August 20, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to www.regulations.gov

Re: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies

Dear Secretary Becerra:

The American Nurses Association (ANA) is pleased to comment on the Centers for Medicare & Medicaid Services (CMS) Fiscal Year 2025 Prospective Payment System proposed rule for home health. ANA appreciates thoughtful consideration of the following comments as the agency prepares the final rule. In summary:

1. **ANA Supports New Social Determinants of Health (SDOH) Items as Standardized Assessment Data Elements and Urges CMS to Include Telehealth Capability as a Utility, to Advance Health Equity.**
2. **ANA Urges CMS to Adopt Payment and Measurement Strategies Directly Accounting for Nurse Value in Achieving Outcomes in the Home Health Value-Based Purchasing (HHVBP) Model.**
3. **CMS Improved Oversight of Service Acceptance Must Ensure Agency Nurses Are Consulted to Determine that Agency Care is Available.**
4. **ANA Opposes Therapists Conducting Nursing Care Assessments in Home Health.**
5. **CMS Should Finalize Permanent Respiratory Infection Reporting but Must Consider Infection Risks in Healthcare Personnel and Align Reporting with OSHA.**

ANA is the premier organization representing the interests of the nation's over 5 million RNs, through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA members also include the four APRN roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members.

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1. **ANA Supports New SDOH Items as Standardized Assessment Data Elements and Urges CMS to Include Telehealth Capability as a Utility, to Advance Health Equity.**

ANA supports the proposal to add standardized assessment items related to living situation, food, and utilities, supplementing data collection on health-related social needs. CMS' reasons for proposing these items are evidence-based, sound, and highly relevant to health equity goals for home health beneficiaries. Adding these elements can support providers' and CMS' efforts to reduce health and care disparities. Ultimately, nurses are key in designing, directing, and delivering care that appropriately meets the needs of patients, improves access to needed care, promotes positive outcomes, and reduces disparities. At the point of delivery, attention to living situations, food, and utilities can support treatment decisions and the goals of patients and their caregivers. Identification of needs should also lead to positive steps to improve patients' ability to achieve their health goals while living in their homes. Nurses are well positioned to initiate these steps.

For the purposes of the proposed item on utilities, CMS proposes the assessment ask about electric, gas, oil, or water, and whether service shut offs have been threatened in the past 12 months, presumably due to payment shortfalls. **ANA urges CMS to expand the utilities assessment item to include data on the beneficiary's access to internet or 5G**. Access to information and interactive services online from the home is as vital to health care as any other service traditionally defined as a utility. With expansions in telehealth service offerings and the increasing use of virtual nursing, policymakers must target disparities in access to these innovations. CMS must take the lead in ensuring that all home health beneficiaries have equitable access to prevailing care modalities. A first step is collecting key information through the assessment process.

ANA also recognizes that lengthy and personally intrusive assessment questions can affect the critical relationship between home health personnel and patients. Assessment activities must preserve the ability of the nurse to use a patient- and family-centered approach that allows for natural interactions to better reveal a patient's health-related situations. As such, we urge CMS to work closely with nurses to ensure that agencies conduct assessments that are balanced with the provision of whole person care.

Moreover, we call on CMS to seek out and incorporate nurses' clinical expertise and compassion to support advances in health equity. In particular, CMS must incorporate the recommendations from the National Academy of Medicine's Future of Nursing 2020-2030 report, *Charting a Path to Achieve Health Equity*.[1] Some of the recommendations in the report call on government agencies and other stakeholders to take action that allow nurses to comprehensively address social determinants of health across care settings, allow nurses to practice to the top of their license, support the mental well-being of nurses and ensure a robust and diverse workforce ready for future challenges, and implement payment strategies that support addressing patients' social needs and health equity challenges. The report also specifically calls on CMS, with other federal agencies, to convene nurses and other key stakeholders to work together to identify research areas and other evidence-based approaches that examine the impact of nursing services on patients' health and nurses' well-being. CMS should advance these recommendations as the agency continues its focus on health equity through policies and programs.

[1] National Academy of Medicine; National Academies of Sciences, Engineering, and Medicine. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. https://nap.nationalacademies.org/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to. Accessed August 2024.

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2. **ANA Urges CMS to Adopt Payment and Measurement Strategies Directly Accounting for Nurse Value in Achieving Outcomes in the Home Health Value-Based Purchasing (HHVBP) Model.**

CMS requests comments on specific performance measures and general comments on other future model concepts that may be considered in the expanded Home Health Value-Based Purchasing (HHVBP) model. Generally, ANA strongly believes that developing effective value-based payment methods must involve proper valuation of nursing care at the provider and system levels. The continued expansion of the HHVBP model provides a significant opportunity for Medicare to play a needed leadership role in accounting for the value of nursing in home health care.

The need for Medicare to reconsider payment strategies is clear from the near constant reports of nursing shortages, and providers' frequent assertions of challenges in hiring and retaining registered nurses (RNs). Agencies' staffing decisions, along with their lack of attention to challenges in the work environment, have contributed to this situation. So has payment policy. The outmoded view that nursing capacity represents only provider costs to the bottom line has led to insufficient investment in the home health nursing workforce. Nurses not only provide the skilled care that is the basis of home health coverage, but also serve as "eyes and ears" in the home, identifying and documenting the need for assistive care and other supports. Nurses are often able to connect patients with resources addressing health-related social needs, playing an important role in advancing health equity.

In short, it is the nursing workforce that most enhances the value of Medicare home health care, as they improve health outcomes, reduce hospital readmissions, and help avoid overutilization of emergency services.

However, home health nurses face burnout from stressful work environments where they bear the burden of staffing shortages, administrative demands, and risks of violence.[2] Increased staffing and support are consistently named as the second-most desired improvement for work satisfaction, with increased salary the most desired. Nurses in home health are among the lowest paid RNs, compared to those in other settings.[3] Unless Medicare policymakers incentivize improvements in nurse working environments, patient access to high-quality, equitable services will be increasingly undermined at the point of care, in communities, and across patient populations. **ANA urges CMS to work with stakeholders to develop nurse valuation methodologies and adopt payment policy to incentivize nursing workforce expansions in home health.**

In addition, ANA strongly urges CMS to collect financial information from agencies that reveal their direct and indirect costs associated with delivery of high-quality nursing services, and this information should be available to the public. **The proposed measure of Medicare spending per beneficiary could be a useful first step, provided the collected data shows the cost of nursing care.**

3. **CMS Improved Oversight of Service Acceptance Must Ensure Agency Nurses Are Consulted to Determine that Agency Care is Available.**

[2] American Nurses Foundation. 2022 Workplace Survey. August 2022. Accessible online at https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need-to-know/covid-19-survey-series-anf-2022-workplace-survey/
[3] See Journal of Nursing Regulation. April 2023

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CMS is proposing changes in Conditions of Participation to require home health providers to develop and consistently apply an acceptance of service policy, updated annually. Part of that acceptance of service policy would include information that addresses the agency's capacity, case load, patient case mix, staffing levels, and staff competencies. CMS proposes these changes to address delays in home health initiation, noting that many agencies often overextend or accept patients they cannot adequately serve.

ANA agrees with CMS' overall goals of improving the timeliness of home health initiation, reducing delays, and enhancing patient outcomes. However, we caution CMS that appropriate patient placement with any particular home health agency is more nuanced than simply tracking staffing numbers and general competencies. Patient acuity levels and care needs dictate the level of care that a home health nurse, and therefore the agency, will have to commit to meet the needs of each patient. Consultation with nurses within the agency is vital as they have the clinical expertise and experience to determine if the agency can take on additional patients. As such, **CMS must ensure that any acceptance of use policy process includes nurse input to determine whether a patient placement within an agency is possible based on patient acuity and care levels.**

4. ANA Opposes Therapists Conducting Nursing Care Assessments in Home Health.

CMS is proposing modifications to Conditions of Participation to allow therapists to conduct comprehensive assessments when both therapy and nursing care are ordered. During the COVID-19 public health emergency (PHE), CMS waived regulatory provisions and allowed therapists to conduct these assessments, and the current proposal would make these provisions permanent.

ANA cannot support this proposal. While therapists are highly trained and educated and are able to assess patient needs in their respective fields, they do not have the expertise to conduct the comprehensive assessments necessary for nursing care. For example, one occupational therapy school states, "Our occupational therapy program teaches students to restore, reinforce and enhance performance through meaningful activities or occupations that help individuals learn the skills and functions required to take care of themselves, be productive and improve overall health and well-being."[4] For another example, a physical therapy program states, "Students learn to manage patients and clients with musculoskeletal, neuromotor, cardiopulmonary, and integumentary dysfunction. The curriculum also guides students' exploration of the legal/ethical aspects of patient care as well as issues of communication, health promotion, policy, and practice management."[5] These definitive descriptions apply to specific activities and parts of human physiology but are not co-extensive with nurse training, education, and practice standards.

The education that therapists receive makes them highly qualified to assess and treat patients within their field, but that is not the whole person care that nurses provide. Without training in this care, therapists do not have the education or knowledge necessary to conduct comprehensive assessments.

[4] Towson University. Department of Occupational Therapy & Occupational Science. https://www.towson.edu/chp/departments/occutherapy/#:~:text=Our%20occupational%20therapy%20program%20teaches,overall%20health%20and%20well%2Dbeing. Accessed July 25, 2024.
[5] George Washington School of Medicine & Health Sciences. The Physical Therapy Program. https://physicaltherapy.smhs.gwu.edu/curriculum#:~:text=Students%20learn%20to%20manage%20patients,%2C%20policy%2C%20and%20practice%20management. Accessed July 25, 2024.

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The training and expertise of a nurse is especially relevant as Medicare advances its equity agenda and home health agencies are increasingly engaged in assessing health-related social needs of patients.

ANA, and other nursing organizations, have long recognized nursing shortages in some areas of the country, and these workforce gaps must be addressed in federal policy. However, elevating other practitioners and allowing them to assess patients outside of their scope of practice is not a helpful solution. If nursing care is ordered, nurses should conduct the nursing assessment. Otherwise, a symptom or social determinant could be overlooked, resulting in incomplete or counterproductive care plans and compromising care quality. **ANA urges CMS not to finalize this proposal.**

5. **CMS Should Finalize Permanent Respiratory Infection Reporting But Must Consider Infection Risks in Healthcare Personnel and Align Reporting with OSHA.**

ANA appreciates CMS' continued attention to respiratory illness impacts on patients in healthcare facilities and in home healthcare delivery. This is especially important for nurses due to their direct patient care role and constant exposure to these infections. In fact, COVID-19 infections among nursing home healthcare staff are on the rise again at a rate of 6.2 in early August 2024.[6] COVID-19 and RSV hospitalizations are also trending up, including combined respiratory infection hospitalizations.[7] The proposed permanent requirement of infection data reporting to the Centers for Disease Control and Prevention (CDC) will continue to be important for local, state, and federal public health departments to offer targeted support and supplies. Additionally, including health-related social needs data in the collection from patients will also be necessary for addressing the impacts of health care inequities.

However, CMS is missing the critical impact of infections among nurses and other healthcare personnel, which is currently included in the pandemic-era final rule but omitted from the proposed permanent requirement. This data will be necessary to protect staff, patients, and public health. We note that the Occupational Safety and Health Administration's (OSHA's) COVID-19 Emergency Temporary Standard's reporting requirements are still in place, and will be maintained in the event of a final OSHA COVID-19 rule.

OSHA's ETS requires reporting of COVID-19 hospitalizations and deaths of staff and keeping a COVID-19 staff infection log, as well as OSHA's regular work-related injury and illness reporting process. Additionally, OSHA is currently working on a much-needed Infectious Disease Standard which could also include respiratory infection reporting for healthcare professionals. **ANA urges CMS to align with OSHA to harness the data necessary to protect home health patients and staff from respiratory infections**. As nurses bear the burden of reporting and data collection, it will impact their ability to provide care while being safe at work. Pursuing automated reporting and other tools to decrease this burden will be necessary.

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[6] Centers for Disease Control and Prevention, *Confirmed COVID-19 Cases among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week – United States*, available at: https://www.cdc.gov/nhsn/covid19/ltc-report-overview.html#anchor_1594393306

[7] Centers for Disease Control and Prevention, *Respiratory Virus Activity Levels*, available at: https://www.cdc.gov/respiratory-viruses/data/activity-levels.html?CDC_AAref_Val=https://www.cdc.gov/respiratory-viruses/data-research/dashboard/activity-levels.html

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For successful implementation of these reporting requirements and new reporting processes under a future PHE, CMS must utilize the frontline and clinical knowledge of nurses. If CMS chooses to bypass notice and comment feedback for future PHE reporting proposals, CMS must collect feedback from nurses and subject matter experts now. ANA also urges CMS to rely on advisory committees and councils in this instance while ensuring nurses are at the table.

ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with HHS. Please contact Tim Nanof, Vice President, Policy and Government Affairs, at (301) 628-5166 or Tim.Nanof@ana.org, with any questions.

Sincerely,

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer/EVP

cc: Jennifer Mensik Kennedy, PhD, MBA, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Officer

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