Texas Association for Home Care & Hospice (TAHC&H)

2025 Federal Legislative Priorities

Ensure appropriate and adequate reimbursement for Medicare home health services

Medicare home health agencies (HHAs) continue to operate under payment rate cuts that far exceed any other provider sector. In addition, home health providers continue to receive annual inflationary updates that fall well short of actual inflation. CMS' continued flawed implementation of the budget neutrality provisions of the Bipartisian Budget Act of 2018's changes to the home health payment system have resulted in a cumulative decrease of 8.79% over the last three years. Combined with the market basket forecast error of 6.6% over the past four years[1], these two issues have significantly impacted the home health benefit and created additional challenges for providers and patients. CMS continues to use its flawed methodology to calculate the impact of provider behavior under PDGM under a budget neutrality requirement. CMS has also suggested it may "claw back" billions of dollars through future cuts from the home health benefit. In total, the permanent and temporary cuts are now estimated to reduce home health payments by more than $25 billion over the next ten years. Access to home health care is being delayed and in some cases, non-existent, as HHAs continue to struggle under the new payment model due to these massive cuts, despite CBO scoring the original proposal at a "0" in 2018. **TAHC&H urges against additional reductions to the home health benefit. Further cuts will jeopardize access to home health care, which is broadly preferred by Medicare beneficiaries, and helps patients avoid costly hospital and nursing home stays. TAHC&H supports regulatory or legislative efforts to address these continued reductions.**

Medicare Advantage

Home health agencies continue to face significant challenges under the Medicare Advantage (MA) program, including inconsistent reimbursement rates, administrative burdens, and inadequate payments that fail to reflect the cost of care. Unlike traditional Medicare, MA plans often underpay home health providers, delay authorizations, and impose arbitrary coverage denials, creating unnecessary barriers to care. To ensure fair and sustainable reimbursement for home health services, Congress must transition MA to payment models that at a minimum align with traditional Medicare reimbursement structures to provide stability and predictability for home health agencies. **Congress and the Administration should further review the MA program to assess disparities in MA home health reimbursement and ensure rate standardization. Data accuracy and transparency must also be improved so that MA plan reporting accurately reflects the true cost of care and services provided.**

Ensure permanent telehealth flexibility in the home health and hospice benefit

Telehealth (including telephonic, telemonitoring, and video conferencing) enables providers to deliver care safely and effectively. Currently, home health agencies are allowed to accept orders from a physician, nurse practitioner or physician assistant for home health after a face-to-face visit has been completed either in person or using telehealth. The administrative component of the certification process ensures timeliness of services for Medicare beneficiaries in need of these medically necessary services. Additionally, COVID era flexibilities extended the face-to-face component to Hospice agencies as well, ensuring these critical services can be delivered to beneficiaries in their last days of life. We appreciate Congress' continued extension of these flexibilities, which currently expire on September 30, 2025; however, we urge these flexibilities be permanently extended as they have proven to improve the quality and efficiency of care, **TAHC&H supports legislation making these flexibilities permanent.**

[1] CMS updates payment rates each year by using the latest market basket *projections* available at the time; however, in subsequent quarters CMS publishes updated, final market baskets. From CY 2021 – CY 2024, CMS' projected market basket updates have fallen short by -6.6%.

Ensure any Medicaid reforms do not limit patient access to HCBS services

a. Medicaid Home and Community-Based Services (HCBS) offer essential state and federally funded services to help Medicaid enrollees with complex care needs get the support they need to continue living in their homes in lieu of more costly institutional settings. As Congress continues to assess options to reduce federal spending, particularly in light of the reconciliation framework that includes instructions to find $880 billion in program reductions, **we support policies that prioritize ensuring access to the high-value and cost saving home and community-based programs that have proven to reduce overall health care spending in Medicaid.**

b. In April 2024, CMS finalized a rule requiring that states ensure at least 80% of all Medicaid HCBS payments are spent on compensation for direct care workers, such as nurses, home health aides, and others who directly support Medicaid beneficiaries in activities of daily living at home. The remaining 20% of the payments are expected to cover all the other HCBS operating expenses. TAHC&H opposed this "80/20 Rule" being finalized and remains concerned about the lack of data from CMS to support the need for the rule, potential exacerbation of existing workforce shortages, especially in small and rural communities, and adverse impacts on affordability, among other issues. In 2024, Rep. Kat Cammack (R-FL) introduced a bill to prohibit CMS from implementing the 80/20 Rule that was cosponsored by several members of Congress from Texas. **TAHC&H supports legislative or regulatory efforts to prohibit CMS from implementing the 80/20 requirement.**

Support Targeted Hospice Program Integrity and Maintain Hospice Services

In 2020, Congress directed CMS to establish the Special Focus Program (SFP) to enhance enforcement for a subset of underperforming hospices that CMS "has identified as substantially failed to meet" Medicare requirements. Congress intended the SFP as a tool to protect patients by targeting and correcting serious compliance issues identified by surveyors, with the poorest performing hospices being placed on a public Hospice SFP List until their record of compliance with Medicare requirements improved. Despite that clear statutory mandate, CMS promulgated the SFP Final Rule which used an algorithm to select hospices for the SPF that included not only findings of noncompliance with Medicare requirements but also indicators unrelated to compliance with Medicare requirements. In December 2024, CMS published a list of providers using this flawed algorithm, which publicly labeled high-quality hospices as "poor performers" while overlooking true poor performers. In February 2025, a multi-state coalition of hospices and hospice associations legally challenged the CMS SFP resulting in CMS removing the list of agencies and temporarily ceasing the program. Because the rule does not meet the statutory intent**, TAHC&H supports CMS's withdrawal of the current SFP rule and a process to work with the industry to craft rules that align with Congress' intent.**

Veterans Affairs

The Veterans Affairs (VA) Community Care Program currently reflects inconsistencies that contribute to unequal access to home care services for veterans. The variability in Care Coordination (CC) using Standardized Episodes of Care (SEOC) results in inequitable access to medically necessary services. Care Coordinators, who are non-medical providers, frequently utilize a Case Mix Index (CMI) assessment after a SEOC has been generated, which can lead to reductions in the level of services provided to veterans. This approach grants Care Coordinators excessive authority over care modifications, which may undermine clinical decisions. Additionally, medical providers who initiate services through the SEOC process may encounter denials or modifications to their orders by Care Coordinators, affecting the continuum of care. **It is essential that a national standard be established for all Department of Veterans Affairs Community Care staff to ensure that the SEOC is applied consistently, without subsequent modifications. This will help guarantee that veterans receive appropriate, timely, and high-quality in-home care, irrespective of their location or Care Coordinator assignment.**