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August 29, 2025

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1828-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1828-P - Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and HH Value-Based Purchasing Expanded Model; Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies; published at Vol. 90, No. 125 Federal Register 29108-29339 on July 2, 2025.

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

Dear Administrator Oz,

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 2026. 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, infusion pharmacy, specialty pharmacy, palliative care, and hospice care. In 2024, UnityPoint at Home provided 222,400+ home care visits and 197,300+ home medical equipment orders. 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. The CMS Innovation Center found both HHVBP and MCCM reduced total Medicare expenditures, consistent with UnityPoint at Home's performance.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. **As a member of the National Alliance for Care at Home (Alliance) and the Iowa Health Care Association, we generally support the comments submitted by these organizations to this rule.** In addition, UnityPoint at Home respectfully offers the following comments to the proposed regulatory framework.

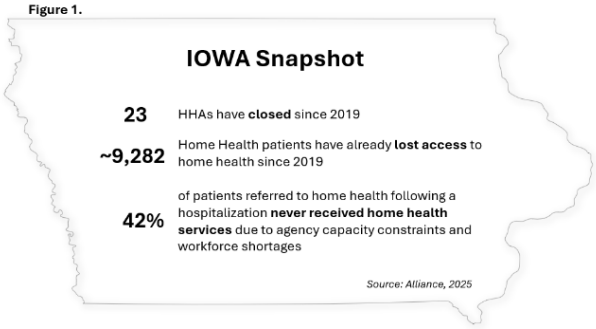
GENERAL COMMENTS

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 alternatively a less-costly Home Health episode with or without an initial hospital stay. In-home care is also an opportunity to enhance the patient experience and meets the patient where they are. This is the difference that Home Health can drive if guidelines appropriately incentivize these services.

While there is great promise in providing healthcare 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, making the case mix cutoffs faulty.[1] Instead, acuity is an escalating target as average case complexity increases. HHAs struggle with staffing, the increased expenses of salaries and benefits, and the unique and significant amount of non-productive time due to travel and lengthy regulatory documentation requirements, which is also growing as the number of HHAs decrease and the number of employees in those HHAs decrease. With healthcare consolidation being second-guessed by regulators, policymakers, and the media, we question that this rule 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 or approved to serve patients in a rural zip code, licensure/approval 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 Home Health rural add-on was 10% and decreased over time to 5%, 3%, 4%, 2% and eventually 1% in CY 2023.

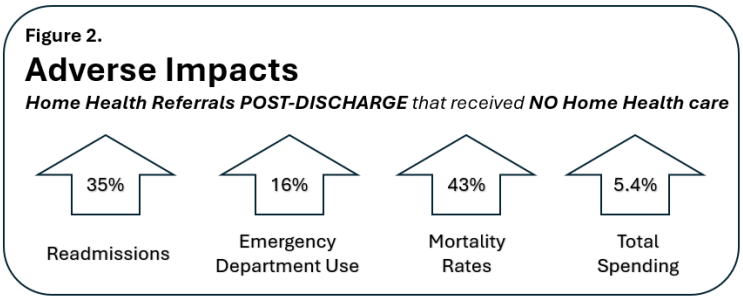
Figure 1.



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 (see Figure 1 – Iowa Snapshot).

[1] Page 29301 – "*To define case mix cutoffs, low, medium, or high acuity are based on less than the 25th percentile, between the 25th and 75th percentiles, and greater than the 75th percentile of average HCC scores, respectively, across HHAs in CY 2021.*"

Nationally, when patients were referred but did not receive home health care after hospitalizations, outcomes suffered (see Figure 2 – Adverse Impacts). **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 and/or CMMI 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 we have 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 6.4% aggregate rate reduction for CY 2026 – a $1.135 billion decrease from CY 2025. This rate includes a proposed update of 2.4% combined with a permanent prospective cut of -3.7% based on PDGM and behavioral assumptions, a temporary adjustment reduction of -4.6%, and a -0.5% adjustment decrease for the updated FDL ratio. CMS also proposes to recalibrate the case-mix weights and LUPA thresholds using CY 2024 data.

Comment: CMS is proposing a nearly 9% reduction in the home health 30-day payment rate, marking the most significant single-year reimbursement cut to the home health industry in recent memory. The combined impact of the permanent and temporary adjustment is both unrealistic and unsustainable. CMS acknowledged this injustice when considering this cumulative approach last year – "*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.*"[2] It is unfathomable that CMS would arbitrarily apply this extreme cut to an entire industry where beneficiaries prefer and choose to receive care. Applying these extreme cuts to the most cost-effective setting in healthcare will be catastrophic for the vulnerable populations serviced by home health. Other, more costly, healthcare settings are not penalized at similar lengths.

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 healthcare 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

[2] Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update Proposed Rule, 89 (128) Federal Register 55337.

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 healthcare or other non-healthcare industries increase wages, Home Health must compete or lose experienced team members such as 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 non-routine 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**. Supply costs are not regulated, thus even when attempting to provide the most cost-effective, appropriate option, the costs of supplies can exceed what an HHA is able to provide under the given payment. For this reason, it is common in this industry for some for-profit HHAs not to accept patients to care that will require a high supply need.

- Mileage: For Home Health, particularly in rural areas, this reimbursement component is crucial. From an HHA 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. 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 SIXTH 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-2019 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 reverse the overly broad application of PDGM behavioral assumptions to assure accuracy and validity. **The proposed permanent behavioral adjustment of -4.059% is not sustainable, and 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 the 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 reflects individuals actually receiving the Home Health benefit. This is evident in both CY 2026 rate proposals related to MS Rehab 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 Rehab 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 8 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 7.86 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.

Fifth, **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. And in terms of beneficiary access, MedPAC found that "on average, MA enrollees received fewer visits than FFS beneficiaries within the same HHA."[3]

Finally, a **global reduction is contrary to the focus of CMS to target fraud, waste, and abuse**. A universal reduction is not a targeted approach. Rather it presumes that all HHAs can absorb significant reimbursement reductions. Most nonprofit HHAs have tight operating margins and their patients will be disproportionately impacted. For 2023, MedPAC found an 8.2 percent difference in FFS Medicare margins between for-profit and nonprofit freestanding HHAs, and alarmingly, an average –16.5 percent FFS Medicare margin for hospital-based HHAs.[4]

For the reasons stated above, **UnityPoint at Home requests that CMS finalize a rate update that supports**

[3] Chapter 3: Examining home health care use of Medicare Advantage enrollees, June 2025 Report to the Congress: Medicare and the Health Care Delivery System, page 167 accessed at https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch3_MedPAC_Report_To_Congress_SEC.pdf

[4] March 2025 Report to the Congress: Medicare Payment Policy, Chapter 7: Home health care services, pages 241-242 accessed at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf

financial stability for HHAs and avoids industry-wide financial adversity. Industry disruption, which significantly reduces healthcare access in a community-based and low-cost setting, is ill-timed, ill-advised, and counterintuitive to serving patients where they are.

FACE-TO-FACE ENCOUNTER POLICY

In addition to nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), CMS proposes to allow physicians to perform the face-to-face encounter regardless of whether they are the certifying practitioner or whether they cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.

Comment: UnityPoint at Home supports this policy.

HOME HEALTH QUALITY REPORTING PROGRAM (HHQRP)

CMS proposes to (1) remove the COVID-19 Vaccine: Percent of Patients Who Are Up to Date measure, (2) remove four SPADES under the SDOH category, (3) clarify its policy to reconsider submission of complete and timely data, (4) implement a revised HHCAHPS Survey beginning with the April 2026 sample month, and (5) update regulatory text to account for all-payer data submission of OASIS data.

Comment: Aside from input below on HHCAHPS Survey administration and public reporting, UnityPoint at Home supports these changes.

Overall, UnityPoint at Home raises concern about patient survey fatigue due to the sheer number of surveys being asked of patients across care settings. Specific to the HHCAHPS Survey:

- Survey Length: We consistently receive feedback from our patients that it is too long. It is currently 34 questions and, according to Press Ganey, it takes an average of 12 minutes to complete.[5] **We support efforts to streamline**. Composite scoring does not shorten the time needed to complete the survey.
- Survey Completion: The definition of a "completed survey" is completing at least 50% of the core questions (or at least 10 of the 20 questions, excluding questions in skip patterns and in the "About You" section). Responses of "Don't Know" and "Refuse" are deemed non-responsive. **UnityPoint at Home believes that all HHCAHPS Surveys with at least one response should be included in the response rate and deemed to be complete**.
- Case-Mix Adjustment for Diagnosis: **We are extremely concerned and oppose the removal of adjustments for the diagnoses of schizophrenia or dementia**. Despite findings these adjustments were "no longer significant," we do not believe that one Mode Experiment is adequate testing for this blanket policy given its potential impact on generally low response rates for HHCAHPS Surveys. Also, with the unpredictable nature of these diagnoses, completed surveys may not accurately reflect the totality of the patient experience. We also believe that this policy will have the unintended consequence of lemon-dropping these patients with these

[5] https://info.pressganey.com/press-ganey-blog-healthcare-experience-insights/home-health-cahps-101-what-this-patient-survey-means-for-home-care-organizations

diagnoses.

REQUEST FOR INFORMATION: HHQRP QUALITY MEASURE CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

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

Comment: The OASIS-E1 SOC assessment is fairly comprehensive, capturing nearly 200 data elements. **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**. In its current form, capturing and documenting onboarding information for one patient can take up to four hours. We would rather spend time on direct care and less on data gathering and documentation.

REQUEST FOR INFORMATION: FINAL DATA SUBMISSION PERIOD

CMS seeks input on reducing the final data submission period from 4.5 months to 45 days. Feedback is solicited on how this reduced timeframe may improve timeliness and actionability of quality measures, improve public display of information, and impact HHA workflows and/or require system updates.

Comment: UnityPoint at Home supports reducing the deadline for OASIS assessments from 135 days to 45 days. We agree that public reporting on Home Health Compare is valuable for patients and families and should be more timely.

REQUEST FOR INFORMATION: ADVANCING DIGITAL QUALITY MEASUREMENT IN THE HH QRP

CMS solicits comments to assess the feasibility of using the FHIR standard for the submission of OASIS data. The objective is to explore how HHAs typically integrate technologies with varying complexity into existing systems and how this affects HHA workflows. Input is sought on integration challenges or opportunities as well as support required to implement OASIS submissions.

Comment: UnityPoint at Home offers input on selected questions below.

To what extent does your HHA use health IT systems to maintain and exchange patient records? If your agency has transitioned to using electronic records, in part or in whole, what types of health IT does your HHA use to maintain patient records? Are these health IT systems certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program?

UnityPoint at Home utilizes EMR technology for home health patient documentation and care. We have a single instance of EMR for all patient care platforms within our health system. This software utilizes CERHT requirements for patient data exchange through various Health Information Exchange and EMR functionality. We maintain the most current CEHRT version of Epic, as defined by the ONC.

Does your HHA submit patient assessment data to CMS through your current health IT system? If a third-party intermediary is used to report data, what type of intermediary service is used? How does your agency currently exchange health information with other healthcare providers or systems, specifically between HHAs and other provider types? What about health information exchange with other entities, such as public health agencies? What challenges do you face with electronic exchange of health information?

UnityPoint at Home exchanges data with other healthcare providers and public health agencies across our multistate footprint, but faces challenges due to inconsistent state data sharing laws, regulations, and submission methods. In one state, providers pay a third-party vendor to submit CMS-required

state-level public health data. That vendor created unique submission requirements different from USCDI standards, which are financially burdensome and resource intensive. Additionally, not all healthcare providers maintain direct addresses for data exchange, and the NPPES provider directory is often outdated. Lastly, some HHAs use third-party EMR support which can complicate direct address sharing.

Are there any challenges with your current electronic devices (for example, tablets, smartphones, computers) that hinder your ability to achieve interoperability, such as collecting, storing, sharing, or submitting data? Please describe any specific issues you encounter. Does limited internet or lack of internet connectivity impact your ability to exchange data with other healthcare providers, including community-based care services, or your ability to submit patient assessment data to CMS? Please specify.

Due to "being in the field" for home health care, connectivity issues often hinder immediate data exchange. Internet connectivity may be limited, especially in rural areas. Workarounds like hotspots, network locations, and VPNs are in place, but are not always available.

What steps does your HHA take with respect to the implementation of health IT systems to ensure compliance with security and patient privacy requirements such as HIPAA?

UnityPoint at Home reviews HIPAA laws to ensure we are meeting and protecting Patient Health Information requirements. UnityPoint at Home further investigates state requirements to ensure we meet the most strict laws to maintain compliance.

Does your HHA refer to the Safety Assurance Factors for EHR Resilience (SAFER) Guides to self-assess EHR safety practices?

Yes. Portions of the SAFER Guides and a "home grown" security risk assessment are utilized for services provided in the home.

Does your facility have any experience using technology that shares electronic health information using one or more versions of the United States Core Data for Interoperability (USCDI) standard?

UnityPoint at Home has experience with the USDCI standard and APIs based on the FHIR standard. While we support structured data elements to assist in standardized reporting, platforms to collect, warehouse, and ultimately report data vary, which adds provider burden. In one of our states, a third-party vendor serves as an HIE and data warehouse for the State public health agency and is charged with supporting our state's public health data submission utilizing USCDI standards. This vendor created their own message system to submit USCDI data that does not utilize EMR software technology standards outlined under ONC's CEHRT standards. To submit USCDI data, providers must now "build" interface connections. Additionally, the vendor often exceeds base data submission guidelines for public health reporting standards under the USCDI. This nonstandard reporting requires extra burden and expense for providers.

How could the Trusted Exchange Framework and Common Agreement™ (TEFCA™) support CMS quality programs' adoption of FHIR®- based assessment submissions consistent with the FHIR® Roadmap? How might patient assessment data hold secondary uses for treatment or other TEFCA™ exchange purposes?

UnityPoint Health, our parent organization, is a member of TEFCA under the Epic Nexus contract. This ensures standardized FHIR API use and data sharing among QHIN organizations and facilitates sharing of patient assessment and EMR data. Non-TEFCA sites face barriers due to inconsistent standards.

What other information should we consider that could facilitate successful adoption and integration of FHIR®-based technologies and standardized data for patient assessment instruments like the OASIS?

For FHIR technology to be easily adaptable and capable of expanding the Health Information Exchange, FHIR technology needs to be standardized and consistent across EMR vendors, healthcare facilities, and those identified entities receiving the data, such as public health agencies and CMS.

HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

CMS proposes to add a ninth measure removal factor for situations when it is not feasible to implement the measure specifications. CMS also proposes to remove three measures from the measure set due to revisions to the HHCAHPS Survey and add four measures. To align with measure set changes, individual measure weights and category weights are updated.

Comment: UnityPoint at Home was an initial participant in the original HHVBP Model in Iowa. According to CMS, the original model "*resulted in an average 4.6 percent improvement in HHAs' total performance scores (TPS) and an average annual savings of $141 million to Medicare without evidence of adverse risks. The evaluation of the original model also found reductions in unplanned acute care hospitalizations and skilled nursing facility (SNF) stays, resulting in reductions in inpatient and SNF spending*."[6] To avoid burden and align incentives, the initial model utilized existing OASIS and HHCAHPS measures in addition to claims-based measures. **This rule highlights the continued divergence of the Expanded HHVBP from the HHQRP. Program incentives are different, making prioritization by HHAs difficult**.

- Addition of Three OASIS-Based Function Measures – As recommended by the TEP, CMS proposes to include (1) Improvement in Bathing (based on OASIS item M1830); (2) Improvement in Upper Body Dressing (based on OASIS item M1810); and (3) Improvement in Lower Body Dressing (based on OASIS item M1820). First, we disagree with the inclusion of Section M items altogether. While intended to complement the Discharge Function Score measure, the reversion to include Section M items seems counterproductive as the OASIS E1 uses Section GG items. CMS' rationale for transitioning the assessment to GG items was to be able to benchmark cross continuum. **We would rather rely solely on the discharge function score and wait for the future and "permanent" Section GG items, instead of temporarily using Section M measures for benchmark, achievement, and improvement thresholds**. When temporary / interim measures are introduced, we anticipate this will create confusion and disjointed benchmarks when the eventual transition to Section GG measures are made. Second, we disagree with the CMS' approach to functional assessment weighting. **The proposed HHVBP points/weights disregard resources needed to care for, assist, and make progress with patients with functional impairments**. For example, a bathing assessment of A5 or A6 currently equates to 18 OASIS points, whereas the proposed HHVBP score is 3.5 points. Bathing, dressing, and ambulation generally require labor-intensive work and more frequent visits. Although functional assessments suggest the need for robust home care aide services, the proposed HHVBP weighting (as well as OASIS scoring) and inadequate reimbursement does not suggest that HHAs

[6] https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model

should prioritize such services. Third, **UnityPoint at Home urges CMS to continue to de-emphasize self-reported OASIS measures, and instead recalibrate HHVBP scoring to target claims-based and patient experience measures to 2025 weights**. We do not support re-weighting OASIS-based to 40%; nor do we support including more OASIS measures. Self-reported measures are subject to reporting manipulation, provider subjectivity, and greater administrative burden. Overall, OASIS measures should be reduced from its current 35% weight and not increased.

- Addition of Medicare Spending Per Beneficiary Post-Acute Care (MSPB—PAC) – Although UnityPoint at Home generally supports claims-based measures, this measure is overly broad and holds HHAs responsible for services outside the home health episode**. UnityPoint at Home does not support including this measure in the HHVBP measure set.** This claims-based measure holds HHAs accountable for Medicare payments for an episode of care that includes the period during which a patient is directly under HHA care, as well as a defined period after the end of HHA treatment. The MSPB-PAC measure captures Medicare spending for most Part A and B services during the episode of care, excluding services that are clinically unrelated to post-acute care treatment or services over which HHAs may have limited to no influence (for example, routine management of certain preexisting chronic conditions). First, Home Health is a low-cost, high-quality service but it is not a comprehensive benefit and should not be treated as such. Home health services do keep patients out of inpatient settings and should not be penalized if (1) to prevent an inpatient admission one or more physician visits, including specialist visits, occur, or (2) patients do not receive timely physician orders to treat them in the home. For instance, many primary care providers do not have after-hours on-call services, so patients are sent to costly levels of care for timely treatment. In other instances, when physicians are reached after-hours, typical responses are to "send the patient to the ER" instead of critically thinking about the case for a home-based solution or treatment. Until regulations are established that require physicians to be available after hours and penalize them for automatically referring to the ER, it is nonsensical to hold HHAs accountable for this uncontrollable metric. Generally, it is foolhardy to believe that Home Health services without support from other healthcare professionals should manage an increasingly acute and chronic population. It is the individualized wrapping of healthcare services that avoid hospitalizations and maintain patients in the community. Second, this measure will undoubtedly increase patient cherry-picking by for-profit HHAs as extraneous costs attributed to a Home Health episode will drive up Home Health costs. We encourage CMS to monitor this concern. Third, ultimately patients lose. Patients that are now able to be cared for in their homes will be hospitalized.
- HHCAHPS Reweighting – **UnityPoint at Home opposes the reduction in patient experience measures and urges CMS to recalibrate HHVBP scoring to target patient experience and claims-based measures to 2025 weights**. Specifically, CMS should reweight the remaining two HHCAHPS measures at 15% each and 30% for the measures type. We reiterate our concern that the OASIS based measures are overemphasized and subject to reporting manipulation.

REQUEST FOR INFORMATION: HHVBP QUALITY MEASURE CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

CMS seeks input on one specific performance measure as well as general comments on other potential future model concepts that may be considered for inclusion in the expanded HHVBP Model. Stakeholders are encouraged to consider how to reduce burden on HHVBP Model participants without compromising on the quality of care.

Comment: UnityPoint at Home appreciates the opportunity to provide stakeholder input. **UnityPoint at Home does not support growth of the Expanded HHVBP measure set without further clarity related to impact on and alignment with the HHQRP and how CMS intends to curb administrative burden and duplicative work and reporting**. In general, we prefer static and accurate measure sets without frequent changes.

- Falls With Major Injury Measure (OASIS-Based and Claims-Based): While intended as a cross-setting measure, this measure is difficult for HHAs which do not have "captive" patients. Without cognitive qualifiers, it is challenging to prevent falls despite mitigation efforts including environmental safeguards/alterations, patient/caregiver education, ambulatory aids, and even technology (such as remote monitoring). *To treat HHAs like Hospital or SNF settings, we would suggest that this measure be limited to falls with major injury that occur while HHA providers and/or team members are present on a home visit*. **As proposed, we would not support inclusion**.
- Measuring HHA Performance on Forthcoming HHCAHPS Items Based Only on HHA Achievement: **We do not support** as there is merit to being able to demonstrate improvement against yourself as opposed to being solely benchmarked to your peers. Additionally, HHCAHPS deciles are fairly compact, so a change to "achievement only" may not reflect overall quality.
- Adding Three Remaining Items in the Specific Care Issues HHCAHPS Measure as Single Item Measures: **We reiterate that patient experience and claims-based measures should reflect at least 2025 scoring weights**. While we are indifferent about the consolidation of three items in the HHCAHPS specific care issues measure, the HHCAHPS is still too long, which frustrates patients and negatively impacts survey completion. Please reference our HHCAHPS comments under the HHQRP narrative above in this letter.

HOME HEALTH CONDITIONS OF PAYMENT (CoPs) UPDATES

CMS proposes technical changes to update terminology to clarify that the requirement for reporting OASIS information applies to all HHA patients receiving skilled services.

Comment: We support the technical changes.

DMEPOS PROVIDER ENROLLMENT

CMS proposes several provisions related to DMEPOS provider enrollment. CMS also proposes revised DMEPOS accreditation policies as well as an exemption process for prior authorization of certain DMEPOS suppliers.

Comment: UnityPoint at Home is a member of the Midwest Association for Medical Equipment Services

and Supplies (MAMES) and VGM[7] and supports their DME comment letters. UnityPoint at Home provides input on select issues that follow.

DMEPOS Liability Insurance – Suppliers are required to have comprehensive liability insurance policy of at least $300,000 that covers the supplier's place of business, customers, and employees. To assure that the insurance policy is signed by an individual with the authority to obligate the HHA, CMS proposes to modify §424.57(c)(10) such that an ''authorized official'' of the supplier (as that term is defined in §424.502) must sign the liability insurance policy.[8] As part of a health system and potentially when an HHA is hospital-based, the liability insurance may be at a health system or hospital level and would not allow for the authorized official of the supplier to sign the policy. It is unclear whether reference to "direct owner" would extend to authorized officials of a parent organization. **We recommend that the proposed language be expanded to allow for non-supplier authorized officials to sign Liability Insurance policies for HHAs wholly owned by health systems or hospitals**.

Medicare provider enrollment provisions –

- Definition of "Abuse of Billing Privileges" – "Abuse of billing privileges" is among the reasons that CMS may revoke or deny a Medicare provider's enrollment. CMS proposes to expand this definition for situations in which "the beneficiary attests that the item(s) or service(s) identified on the provider's or supplier's claim or claims was not or were not rendered or furnished."[9] **As pointed out by CMS, paragraphs (a)(8)(i)(A) through (C) are not exclusive, which renders this new language unnecessary**. **This is already something that beneficiaries can, and do, report.** In our experience, beneficiaries do review their statements and question services provided. We field calls / emails and receive patient satisfaction survey comments and in many cases beneficiaries in good faith have "misremembered" not receiving the service (i.e., the service was provided) or did not understand the billing statement (e.g., various components for items such as CPAP supplies). Examples of areas where patients do not remember include, but are not limited to, DME deliveries at the time of discharge from a hospital as well as services provided at a clinic through a consignment closet. The unintended consequence of including specific attestation language is that all attestation cases are not accurate and/or "serious."[10] While we do believe that billing concerns should be addressed, we urge caution when attestations alone trigger a revocation process for provider and supplier billing privileges without any form of due process. Once billing privileges are revoked, privileges are not easily or quickly restored.

[7] A healthcare Member Service Organization

[8] §424.502 defines "authorized official" as "an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. For purposes of this definition only, the term 'organization' means the enrolling entity as identified by its legal business name and tax identification number."

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[10] In the proposed rule, CMS references the "seriousness of the attestation cases we have seen" to justify this proposal; yet the proposed revision does not limit attestations to "serious" cases.

- Retroactive Revocation of DMEPOS Providers and Suppliers – CMS proposes to expand its authority to retroactively revoke a provider's or supplier's billing privileges. These additions apply when a provider or supplier has engaged in "action or inaction resulting in noncompliance and/or otherwise concerning conduct."[11] **We recommend that retroactive revocation should only apply in situations in which the provider or supplier acted in blatant disregard**. The situations that CMS proposes to include often require external submissions or approvals and should not penalize providers and suppliers who act in good faith and should permit a period of time to cure (e.g., institute a corrective action plan and/or pay back any overpayment). Unilaterally taking away billing privileges without appeal rights or some form of due process to get back into compliance or otherwise correct omissions does not distinguish between fraudulent suppliers and those who made mistakes. Other providers are afforded this opportunity for standard and condition-level deficiencies and DME should be treated similarly.

DMEPOS Supplier Accreditation Process – UnityPoint at Home offers input on select issues below:

- Accreditation Organizations (AOs) Program Requirements – **We support increased standards proposed for AOs when reasonable and comparable to the requirements already established for home health, hospice, and home infusion therapy suppliers**. UnityPoint at Home also provides accredited Home Health, Hospice, and Home Infusion Therapy Supplier services, and all industries have comparable standards for their AOs including, but not limited to, complaint surveys, and allowing for corrective action plans and appeal rights versus immediately moving to termination of provider numbers and/or billing privileges. Similar requirements for DME would be supported.

- Role of Accreditation Organizations (AOs) – AOs are HIPAA Business Associates to DME Suppliers (the covered entity) to help Suppliers provide the best quality/safest care to patients with a focus on quality performance and improvement. While charged with reviewing quality, AOs also review compliance with DME quality standards and Supplier standards. AOs examine information on the Form 885S – licensure, personnel records, types of equipment listed on the accreditation, and enrollment, but they do not dive into claims. The role of an AO is not combatting fraud, which is handled by the OIG, MACs contracted by CMS, and the various program integrity auditors and departments. The AO oversight role should not be expanded to combat fraud through increased surveys. This substantially shifts the nature of the relationship between an AO and DME Supplier to be more adversarial versus a partner in the name of quality, safety, and improvement. Additionally, covered entities pay AOs for accreditation status to demonstrate proficiency at meeting and/or exceeding quality requirements. In contrast, OIG, MACs, and program integrity auditors and departments focus on fraud, waste, and abuse and possess expertise in using data in evaluating and/or examining high-risk areas for investigation in their focused audits. **The roles of AOs and Fraud investigators are separate and distinct and should remain as such**.

- Tackling Fraud and Abuse – We encourage CMS to explore artificial intelligence (AI) to examine

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information that CMS already collects and has access to. This would include claims data as well as information gathered from Targeted Probe and Education (TPE), Recovery Audit Contractors (RAC), and Supplemental Medical Review Contractors. As shown through the recent criminal cases cited in the rule's narrative, the financial loss to the program are from kickbacks and collusion to bill for non-medically necessary services, upcoding, or false physician orders. **Accreditation Organizations are not and should not be involved in this work**. In addition, CMS states that the overarching purpose of the enrollment process is to help confirm that providers and suppliers seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements. We believe that CMS site surveys would be more appropriate for this role and encourage CMS to consider whether revalidation could effectively gather the data necessary to prevent unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare.

- Frequency of Surveys and Reaccreditations – CMS proposes to require DMEPOS suppliers to be surveyed and reaccredited at least once every 12 months, instead of on a three-year cycle. The CMS cost estimate is unrealistically low in stating that only 24 new positions among the AOs would be required, particularly since larger chain DMEs are not receiving surveys at all locations currently. **We oppose this change and encourage CMS to explore alternative approaches to strengthen fraud and abuse safeguards with program integrity auditors and other departments and agencies whose focus is fraud and abuse efforts**. This significant increase in Accreditation Organization (AO) survey frequency represents an overly broad approach based on the flawed assumption that all DMEPOS suppliers are bad actors. In our AO contract, there is already a provision that allows for more frequent site visits for cause, including complaints. Site visitation on a more frequent basis should be targeted and left to the discretion of the AO, instead of wholesale mandated by CMS. Alternatively, **CMS could establish criteria for Suppliers that need more oversight, such as initial enrollments, change in ownership or management interest enrollments, or DMEs with a large number of locations that are currently not being surveyed.** For instance, CMS could target more oversight for suppliers with prior 855S revalidation or update issues, large number of beneficiary complaints regarding quality of care, or those with concerning audit results from the various program integrity auditors and contractors. Instead, as proposed, all DMEPOS suppliers will be subject to increased financial and workforce burdens from actual survey cost as well as survey preparation and response, which is time-consuming and diverts resources from direct patient services. Finally, with the multiple changes proposed for AOs, we suggest that CMS delay an increase in survey frequency to allow AOs to increase their capacity and operationalize the new requirements.

Prior Authorization Exemption for Certain DMEPOS Suppliers – **UnityPoint at Home supports** this exemption for a 90% or greater provisional affirmation rate during initial or periodic assessments and consistent compliance with Medicare requirements.

DMEPOS COMPETITIVE BIDDING PROGRAM

CMS proposes DMEPOS Competitive Bidding Program (CBP) revisions; however, this rule does not specify applicable product categories nor detail the next competition timeframe. To provide beneficiaries with

current and fully supported technology, CMS proposes to reclassify all continuous glucose monitors (CGMs) and insulin infusion pumps under the frequent and substantial servicing payment category.

Comment: UnityPoint at Home is a member of the Midwest Association for Medical Equipment Services and Supplies (MAMES) and VGM[12] and supports their DME comment letters.

As proposed, UnityPoint at Home opposes the CBP and encourages CMS to pause this effort and engage DMEPOS providers and suppliers to revisit the DMEPOS CBP efficacy and substance. According to CMS, benefits of DMEPOS CBP include reducing excessive Medicare payments, providing the best value to achieve positive health outcomes for Medicare beneficiaries, decreasing incentives for supplier fraud, and ensuring beneficiary access to covered DMEPOS items and services.[13] We believe these benefits misrepresent the impact of CBP on DMEPOS beneficiaries, items/services, providers and suppliers. Ultimately, CBP prioritizes price and should not be characterized as a fraud tool. In the first iteration of CBP, 20% of active suppliers were forced to close within one year. CBP efforts to limit suppliers force consolidation, restrict the marketplace, limit beneficiary choice, disrupt beneficiary plans of care, and may actually degrade health outcomes. It is vital to remember that DME is not a commodity. It is a lifeline for beneficiaries allowing them mobility and independence, engagement versus isolation, and relief versus pain. Beneficiary choice and access should not be eroded. Beneficiaries need products and do not have time to wait for products to be shipped; which in turn forces beneficiaries to go to non-competitive bid suppliers and to pay privately instead of using the Medicare benefits they are entitled to.

As a nonprofit, health system-based DME Supplier, **UnityPoint at Home requests that CMS exempt health system-based as well as hospital-based suppliers from the CBP**. As proposed, the CBP will create challenges for these DME Suppliers in providing high-quality service meeting all of a beneficiary's treatment needs. As part of broader, coordinated care during transitions from inpatient to home, DME is already subject to significant oversight including, but not limited to, Medicare Quality Standards, accreditation standards, and insurance payer guidelines. Health system- and hospital-based DME Suppliers are crucial and operate in an environment that ensures continuity of care for beneficiaries with complex medical needs, in which multiple pieces of equipment/supplies are required, delays from third-party suppliers can postpone time-sensitive discharges or increase readmission risks, and specialized equipment needs do not fit within a wholesale DME Supplier inventory or expertise. Health system and hospitals will face operational and financial challenges when forced to outsource DME under CBP, which can lead to delays and adverse patient outcomes. Additionally, clinicians support health system- and hospital-based DME due to their ease of use, faster discharges, and better patient education. There is precedence of CBP exemptions as CMS has exempted critical access hospitals, VA suppliers, and rural areas. Such an exemption also aligns with CMS goals to improve outcomes, reduce readmissions, and enhance patient experience.

UnityPoint at Home offers input on the select proposals related to the DMEPOS CBP below:

Determining Payment Amounts and the Number of Contracts Awarded for the DMEPOS CBP – CMS proposes (1) for lead items, to replace "maximum bid" methodology with "75th percentile of bids"; (2) for

[12] A healthcare Member Service Organization
[13] Page 29230

non-lead items, to use a state-based calculation instead of a nationwide or regional calculation; and (3) to limit the number of contracted suppliers. **UnityPoint at Home opposes these changes and believes that they prioritize a price point over access, choice, and quality**. The 75th percentile of bids for lead items is an arbitrary percentage without basis on standard auction or bid processes and disregards market rates and cost of goods. Likewise, the simplified bid process for non-lead items blindly and significantly reduces reimbursement disregarding costs of goods as well as shipping and freight costs. The reduction of product category bid winners from 5 to 2 winners forces supplier consolidation. Fewer suppliers means fewer product choices adversely impacting patient access to care and service and discounting the bid winning supplier's actual capacity to serve any area.

Inflation Adjustments to Single Payment Amount (SPA) – CMS applies inflation adjustments to the SPA equal to the CPI-U for the 12-month period ending 6 months prior to the beginning of the respective second and third year. The updated rate is capped at the unadjusted rate or 110% of the adjusted rate. **We agree that an inflationary index should be included**. *We suggest that, if CMS places caps on inflationary growth, it should also place caps on its downward pricing constructs*.

Bid Limits and Conditions for Awarding Contracts if Savings Are Not Expected – CMS proposes bid limits based on the most recent SPA plus 10% or the unadjusted fee schedule amount. Different bid parameters are proposed for lead items in a product category in a Round of Innovation Demonstration (RID) CBP, including the rental of class II continuous glucose monitors and insulin infusion pumps. **This methodology is unsustainable** as there will be ever diminishing returns. While reimbursement continues to decrease, suppliers will increasingly exit the market and items will not be available. What seems to have been lost is that the lowest cost alternative for care is in the home, and DME items and services support community placements and prevent avoidable hospitalizations. For instance, the annual DME cost of providing oxygen to a beneficiary is less than one day of an inpatient hospital stay. Cost avoidance and quality care are not prioritized in the CBP matrix.

Revising the Definition of "Item" Related to Medical Supplies – Section 1847(a)(2) limits the CBP to the following items and services: (A) Covered items defined in §1834(a)(13); (B) Enteral nutrients, equipment, and supplies as described in §1842(s)(2)(D); and (C) Off-the-shelf orthotics described in §1861(s)(9). CMS proposes to expand CBP covered items to include catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and certain covered osteoporosis drugs.

This expansion is contrary to law and Congressional intent. First, §1834(a)(13) states in part "*Covered item.—In this subsection, the term "covered item" means* ***durable medical equipment*** *(as defined in section 1861(n)), including such equipment described in section 1861(m)(5), but not including implantable items for which payment may be made under section 1833(t). [bold added]*." The section 1861(n) definition does not reference catheter or ostomy care. Section 1861(m)(5) reads "*medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug (as defined in subsection (kk)), but excluding other drugs and biologicals) and* ***durable medical equipment*** *and applicable disposable devices (as defined in section 1834(s)(2)) while under such a plan [bold added].*" **The plain language of §1861(m)(5) clearly distinguishes medical supplies from DME**, and catheters and ostomy care are examples of medical supplies, not DME. Second, this interpretation is

bolstered by §1847(a)(2)(B), which is limited to enteral (and not parenteral) items and services. Specifically, §1847(a)(2) reads "*Other equipment and supplies.—Items and services described in section 1842(s)(2)(D), other than parenteral nutrients, equipment, and supplies."* Section 1842(s)(2)(D) states "*Parenteral and enteral nutrients, equipment, and supplies.*" When the sections are read together, DMEPOS CBP is intended to only apply to services and items that are entered directly into the bloodstream and not via the gastrointestinal tract. Third, to support CMS' position, there is no statutory reference to tracheostomy and/or urological supplies for the DMEPOS CBP (as ostomy is specifically excluded).

Aside the legal overreach, **this inclusion of ostomy, tracheostomy, and urological supplies represents unacceptable patient care risks**. Ostomy, urological, and tracheostomy products all require a high degree of specialized care and support to prevent infections and other serious complications. Prescribed ostomy and urological products are used to manage medical conditions that interfere with or do not allow for normal bowel and/or bladder function. The complexity and uniqueness of a product is needed to meet the distinct and highly variable needs of patients to appropriately manage biological waste. High quality tracheostomy products are designed to ensure patient comfort, safety, and effective airway management. CBP is inappropriate for these items and services. It will force specialized suppliers with expertise in support of these vulnerable patient populations out of the market. Commoditized, low-margin pricing will reduce innovation and incentivize suppliers to seek the lowest-cost products, minimizing consumer choice and access to the most medically appropriate item. For these medically complex patients, choice and continuity of care may be jeopardized. These are items that demand patient education and outreach and represent conditions for which there are heightened risks of complications. **We urge CMS to abandon this proposal**.

Aside from the expansion of "covered item," its present definition overlaps with pharmacy operations for infusion services. Both DME Suppliers and pharmacies may bill for enteral nutrients. DME uses A codes and pharmacy uses F codes. Many DME providers simply do not provide this service and defer to pharmacies. **The overlap with other healthcare sectors should be considered when mandating CBP items and categories**.

Remote Item Delivery (RID) CBP – CMS is proposing to phase-in national or regional RID CBPs for certain product categories. Details are lacking on covered items, phase-in timeframe, national versus regional distribution, how storefront operations would work, etc. It is difficult to provide detailed feedback in the absence of a more structured framework. Initial feedback include:

- Number of Suppliers: **CMS should not limit national or regional RID suppliers** for urological, ostomy, tracheostomy, CGM, insulin infusion pumps, and off-the-shelf orthotics.
- Service versus Shipping: DMEPOS should not be operated like Amazon. RID appears to focus on the delivery component of DMEPOS. **Missing is the outreach or education component provided to the beneficiary when they receive the item**. Off-the-shelf items many times still require fitting and in-person education. For instance, our staff have assisted Medicare beneficiaries out in the community wearing braces incorrectly, potentially harming versus healing their injury. These braces were received through other suppliers who shipped or delivered the item with no education. CBP fails to consider the individualized patient care aspect of DME and how

beneficiaries will receive that service under RID.

- Rural and Same-Day Access: We agree that RID should not be required to have storefronts; however, national or regional RIDs will be limited in their ability to accommodate same-day delivery. With our largest service area in Iowa, we are concerned with rural access. If the beneficiary wishes to go in and receive items the same day, it appears that the RID proposal requires them to hunt or drive hundreds of miles to a contracted supplier or they are stuck paying privately from a non-contracted supplier. If ostomy and urological items are included, it is unacceptable if beneficiaries run out of supplies due to increased charges or backorder shortages. **Thoughtful exceptions to RID to enable supplies and services at storefront locations are vital to prevent sores, infections, or obstructions without necessitating an avoidable trip to the emergency room**.

Payment for Continuous Glucose Monitors and Insulin Infusion Pumps – CMS proposes to change the payment category for Class II CGMs and insulin infusion pumps to Frequently and Substantial Servicing (FSS) for CBAs and non-CBAs. **As a new and evolving technology, we request that CGM be excluded from CBP**. Based on 2025 rates, CMS estimates that the monthly rental CGM bid ceiling would be $272.69 and insulin infusion pump rental rate would be $226.22. **This proposed pricing recategorizing of CGMs and insulin infusion pumps is staggeringly low and unsustainable.** As estimated, these prices would not allow suppliers to cover the costs of the monthly supplies for many patients let alone change out the unit to new technology as often as proposed. Finally, CMS notes that they expect CGMs and insulin infusion pumps to be in the same product category. **We oppose the potential inclusion of CGMs and insulin infusion pumps in the same product category, as many CGM suppliers do not furnish insulin pumps.**

Revising the Submission of Financial Document Requirements for the DMEPOS CBP – CMS proposes to reduce financial documentation to credit reports. Prior iterations of the CBP required submission of tax returns, income statements, balance sheets, and cash flow documentation. **UnityPoint at Home urges CMS to retain the current requirements to assure the financial capacity and stability of suppliers**. This proposal encourages inexperienced low-ball bidders, increases the likelihood that suppliers may bail mid-contract, and ultimately could leave our patients with fewer choices and care disruptions. This is not the area to cut, and in fact we recommend that CMS provide clearer documentation guidelines, particularly for suppliers that are subsidiaries.

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 in the short term.

Comment: UnityPoint at Home encourages CMS to continue a platform to test the Acute Hospital Care at Home services beyond 2025. Such a platform would enable patients to be cared for at home and support efficiencies within the inpatient setting. Under the leadership of UnityPoint at Home, UnityPoint Health (our parent organization) 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 as well as to bill and be reimbursed under this Medicare waiver. As of August 15, 2025, 144 health systems with 411 CCNs in 39 states have applied and been approved to participate in this waiver.[14] Given the infrastructure investment needed to stand up this program and the uncertainty of its duration, UnityPoint Health only operates this model in two of our eight markets, and it is likely that more UnityPoint Health hospitals as well as other healthcare systems would participate under a program that has a longer duration and firm regulatory standing.

Additionally, UnityPoint Health urges CMS to authorize a full array of Medicare At Home services and permit patient admissions that originate from the home. While we recognize that CMS stood up the Hospital at Home waiver as a result of a national public health emergency, it has proven its efficacy. 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 ACO waiver in which appropriate services were 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 welcome the opportunity to further engage with CMS and/or CMMI on this topic**.

ADDITIONAL INPUT – REIMBURSEMENT FOR REMOTE PATIENT MONITORING (RPM) WITH TELEHEALTH NURSING SUPPORT

CMS currently provides no reimbursement, sharing savings, or other credit for telehealth services provided in the home health setting.

Comment: Despite promising RPM outcomes, lack of reimbursement disincentivizes HHAs from implementing a home health RPM with a telehealth nursing support program that includes remote monitoring, video visits, and coordinated care protocols. To meet patients where they are at, we urge CMS to:

- **Establish payment or shared savings models for home health RPM with accompanying telehealth nursing support that achieve measurable reductions in hospitalizations, emergency visits, or other avoidable utilization.** Given that CMS has already embraced innovation in other sectors, such as the Hospital at Home waiver, we urge CMS to take similar steps in home health. Allowing for RPM with telehealth nursing support flexibility, paired with the appropriate reimbursement, would unlock substantial system-wide value, particularly for geographically isolated patients and patients at-risk for hospital readmission, such as individuals who are

[14] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

medically complex.

- **Collect comprehensive data from HHAs that are already leveraging telehealth and RPM**, particularly those demonstrating improved outcomes such as reduced hospital readmissions. Before considering new models or programmatic changes, we ask that CMS evaluate how existing home health programs supported by RPM and telehealth nursing are impacting cost, quality, access, and outcomes. A data-driven approach will help identify what is working in the current landscape and guide future policy in a way that supports proven innovation.
- **Allow integration of RPM with telehealth nursing support services into the home health plan of care**, recognizing that these tools—while not a substitute for all in-person visits—can be a safe, efficient, and scalable complement for many patients, particularly those who are medically-complex and those living in rural or underserved areas, as these groups of patients are at elevated risk for hospital readmission.

Furthermore, we urge CMS to work with Congress to remove the statutory prohibition in Section 1895 of the Social Security Act that prevents telehealth from being counted as a reimbursable home health visit (42 U.S.C. § 1395fff(e)(1)). This prohibition could be lifted entirely or replaced with a scaled policy requiring a certain percentage of in-person visits; it may also be feasible for CMS to waive the prohibition for participants of the Medicare Shared Savings Program (MSSP), just as the three-day stay requirement has been waived for MSSP accountable care organizations.

ADDITIONAL INPUT – DISPROPORTIONATE SHARE PAYMENT FOR HIGH-NEED HHAs

The current home health payment system does not adequately distinguish between freestanding, for-profit HHAs and health system- or hospital-based HHAs.

Comment: As background, for-profit HHAs can pick and choose their patients, selectively admitting higher-margin patients with a specific focus on payers that can provide opportunity for higher margins and avoiding patients that require resource-intensive care and/or receive Medicaid benefits. Furthermore, freestanding for-profit HHAs, which tend to serve higher-margin, lower-acuity patients, reported an average Medicare profit margin of 21.5% in 2023 according to MedPAC's 2025 report to Congress[15]. Because of the large-scale consolidation of these organizations, MedPAC's view of HHA margins continues to be heavily weighted by freestanding, for-profit HHAs and inaccurately reflects the reality of most nonprofit health system- and hospital-based HHAs across the country.

UnityPoint at Home is a nonprofit health-system-based HHA. Nonprofit HHAs — many of which serve as safety-net providers for medically complex and underserved populations—operate generally at negative or low margins. UnityPoint at Home has implemented several budget modifications to conserve resources and work to ensure that patients can continue to receive the care they need. According to available claims data, the majority of freestanding HHAs in Iowa served less than 11 Medicaid patients in 2022. For that same period, UnityPoint at Home served approximately 2,700 Medicaid patients. UnityPoint at Home

[15] March 2025 Report to the Congress: Medicare Payment Policy, Chapter 7: Home health care services, page 242 accessed at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf

services the patients that are at highest risk of poor clinical outcomes and/or readmission without additional support after hospital discharge, regardless of payer source. We are very concerned that the long-term economics of providing home health care in our region may become unsustainable when considered alongside the broader financial pressures facing health system- and hospital-based HHAs.

To address this structural imbalance, **we urge CMS to work with Congress to establish a Disproportionate Share Home Health (DSH-HH) payment, modeled after the existing DSH program for hospitals.** A recent JAMA Health Forum article[16] found that targeted DSH payments significantly improved outcomes for low-income patients in hospital settings. Extending this logic to the home health sector will help correct misaligned incentives, stabilize safety-net providers, and promote access for patients most in need.

As such, we specifically recommend that this payment:

- Apply to HHAs that exceed the median threshold for Medicaid visits, based on cost report data.
- Consider patient mix factors, such as MA enrollment and Patient-Driven Groupings Model (PDGM) categories that are disproportionately under-compensated (e.g., behavioral health, Medication and Management, Teaching and Assessment-cardiac).

ADDITIONAL INPUT – DEREGULATION

CMS seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other stakeholders participating in the Medicare program.

Comment: UnityPoint at Home suggests the following:

- Eliminate the Medicare Prior Authorization of Home Health Services Demonstration (CMS–10599). While CMS has "paused" this demonstration, we request that it be eliminated altogether or, in the alternative, more narrowly targeted to HHAs with a record of compliance issues. Casting the demonstration to entire states was overly broad.
- Reimburse home infusion supplies when the infusion medication is covered under Medicare Part D. Current state is that Part D plans cover IV antibiotics, fluids, and other inexpensive drugs, but the home infusion per diem is not covered. As a result, beneficiaries must travel to infusion centers or alternatively pay a private pay daily rate to receive an infusion in the home setting.
- Waive the homebound status requirement for home health beneficiaries in a risk-bearing Medicare ACO, including the Medicare Shared Savings Program.
- Recalibrate disciplinary actions for technical and/or single instance errors in coordination with other healthcare service lines. Currently one minor error on a consent or Notice of Election cancels reimbursement, requires days of care to be written off, and requires the beneficiary to be "readmitted."
- Add flexibility to Durable Medical Equipment benefit:
    - Eliminate the face-to-face requirement to promote timely access or authorize a

[16] Chatterjee P, Schpero WL. Realigning Reality With Intent in Funding Safety-Net Hospitals. JAMA Health Forum. 2023 Jul 7;4(7):e232000. doi: 10.1001/jamahealthforum.2023.2000. PMID: 37477924.

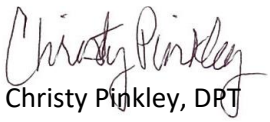
telemedicine visit to meet this requirement;

- Remove health system- or hospital-based DME operations from the competitive bidding process; and
- Reduce administrative requirements, such as administrative elements unrelated to medical/clinical necessity.

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,

Jenn Ofelt, MHA, MSN, RN
President
UnityPoint at Home



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Vice President, Home Medical Equipment
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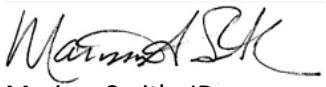

Marissa Smith, JD
Vice President, Accreditation and Regulatory Affairs
UnityPoint at Home

Cathy Simmons, JD, MPP
Executive Director, Government & External Affairs
UnityPoint Health