQUEST FOR INFORMATION: ACCESS TO HOME HEALTH AIDE SERVICES**

CMS seeks stakeholder feedback on information related to ensuring the appropriate access to and provision of Home Health aide services for all beneficiaries receiving care under the Home Health benefit.

Comment: UnityPoint at Home offers the following input.
• **Why is utilization of Home Health aides continuing to decline as shown in Table B2 and Figure B4 if the need for these services remains strong?** Utilization of Home Health aides is declining, and the root cause is multifactored. First, we cannot find this workforce. These are essentially non-skilled positions, and HHAs compete with non-healthcare entities for recruitment and retention. In terms of pure wages, we are competing with retailers, such as Walmart, Target or KwikStar, which pay equal or more for lesser job responsibilities and compliance rules. Home Health aides must also own reliable and consistent transportation, which is not attractive, at times, to this role with a lower pay scale. Competing settings that offer similar pay scales are more attractive in that the worker does not need to own a vehicle, or incur costs associated with that ownership, to work their shift. Second, from an operational perspective, reduced Home Health reimbursement forces service cuts, and retention of skilled and therapy positions will be prioritized over nonskilled positions, such as Home Health aides. Third, the episodic reimbursement structure does not afford redundancies, so skilled team members are often asked to perform these aide tasks in lieu of a separate Home Health aide visit. Fourth, employment of Home Health aides carry an added administrative burden and expenses to assure compliance with Home Health COPs and clean audits from survey agencies. When tasks are delegated to unlicensed professionals, there are associated trainings, management and oversight of those individuals to avoid survey deficiencies.

• **To what extent are higher acuity individuals eligible for Medicare (for example, individuals with multiple co-morbidities or impairments of multiple activities of daily living) having more difficulty accessing Home Health care services, specifically Home Health aide services?** Home Health referrals are routinely turned away due to lack of workforce capacity, which results from tight margins and reduced payer reimbursement. At UnityPoint at Home, when capacity limitations force us to turn away patients who are eligible for the Home Health benefit, we prioritize serving patients with higher acuity and immediate needs. Those whose plan of care may include Home Health aide services are included; however, other services are also impacted, such as social work and therapy.

• **What are notable barriers or obstacles that HHAs experience relating to recruiting and retaining Home Health aides? What steps could HHAs take to improve the recruitment and retention of Home Health aides?** In the proposed rule Ensuring Access to Medicaid Services (CMS-2442-P), CMS proposed to improve recruitment and retention efforts by requiring that at least 80% of Medicaid payments for personal care, homemaker, and Home Health aide services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit). While this was not adopted, UnityPoint at Home discourages CMS from taking a similar tact using Medicare Home Health payments. Although UnityPoint at Home supports initiatives for CMS to bolster the Home Health workforce, a mandated pass-through and the implication that a 20% remainder would be sufficient to not only cover administrative overhead but produce a profit woefully disregards the time and effort needed to support this unlicensed workforce under Federal and state regulations, including Home Health COPs and requiring management, education and oversight of the Home Health aides themselves.

• **Are HHAs paying Home Health aides less than equivalent positions in other care settings (for
example, are aides in the inpatient hospital setting or nursing home setting paid more than in Home Health? What are the reasons for the disparity in hourly wages or total pay for equivalent services? As part of an integrated health care system, UnityPoint at Home uses the same pay scale as our inpatient counterparts when recruiting and hiring of Home Health aides. But as noted previously, Home Health aides require a heightened critical thinking skillset with the ability to work independently that is not as crucial in a facility-based environment where other team members are physically present.

- **In what ways could HHAs ensure that Home Health aides are consistently paid wages that are commensurate with the impact they have on patient care that they provide to Medicare beneficiaries?** Payor mix, reduction in payment rates, and rising costs of recruitment and retention negatively impact the HHAs ability to provide reimbursement and subsequent annual pay increase commensurate with other settings.

- **How effective is the coordination between Medicare and Medicaid to ensure adequate access to Home Health aide services?** Please share insights on the level of utilization of Medicaid benefits by dually eligible beneficiaries for additional Home Health aide services that are not being provided by Medicare. The Program for All-Inclusive Care of the Elderly (PACE) is a capitated model established through a three-way partnership with the PACE Organization, CMS and the State. PACE is effective for those dual eligible beneficiaries meeting program requirements.

- **Are physicians’ plans of care less reliant on Home Health aide services in the past, or are HHAs less willing/able to provide these services?** If so, what are the primary reasons for why such services are not provided? It is misguided to associate the decline in Home Health aide utilization to physicians’ plans of care. When staffing does not exist, plans of care do not necessarily dictate the team member providing the service/role, but rather the service/role itself. The root cause of the decline is that CMS Home Health episodic reimbursement does not support robust staffing, particularly in rural areas where one team member may need to wear several hats. In many cases, HHAs cannot justify a separate visit by a Home Health aide when nurses or occupational therapists can perform these functions within their scope of practice during a skilled or therapy visit.

- **What are the consequences of beneficiary difficulty in accessing Home Health aide services?** When workforce challenges exist, capacity to serve eligible patients is compromised. When team members are not practicing at the top of licensure, this impacts the number of patients and the acuity level of patients being served.

**REQUEST FOR INFORMATION: PRINCIPLES FOR SELECTING AND PRIORITIZING HH QRP QUALITY MEASURES AND CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS**

CMS seeks stakeholder feedback to gather input on existing gaps in HH QRP measures and to solicit public comment on either fully developed HH measures, fully developed measures in other programs that may be appropriate for the HH QRP, and measurement concepts that could be developed into HH QRP measures, to fill these measurement gaps.

**Comment:** UnityPoint at Home appreciates the opportunity to offer input on future direction of the HH
QRP. First, we support the proposed principles for selecting and prioritizing HH QRP measures as these principles are aligned with other care settings and provide quality measure continuity. Second, CMS seeks input on identified measurement gaps, including in the areas of cognitive function, behavioral and mental health, and chronic conditions and pain management. UnityPoint at Home supports the specific recommendations contained in NAHC’s comment letter on identified measurement gaps.

ADDITIONAL INPUT – AT HOME CARE DELIVERY AND PAYMENTS

In November 2020, CMS announced the Acute Hospital Care at Home waiver, building upon the Hospital Without Walls program. Acute Hospital Care at Home is for beneficiaries with defined acute conditions who require an acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis. In order to gather more data, Congress extended this waiver program beyond the PHE through 2024.

Comment: CMS should consider facilitating a demonstration program to evaluate and create case uses beyond the limited diagnoses currently recognized under the Acute Hospital Care at Home waiver. UnityPoint Health, under the leadership of UnityPoint at Home (our Home Health arm), was one of the first six health systems with extensive experience providing acute hospital care at home approved for the hospital at home waiver. UnityPoint Health was the first to enroll a patient and to bill and be reimbursed under this waiver. As of May 30, 2023, 125 health systems with 281 hospitals in 37 states have applied and been approved to participate in this waiver. Given the infrastructure investment needed to stand up this program and the uncertainty of its duration, it is likely that more hospitals would participate under a program that has a longer duration and regulatory standing. UnityPoint Health encourages CMS to continue a platform to test the Acute Hospital Care at Home services beyond 2024.

Additionally, UnityPoint Health would welcome the opportunity to further discuss the potential for operationalizing a full array of Medicare At Home services with CMS. While we recognize that CMS stood up the hospital at home waiver as a result of the COVID-19 pandemic to avoid exposure to and spread of the COVID-19 infection, its efficacy beyond the pandemic and an inpatient setting is undeniable. Best practices and lessons learned from shifting care delivery to patients’ homes should be built upon, with the purpose of expanding At Home services from other care settings. UnityPoint Health has implemented an At Home care model that is a safe, high quality and cost-saving alternative for patients. By shifting care to home with the proper supports, UnityPoint Health has maintained high patient satisfaction rates (99+) and achieved outstanding clinical outcomes, including markedly reduced readmission and preventable ED visit rates. This was accomplished through a post-acute care bundling strategy under an accountable care organization waiver in which appropriate services are wrapped around the patient. Our bundles include a hospital to home (2-hour response time), primary care at home (4-hour response time), palliative care at home, and skilled nursing facility at home. Starting in 2023, UnityPoint Health began offering At Home services in some of our commercial health plan contracts. We attribute our expansion to commercial plans as a direct result of being able to demonstrate proof of concept via the Medicare waiver program.
We are pleased to provide input on this proposed rule and its impact on our patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,

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