UnityPoint at Home

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August 26, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1803-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1803-P - Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies; published at Vol. 89, No. 128 Federal Register 55312-55425 on July 3, 2024.

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 2025. UnityPoint at Home is the Home Health Agency (HHA) affiliated with UnityPoint Health, one of the nation's most integrated health care systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment, pharmacy, palliative care, and hospice care. In 2023, UnityPoint at Home provided nearly 266,000 home health visits. 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 the Medicare Shared Savings Program model, was an initial participant in the Home Health Value-Based Purchasing (HHVBP) 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 30-day

period, it is possible for a chronically ill patient with a progressive disease state to have two or more hospital stays or a Home Health episode with or without an initial hospital stay. In-home care is also an opportunity to enhance the patient experience and desire to meet the patient where they are at. This is the difference that Home Health can drive if guidelines appropriately incentivize these services.

While there is great promise in providing health care services in the home, CMS is eroding the traditional Home Health benefit, adversely affecting HHAs, and ultimately reducing access for Medicare beneficiaries. The Home Health benefit was initially developed to serve a different population than the Home Health patients of today who are more acute, more complex, and more resource intensive. As a whole, the industry is not serving low-acuity patients, specifically at the CMS expected projection from 2018 and 2019 as referenced in the proposed rule. HHAs struggle with staffing, the increased expenses of salaries and benefits and the unique significant amount of non-productive time due to travel, which is also growing as the number of agencies decrease and the number of employees in those agencies decrease. 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.

With respect to rural access, Home Health deserts are growing. While HHAs may be licensed in a rural zip code, licensure does not equate to utilization. As workforce challenges persist and reimbursement decreases, HHAs are forced to staff smaller geographies for efficiencies although their covered zip codes may remain static in hopes that staffing or reimbursement may improve. **The Home Health benefit itself must be re-examined and reinforced to incentivize rural outreach.** The elimination of the rural add-on payment in 2024 is not aligned with other prospective payment systems – hospital inpatient, hospital outpatient, and physician fee schedule – which provide payment add-ons or even special designations to support the increased cost of access in rural areas. Dating back to 2000, the rural add-on was 10% and decreased over time to 5%, 3%, 4%, 2% and eventually 1% in CY 2023.

As reiterated from our past comment letters, 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 to the same number of beneficiaries as in previous years. 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 Acute Hospital Care At Home model, and led the industry in development of episodic At-Home bundles (see Additional Input response at the end of this letter).

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

CMS proposes a 1.7% aggregate rate reduction for CY 2025 – a $280 million decrease from CY 2024. This reduction includes a permanent prospective cut of 4.067% based on PDGM and behavioral assumptions. CMS also proposes a new occupational therapy LUPA add-on factor as well as updates to the physical

therapy, skilled nursing, and speech-language pathology LUPA factors.

Comment: As stated by CMS, "we recognize that implementing both the permanent and temporary adjustments in the same year may adversely affect HHAs. Given that the magnitude of both the temporary and permanent adjustments together for CY 2025 rate setting may result in a significant reduction of the payment rate, we are not proposing to take the temporary adjustment in CY 2025."[1] The permanent adjustment alone will result in a -4.067 percent adjustment for CY 2025. **UnityPoint at Home opposes the continued erosion of Home Health episodic rates**. This year's 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 equates to less patients being served and poorer population health outcomes.

First, with inflationary pressures, **proposed rate reductions contradict 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 health care or other non-health care 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. Although UnityPoint at Home 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

[1] Page 55337 of the proposed rule.

caseloads as those in larger urban settings, like New York City. Smaller caseloads in rural service areas 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. Vehicle wear and tear 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 equates to a wage decrease. As noted above, the combination of cost of the employee given the lack of comparable productivity and excessive mileage/reimbursement is driving HHAs to rethink the outlying territories they service, thus reducing overall access to Home Health. And as an aside, while advances in telehealth and remote monitoring have been useful, they are not a panacea for rural access – technology cannot always substitute for an in-person visit and, in the case of remote monitoring, its equipment can be costly with limited shelf-life, Medicare does not provide reimbursement, and it has added documentation burden.

This is the fifth 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 to pursue a path of rate reductions that undercuts the financial viability of a huge segment of the Home Health industry. Sustainability of HHAs will be futile and continue to lead to closures and acquisitions, further reducing the beneficiary's choice of provider and access to providers. 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 -4.067% 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 being discharged from hospitals also facing reimbursement and nursing shortage challenges. We are frustrated that the CMS methodology does not account for the acuity shift that reflect individuals *actually receiving* the Home Health benefit. This is evident in both CY 2025 rate proposals related to MS Therapy and Wound clinical groupings. While these groupings are comprised of patients that are complex, resource intensive, and a higher compliance risk, it is puzzling that CMS would propose further rate reductions. With all things being equal, patient selection does not favor patients whose condition may require more supplies, more labor / staffing, an increased number / frequency of visits, and/or greater stay of care durations. For the Wound clinical grouping, service intensity and resources seem to result in more service denials.

- 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 – these positions are in demand industrywide, and the market

dictates higher wages. For the largely therapy-driven MS Therapy clinical grouping, this is particularly problematic for not only hiring therapists but then providing the level of services required. For instance, we have had a physical therapist vacancy for 7 ½ years in one of our rural markets. Additionally, the PDGM structure disincentivizes patient referrals that require more therapy services, despite a heightened mortality risk due to their homebound status. For high acuity patients requiring a lot of therapy, current methodology places these patients within the low or medium functional impairment level, which places significant financial pressures on our ability 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 and arbitrary 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 continue to 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.

Third, **we appreciate that CMS still recognizes low-utilization payment adjustment (LUPA) per visit payments, although the amounts are minimal and not aligned with inflation**. 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 8.00 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.** 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.

HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

CMS proposes to collect four new items and modify one current item as standardized patient assessment data elements in the Social Determinant of Health (SDOH) category. CMS also proposes an update to all-payer data collection to begin with the start of care OASIS time point instead of at time of discharge.

Comment: HHAs collect 200 data elements in the OASIS-E1 SOC assessment. UnityPoint at Home agrees that capturing meaningful and actionable SDOH items can enhance quality of life. **We support SDOH item collection with the caveat that the process is not administratively burdensome and not duplicative**. We question both the burden and repetitiveness of these data points in producing meaningful, new insights. UnityPoint at Home is part of an integrated health system that includes hospitals, urgent care centers, primary care and specialty clinics, and behavioral health settings, and we can attest that SDOH information is already being collected at numerous sites of care. From the home health perspective, it is highly unlikely that HHAs will be seeing a patient that has not recently been seen in another care setting, and therefore recently been asked these same SDOH questions. Prior to adding more assessment items (regardless of number), we request that CMS consider:

- How additional data collection may be streamlined into current collection processes? CMS should consider if data elements can be removed when new elements are proposed. OASIS will now include 204 elements.
- Will HHAs be collecting new or repetitive information? CMS could consider requiring referral sources to provide this information to HHAs to avoid duplicative effort from a health care workforce systemically plagued by staffing shortages.
- Whether the HH QRP IRC accurately reflects time and effort associated with data item collection? CMS suggests that clinician burden per OASIS assessment will increase 0.9 minutes for all four new items. When patients are identified as needing SDOH resources, it is unrealistic to suggest that clicking a button on an OASIS assessment will suffice. These questions entail discussion, commentary, and follow up. Additionally, for individuals with SDOH needs, many require resources in more than one SDOH category, which exponentially multiplies time and effort.
- If items are repetitively collected, how does such collection impact patient experience? In our experience, multiple collection points for the same information are often frustrating for our patients. We are told “I just gave that information to my doctor” or “the hospital just asked me this last week.” Ultimately, this negatively impacts patients’ perception of whether HHAs or our providers are informed or up to date.

To clarify, the above concerns may be translated to any additional data collection elements, and the current SDOH data element proposal is just an example of the expansion that CMS is currently proposing.

As for the proposed update to the all-payer data collection, UnityPoint at Home supports the point in time collection change. We do caution that an all-payer approach may have unintended consequences of reducing patient access as all payers do not require an OASIS assessment. When HHAs negotiate with other payers, HHAs must now embed costs related to OASIS assessment and reporting (i.e. sunk costs are increased). We have noted that, in several of our markets, multiple HHAs did not get favorable renegotiations, and other HHAs either opted out or were opted out of payer networks. Mandates,

including all-payer data collection, disproportionately impact small and/or rural HHAs.

REQUEST FOR INFORMATION: HH QRP QUALITY MEASURE CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

CMS seeks input on four concepts for future inclusion within the HH QRP.

Comment: As referenced in our HH QRP response, the OASIS-E1 SOC assessment is fairly comprehensive capturing 200 data elements with four additional SDOH elements proposed in this rule. **While UnityPoint at Home supports capturing meaningful and actionable items, the collection of additional items must be balanced with administrative burden and risk of duplication / assessment fatigue**. We offered considerations that CMS could evaluate in this process and urge that the process be streamlined versus more robust. CMS could additionally contemplate how it may facilitate streamlined data collection by serving as a repository for certain information and even pre-populating fields.

On the topics listed, we offer the following:

- Vaccinations – HHAs do not have access to national databases or oftentimes direct access to visit or immunization records. As such, the primary source of this information will be self-reporting and often unreliable.
- Depression – This is already covered. HHAs conduct PHQ 9 screening. If screening indicates, HHAs are responsible for provider follow up. And in terms of redundancy, this is a perfect example. It is not uncommon that an individual may be subject to a PHQ 9 screen four times over the course of one week – hospital, follow-up appointment, transitional care management (TCM) phone call, and home health.
- Pain Management – This is covered in OASIS and plans of care as well as in the HH CAHPS.
- Substance Use Disorders (SUD) – This is a need, and UnityPoint at Home has been seeing more patients/referrals with this condition. Generally, this population is frequently rejected by HHAs due to increased hospitalization risk and the tendency to not progress at a quick rate. We encourage CMS to explore not only the collection of SUD information but also to use SUD information for risk-adjusted payments to support additional resources and increased risk for rehospitalization.

REQUEST FOR INFORMATION: FUTURE PERFORMANCE MEASURE CONCEPTS FOR THE EXPANDED HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

CMS seeks input to build upon recommendations from the Expanded HHVBP Model's Implementation and Monitoring technical expert panel (TEP).

Comment: UnityPoint at Home was an initial participant in the original HHVBP Model in Iowa. The seventh-year annual report found that "the original HHVBP Model did reduce unplanned hospitalizations, reduced the number of ED visits leading to hospitalization, and increased quality as measured through the TPS for beneficiaries requiring home health services." To avoid burden and align incentives, the initial model utilized existing OASIS and HH CAHPS measures in addition to claims-based measures. This RFI highlights a continued divergence of the Expanded HHVBP from the HH QRP. Program incentives are different, making prioritization by HHAs difficult. **UnityPoint at Home does not support growth of the**

Expanded HHVBP measure set without further clarity related to impact on and alignment with the HH QRP and how CMS intends to curb administrative burden and duplicative work and reporting.

MEDICARE HOME INTRAVENOUS IMMUNE GLOBULIN (IVIG) ITEMS AND SERVICES

*The proposed CY 2025 home IVIG items and services payment rate is the CY 2024 IVIG items and services payment rate of $420.48 updated by the proposed home health payment update percentage of 2.5 percent ($420.48 * 1.025 = $430.99).*

Comment: Overall utilization of this benefit continues to plummet year over year. This is disappointing for a once-promising benefit. While we applaud Congress for its intention to create a comprehensive Medicare home infusion benefit in the 21st Century Cures Act, flawed implementation by CMS has led to operational hurdles and major access issues for Medicare beneficiaries. As currently structured, we still believe CMS has established a complex, costly, and inefficient process for a limited benefit and have detailed our concerns in past annual comment letters dating back to the CY 2019 proposed Home Health payment rule. Alternatively, **UnityPoint at Home does support the Preserving Patient Access to Home Infusion Act (H.R. 4104 / S. 1976).** This legislation would restore congressional intent and promote access to home-based care by mirroring the successful model employed by nearly every commercial plan.

HOME HEALTH CONDITIONS OF PAYMENT (CoPs) UPDATES

CMS proposes to require HHAs to develop, implement, and maintain a patient acceptance to service policy, which must address, at a minimum, the following criteria: anticipated needs of the referred prospective patient, HHA's caseload and case mix, HHA's staffing levels, and skills and competencies of the HHA staff. CMS also proposes that HHAs make available to the public accurate information regarding the services offered by the HHA and any service limitations related to types of specialty services, service duration, or service frequency.

Comment: UnityPoint at Home opposes placing more directives within HH CoPs. As described in the preamble, this issue would seem to fall squarely within state and regulatory body oversight. During state and regulatory assessments/surveys, HHAs provide regulators with both referral lists and lists of individuals not accepted into care. Regulators do review these lists and delve into reasons for patient rejections/denials by HHAs. If CMS believes that patient acceptance to service processes and procedures should be beefed up, there is an existing forum for this review with experienced evaluators to identify and solve for these issues. **To address this concern more directly, we recommend that CMS supplement the admissions criteria guidance to surveyors under the state operations manual and let state and regulatory bodies do their jobs**. This does not require further CoP revisions.

REQUEST FOR INFORMATION: REHABILITATIVE THERAPISTS AND HHAs SCOPE OF SERVICES

CMS seeks information on two issues: (1) the feasibility of rehabilitative therapists conducting the comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care; and (2) how HHA scope of services interact with HHA operations – specifically, information on communications between patients' physicians and allowed practitioners in establishing and reviewing the plan of care; and how the physician and allowed practitioners ensure patients receive the right mix, duration, and frequency of services to meet measurable outcomes and goals.

Comment: UnityPoint at Home appreciates the opportunity to provide stakeholder input and offers feedback on select questions below.

Rehabilitative Therapists Conducting the Initial and Comprehensive Assessment

Assessment bottlenecks are often the result of workforce shortages, particularly in professions like nursing. The bottom line is that patient access will be timelier if more clinicians/disciplines are able to conduct assessments. **We applaud CMS for considering how to better leverage home health clinicians to promote top-of-licensure practice and embed flexibility into HHA operations**. Home Health CoPs on this topic were written when educational and training requirements were vastly different and much less strenuous than today. In addition to nurses, HHAs should be able to rely on PTs to conduct initial assessments with guardrails for multiple-discipline orders. Entry-level PTs in particular have a doctorate degree. PT coursework encompasses assessments, and PT scope of practice includes prescribing their own therapy and, in many States, prescribing medications as well. PTs are trained to make critical identification, including to know when and how to call/contact a nurse or a physician. Furthermore, the competency of PTs to perform initial assessments is also reinforced by the fact that the majority of the OASIS assessment is aligned to the PT scope of practice. While PTs currently conduct therapy-only initial assessments, the doctoral preparation of PTs makes them an appropriate substitute for a nurse in the initial nursing assessment as long as guardrails are present to dictate when a nurse should be present or perform an initial assessment. Guardrails could include certain conditions / diagnoses. For instance, HHAs may want a nurse to conduct the initial assessment for patients requiring certain wound care, lab draws, IVs, or other skilled services. Additionally, when an initial assessment conducted by a PT identifies a nursing need, HHAs may want to trigger an expedited timeframe (e.g. 72 hours) for a nurse to assess clinical needs, medication, and disease management, and the like. During the COVID PHE, UnityPoint at Home utilized the assessment waiver to great success – PTs performed initial assessments, timely access was increased, staffing models were more efficient, and no adverse outcomes resulted. And nationally as an industry, there was not a drop in the national benchmarks or thresholds when the waiver was in place to permit PTs to open nursing cases.

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

  For any HHA therapist (PT, OT, and speech), it only makes sense that they conduct initial assessments for therapy-only cases. During the PHE waiver, UnityPoint at Home utilized PTs to conduct certain multi-disciplinary assessments with guardrails. This waiver was implemented in the absence of prescriptive Home Health CoPs or regulations. Should CMS decide to authorize this practice, we urge CMS to simply permit this flexibility within the initial assessment CoP and without prescriptive regulatory requirements. Based on the CoP, HHAs would adopt an assessment practice or process, and state agencies / regulators would evaluate the HHA practice to assure they are using it appropriately – are the HHAs sending the right discipline (i.e. PT versus OT), are the skills commensurate to the patient need (i.e. infusion competency nurse for infusion patient), is the nurse follow up timely, were labs drawn e PT opened a nursing care, whether lab draws occurred timely, etc.

- Do the education requirements for entry-level rehabilitative therapist provide them with the skills to perform both the initial assessment and comprehensive assessment? Is this consistent across all the therapy disciplines? How does this compare with entry-level education for nursing

staff?

The PT scope of practice is remarkably similar to a nurse. Entry-level PTs have a doctorate degree. PT coursework includes assessments, and PTs are even allowed to prescribe medications. Entry-level nurses may have a RN (e.g. two-year degree).

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

UnityPoint at Home utilized the waiver and did not experience adverse quality outcomes.

- For the HHAs and therapists that conducted the initial assessment and comprehensive assessment under the PHE waiver, what were the benefits and were there any unintended consequences of this on patient health and safety?

UnityPoint at Home utilized the waiver. The initiation of care was more timely, staffing workflows were more efficient, and no unintended consequences to patient health and safety were noted.

- What challenges, barriers, or other factors, such as workforce shortages, particularly in rural areas, impact rehabilitative therapists and nurses in meeting the needs of patients at the start of care and early in the plan of care?

Workforce challenges persist for nursing and therapy disciplines and cause delays in start of care.

Plan of Care Development and Scope of Services Home Health Patients Receive

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

Home Health benefit CoPs set the floor for our business plan and, in some cases, the prescriptive nature of the CoPs hamper or even prevent services from being offered. For example, the choice to provide medical social work in the business model is directly tied to the ability to meet the CoP of a Masters-prepared Social Worker (MSW). In many rural areas, only Bachelors-prepared Social Workers (BSW) are available, but the CoP requires MSWs to supervise BSWs. The Home Health CoP is effectively restricting the BSW scope of practice. Therefore, many HHAs are simply unable to provide medical social work. As a larger organization with 13 home health service areas, UnityPoint at Home is only able to employ MSWs in two HHAs and must rely on staffing agreements for MSWs to review BSW-prepared care plans at our affiliated HHAs. Another CoP constraint restricts the use of contract employment; specifically, that one discipline must be comprised solely of employees (i.e., W-2 status). Within the current health care industry environment plagued with workforce shortages, this further complicates staffing decisions and creates a no-win situation. In one State, we address this by employing social work so that we can contract for nurses. In another State, the Home Health CoP is further refined by the State which specifies nursing as the employed discipline and effectively requires any contracted nursing arrangements to receive State approval.

HHAs are also constrained by reimbursement and must balance the ability to serve patients while sustaining operations. The Medicare Home Health benefit has no level of reimbursement that covers HHAs expenses to provide the *maximum* level of services allowed within the benefit manual. HHA services need to be flexible to meet individual needs; however, industry utilization

patterns seem to vary within service areas based on ownership and/or affiliation.

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

  Patient acuity and demand for home-based services is ever increasing. With limited staffing and resources, the question that CMS should ask is what factors influence HHAs' acceptance of a referral. For UnityPoint at Home, acceptance depends upon staffing capacity to meet the level of patient acuity, the presence of a willing and able caregiver, and a safe environment to permit patient progress. This is truly a case-by-case decision that may have point-in-time staffing constraints.

MEDICARE PROVIDER ENROLLMENT

CMS proposes to add providers and suppliers that are reactivating their Medicare billing privileges to the categories of new providers and suppliers that may be subject to additional oversight, such as a provisional period of enhanced oversight (PPEO) for 30 days to one year.

Comment: UnityPoint at Home appreciates CMS' desire to reduce and prevent fraud, waste, and abuse and supports oversight by CMS when warranted. As proposed, PPEO is permissive and not mandated for these providers/suppliers. While we generally support the addition of PPEO in the CMS oversight toolbox for certain providers and suppliers reactivating their Medicare billing privileges, PPEO entails significant administrative costs for prepayment reviews and capping payments that add unnecessary stress on nonfraudulent providers/suppliers. **We urge CMS to use constraint and target its PPEO efforts, such as establishing guardrails to limit the blanket PPEO use.** Such guardrails may include reactivations due to missing a revalidation period, moving to a new owner who has not had fraudulent/abusive behavior, not billing within a 6-month period, or other reasons that fail to raise suspicion of reactivation for inappropriate (i.e. fraud, waste, and abuse) purposes.

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. To monitor progress, Congress extended this waiver program beyond the PHE through 2024.

Comment: UnityPoint Health encourages CMS to share waiver uptake and program outcomes with Congress in order to continue a platform to test the Acute Hospital Care at Home services beyond 2024. This platform enables patients to be cared for at home and supports efficiencies within the inpatient setting. Under the leadership of UnityPoint at Home (our Home Health arm), UnityPoint Health was one of the first six health care 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 Medicare waiver. As of August 7, 2024, there are 334 CCNs approved representing 136 health systems with 335 facilities in 38 states that 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, UnityPoint Health has limited our participation to two hospitals; however, it is likely that more hospitals would participate under a program that has a longer duration and firm regulatory standing.

Additionally, UnityPoint Health would welcome the opportunity to further discuss with CMS the potential for operationalizing a full array of Medicare At Home services and permitting patient admissions that originate from the home. 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 (97%) 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 hospital to home (two-hour response time), primary care at home (four-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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