MEDICARE RIGHTS CENTER
Getting Medicare right

266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

August 27, 2021

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1747-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: RIN-0938-AU37; CMS-1747-P: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements

Dear Administrator Brooks-LaSure:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on this proposed rule from the Centers for Medicare & Medicaid Services (CMS). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

We have grave concerns that many of the policies in this proposed rule will continue or exacerbate a shift away from providing home health care for those with chronic conditions who are not expected to improve.

Home health is a valuable and necessary benefit that can help people with Medicare live safely in their homes instead of in institutions such as nursing facilities. But in our experience, beneficiaries often lack meaningful access to home health. They may not receive the type or scope of care they need for the length of time they need it.

Washington, DC Office:
1444 I Street NW, Suite 1105
Washington, DC 20005
202.637.0961

www.medicarerights.org www.medicareinteractive.org

Often, this is due to home health agency decisions about which beneficiaries to serve. While some of these calculations may be simple misunderstandings or misapplications of Medicare's rules—as seen in the myriad *Jimmo v. Sebelius*[1] cases—others are likely due to the misaligned financial incentives that make serving people with chronic conditions who are not expected to improve less profitable than delivering short-term care to people who are recovering from illness or injury.

For example, the Home Health Value-Based Purchasing (HHVBP) Model requires home health agencies to show beneficiaries are improving in order to maximize payment.[2] This necessarily encourages agencies to serve some beneficiaries—those who have conditions that are likely to improve—over others. Such a focus on improvement runs counter to the *Jimmo v. Sebelius* settlement which affirms that Medicare covers care to maintain or prevent deterioration of a patient's functional status, not solely to improve functional abilities. It is the need for skilled care that controls. As CMS itself states:

> The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question.[3]

The improvement standard, however, is built in to the HHVBP model, with quality measures only reflecting how much beneficiaries improve under the care of a home health agency. CMS's plan to extend the geographic scope of this model will only lead to greater incentives nationally for agencies to choose beneficiaries who will improve—meaning less access for people who cannot and will not improve but who qualify for and need home health.

Similarly, the Patient Driven Groupings Model (PDGM) rewards agencies for providing short-term care, with payment falling off after an initial 30-day period.[4] Those with chronic conditions become less profitable after 30 days, but their need for care does not change. And Medicare home health is not time limited; "to the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries … for an unlimited number of covered visits."[5]

As noted in the proposed rule, MedPAC reported in 2019 that home health visits declined by 88% between 1998 and 2017[6] despite no change in the law. We urge CMS to identify what has eroded access to this important care and to reverse course on any proposals and established rules that have contributed to it, including any financial misalignments. As noted above, if agencies are permitted or incentivized to pick and choose which beneficiaries they will serve, they are likely to prefer those who

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[1] *Jimmo v. Sebelius*, No. 5:11-CV-17 (D. VT).
[2] Joyce Famakinwa, "Home Health Value-Based Purchasing Model Could Limit Access to Care, Critics Caution," Home Health Care News (February 10, 2021), https://homehealthcarenews.com/2021/02/home-health-value-based-purchasing-model-could-limit-access-to-care-critics-caution/.
[3] Centers for Medicare & Medicaid Services, "Jimmo v. Sebelius Settlement Agreement Fact Sheet" (last accessed August 25, 2021), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf.
[4] Center for Medicare Advocacy, "Medicare Home Health Coverage: Reality Conflicts with the Law" (April 27, 2021), https://medicareadvocacy.org/issue-brief-medicare-home-health-coverage-reality-conflicts-with-the-law/.
[5] 42 CFR §§409.48(a)-(b).
[6] 86 Fed. Reg. 35874, 35958.

are more profitable and may leave others to languish without proper care. Agencies that must show beneficiaries are improving in order to maximize payment will often not choose to care for people who cannot and will not improve. Similarly, agencies that receive a bonus for new beneficiaries may perceive themselves as losing money for maintaining coverage of existing clientele.

Home health coverage for preventing or slowing deterioration must not be simply theoretical but must be truly available to qualifying Medicare beneficiaries.[7] Accordingly, current and future CMS rulemaking must consider not just what care home health agencies are permitted to deliver, but what they actually deliver; not just what agencies may be theoretically available to beneficiaries, but what agencies are actually willing to provide care for those beneficiaries.

Both the physical and the financial health and well-being of beneficiaries is at stake. We cannot squeeze beneficiaries out of the care they need. Models and payment systems must be reformed when and where they promote these perverse incentives and strong oversight must be in place to root out pernicious discrimination against people with chronic conditions.

We urge thoughtful consideration and review of any policies that incentivize short-term care or care for individuals who are likely to improve but leave hundreds of thousands of older adults and people with disabilities who need care to halt or slow their health and functional declines without access to important home health benefits.

Conclusion

Thank you again for the opportunity to comments on this proposed rule. For further information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi

Fred Riccardi
President
Medicare Rights Center

[7] *Id.*