

August 16, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1766-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

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

Re: Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements (87 F.R. 37600, proposed June 23, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments regarding CMS-1766-P, which addresses payment for home health services.

NASW represents more than 110,000 social workers nationwide. Social workers play an essential role in serving Medicare beneficiaries across an array of settings, including in home health agencies (HHAs). Home health social workers are dedicated professionals whose efforts enhance residents' quality of life and quality of care. Yet, these social workers struggle to meet beneficiaries' needs in the face of systemic challenges, and NASW is concerned that beneficiary access to other home health services is becoming increasingly limited.

NASW's comments on this proposed rule address the following topics:

- home health prospective payment system (HH PPS), including the use of telecommunications technology
- home health quality reporting program (HH QRP), including data collection and health equity
- expanded HH value-based purchasing (HHVBP) model, including request for comment on health equity

## Section II.B: Proposed Provisions for CY 2023 Payment Under the HH PPS

In its August 2020 comments<sup>1</sup> on CMS’s proposed CY 2021 rule for HH PPS,<sup>2</sup> NASW noted that home health social workers had observed disturbing trends since the January 2020 implementation of PDGM. These trends included increased reliance on computer models, rather than clinical judgment, to determine the number of visits each home health discipline was allowed. Social workers also expressed that HHAs had informed them the Medicare home health benefit no longer included medical social services as a result of PDGM—information in direct contrast to CMS’s *Medicare Learning Network Matters* article of February 2020.<sup>3</sup> Both types of occurrences compromised service delivery to home health clients.

NASW remains concerned that PPS and PDGM payments disadvantage beneficiaries by incentivizing HHAs to “cherry pick” the most profitable beneficiaries—those who are referred following a stay in an inpatient hospital, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility and who have short-term needs. This prioritization continues to decrease not only home health access for beneficiaries admitted from the community who have not had a recent inpatient stay, but also beneficiaries who are eligible under the *Jimmo* settlement agreement<sup>4,5</sup> for OT, PT, SLP, or skilled nursing services to maintain function or slow decline (commonly referred to as “maintenance goals”).

By allowing HHAs to underdeliver services and retain a full 30 days of service payment as profit, PDGM has enabled HHAs to prioritize profits over meeting the needs of beneficiaries in an equitable manner consistent with Medicare statute. As noted in the proposed rule (p. 37680) and the March 2019 report of the Medicare Payment Advisory Commission (MedPAC; Table 8-12, p. 292),<sup>6</sup> profit margins for freestanding HHAs jumped by nearly 5 percent between 2019 (15.4 percent) and 2020 (20.2 percent). Based on these high margins, MedPAC (2022) has concluded that HHAs have a strong incentive to serve Medicare beneficiaries and, indeed, “have excess capacity to serve additional Medicare patients” (p. 270). Yet, HH services provided to beneficiaries have been dropping over time:

- Total visits for all HH disciplines per beneficiary for a 30-day episode dropped by 17 percent between 2018 and 2021.<sup>7</sup>

<sup>1</sup> Mangum, A. (2020, August 24). *NASW comments on the calendar year 2021 proposed rule for home health* (CMS-1730-P) [Letter]. National Association of Social Workers. <https://bit.ly/NASW-HH21comments>

<sup>2</sup> Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, 85 F.R. 39408 (proposed June 30, 2020) (to be codified at 42 C.F.R. pts. 409, 414, 424, & 484).

<sup>3</sup> Centers for Medicare & Medicaid Services. (2020). *The role of therapy under the home health patient-driven groupings model (PDGM)* (Medicare Learning Network Matters article number SE20005). <https://www.cms.gov/files/document/se20005.pdf>

<sup>4</sup> Centers for Medicare & Medicaid Services. (2021). *Jimmo settlement*. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>

<sup>5</sup> Center for Medicare Advocacy. (2022). *Jimmo update: CMS reminds providers and contractors of Medicare coverage to maintain or slow decline*. <https://medicareadvocacy.org/jimmo-update-cms-reminds-providers-and-contractors-of-medicare-coverage-to-maintain-or-slow-decline/>

<sup>6</sup> Medicare Payment Advisory Commission. (2019). *March 2019 report to the Congress: Medicare payment policy*. <https://www.medpac.gov/document/march-2019-report-to-the-congress-medicare-payment-policy/>

<sup>7</sup> All data from 2021 and comparative data for 2018 and 2021 cited in this list are from Table B3 (p. 37606) of the current HH PPS proposed rule.

- During that same period, home health aide visits declined by 35 percent. Considered longitudinally, home health aide services have decreased from an average of 6.7 visits per beneficiary per 30 days in 1998<sup>8</sup> to less than one-half of a visit (0.47) per month in 2021—a drop of 94 percent.
- Similarly, the average rate of medical social service visits per beneficiary per 30-day period has dropped by 38 percent between 2018 and 2021 and by 97 percent between 1998 (1.5 visits) and 2021 (0.05 visits).
- Less drastic, but still significant, visits by OTs, PTs, and SLPs decreased by 17, 24, and 29 percent, respectively, between 2018 and 2021; skilled nursing visits dropped by 12 percent during that time period and by 43 percent between 1998 (7.05 visits per beneficiary per 30 days) and 2021 (4.05 visits).
- Longitudinally, total home health visits per beneficiary per 30 days have decreased by almost half between 1998 (15.8 visits) and 2021 (8.22 visits).

Furthermore, recent research conducted by the Center for Medicare Advocacy has found that HHAs themselves don't understand or are unable to provide all services specified in the Medicare home health benefit.<sup>9</sup> For example, although the home health statute covers 28 or more hours of home health aide care per week, many HHAs surveyed had misconceptions about this aspect of the benefit, and only 2 to 4 percent stated they could provide 20 hours or more of aide care per week.

The preceding data illustrate a growing trend of HHAs reducing service delivery to Medicare beneficiaries to maximize profits. NASW believes that HHAs should not maintain high profit margins from traditional Medicare payments without providing the services beneficiaries need (and to which they are entitled under Medicare law). If HHAs served all beneficiaries who qualified for home health, at the level of service for which they qualified, profits would be much more reasonable and rate cuts would not be necessary. Consequently, NASW is concerned that CMS's proposal to reduce the PPS base rate to HHAs in CY 2023 will exacerbate service reductions to beneficiaries without curbing profit margins. Instead, we urge CMS to review PDGM and develop payments, policies, and enforcement practices that support home health care for all individuals who qualify for Medicare coverage under the law.

### **Section II.K: Comment Solicitation on the Collection of Data on the Use of Telecommunications Technology Under the Medicare Home Health Benefit**

The telehealth flexibilities provided to HHAs during the COVID-19 public health emergency (PHE) have helped facilitate access to home health services for some Medicare beneficiaries while reducing risk of infection for these beneficiaries, family care partners (as defined by each beneficiary), and home health staff. NASW believes that telecommunications use by HHAs is appropriate if it is justified in the plan of care. Yet, because of the unique nature of home health care and the physical and psychosocial

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<sup>8</sup> Data are from the previously cited MedPAC report to Congress in March 2019 (footnote 6).

<sup>9</sup> Center for Medicare Advocacy. (2021). *Center For Medicare Advocacy home health survey: Medicare beneficiaries likely misinformed and underserved* [Special report]. <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>

challenges faced by beneficiaries and family caregivers, in-person service delivery by HHAs is usually optimal. Moreover, research has found inequities in telehealth access and use (in various settings) during the COVID-19 pandemic, especially for people with limited English proficiency,<sup>10,11</sup> Black people,<sup>12,13,14</sup> people living in rural areas,<sup>15</sup> and women, individuals with low incomes, older adults, and people who are Asian or Latino.<sup>16</sup> Living with a disability can also affect one’s access to and use of telehealth.<sup>17</sup> Regardless of demographic characteristics, access to technology plays a primary role in telehealth disparities: One study showed a cross-community association between lack of internet access and death from COVID-19.<sup>18</sup>

Given these considerations, the country’s ongoing struggles with COVID-19, and the recently declared monkeypox PHE,<sup>19</sup> NASW believes that telecommunications use by HHAs—with the exception of services provided by home health aides, who provide hands-on personal care—may be appropriate if it is justified in the plan of care and does not supplant needed in-person care. We simultaneously urge CMS to collect and analyze robust data to monitor the use of telecommunications technology by HHAs. Such data collection and analysis should include beneficiary characteristics and utilization patterns, including identification of beneficiaries who cannot use telecommunications because of technological limitations or other factors. Additionally, NASW recommends that CMS identify a process for HHAs to report beneficiaries with legitimate orders for services whom HHAs decline to serve.

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<sup>10</sup> Eberly, L. A., Kallan, M. J., Julien, H. M., Haynes, N., Khatana, S. A. M., Nathan, A. S., Snider, C., Chokshi, N. P., Eneanya, N. D., Takvorian, S. U., Anastos-Wallen, R., Chaiyachati, K., Ambrose, M., O’Quinn, R., Seigerman, M., Goldberg, L. R., Leri, D., Choi, K., Gitelman, Y., ... & Adusumalli, S. (2020). Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. *JAMA Network Open*, 3, e2031640. <https://doi.org/10.1001/jamanetworkopen.2020.31640>

<sup>11</sup> Rodriguez, J. A., Saadi, A., Schwamm, L. H., Bates, D. W., & Samal, L. (2021). Disparities In telehealth use among California patients with limited English proficiency. *Health Affairs*, 40, 487–495. <https://doi.org/10.1377/hlthaff.2020.00823>

<sup>12</sup> Please refer to the previously cited article by Eberly et al. (footnote 10).

<sup>13</sup> Wong Samson, L., Tarazi, W., Turrini, G., & Sheingold, S. (2021). *Medicare beneficiaries’ use of telehealth in 2020: Trends by beneficiary characteristics and location* (Research Report HP-2021-27). U.S. Department of Health and Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf>

<sup>14</sup> Jacobs, M., & Ellis, C. (2021). Telemedicine disparities during COVID-19: Provider offering and individual technology availability. *Journal of the American Geriatrics Society*, 69, 2432–2434. <https://doi.org/10.1111/jgs.17280>

<sup>15</sup> Please refer to the previously cited article report by Wong Samson et al. (footnote 13).

<sup>16</sup> Please refer to the previously cited article by Eberly et al. (footnote 10).

<sup>17</sup> Valdez, R. S., Rogers, C. C., Claypool, H., Triesmann, L., Frye, O., Wellbeloved-Stone, C., & Kushalnagar, P. (2020). Ensuring full participation of people with disabilities in an era of telehealth. *Journal of the American Medical Informatics Association*, 28, 389–392. <https://doi.org/10.1093/jamia/ocaa297>

<sup>18</sup> Lin, Q., Paykin, S., Halpern, D., Martinez-Cardoso, A., & Kolak, M. (2022). Assessment of structural barriers and racial group disparities of COVID-19 mortality with spatial analysis. *JAMA Network Open*, 5, e220984. <https://doi.org/10.1001/jamanetworkopen.2022.0984>

<sup>19</sup> U.S. Department of Health and Human Services. (2022, August 4). *Biden-Harris administration bolsters monkeypox response; HHS secretary Becerra declares public health emergency* [News release]. <https://www.hhs.gov/about/news/2022/08/04/biden-harris-administration-bolsters-monkeypox-response-hhs-secretary-becerra-declares-public-health-emergency.html>

### **Section III: HH QRP**

NASW believes quality reporting is an important part of health care delivery and quality improvement. We are concerned that the HH QRP does not reflect the full range of beneficiaries who qualify for home health services. The current criteria favor services for individuals with conditions that can

improve. The home health quality measures, when combined with the previously described payment incentives and commonly used claims processing and audit practices, disadvantage beneficiaries with maintenance goals. Moreover, quality criteria supporting discharge to the community discriminate against beneficiaries with long-term or chronic conditions who may be eligible, under the *Jimmo* settlement, for unlimited access to home health services. To remedy this problem, NASW recommends that CMS expand the CAHPS home health survey to identify premature or untimely discharge from necessary home health services. Such action is essential to address the growing crisis in early and inappropriate discharges.

#### **Section III.D: Proposal To End the Suspension of OASIS Data Collection on Non-Medicare/Medicaid HHA Patients To Require HHAs To Submit All-Payer OASIS Data for Purposes of the HH QRP, Beginning With the CY 2025 Program Year**

NASW supports CMS’s proposal to resume collection of OASIS data on patients who are not Medicare or Medicaid beneficiaries. Such collection is important to promote high-quality service delivery to all individuals, regardless of payer, and to prevent discrimination based on payer. We also support all-payer data collection, which may reveal any discriminatory bias toward Medicare beneficiaries.

The proposed data collection method is congruent with CMS’s focus on health equity and social determinants of health. Yet, NASW believes that expansion of data collection should not take precedence over statistical reporting requirements, which can make known lack of access to home health services by Medicare beneficiaries.

#### **Section III.G: Request for Information: Health Equity in the HH QRP**

NASW appreciates CMS’s focus on health equity across settings, including home health, and we share CMS’s concern about disparities in home health access and quality. We support all three of CMS’s proposed domains as positive steps in promoting health equity and offer the following comments to enhance the proposals:

- Domain 1: actions the HHA is taking with respect to health equity and community engagement in its strategic plan

As noted previously, NASW is concerned that CMS’s policies and practices for home health quality reporting, claim payment, and auditing do not promote health equity for beneficiaries with long-term or chronic conditions. Consequently, we encourage CMS to require HHAs to report two types of data: (1) data about beneficiaries who meet qualifying criteria for coverage, but for whom the HHA declines assessment for services and (2) data about premature

discharge from HHAs. Such data collection would provide meaningful insight into reducing health disparities.

- Domain 2: training HHA board members, HHA leaders, and other HHA staff in culturally and linguistically appropriate services, health equity, and implicit bias  
Training all staff, including indirect care and support staff, on the full scope of the Medicare home health benefit and the availability of services to maintain function or slow decline is essential to realizing health equity.
- Domain 3: organizational inclusion initiatives and capacity to promote health equity  
NASW encourages CMS to modify its proposal requiring HHAs to attest to *whether* equity-focused factors were considered in the hiring of HHA senior leadership, direct care staff, and indirect care or support staff to *how* such factors were considered. Furthermore, we recommend that the proposal include not only hiring of staff, but also promotion of staff.

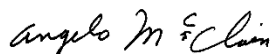
NASW supports public reporting (including on Care Compare) of HHA data related to health equity. However, the meaningfulness of the data will depend on the extent to which they incorporate the indicators recommended and the context provided to the public.

#### **Section IV.C: Request for Comment on a Future Approach to Health Equity in the Expanded HHVBP Model**

NASW appreciates CMS’s consideration of how to promote health equity within the expanded HHVBP model. Yet, we are concerned that competitive criteria for HHVBP payment incentives would erect further barriers to care for people with long-term and chronic conditions. The risk adjustment factors for individuals with maintenance goals are not sufficiently weighted in the HHVBP program to incentivize HHAs to serve beneficiaries whose conditions may not improve, especially in the context of payment, quality reporting, and auditing policies and practices that favor beneficiaries with strong rehabilitation potential. As stated previously, NASW recommends that CMS engage in two actions: (1) develop a mechanism to track beneficiaries who are unable to access care or are prematurely discharged from care and (2) enforce the home health conditions of participation.

Thank you for the opportunity to comment on the proposed rule and for your consideration of NASW’s comments. We look forward to collaborating with CMS to enhance the quality of home health services for Medicare beneficiaries. Please contact me at [naswceo@socialworkers.org](mailto:naswceo@socialworkers.org) if you need additional information.

Sincerely,



Angelo McClain, PhD, LICSW  
Chief Executive Officer