LTA Proposed Rule Public Comments

Document ID	Docket ID	Tracking Number	Posted Date	First Name	Last Name	State	Organization Name	Category	Attachment Files	Comment
CMS-2023-0113-0648	CMS-2023-0113	llv-ldmk-er5v	2023-09-14T04:00Z				**AARP**	Consumer Group	https://downloads.regulations.gov/CMS-2023-0113-0648/attachment_1.pdf	Attached please find AARP's comments on CMS–1780–P. Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements. Thank you for your consideration of AARP's comments.
CMS-2023-0113-0895	CMS-2023-0113	llx-61xy-gnqo	2023-09-14T04:00Z				**AccentCare**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0895/attachment_1.pdf	AccentCare's comment letter attached. CMS–1780–P.
CMS-2023-0113-0604	CMS-2023-0113	llv-byas-0gzd	2023-09-14T04:00Z				**Advancare Healthcare Services, LLC**	Health Care Industry - PI015		Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Advancare Healthcare Services, LLC provides home health services in Illinois. Specifically, we serve the greater Chicagoland area including the following counties: Cook, DuPage, Will, Kane, Lake, Kendall, McHenry, Boone and Dekalb. We have been a Medicare participating home health agency since 2005 and currently have a patient census of 250. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we are facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals without care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.
CMS-2023-0113-0798	CMS-2023-0113	llw-q24f-jfub	2023-09-14T04:00Z				**ADVION (formerly National Association for the Support of Long Term Care)**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0798/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0737	CMS-2023-0113	llw-ka4e-fb91	2023-09-14T04:00Z				**Advocate Health**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0737/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0769	CMS-2023-0113	llw-nz86-wl8c	2023-09-14T04:00Z				**Advocate Health**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0769/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0464	CMS-2023-0113	llq-qp1r-13ln	2023-09-12T04:00Z				**Aegis Therapies**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0464/attachment_1.docx	See attached file(s)

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CMS-2023-0113-0470	CMS-2023-0113	llq-se41-bb0w	2023-09-12T04:00Z				**AIROS Medical, Inc.**	Health Care Professional or Association - HC001	https://downloads.regulations.gov/CMS-2023-0113-0470/attachment_1.pdf	As a patient (breast cancer in 2010), lymphedema therapist and clinical advisor, I am grateful that Medicare will now cover lymphedema compression garments and materials. I am concerned that some details, such as who may offer a fitting for a covered garment and which types of and aspects of garments will comply with coverage, may continue to lead to confusion of and delay to coverage. Such delays can impair or even negate the benefits achieved during the covered therapy visits, leading to an increased medical burden that is entirely avoidable. My comments are made in further length in the attached letter. I will be a Medicare reciepient starting in November and am hopeful that when I need garments in the new year, I will not run into difficuly obtaining them. I am submitting comments on behalf of the organization for whom I serve as a clinical advisor, AIROS Medical, Inc, a pneumatic pump company. The attached letter expresses my own concerns which are shared by our organization.
CMS-2023-0113-0875	CMS-2023-0113	llw-zdz2-2gqr	2023-09-14T04:00Z				**Aliance for Nursing Informatics**		https://downloads.regulations.gov/CMS-2023-0113-0875/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0768	CMS-2023-0113	llw-nu17-4jou	2023-09-14T04:00Z				**All Care Visiting Nurse Association of Greater Lynn, Inc.**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0768/attachment_1.pdf	CMS-1780-P; RIN 0938-AV03
CMS-2023-0113-0874	CMS-2023-0113	llw-z30l-f2vh	2023-09-14T04:00Z				**Alliance for Nursing Informatics**	Health Care Professional/Association - Nurse	https://downloads.regulations.gov/CMS-2023-0113-0874/attachment_1.pdf	Please see the attached comments from the Alliance for Nursing Informatics
CMS-2023-0113-0871	CMS-2023-0113	llw-xh98-exex	2023-09-14T04:00Z				**Allina Health**	Hospital - HPA35	https://downloads.regulations.gov/CMS-2023-0113-0871/attachment_1.pdf	Dear Administrator Brooks-LaSure: On behalf of Allina Health, this letter is in response to the request for comments on the Home Health Prospective Payment System for Calendar Year 2024 proposed rule. We appreciate the opportunity to provide comments on updates to the Prospective Payment System, Quality Reporting Program, Value-Based Purchasing Program, and offer comments about challenges with recruiting and retaining home health aides. See attached document for the entirety of our letter.
CMS-2023-0113-0765	CMS-2023-0113	llw-o0ry-kcu4	2023-09-14T04:00Z				**Alpha Home Health and Hospice**			• CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. • The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. • Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. • The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. • CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. • The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year.
CMS-2023-0113-0889	CMS-2023-0113	llx-3ej0-z5ua	2023-09-14T04:00Z				**Amedisys, Inc.**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0889/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0716	CMS-2023-0113	llw-hg3m-fgpd	2023-09-14T04:00Z				**America's Physician Groups**	Health Care Professional/Association - Physician	https://downloads.regulations.gov/CMS-2023-0113-0716/attachment_1.pdf	APG appreciates the care with which CMS exercises the agency's statutory responsibility to implement the BBA 2018 changes to the home health prospective payment system and serves as a steward of the Medicare Trust Funds. We encourage CMS to proceed with an abundance of caution when finalizing payment changes for 2024. All projections of future behavior changes on the part of health care providers risk not aligning with actual experience. If projections call for payment reductions that turn out to be excessive, the result may be reduced beneficiary access to needed services and reductions in quality of care. APG members are mindful of the impact of challenges that affect all health care providers, including workforce shortages, economy-wide inflation, and the ongoing effects of the COVID-19 pandemic. The reality of these economic challenges is, unfortunately, not reflected in plans for health care provider payment updates set in statute. As the Medicare Trustees have noted, health care providers have historically achieved lower productivity growth than is required in payment update formulas. APG requests that CMS consider mitigating the impact of the proposed permanent home health payment reduction through a delay, phase-in, or other means. In general, we suggest that any payment reductions the agency proposes should, if necessary, result in only moderate year-to-year change to allow time to evaluate the impact on beneficiary access to services and quality of care. If needed, additional reductions can always be implemented for future years.
CMS-2023-0113-0689	CMS-2023-0113	llw-cac0-siys	2023-09-14T04:00Z				**American Academy of Hospice and Palliative Medicine**		https://downloads.regulations.gov/CMS-2023-0113-0689/attachment_1.pdf	On behalf of the more than 5,600 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment on the Calendar Year (CY) 2024 Home Health proposed rule (CMS-1780-P). AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality, equitable palliative and hospice care. Our feedback in the attached document centers on select proposed policies in this rule that address hospice care. AAHPM would be pleased to work with the Centers for Medicare and Medicaid Services to address our recommendations.
CMS-2023-0113-0665	CMS-2023-0113	llv-v0g7-2kn4	2023-09-14T04:00Z				**American Academy of Physician Associates**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0665/attachment_1.pdf	Official comments of the American Academy of Physician Associates

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CMS-2023-0113-0379	CMS-2023-0113	lln-x5hj-mpkb	2023-09-11T04:00Z				**American Association for Men in Nursing**		https://downloads.regulations.gov/CMS-2023-0113-0379/attachment_1.pdf	RE: CMS-1780-P. Comments relating to Medicare Program; 2024 Home Health Prospective Payment System Proposed Rule Dear Administrator Brooks-LaSure: We write to thank you for your efforts in implementing the provisions of the Helping Our Senior Population In Comfort Environments Act that were included in the Consolidated Appropriations Act, 2021. Your efforts will ensure that Medicare beneficiaries have access to high-quality hospice care while continuing to provide access to our diverse patient populations. We are also grateful that the Centers for Medicare and Medicaid Services (CMS) has begun rulemaking to expand quality within care provided to hospice patients including the Special Focus Program (SFP). On June 30, 2023, CMS released the 2024 Home Health Prospective Payment System Proposed Rule, which includes a proposed alteration in the methodology for identifying hospices for inclusion in the SFP beginning in early 2024. As a professional nursing organization, the American Association for Men in Nursing (AAMN) maintains a mission "to shape the practice, education, research, and leadership for men in nursing and advance men's health." Many of our members and leaders are providers and nurses within hospice care. We continuously strive to provide our members with relevant and up-to-date information on practice, education, and research. This serves as the foundation of our educational activities, partnership engagement, and research foci. Based on a review of the proposed SFP, AAMN has concerns that the change may have unintended consequences and will limit access to patients within underserved and diverse communities. Although the proposed methodology and algorithm is focused on improving quality, the change may lead to utilizing inconsistent and subjective data and would target hospice providers using quality indicators derived from certain data sources. We strongly agree with CMS that patients and their families must have a voice in the process and the focus of any change should be quality improvement. We are concerned the algorithm may fail to identify hospices delivering poor-quality and unsafe care and will instead identify the hospices that provide care to large, diverse, and historically underserved patient populations. Given this, we urge CMS to delay its implementation of the proposed SFP methodology while it considers stakeholder feedback and works to improve the SFP algorithm to be more objectively based on standardized quality metrics. We further urge CMS to implement a preview year where all hospice providers are given notice of their performance rankings, as applied by the algorithm metrics. While we recognize the significance of any delay, we believe these steps are critical to ensure that CMS achieves its objective — to address the issues that place hospice beneficiaries at risk of receiving unsafe and poor-quality care without risking access to communities that need it. Regards, Curry Bordelon, DNP, CRNP, MBA Vice President, AAMN Jason Mott, PhD, RN President, AAMN
CMS-2023-0113-0546	CMS-2023-0113	llu-x8so-rnyi	2023-09-14T04:00Z				**American Association of Nurse Practitioners**	Health Care Professional/Association - Nurse Practitioner	https://downloads.regulations.gov/CMS-2023-0113-0546/attachment_1.pdf	Please find attached comments from the American Association of Nurse Practitioners
CMS-2023-0113-0698	CMS-2023-0113	llw-f50l-hh99	2023-09-14T04:00Z				**American Hospital Association (AHA)**	Health Care Provider/Association - Hospital	https://downloads.regulations.gov/CMS-2023-0113-0698/attachment_1.pdf	Please find attached comments from the American Hospital Association (AHA). Please contact Jonathan Gold (Jgold@aha.org) with any questions.
CMS-2023-0113-0395	CMS-2023-0113	llo-4fp6-9kld	2023-09-11T04:00Z				**American Nurses Association**		https://downloads.regulations.gov/CMS-2023-0113-0395/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0584	CMS-2023-0113	llv-6q78-sfi4	2023-09-14T04:00Z				**American Occupational Therapy Association**	Health Care Professional/Association - Occupational Therapis	https://downloads.regulations.gov/CMS-2023-0113-0584/attachment_1.pdf	Please see attached file for comments on scope and payment for lymphedema treatment items proposed within the new benefit implemented in response to the lymphedema treatment act.

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CMS-2023-0113-0731	CMS-2023-0113	llw-j8hm-xhdn	2023-09-14T04:00Z				**American Physical Therapy Association**	Health Care Professional/Association - Physical Therapist	https://downloads.regulations.gov/CMS-2023-0113-0731/attachment_1.pdf	Please see the attached comment letter on the proposed rule entitled "Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update"(CMS-1780-P), submitted on behalf of the American Physical Therapy Association (APTA).
CMS-2023-0113-0746	CMS-2023-0113	llw-l9g8-kfo2	2023-09-14T04:00Z				**American Physical Therapy Association**	Health Care Professional/Association - Physical Therapist	https://downloads.regulations.gov/CMS-2023-0113-0746/attachment_1.pdf	Please see the attached comment letter on the lymphedema provisions of the proposed rule entitled "Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements"(CMS-1780-P), submitted on behalf of the American Physical Therapy Association (APTA). Given the distinct nature of the lymphedema benefit and significance of these proposals, APTA has submitted two separate letters to address the home health provisions and the lymphedema provisions.
CMS-2023-0113-0673	CMS-2023-0113	llw-6q79-b96s	2023-09-14T04:00Z				**American Physical Therapy Association Private Practice**	Association - Other	https://downloads.regulations.gov/CMS-2023-0113-0673/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0813	CMS-2023-0113	llw-qzwh-fg3m	2023-09-14T04:00Z				**American Podiatric Medical Association (APMA)**	Health Care Professional/Association - Physician	https://downloads.regulations.gov/CMS-2023-0113-0813/attachment_1.pdf	Attached please find comments on behalf of the American Podiatric Medical Association (APMA) related to File Code CMS-1780-P: Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update. We welcome the opportunity to discuss these issues further, and if you need additional information, please contact APMA's Senior Director for Health Policy and Practice, Scott Haag, JD, MSPH, at shaag@apma.org or (301) 581- 9233.
CMS-2023-0113-0085	CMS-2023-0113	ll5-kgz8-n6it	2023-08-22T04:00Z				**Amoena USA Corporation**	Private Industry - Device	https://downloads.regulations.gov/CMS-2023-0113-0085/attachment_1.pdf https://downloads.regulations.gov/CMS-2023-0113-0085/attachment_2.pdf	As a representative of Amoena USA, I am writing to comment on Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. We are pleased to offer our standard, ready-to-wear compression bras/garments for women experiencing, or at risk for, lymphedema of the chest/breast. Our lymphedema compression bras are made of nylon and spandex, and available in a range of sizes. These garments provide medically effective pressure of 15-21 mmHg for the breast and chest. They include features like textured material and 3D technology on the interior fabric to gently stimulate lymph flow under the skin, and they are comfortable to wear when fitted properly, to encourage patients' long-term use for maintenance and prevention of mild to moderate lymphedema. These bras may not fit into the category "Gradient compression garment - torso and shoulder;" it is, in fact, anatomically difficult to create gradient compression for this area. They are slightly graded (please see the attached test documentation), but our product designers would like to suggest a separate new A-code for "Compression garment - torso/chest/breast, each" to include garments like ours. We hear from many women who suffer from lymphedema of the chest and breast -- one breast cancer patient, in particular, stands out. She explained to us that before wearing our garment, she was actually having difficulty breathing and pain in her upper back, due to the swelling in this area. We are happy that our compression bras could offer her all-over relief from lymphedema. We would also like to comment on the proposed coverage for "two compression garments or wraps with adjustable straps for daytime use (one to wear while another is being washed)... to be replaced every 6 months..." -- this is an acceptable and considerate frequency in our estimation, similar to the coverage for mastectomy bras (L8000) with which we are familiar. As a company that assists and supports women after breast cancer, Amoena appreciates the opportunity to comment on this new legislation. Please see the attachment for more detail about our lymphedema compression treatment items. We look forward to January 2024. We would kindly ask that this comment not be posted publicly as the attachments may include proprietary information.

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CMS-2023-0113-0082	CMS-2023-0113	ll5-6220-tdq4	2023-08-22T04:00Z				**Amoena USA Corporation**	Private Industry - Device	https://downloads.regulations.gov/CMS-2023-0113-0082/attachment_1.pdf	This comment is in reference to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. Amoena, the world's leading breast care brand and the developer of the first silicone breast prosthesis, would like to make legislators aware of lymphedema compression treatment items -- bras and accessories -- that support the truncal and thoracic (chest) area. After every breast surgery, some swelling (edema) occurs. Depending on the type of surgery and further treatment (e.g. breast cancer surgery with lymph node removal and/or radiation), chronic lymphedema may also develop, sometimes in the chest, breast, and even the back. Amoena's CuraLymph Compression garments care for these patients, in accordance with established medical guidelines. Medical compression supports lymphatic drainage to prevent and help manage lymphedema of the chest, and breast. Our standard, ready-to-wear compression bras/garments are made of nylon and spandex, and available in a range of sizes. These garments provide medically effective pressure of 15-21 mmHg for the breast and chest. They include features like textured material and 3D technology on the interior fabric to gently stimulate lymph flow under the skin, and they are comfortable to wear when fitted properly, to encourage patients' long-term use for maintenance and prevention of mild to moderate lymphedema. We also offer an accessory, a Lymph Flow Pressure Pad, which should be considered a lymphedema compression treatment item. Other manufacturers call this a "chip pad." Ours is a thin silicone pad with a textured surface, which can be worn inside a compression garment to increase pressure at the direct area of the edema if necessary. It supports the loosening of fibrous tissue as well providing a light massage effect to encourage lymph flow. As a company that assists and supports women along all points in the breast cancer patient journey, Amoena appreciates the opportunity to comment on this legislation. Please see the attachment for more detail about our lymphedema compression treatment items. We look forward to January 2024.
CMS-2023-0113-0657	CMS-2023-0113	llv-qk6j-u1hr	2023-09-14T04:00Z				**Anova Medical Supply, Inc.**		https://downloads.regulations.gov/CMS-2023-0113-0657/attachment_1.pdf	CMS-1780-P This comment is regarding Benefit and Payment of Lymphedema Compression Treatment Items. Submitted by Anova Medical Supply, Inc. (Albany, NY) specialists in medical compression.
CMS-2023-0113-0454	CMS-2023-0113	llq-npnx-34pg	2023-09-12T04:00Z				**Apria Healthcare**	Other Health Care Provider - HPA70	https://downloads.regulations.gov/CMS-2023-0113-0454/attachment_1.pdf	Please see attached.
CMS-2023-0113-0809	CMS-2023-0113	llw-qqal-gbj5	2023-09-14T04:00Z				**Aptiva Therapy LLC**		https://downloads.regulations.gov/CMS-2023-0113-0809/attachment_1.pdf	See attached file(s) Letter Regarding CMS Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Updates.
CMS-2023-0113-0688	CMS-2023-0113	llw-cn3t-shkl	2023-09-14T04:00Z				**Arete Home Health Care**	Health Care Professional/Association - Nurse		Home health care is a much needed and sought after service and has proven enormous benefits to both the patient, families and cost savings to the payor. Home health care is a service needed to help bridge the gaps from in patient facility care to home care and these gaps are better managed in the home. The budgetary cuts proposed will not only negatively financially impact the home health care providers (an industry that is already bleeding) but will do a major disservice to the consumers/patients and will overall have a negative impact on patient care outcomes and fuel major financial increases in healthcare as a whole. We are opposed to the proposed budgetary cuts and are requesting the proposed bill be removed.
CMS-2023-0113-0821	CMS-2023-0113	llw-rbec-iaob	2023-09-14T04:00Z				**Ascension**	Health Care Industry - PI015	https://downloads.regulations.gov/CMS-2023-0113-0821/attachment_1.pdf	Please see attached. Thank you.
CMS-2023-0113-0482	CMS-2023-0113	llq-xidc-v89p	2023-09-12T04:00Z				**Association of Home Care Coding & Compliance**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0482/attachment_1.pdf	Please see attached comment letter from the Association of Home Care Coding & Compliance.

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CMS-2023-0113-0478	CMS-2023-0113	llq-viwq-q7ki	2023-09-12T04:00Z				**ATHOME THERAPY SOLUTIONS PLLC**	Health Care Provider/Association - Home Health Facility		We are writing on behalf of Still Waters Home Health Agency , a dedicated Medicare certified home health agency based in Cordova, TN. We would like to express our strong opposition to the proposed cuts for the 2024 Home Health Reimbursement System as put forth by the Centers for Medicare & Medicaid Services. First and foremost, we commend CMS for their efforts to continually evaluate and improve the healthcare reimbursement system. However, we firmly believe that the proposed cuts to home health reimbursement rates in 2024 will have detrimental consequences on patient care, agency sustainability, and the overall quality of care provided to our senior community members who have been relying for skilled services provided by agency such as ours . Home health agencies like ours play an integral role in the healthcare ecosystem by delivering personalized and comprehensive care to patients in their homes. Our skilled nursing, therapy services, and the entire healthcare team greatly contribute to patients' recovery, overall well-being, and independence.This proposed reimbursement cuts threaten our ability to maintain the high standards of care that our patients rely on. These potential cuts are concerning as they come at a time when the demand for home health services is on the rise due to an aging population and increased preference for in-home care. It is our shared responsibility to ensure that patients have access to the necessary care to lead healthier lives and prevent avoidable hospitalizations. By implementing these proposed cuts, CMS risks compromising the patient outcomes and forcing agencies to make difficult choices that could negatively impact the patients care. We urge CMS to consider the broader implications of these cuts and to work with home health agencies to find alternative solutions that maintain the delicate balance between affordability and high-quality care. Rather than diminishing the resources available to agencies, we propose a dialogue that focuses on optimizing operational efficiency, reducing administrative burdens, and enhancing care coordination to ensure patients continue to receive the services they need and deserve. In conclusion, we request that CMS re-evaluates the proposed cuts to the 2024 Home Health Reimbursement System and engages in meaningful discussions with industry stakeholders to explore viable alternatives. Together, we can ensure that the home health ecosystem remains robust, capable of providing exceptional care, and upholding the principles of patient-centered healthcare. Thank you for your time and consideration. Sincerely, Pinaky Chakravarty,COO Lisa Carr,Director of Professional services Still waters Home Health Agency
CMS-2023-0113-0837	CMS-2023-0113	llw-s9rd-a7ly	2023-09-14T04:00Z				**Aveanna Healthcare**		https://downloads.regulations.gov/CMS-2023-0113-0837/attachment_1.pdf	Attached please find Aveanna Healthcare's comments on the proposed rule. Thank you.
CMS-2023-0113-0360	CMS-2023-0113	llm-rdhf-3j5r	2023-09-11T04:00Z				**AW Healthcare**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0360/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0606	CMS-2023-0113	llv-c6ur-3v68	2023-09-14T04:00Z				**BayCare Health System**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0606/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0449	CMS-2023-0113	llq-ndtl-bkq0	2023-09-12T04:00Z				**BayCare Home Care, BayCare Health System**	Home Health Facility - HPA25		I can't believe that at a time when the price of literally EVERYTHING has skyrocketed... you feel that this is the best time to CUT funding to Home Health??! When you drive Home Health Agencies, who are already struggling to break even, out of business you realize that you'll only be left paying for Skilled Nursing Care, ER, and Inpatient Hospitalization bills... ALL of which are exponentially higher in cost. I don't know who does your math, but I think they need to take a second look at this because they have no idea what they are doing. I'd say this is 'penny wise, pound foolish' but in all honesty it's just foolish. This proposed rule shows just how completely disconnected you are from the reality of caring for people. Let me be very clear in saying that Medicare needs Home Health just as much as Home Health needs Medicare. If you want to decrease the cost of healthcare, driving people to SNF's and IP Hospitals is the exact opposite of what will achieve that goal. Why not continue with Home Health Value Based Purchasing efforts and put your investment into higher quality, lower cost outpatient care.
CMS-2023-0113-0394	CMS-2023-0113	llo-49df-62n2	2023-09-11T04:00Z				**Benton County Health Department**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0394/attachment_1.pdf	Please see attached files below. thank you

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CMS-2023-0113-0802	CMS-2023-0113	llw-q9vl-ed4i	2023-09-14T04:00Z				**Berkshire VNA/Berkshire Medical Center**		https://downloads.regulations.gov/CMS-2023-0113-0802/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0750	CMS-2023-0113	llw-lw02-y6zk	2023-09-14T04:00Z				**BJC Home Care Services**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0750/attachment_1.pdf	Please see attached from BJC Home Care Services in St. Louis, MO.
CMS-2023-0113-0705	CMS-2023-0113	llw-g8iu-1odo	2023-09-14T04:00Z				**Bridge Home Health and Hospice**	Home Health Facility - HPA25		The proposed rule would have a negative impact on home health agencies and their ability to run their agency with enough resources to provide high quality care with positive outcomes. This year is no different than last year where the cost to provide care has only increased over the last year with pay increases needed to recruit and retain high quality nurses, mileage expense increases, supply expense increases, and pretty much every other expense has increased. A decrease in funding will only drive agencies out of business and ultimately have a negative impact on patients. I am all for structuring reimbursement to reward agencies that perform well with high quality outcomes, low re-hospitalization rates, and high service excellence while helping our aging population to age in place. My agency will sign up for that everyday of the week but you need to reimburse a fair rate for us to do our jobs effectively and have the resources to be successful in our jobs.
CMS-2023-0113-0808	CMS-2023-0113	llw-qo7k-j7ly	2023-09-14T04:00Z				**BrightSpring Health Services**		https://downloads.regulations.gov/CMS-2023-0113-0808/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0522	CMS-2023-0113	llt-vw12-cf6i	2023-09-12T04:00Z				**Byram Healthcare Centers Inc.**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0522/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0692	CMS-2023-0113	llw-dgyv-hzlq	2023-09-14T04:00Z				**California Hospital Association**		https://downloads.regulations.gov/CMS-2023-0113-0692/attachment_1.pdf	Please see the attached comments submitted on behalf of the California Hospital Association. Please reach out to Chad Mulvany, vice president of federal policy, at cmulvany@calhospital.org with any questions.
CMS-2023-0113-0751	CMS-2023-0113	llw-mb99-myzp	2023-09-14T04:00Z				**Care Central VNA and Hospice**	Health Care Provider/Association - Home Health Facility		Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comments on the proposed rules within “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Care Central VNA and Hospice, Inc. provides home health services in Massachusetts. Specifically, we serve the central and western parts of the state including Franklin, Worcester, Middlesex, Hampshire, and Hampden Counties. We have been a Medicare participating home health agency since 1966 and currently have a patient census of 600. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Respectfully, Care Central VNA & Hospice, Inc.
CMS-2023-0113-0609	CMS-2023-0113	llv-cfd9-ivux	2023-09-14T04:00Z				**Caring Across Generations**		https://downloads.regulations.gov/CMS-2023-0113-0609/attachment_1.pdf	See attached for response from Caring Across Generations on the RFI regarding Medicare Home Health Aides.

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CMS-2023-0113-0539	CMS-2023-0113	llu-uey3-ge8y	2023-09-14T04:00Z				**Caring Touch Medical, Inc.**	Government - Federal	https://downloads.regulations.gov/CMS-2023-0113-0539/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0653	CMS-2023-0113	llv-n204-8u5a	2023-09-14T04:00Z				**Castor Home Nursing Inc**	Health Care Provider/Association - Home Health Facility		As a certified home health agency based in Illinois, we cannot emphasize enough the profound implications that the proposed cuts could impose on both our vulnerable home health patients and our dedicated providers. The potential aftermath of these cuts is poised to be nothing short of catastrophic. Alarmingly, projections indicate that a substantial portion of Medicare-certified home health agencies, including our own, could be pushed into financial jeopardy due to these impending cuts. The gravity of this situation becomes even more pronounced when we acknowledge that the scale of these cuts far surpasses the initial estimations. The cumulative impact over the next decade is projected to reach billions of dollars, an astronomical figure with the potential to reverberate throughout the entire home health sector. Moreover, we must highlight the pivotal role that home health services play, especially in rural areas, in facilitating the seamless transition from hospital to home. In regions where access to clinicians is already a challenge, home health acts as a lifeline for patients striving to recover within the familiar comfort of their own homes. With hospital stays increasing in duration, the absence of robust home health services could compound the struggles faced by patients, making the transition from a hospital environment to their homes an even more daunting endeavor. Representing the interests of rural areas and advocating for the welfare of our patients, we earnestly beseech for a reconsideration of these proposed cuts. It is crucial to recognize that the impact goes beyond mere financial calculations. The very essence of compassionate care and the well-being of our patients are hanging in the balance. It is incumbent upon all of us to uphold the integrity of our healthcare ecosystem, safeguarding the essential bond between patients and providers, irrespective of the challenges we face.
CMS-2023-0113-0555	CMS-2023-0113	llv-0b6e-j6yw	2023-09-14T04:00Z				**CCS Medical**		https://downloads.regulations.gov/CMS-2023-0113-0555/attachment_1.pdf	Please accept CCS MEDICAL comments in the attached letter.
CMS-2023-0113-0805	CMS-2023-0113	llw-qdo3-mnqj	2023-09-14T04:00Z				**Center for Medicare Advocacy**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0805/attachment_1.docx	See attached file(s)
CMS-2023-0113-0840	CMS-2023-0113	llw-sf6f-4ilf	2023-09-14T04:00Z				**Christopher & Dana Reeve Foundation**		https://downloads.regulations.gov/CMS-2023-0113-0840/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0466	CMS-2023-0113	llq-rb3w-5bhw	2023-09-12T04:00Z				**Columbine Medical Equipment**			I support the endorsement of the US Medical Compression Alliance in regards to changes we want to see in the proposed bill.
CMS-2023-0113-0711	CMS-2023-0113	llw-gshw-vhlv	2023-09-14T04:00Z				**Comfort Care Medical Equipment, Inc.**		https://downloads.regulations.gov/CMS-2023-0113-0711/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0011	CMS-2023-0113	lkc-p5ql-tdl3	2023-08-10T04:00Z				**Community Health**	Home Health Facility - HPA25		This proposed rule not only is a slap in the face to our agencies that are providing excellent and essential care during a time when our patients are needing and requesting as much care be provided in the home as possible, this proposed rule is irresponsible and not at all research based. It is purely an effort to ruin home health as an industry and as an available avenue of care for the population. Shame to you who are considering this rule. Taking away money from agencies who are already struggling with high costs of care, nursing shortages and inability to break even is irresponsible.

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CMS-2023-0113-0582	CMS-2023-0113	llv-6i43-gcyh	2023-09-14T04:00Z				**Comprehensive Health Network**	Home Health Facility - HPA25		The methodological approach being used to determine the cuts is flawed. Not only is it flawed there have been many changes and expense increases caused by Covid-19, wage inflation, and the economy that have contributed to much higher cost of care. Medicare home health care is a vital necessity and keeps people in their homes where they are safer, happier, and at a lower level of expense. During Covid-19 Nursing homes and hospitals were full Home Care providers stepped up to the plate and took care of patients that were very ill in their homes and did so with very high quality of care. The cost of home care is very small in the big picture and saves the healthcare system so much more money than can even be measured. Homecare can focus on the patient and develop a personalized plan that is hard to do in a hospital or nursing home as clinicians can see what their home environment looks like and the things that may be obstacles for them. • Home health is patient preferred. 94% of Medicare beneficiaries and 86% of adults say they would prefer to get post-hospital, short-term care at home instead of a skilled nursing facility. • Home health saves Medicare money. CMS's own estimates show that through the expanded Home Health Value Based Purchasing Model, the Medicare Trust Fund should save nearly $3.37 billion over five years due to avoided hospitalizations and skilled nursing facility placement. • Hospitals can discharge patients sooner. Unfortunately, hospital lengths of stay have increased and will increase even more if patients are not able to move easily from hospital to home. Prior cuts to the traditional Medicare program including implementation of Medicare Advantage plans have already cut millions from the providers. The Medicare advantage plans cut services yet their bottom lines have fattened. These cuts will mainly hurt the lowest economical level and will add to the variation we are already seeing in social determinants of health Economic and social conditions that influence individual and group differences in health status. This cut will affect the least of the least in the care that they receive as it will put providers out of business as well as reduce the amount of care that can be given.
CMS-2023-0113-0774	CMS-2023-0113	llw-omtb-3b5f	2023-09-14T04:00Z				**Compression & Mastectomy Solutions**	Other Health Care Professional - HC075	https://downloads.regulations.gov/CMS-2023-0113-0774/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0499	CMS-2023-0113	llr-cdfg-2k6z	2023-09-12T04:00Z				**Compression Obsession, Inc.**	Health Care Provider/Association - Other		I am commenting as biller employed by a supplier that provides comprehensive in person service for patients who need compression garments. 1. &414.1680 Frequency Limits - I suggest that the wording be changed from "affected limb or area of the body" to more precise wording "affected limb or body part". The current wording could be construed to mean that a patient with lymphedema in one upper limb would be allowed one armsleeve and one handpiece only, because that is two per affected limb. Compression garments are very often supplied as two or more garments to treat a single limb. (See &CFR410.2 where "limb or body part affected by lymphedema" is used in the definition). Another commenter also brought up this issue and suggested that the wording be changed to "sets". I have encountered commercial claims being denied for "exceeds limit" when a claim was submitted for FOUR units, i.e. TWO armsleeves and TWO handpieces when the plan only allows 2 garments within a time period. The proposal to implement a separate fitting component where payment is made to a therapist for taking measurements is impractical and possibly impossible for this supplier. This part or the proposal would place an additional regulatory burden on us. This supplier maintains a physical office where patients can attend a complimentary fitting appointment with a trained fitter, be measured, try on samples, examine materials, receive donning instructions, be informed of garment care, and most importantly be guaranteed that the garment fits correctly, meets their needs, and is free of defects. This supplier would welcome requirements for education and training standards that lead to garment fitting certification, perhaps like a BOC Mastectomy Fitter Certification. Reimbursement rates are too low. This supplier will remain non-participating and not accept assignment. Over the past 14 years that I have worked here, more suppliers have ceased supplying custom garments or stopped supplying compression garments all together than have opened as compression garment suppliers. We suspect this is due to high overhead and low reimbursement rates. The expansion of HCPCS codes to include all types of compression garments will eliminate the uncertainty of using A6549 for many different items. The more concise code definitions will be of great help.
CMS-2023-0113-0666	CMS-2023-0113	llv-w7p7-a828	2023-09-14T04:00Z				**Connected Health Initiative**		https://downloads.regulations.gov/CMS-2023-0113-0666/attachment_1.pdf	See attached for comments of the Connected Health Initiative
CMS-2023-0113-0704	CMS-2023-0113	llw-g7cw-idhm	2023-09-14T04:00Z				**Cornerstone**	Home Health Facility - HPA25		As an RN who has been involved in home health for more than 30 years, I am VERY concerned about the Medicare cuts and how they will impact our growing geriatric population. With rising costs for literally everything, clinician shortages, lasting impacts of the pandemic to name a few, these cuts may be the last straw for many already struggling agencies. Without adequate funding, this mightily needed service will become a thing of the past. And the thing I understand the least is how comparatively, home health is BY FAR the least expensive option to care for these folks. Why would you want to cut the throat of this effective and efficient way to keep people medically safe in their home environment?
CMS-2023-0113-0835	CMS-2023-0113	llw-s7f1-cx0r	2023-09-14T04:00Z				**Council for Quality Respiratory Care**	Health Care Provider/Association - Other	https://downloads.regulations.gov/CMS-2023-0113-0835/attachment_1.pdf	Please see the attached comment letter from the Council for Quality Respiratory Care
CMS-2023-0113-0390	CMS-2023-0113	llo-3pft-6okc	2023-09-11T04:00Z				**CoxHealth at Home**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0390/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0463	CMS-2023-0113	llq-qysf-l1n7	2023-09-12T04:00Z				**Curant Health Group, Inc**	Home Health Facility - HPA25		Reduction in reimbursement is going to hurt our ability to care for our communities. As a post acute provider in transitioning care for our patients from acute to post acute to home, maintain all the clinical regulatory requirements', compliance, etc. The cost for small agencies to absorb in light of rising expenses in delivery of care has been detrimental to home health agencies. As a rural border city Home Health agency, we see the profound quality and patient centric care that Home Health services has on our patients - but we also see the substantial toll that providing those services take on providers and caregivers. One of the universal challenges we hear from all agencies is staffing and the constraint that reimbursement rates have on an agencies' ability to pay higher wages and attract prospective employees to fill vacant roles, this has a direct impact on the quality, types and frequency of services that Medicare beneficiaries can receive. We appreciate CMS' acknowledgement and request for comment in the 2024 proposed rule regarding the decline in number of agencies and home health aide services. Referral refusal rates are also at an all time high in Home Health at 76%. This is impacting the timely initiation of care for many patients, putting our most vulnerable seniors at risk and creating unnecessary barriers to care for Medicare beneficiaries. Step By Step Home Health recommends a payment multiplier for telecommunications technology, as well as additional reimbursement to assist in attracting and retaining licensed nurses be added to PDGM to incentivize the use of technology and nursing staff recruitment to assist and support Home Health agencies to increase patient capacity with the staffing levels they have today. CMS itself is promoting telehealth and virtual services to providers, for example in "Telehealth for providers: what you need to know," which describes the benefits as "increase continuity of care, extend access to care beyond normal hours, reduce transportation costs, help rural organizations, and support patients with chronic conditions." These are all benefits that are needed in Home Health and areas that Home Health is uniquely set up to collect the outcomes data needed to identify the impact to older adults. Therefore, we ask you to go beyond just collecting information on how telecommunications software is used in Home Health, we are urging you to act by adding one more layer to the Patient-Driven Groupings Model that adds a case-mix adjustment if the agency is using telecommunications software in practice. But in doing so, you need the nursing staff to facilitate the operational use with on-site technology. We strongly believe that doing so will layer the necessary incentives for agencies to leverage technology, which in-turn will reduce CMS's total spend (as it will reduce avoidable hospitalizations, emergency dept visits and overall total cost of care). This furthers the goals of CMS, addresses patient capacity and provides incentives to organizations to participate ensuring a high quality data-set to study. Thank you for seeking comment and engaging Home Health stakeholders in the regulatory process. In closing, we thank you for the opportunity to provide commentary on this proposed rule. Should you have any questions about these comments, please contact Michael A. Anaya, Sr., MPA, LFACHE or Stacey Anaya, RN, at maanayasr@curanthealthgroup.com or spanaya@sbshh.com. Curant Health Group, Inc., will continue to engage and share our expertise on home health and personal home care services with CMS and other regulators to advocate for patient access. As an organization, we believe Home Health provides significant value to patients and ask for CMS to support Home health agencies and providers so that they can continue to care for their communities.

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CMS-2023-0113-0617	CMS-2023-0113	llv-doue-mcnm	2023-09-14T04:00Z				**D&J Sales Company, LLC dba D&J Medical Orthotics Prosthetics Compression**	Private Industry - Health Care	https://downloads.regulations.gov/CMS-2023-0113-0617/attachment_2.pdf https://downloads.regulations.gov/CMS-2023-0113-0617/attachment_1.docx https://downloads.regulations.gov/CMS-2023-0113-0617/attachment_1.pdf	COMMENT FROM: D&J MEDICAL ORTHOTICS PROSTHETICS COMPRESSION Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1780-P, P.O. Box 8013, Baltimore, MD 21244-8013 We are an American Board Certified Orthotic & Prosthetic accredited provider of custom orthotic, prosthetic devices and lymphedema garments. All our clinicians and fitters are trained and certified. We would like to comment on the following areas of the CMS proposed new ruling for implementation of the Part B benefit for lymphedema compression treatment. VII. Proposed Changes Regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items We applaud CMS for the consideration of coverage for lymphedema compression treatment. We have been providing lymphedema garments for nearly 20 years and could not be happier for our Medicare patients and the relief this will bring after so many years of no coverage. We also approve and agree with the comments submitted by the United States Medical Compression Alliance (USMCA). We feel our comments are in alignment based on over 20 years of experience working with lymphedema patients together. OUR ASKS TO CMS – Please find detailed information for each of the following ASKS: Consider USMCA's proposed reimbursement methodology. Consider all fittings must be done by the entity that is billing the garment. Consider Future ABC Credentialing for all compression fitters. Consider HCPCS codes for Efficacy Aids, Modifications as add on codes. Consider adding the USMCA proposed 300 HCPCS codes to include all body parts. Consider keeping all current codes in place. Consider code description to include the wording custom, each, and add Class with mmhg. Consider adding additional codes for wraps to include Above Knee and Full Leg. Consider using the USMCA proposed reimbursement methodology. Consider 3 daytime garments every 6 months and 2 nighttime sets per year. Again, we applaud CMS for considering coverage for the Medicare Lymphedema Community. We appreciate the opportunity to comment on the proposed ruling and we hope that you will take all comments into consideration for the welfare of all patients. Our hope is to be able to continue to help our patients for another 20 years and more. Please help us. Thank you, D&J MEDICAL OWNERS AND STAFF
CMS-2023-0113-0420	CMS-2023-0113	llp-inej-r11u	2023-09-11T04:00Z				**Diabetes Technology Access Coalition**		https://downloads.regulations.gov/CMS-2023-0113-0420/attachment_1.pdf	Please find attached the comment letter from the Diabetes Technology Access Coalition (DTAC). Thank you for the opportunity to provide these comments.
CMS-2023-0113-0824	CMS-2023-0113	llw-rfel-wag7	2023-09-14T04:00Z				**Ekso Bionics**	Device Industry - PI005	https://downloads.regulations.gov/CMS-2023-0113-0824/attachment_1.pdf	Please see attached.
CMS-2023-0113-0753	CMS-2023-0113	llw-m07q-mxni	2023-09-14T04:00Z				**Elara Caring**	Government - Federal	https://downloads.regulations.gov/CMS-2023-0113-0753/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0724	CMS-2023-0113	llw-ic71-hirq	2023-09-14T04:00Z				**Enovis**	Private Industry - Device	https://downloads.regulations.gov/CMS-2023-0113-0724/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0881	CMS-2023-0113	llx-1t1g-rdls	2023-09-14T04:00Z				**Fairfield Pumps**			Coverage Rules and Reimbursement for the Measuring of Compression Garments i believe it would be helpful for patients and wise for Medicare to cover measurements. Many patients, for some reason, get anxious about a non professional measuring Many therapist/doctor's offices aren't enthusiastic about measuring either. If the wrong size sleeves are sent , patient has no recourse. Once the package is opened, companies will not accept the return, Measuring will ensure the best results and compliance. if the wrong-sized garment is used, treatment is not as effective as it should/could be. It can get complicated, especially in rural areas, for providers to access a professional measurer/fitter. It often delays the process and patient goes without the treatment they need longer than expected.
CMS-2023-0113-0880	CMS-2023-0113	llx-1dg9-71xt	2023-09-14T04:00Z				**Fairfield Pumps LLC**	Device Industry - PI005		Coverage for Accessories • Additional covered items will include accessories such as zippers in garments, liners worn under garments or wraps with adjustable straps, and padding or fillers that are necessary for the effective use of a gradient compression garment or wrap with adjustable straps. ANSWER ** As a DME provider, Accessories are important. Under garment liners would ensure patient's wear appropriate garments to ensure maximum compliance. Additionally, padding and fillers are important so sleeves fit properly. For example, a patient has a very large thigh due to excessive lymphedema, flaps etc. and the rest of their leg is not as swollen. With a normal leg sleeve, the compression is not as effective on the lower part of the leg because the sleeve provided had to be fit XXL size while the remainder of the leg is a L size. Padding and fillers would remedy that situation...that or allowing custom made sleeves.
CMS-2023-0113-0842	CMS-2023-0113	llw-sn1u-54j0	2023-09-14T04:00Z				**Florida Independent Living Council**		https://downloads.regulations.gov/CMS-2023-0113-0842/attachment_1.pdf	Please see attached comments provided by the Florida Independent Living Council.
CMS-2023-0113-0831	CMS-2023-0113	llw-s0ac-6j86	2023-09-14T04:00Z				**Greater New York Hospital Association (GNYHA)**		https://downloads.regulations.gov/CMS-2023-0113-0831/attachment_1.pdf	Greater New York Hospital Association's CY 2024 Home Health PPS Comment Letter
CMS-2023-0113-0475	CMS-2023-0113	llq-t446-7838	2023-09-12T04:00Z				**Greenbelt Home Care**		https://downloads.regulations.gov/CMS-2023-0113-0475/attachment_1.pdf	PLEASE REFER TO THE ATTACHED FILE and please hear my voice - we are just a small home health agency from a rural area in Iowa but what we do matters. Thank you for your time and for reading my attached comment
CMS-2023-0113-0708	CMS-2023-0113	llw-genf-hdc6	2023-09-14T04:00Z				**Hackensack Meridian Health**	Hospital - HPA35	https://downloads.regulations.gov/CMS-2023-0113-0708/attachment_1.pdf	On behalf of Hackensack Meridian Health (HMH), we thank you for the opportunity to comment on the Calendar Year (CY) 2024 Medicare Home Health Prospective Payment System (PPS) Proposed Rule (or the "CY 2024 Home Health PPS Proposed Rule"). Our comments focus on the Center for Medicare & Medicaid Services' (CMS) proposed 2.2 percent payment reduction for 2024. HMH believes the proposed payment reduction does not align with CMS' stated objective to support more home and community-based care and services that are person-centered and responsive to beneficiary choice. We are concerned that the cut will limit communities' access to high quality, reliable home care services, particularly following hospitalization for an acute illness. We fear the successive year-over-year reductions – including a reimbursement cut of 17 percent to the state's post-acute providers in 2022 due to a labor market area delineation revision – will unjustly hinder the ability of New Jersey home health providers, like HMH, to sustain operations at the current level. Please see the attached file for our full comments.
CMS-2023-0113-0203	CMS-2023-0113	llj-mrfo-oequ	2023-08-29T04:00Z				**Hands or Wellness Home Healthcare**		https://downloads.regulations.gov/CMS-2023-0113-0203/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0424	CMS-2023-0113	llp-nvzt-83ut	2023-09-11T04:00Z				**Harmony Home Care**	Health Care Provider/Association - Home Health Facility		The proposed cuts will be devastating to the home health industry. Over the last several years the entire country has suffered the consequences of unprecedented inflation. Home Health is no exception to this fact. Every facet of our business has seen increased costs. The most detrimental cost increases are labor and medical supplies. Large hospital systems have been offering large sign-on bonuses, as much as $35,000.00, and large pay increases that have made it much more difficult for other providers to acquire the necessary labor to provide much needed care to patients. In addition to the significant increase in labor and medical supply costs, our general and administrative costs have gone up. Nearly every vendor/service provider, from medical waste disposal to information technology, is charging more for their goods and services due to their own rising cost structures. The unprecedented increase in operating costs has created many challenges. These challenges have been further exacerbated due to the increasing complexity and acuity levels of the average home health patient. Hospitals and skilled nursing facilities continue to struggle with staffing shortages and rising costs. Facilities are discharging patients sooner and sicker than ever before. Additionally, we are seeing trends, nationwide, evidencing a patient's desire to stay in their home. The number of patients wanting to receive care in the home grew substantially during the pandemic. Further cuts to reimbursement will be devastating to the home health sector and will only exacerbate the challenge many patients already face with gaining access to quality home care. Please reconsider the proposed cut to reimbursement along with additional administrative burdens.
CMS-2023-0113-0357	CMS-2023-0113	llm-qdt0-ma1w	2023-09-11T04:00Z				**Haven Home Health & Hospice**	Home Health Facility - HPA25		I am an owner of an home health agency in Southwest Missouri. We are the last independently owned agency for 100 miles. We have less and less Traditional Medicare pateints and more and more Medicare Advantange patients. Medicare advantage pays us a third of what Traditional Medicare pays and in most cases we lose money on the MA plans. We only accept them because it keeps the referral sources happy and because take MA payors we get Traditional Medicare patients. We are only able to survive because of Traditional Medicare. Any cuts will compound the problems in healthcare. With rising nursing salaries which we fully support and decline in number of nurses in the workforce, there will be more and more downward pressure on ethical providers. Please reconsider the position and refrane from making the proposed cuts.
CMS-2023-0113-0224	CMS-2023-0113	llm-e0ei-hlkn	2023-08-29T04:00Z				**Hayswood Home Health**	Home Health Facility - HPA25		The proposed cuts to home health are detrimental to agencies and therefore to the patient population those agencies serve. CMS has a flawed ideology that home health agencies are scamming the system. There are some bad player out there but not the widespread fraud that CMS seems to think there is. Most agencies are just trying to serve their community by taking care of patients and employees. Agencies, such as mine, that still provide a high level of care to patients and provide benefits to employees do so at a loss. For CMS to consistently give punitive pay to providers that have absorbed a decade or more of cuts in some shape or form, increased oversite and markedly higher cost is unconscionable. CMS needs to think about what will happen to patients once agencies close. What will happen to those patients? Where will they go for care and how will they get there? Lastly, what will that cost?

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CMS-2023-0113-0571	CMS-2023-0113	llv-4sy2-cv3f	2023-09-14T04:00Z				**Head and Neck Cancer Alliance**			In our role as patient advocates for thousands head and neck cancer patients, the Head and Neck Cancer Alliance (HNCA) is encouraged by the strides made with the passage of the Lymphedema Treatment Act. CMS's proposed rules providing guidance on the establishment of a new benefit category to allow for reimbursement of head and neck compression garments under A-Codes will address the pressing need for reimbursement of compression garments in the treatment of lymphedema in head and neck cancer survivors. This new benefit category presents a moment of hope for an underserved population grappling with the aftermath of cancer treatments, including surgery, lymph node dissection, and radiation therapy. Head and neck cancer patients experience debilitating side effects including lymphedema, a condition experienced by a vast majority of patients. This chronic and progressive condition stems from damage to the lymphatic system, and the aftermath of untreated lymphedema can be severe, encompassing irreversible fibrosis, recurrent infections, diminished mobility, and a compromised quality of life. Further compounding the challenges, survivors of head and neck cancer often contend with several serious side effects, including malnutrition, dysphagia, difficulty breathing, trismus, xerostomia, lymphedema, and an increased risk of suicide. The urgency for interventions becomes more pronounced when considering the benefits to many patients of treating lymphedema with compression garments, effectively reducing swelling and mitigating the severity of these side effects. HNCA requests CMS to consider the following in the Final Rule: • Per the definition of lymphedema, CMS should not separate ICD-10 (diagnosis) codes or require different diagnosis codes for head and neck cancer survivors with lymphedema. • To prevent inadvertent discrimination against individuals within the head and neck cancer patient community, CMS should institute a prohibition on language that confines the provision of compression services solely to the treatment of lymphedema in the limbs. • Head and Neck compression garments should be replaced no less than every 6 months • Head and Neck lymphedema patients derive advantages from a range of treatment modalities. These encompass manual lymph drainage executed by a Certified Lymphedema Therapist, as well as interventions from Occupational and Physical therapists. Additionally, the utilization of adjunctive therapies like compression garments and pneumatic compression have been shown to improve health outcomes. In cases of medical necessity, a concurrent application of these treatments should be considered. Your consideration of these requests is an invaluable step toward creating a healthcare system that embodies compassion, inclusivity, and equity. We are indebted to your attention to this pressing issue. Thank you for your thoughtful consideration.
CMS-2023-0113-0784	CMS-2023-0113	llw-pawk-8vd0	2023-09-14T04:00Z				**Healing Hands Healthcare**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0784/attachment_1.docx	Healing Hands Healthcare, LLC., provides home health services in Texas, specifically in 22 counties across North Texas which range from the Dallas/Fort Worth metroplex to many rural, medically underserved communities. We have been a Medicare participating home health and hospice agency since 2017 and currently have a patient census of 1,860. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health and hospice services. Recommendations To summarize Healing Hands Healthcare respectfully recommends that CMS: 1. Not finalize the proposed payment reductions in the CY 2024 Proposed Rule. 2. Provide enhanced transparency on the calculation methodology so that service providers and other key partners can assist with the analysis of the data and ensure unintended consequences are avoided. 3. Engage with the provider community and other stakeholders to implement a PDGM budget-neutral payment methodology that is consistent with the Bipartisan Budget Act of 2018 and will ensure greater access to high quality home health services for Medicare beneficiaries. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The referral rejection rate nationally has skyrocketed nearly 20% since 2019 - a trend our agency has also felt locally. This means a significant number of patients are not able to be discharged to receive quality care in their own homes, leading to longer, more costly hospital stays. While there have been many factors contributing to the decline in care availability, the reimbursements under PDGM are a major factor. This staffing crisis is noticeably and actively impacting our service area. We have been unable to expand care in the Dallas/Fort Worth metroplex due to the inability to offer competitive pay rates to clinical staff seeking much higher paying contracts with travel nursing agencies and large hospitals. Several times in the past year we have had to halt acceptance of new patients altogether in these communities. This has also been the case in already medically underserved areas, further limiting access to what has traditionally been their only reasonable option for local healthcare. If the proposed rate cuts are implemented in 2024, this organization and many others will be faced with the difficult decision on whether we remain open at all. There is only so much an HHA can do to produce the highest quality of care when the resources need to deliver care are reduced. While we expect that HHAs will continue to provide an incredibly high level of quality of care as they have done following other rate reductions, we believe that we have reached a breaking point financially. This is further supported by the recently released IPR report that showed the home health national cohort 99th percentile performance for TPS at only 68.07. CMS should abandon its proposals to replace the TNC self-care and TNC mobility measures with the DC functioning measure and to change the base line year to 2023 in the HHVBP model for performance year 2025.

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CMS-2023-0113-0759	CMS-2023-0113	llw-n9kg-hm2l	2023-09-14T04:00Z				**Healthcare Association of New York State**		https://downloads.regulations.gov/CMS-2023-0113-0759/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0186	CMS-2023-0113	llg-p46i-e2or	2023-08-29T04:00Z				**Healthcare Nutrition Council (HNC)**	Association - Other	https://downloads.regulations.gov/CMS-2023-0113-0186/attachment_1.pdf	Please see attached file for comments from the Healthcare Nutrition Council (HNC).
CMS-2023-0113-0762	CMS-2023-0113	llw-nkez-wd2g	2023-09-14T04:00Z				**Hebrew SeniorLife**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0762/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0455	CMS-2023-0113	llq-o8bh-n2h8	2023-09-12T04:00Z				**Henry Ford Health**		https://downloads.regulations.gov/CMS-2023-0113-0455/attachment_1.pdf	On behalf of Henry Ford Health, I am pleased to submit comments on the CMS CY 2024 Home Health Prospective Payment System proposed rule [CMS-1780-P]. Sincerely, Michael S. Ellis, RN, Vice President, Henry Ford at Home, Henry Ford Health
CMS-2023-0113-0739	CMS-2023-0113	llw-kc9a-6eid	2023-09-14T04:00Z				**Home Care Alliance of Massachusetts**		https://downloads.regulations.gov/CMS-2023-0113-0739/attachment_1.pdf	PLEASE SEE ATTACHED PDF FOR COMMENTS

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CMS-2023-0113-0491	CMS-2023-0113	llr-451k-0vp3	2023-09-12T04:00Z				**Homecare and Hospice Association of Utah / Home Care and Hospice Association of Colorado**			Dear Admin. Brooks-LaSure and CMS Leadership, As the Executive Director for the Homecare and Hospice Association of Utah and a Deputy Director for the Home Care and Hospice Association of Colorado, I am appreciative of the support that has been expressed by CMS and the Biden Administration for the value of home care. My comments today address the concern that the 2024 Home Health Proposed Rule is not reflective of those expressions of support and puts patient access at significant risk. • Projections provided by the National Association for Home Care and Hospice and their partners suggest that if the proposed rate cuts are made, 53% of the home health providers in the country will be operating at a negative margin. Although we have heard MedPac's argument that Medicare profit margins are northwards of 20%, their formulas do not consider all expenses and are susceptible to poor cost reporting. It also does not appear that anyone is taking into consideration the fact that if it weren't for traditional Medicare payments, there would not be any Medicare or Medicaid home health services, because Med Advantage and Medicaid reimbursements are already typically below operational costs. Medicare has been supplementing poor Med Advantage and Medicaid reimbursement rates for years. • To compound matters, the Med Advantage industry continues to reduce the size of provider panels. Those agencies that continue to accept their rates, do so primarily because it can help them to secure traditional Medicare referrals if they are able to tell a referral source that they take those Med Advantage payers too. This strategy has resulted in a "race to the bottom." Med Advantage companies are making historic profits while many home health agencies are closing or having to merge with larger organizations. If the 2024 Home Health Rule passes with the proposed rate cuts, it will result in dramatically fewer providers who are at significantly more risk of financial insolvency themselves. In both Utah and Colorado, we have already seen the number of licensed providers shrink since the initiation of PDGM and receive more reports of rural Medicare members not being able to find any providers in their area. Referral conversion rates are dismal (71% in 2022), with fewer patients being seen in home health and more patients waiting in hospitals and skilled nursing facilities to find a home health provider. Data has shown that those patients who are admitted have an increasingly higher acuity. • The Market Basket Index for 2021 and 2022 are far below the actual cost of inflation CMS's budget neutrality methodology, which would result in deep cuts of 9.36% since the beginning of PDGM is fatally flawed. Fewer providers equal fewer patient choices and, unfortunately, often results in decreased quality of care as more providers focus on simply keeping operations open vs. advancing care. We request that CMS consider the following actions to preserve the home health benefit: • Postpone the proposed permanent adjustment and any temporary adjustments • Review MBI rebasing and revision until CMS undertakes a thorough review through a Technical Expert Panel • Withdraw case mix weight recalibrations until CMS reviews the impact on patient access and care, considering that the changes in care may have been driven by reimbursement (e.g., therapy visit numbers) and not the clinical needs of the patient. • Withhold any PDGM budget neutrality-driven rate adjustments until completion of the pending litigation filed by the National Association for Home Care and Hospice as a ruling in favor of plaintiffs cannot undue the harm that patients and providers will suffer while the litigation is pending Thank you for your time and consideration, Matt Matt Hansen, MPT, DPT, MBA Executive Director, HHAU Deputy Director, HHAC director@hhau.org 801-312-9110

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CMS-2023-0113-0421	CMS-2023-0113	llp-m5dj-e7mu	2023-09-11T04:00Z				**Homecare Homebase, LLC.**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0421/attachment_1.pdf	Please refer to the attached Comment Letter from Homecare Homebase CEO Scott Decker regarding the CY 2024 HH PPS NPRM (CMS-1780-P). Homecare Homebase wishes to thank CMS for their consideration of our comments. We appreciate the opportunity to collaborate with CMS to reform Home Health in a way that ensures this cost-effective and patient-preferred means of care continues to serve America's vulnerable seniors.
CMS-2023-0113-0036	CMS-2023-0113	lku-5s4i-9ft0	2023-08-10T04:00Z				**HomePlus**	Home Health Facility - HPA25		Further payment reductions to Home Health will have a detrimental impact on agencies ability to service patients. We are in a rural area in WV and patients do not have many choices in providers. Cutting payments to the home health agencies will decrease patients access to these services and as a consequence, increase hospitalizations and lengthen hospital stays. Further, reductions in rates will reduce our ability to hire skilled nurses/therapists. Please do not cut home health rates.
CMS-2023-0113-0644	CMS-2023-0113	llv-iykw-8c9h	2023-09-14T04:00Z				**HOPE 4 HEALING, INC.**	Other Health Care Provider - HPA70		We are a small, woman owned Durable Medical Supplier (DME). The reimbursements for compression garments, bandages, etc. proposed will likely end DME's that do strictly compression. The suggestion that some of the items get 20% higher than standard Medicaid reimbursement will bankrupt companies, such as mine. A compression glove, for instance generally costs us $80.00 or more to purchase. PA Medicaid pays $6.00. We need to charge much higher than wholesale to support the staff required to process the orders. When you take the administrative costs into consideration, the profit is not there. It is in fact a loss to our company. We have been dealing with this for years and have to take these losses to maintain our contract. With Medicare covering these items and the patients not paying out of pocket any longer, a fair rate needs to be established. I pay staff in the Philadelphia metropolitan area approximately $25.00 per hour or more to process an order and it is still difficult to maintain a regular staff at this salary. The paperwork involved in processing these orders due to our Medicare credentialing takes easily 1.5 hours each and sometimes much longer depending on how long the fitting takes and if a pre-certification is needed. So, if we pay $80.00 for a glove and pay a minimum of $37.50+ administrative processing, we will need to be reimbursed to cover these charges and pay us enough so we can pay the rent, utilities, etc. on the facility itself. We would need a minimum of 150% over our cost to maintain our services to patients. If the standalone DME's can no longer charge all of the Medicare patients out of pocket, it would make it so we cannot remain in business and provide the services they so greatly require from us. Small pharmacies and large DME's that offer compression do not offer the custom measuring that we do and the quick turnaround time that is so greatly needed by patients. If the patients do not get their garments in a timely manner, they will need to receive additional therapy to maintain reduction until garments arrive. It is imperative that the pricing be reevaluated, or this will end my livelihood, my entire staff and many other DME's across the country. We want to offer these services that we are so passionate about, but need compensation to be in line with what we need to survive. We have supported this Act and do not want to make our efforts through the years the reason we lose what me and my business partner have worked 60+ hours a week for 12 years to build. The commercial insurances that cover compression offer mostly fair reimbursement. I'm praying that the manufacturers and commercial insurance company reimbursements are being taken into consideration before the final pricing is released. We have listened to the calls from the Lymphedema Treatment Act staff over the last few months and they do not seem to have any understanding whatsoever of proper pricing if they submitted this pricing as suggested to CMS. I would have appreciated being on a panel to represent the DME side. Thank you. Gretchen Reilly – Owner, Hope 4 Healing, Inc. (Willow Grove, PA) Terri McClanahan – Owner, Hope 4 Healing, Inc. (Altamonte Springs, FL)
CMS-2023-0113-0828	CMS-2023-0113	llw-rs9q-h5bb	2023-09-14T04:00Z				**Horizon Home Health and Hospice**	Health Care Industry - PI015	https://downloads.regulations.gov/CMS-2023-0113-0828/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0695	CMS-2023-0113	llw-ef4l-ouiy	2023-09-14T04:00Z				**Hospice and Palliative Care Association of Iowa**		https://downloads.regulations.gov/CMS-2023-0113-0695/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0845	CMS-2023-0113	llw-t0cu-xuma	2023-09-14T04:00Z				**Hospice and Palliative Care Association of New York State**	Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0845/attachment_1.pdf	See attached file(s) re: CMS–1780–P (Special Focus Program)

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CMS-2023-0113-0873	CMS-2023-0113	llw-z5lp-a32n	2023-09-14T04:00Z				**Hospicio & Home Care San Lucas**	Home Health Facility - HPA25		Challenges that the Home Care industry is facing and that need attention to maximize patient care and serve as a tool to transition patients to an adequate and more cost-effective health scenario. 1. Shortage of personnel vs. increase in demand for services by a population each once again aged. Staff demands higher compensation to offer services. 2. Rehabilitation disciplines (physical therapy) with a degree requirement of Doctorate has caused a decrease in the offer of this discipline creating challenges in access to services and making them more expensive. 3. Limited use permitted to offer services through telehealth and with Reduced refund. This limits the use of this tool as an alternative to the shortage of health professionals in tasks that do not require face-to-face. 4. Minimum wage and nursing wage increase labor laws and inflation after the COVID has made the cost of services significantly more expensive. 5. Reduced Medicare reimbursements for sequestration and other proposed cuts and Medicare Advantage contracts at significant discounts created a huge gap between the increase in costs and the resources available to offer the services. It is requested that these realities currently faced by home health service organizations be considered and that the necessary resources and technological flexibilities be provided to be able to offer access to quality health services. Not having access to home cares would inevitably lead to the use of recurrent and prolonged hospital stays and an increase in excessive costs that would not contribute to the health objectives for the patient or to balance the budget. A patient in Home Care costs an infinite part of what it costs a recurrent hospital stay and the excessive use of other health scenarios. We trust that these comments will be heard and measures will be established that promote the permanence of home care industry.
CMS-2023-0113-0140	CMS-2023-0113	llc-hc53-kpv4	2023-08-22T04:00Z				**Illinois Health and Hospital Association**	Health Care Provider/Association - Hospital	https://downloads.regulations.gov/CMS-2023-0113-0140/attachment_1.pdf	Please see attached letter.
CMS-2023-0113-0124	CMS-2023-0113	lla-x6o8-tt6k	2023-08-22T04:00Z				**Immune Deficiency Foundation**		https://downloads.regulations.gov/CMS-2023-0113-0124/attachment_2.pdf , https://downloads.regulations.gov/CMS-2023-0113-0124/attachment_1.docx , https://downloads.regulations.gov/CMS-2023-0113-0124/attachment_1.pdf	Attached, please find a comment and corresponding attachment from the Immune Deficiency Foundation.
CMS-2023-0113-0594	CMS-2023-0113	llv-9jyb-g5dm	2023-09-14T04:00Z				**Iowa Center for Home Care**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0594/attachment_2.docx , https://downloads.regulations.gov/CMS-2023-0113-0594/attachment_2.pdf , https://downloads.regulations.gov/CMS-2023-0113-0594/attachment_1.pdf	Comments from the Iowa Center for Home Care on the Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update are attached. Thank you for the opportunity to provide comments.
CMS-2023-0113-0850	CMS-2023-0113	llw-tn2b-ny21	2023-09-14T04:00Z				**Iowa Home Care**		https://downloads.regulations.gov/CMS-2023-0113-0850/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0345	CMS-2023-0113	llm-jb5b-bmer	2023-09-11T04:00Z				**Iowa Homecare**	Health Care Professional/Association - Nurse		Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in Iowa. Specifically, we serve Des Moines Area, Marshalltown, Boone, Ottumwa, Knoxville, and many more, including 36 counties. We have been a Medicare participating home health agency for close to 20 years and currently have a patient census of 700-800. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state’s citizens. Sincerely, Alisha Neuroth RN, COS-C Iowa Home Care Marshalltown, Iowa
CMS-2023-0113-0701	CMS-2023-0113	llw-fy1b-qezg	2023-09-14T04:00Z				**J & B Medical, Inc**	Other Health Care Professional - HC075		Compression Garments being covered will be awesome for Medicare patients! The frequency you propose is not realistic and should be looked at again. 3 or 4 garments monthly would be more appropriate with a the need to wear these daily. The fitting process and requirments of the fitter are not clear, they should be different based on custom or OTC prefabricated. If you restrict this to only qualified licensed fitters the access to care in todays market will be limited. I think a non licensed fitter who is properly trained by BOC should be allowed to fit in the catergory. The reimbursement can not be based on Medicaid or Tricare allowables but must be done in a methodology that allows the provider a reasonable profit. If the allowable is to low, we will simply not provide the product or be cash only. We used to bill all of our products to medicare 100% but that has changed in the last 5 years, the allowables are determined by someone who clearly is doing no research on what it will actually cost to provide the product. That has got to change or patients will do with out the therapy because they do not want to pay cash for something Medicare should be covering.
CMS-2023-0113-0844	CMS-2023-0113	llw-sunh-1a3x	2023-09-14T04:00Z				**Johns Hopkins Care at Home**		https://downloads.regulations.gov/CMS-2023-0113-0844/attachment_1.pdf	Please see attached for a comment letter from Johns Hopkins Care at Home.
CMS-2023-0113-0382	CMS-2023-0113	lln-yiy1-xh10	2023-09-11T04:00Z				**Johnson County Community Health Services**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0382/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0615	CMS-2023-0113	llv-dj12-4sgo	2023-09-14T04:00Z				**Justice in Aging**		https://downloads.regulations.gov/CMS-2023-0113-0615/attachment_1.pdf	Justice in Aging's response to the home health aide RFI and comments on the proposed rule are attached.

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CMS-2023-0113-0566	CMS-2023-0113	llv-2a03-7wri	2023-09-14T04:00Z				**K&K Health Care Solutions**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0566/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0383	CMS-2023-0113	lln-yncl-kx1f	2023-09-11T04:00Z				**Keystone Nursing Care Center Inc DBA Keystone Home Health**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0383/attachment_1.pdf	Please see the attached File regarding the Home Health PPS Rate Update.
CMS-2023-0113-0392	CMS-2023-0113	llo-3rp8-pde3	2023-09-11T04:00Z				**Lake Whitney Operations LLC**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0392/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0629	CMS-2023-0113	llv-fhtf-lqh0	2023-09-14T04:00Z				**Lambda Psi Nu Nursing Sorority**	Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0629/attachment_1.pdf	We are also grateful that the Centers for Medicare and Medicaid Services (CMS) has begun rulemaking to implement critical portions of the statute, including the Special Focus Program (SFP). On June 30, 2023, CMS released the Calendar Year (CY) 2024 Home Health Prospective Payment System Proposed Rule, which includes a proposed methodology and algorithm with criteria for identifying hospices for inclusion in the SFP beginning in early 2024. However, we have serious concerns that the current construction of the SFP algorithm has some unintended consequences and will limit access to underserved and diverse communities.
CMS-2023-0113-0718	CMS-2023-0113	llw-hovn-p7fr	2023-09-14T04:00Z				**LIVE-Today Foundation, Inc**		https://downloads.regulations.gov/CMS-2023-0113-0718/attachment_1.pdf	I've been a physician for 30 years but was only been able to practice clinically for 16 years before lymphedema disabled me and stripped me of my lifelong dream. Please review my brief attached letter regarding the proposed rule covering lymphedema compression treatment items.
CMS-2023-0113-0796	CMS-2023-0113	llw-qbh8-f6zw	2023-09-14T04:00Z				**LONGEVITY SURGICAL LLC**	Occupational Therapist - HC050		I am looking at the criteria for coverage and you also need to include the diagnoses for Edema, DVT and PVD. These are also people who desperately need compression garments.
CMS-2023-0113-0794	CMS-2023-0113	llw-pwqd-nl3r	2023-09-14T04:00Z				**Luna**		https://downloads.regulations.gov/CMS-2023-0113-0794/attachment_1.pdf	Thank you for allowing comments on the proposed rule. As a durable medical equipment provider that solely provides compression garments for Lymphedema and has done so for decades we would like to submit our comment. Please see the attached for our official comment.
CMS-2023-0113-0767	CMS-2023-0113	llw-ns3j-3sai	2023-09-14T04:00Z				**Lymphedema Advocacy Group**		https://downloads.regulations.gov/CMS-2023-0113-0767/attachment_1.pdf	Please see attached comment from the Lymphedema Advocacy Group, an all-volunteer nonprofit patient-centered organization. Thank you for your work on this important rule to establish Part B coverage for lymphedema compression supplies.
CMS-2023-0113-0409	CMS-2023-0113	llo-q46x-qh1n	2023-09-11T04:00Z				**Lymphedema Advocate Group**	Home Health Facility - HPA25		I am beyond excited about the Lymphedema Treatment Act. As a cancer survivor and lymphedema patient of 11 years, I have struggled to maintain my lymphedema due to financial resources and the billing code for Medicaid/Medicare. I would like to see a clearer understanding of the layered garment section of the LTA. How many garments would you receive? and how often? Would it be seasonal material? According to the "Medifocus guidebook of lymphedema" updated on January 17, 2023 states, "a recommended surgery option for lymphedema is Excisional (debulking) surgery, Liposuction, Reconstructive microsurgery, and Derivative microsurgery. Will these procedures be in the LTA as an option for lymphedema patients? I have been in physical therapy every year since my surgery until COVID-19. The recommended amount of time to purchase a new garment is every 6 months which is $300-$350 each per sleeve or $200 -$350 every 6 months for wrapping garments if you are doing manual drainage with wraps. Due to this issue, I was forced to order a cheaper sleeve which was not the correct measurement for my arm thus every year I have been in and out of therapy. In the state of Alabama (Birmingham area) we have only one company that is trained and specialized in lymphatic messages. Currently, my lymphedema has spread to the left side of the body(trunk and arm), and while I'm actively in therapy trying to maintain the situation I really believe that if I had a layered garment to help assist with the side that was affected it would have prevented the working side of my lymphatic system to continue to function properly.
CMS-2023-0113-0225	CMS-2023-0113	llm-fcqj-z4at	2023-08-29T04:00Z				**Mayo Clinic**	Health Care Provider/Association - Hospital	https://downloads.regulations.gov/CMS-2023-0113-0225/attachment_1.pdf	Please see the attachment for Mayo Clinic's comment letter.

LTA Proposed Rule Public Comments

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CMS-2023-0113-0459	CMS-2023-0113	llq-p3bj-6crq	2023-09-12T04:00Z				**MedBridge**	Health Care Provider/Association - Home Health Facility		The Honorable Chiquita Brooks-LaSure Administrator Center for Medicare and Medicaid Services Department of Health and Human Services 200 Independence Ave, SW Washington, DC 20201 Subject: Proposed Rule for CY 2024 Home Health [CMS-1780-P] Dear Administrator Brooks-LaSure, MedBridge is a leading digital care organization leveraged by over 345,000 medical professionals across a variety of healthcare specialties, including physical therapy, occupational therapy and nursing. We serve Home Health, Hospitals and post-acute settings nationwide and our clients include 6 of the 10 largest Home Health agencies in the US. MedBridge urges CMS to preserve reimbursement for Home Health to ensure access for vulnerable seniors to quality care in the home. We are commenting in support of the corrective action proposed by the National Association for Home Care & Hospice (NAHC) and the Partnership for Quality Home Healthcare (PQHH) to reduce or eliminate the proposed cut to Home Health reimbursement. The cuts as currently proposed will reduce access to this care setting for vulnerable home-bound older adults. We wish to remind CMS that Home Health is an essential setting that can impact the cost of care by keeping older adults where they want to be, in their own home. As part of our role in the Home Health industry, we see the profound impact that Home Health services have on patients - but we also see the toll that providing those services take on providers and caregivers. One of the universal challenges we hear from all agencies is staffing and the constraint that reimbursement rates have on an agencies' ability to pay higher wages and attract prospective employees to fill vacant roles, this has a direct impact on the quality, types and frequency of services that Medicare beneficiaries can receive. We appreciate CMS' acknowledgement and request for comment in the 2024 proposed rule regarding the decline in number of agencies and home health aide services. Referral refusal rates are also at an all time high in Home Health at 76%. This is impacting the timely initiation of care for many patients, putting our most vulnerable seniors at risk and creating unnecessary barriers to care for Medicare beneficiaries. MedBridge recommends a payment multiplier for telecommunications technology be added to PDGM to incentivize the use of technology to assist and support Home Health agencies to increase patient capacity with the staffing levels they have today. CMS should consider how the use of telecommunications, patient monitoring and virtual care services may be able to reduce the cost of providing care and improve access to Home Health services by improving the operational flexibility of Home health agencies to provide those services. We have seen these interventions increase the capacity of agencies to accept more patients while ensuring they receive the support they need to remain safe in their home by promoting timely check-ins from qualified healthcare professionals that are familiar with the patients' condition and have been using a monitoring platform to collect the data they need to evaluate their progress, response and adherence to their plan of care. CMS has developed telecommunications technology reimbursement successfully across nearly every other healthcare segment outside of Home Health. For example, Part B care settings are successfully leveraging and billing RPM, RTM , CCM & PCM codes which has resulted in additional tools to address the unique needs of patients in those settings and control the rising costs of managing chronic conditions. CMS itself is promoting telehealth and virtual services to providers, for example in "Telehealth for providers: what you need to know," which describes the benefits as "increase continuity of care, extend access to care beyond normal hours, reduce transportation costs, help rural organizations, and support patients with chronic conditions." These are all benefits that are needed in Home Health and areas that Home Health is uniquely set up to collect the outcomes data needed to identify the impact to older adults. Therefore, we ask you to go beyond just collecting information on how telecommunications software is used in Home Health, we are urging you to act by adding one more layer to the Patient-Driven Groupings Model that adds a case-mix adjustment if the agency is using telecommunications software in practice. Thank you for seeking comment and engaging Home Health stakeholders in the regulatory process. In closing, we thank you for the opportunity to provide commentary on this proposed rule. Should you

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CMS-2023-0113-0783	CMS-2023-0113	llw-p8b4-g5fn	2023-09-14T04:00Z				**Medical Device Manufacturers Association (MDMA)**	Association - Device	https://downloads.regulations.gov/CMS-2023-0113-0783/attachment_1.pdf	The attached comments are respectfully submitted on behalf of the members of the Medical Device Manufacturers Association (MDMA).
CMS-2023-0113-0799	CMS-2023-0113	llw-q2o9-h7aj	2023-09-14T04:00Z				**MHCA**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0799/attachment_1.pdf	Please see attached document.
CMS-2023-0113-0727	CMS-2023-0113	llw-ieu0-fekr	2023-09-14T04:00Z				**Michigan Health & Hospital Association**	Health Care Provider/Association - Other	https://downloads.regulations.gov/CMS-2023-0113-0727/attachment_1.pdf	Please see the attached document. Thank you!
CMS-2023-0113-0792	CMS-2023-0113	llw-ptz0-f4eq	2023-09-14T04:00Z				**Moving Health Home**	Health Care Professional or Association - HC001	https://downloads.regulations.gov/CMS-2023-0113-0792/attachment_1.pdf	Please find comments in attachment.
CMS-2023-0113-0811	CMS-2023-0113	llw-qxu1-6ki6	2023-09-14T04:00Z				**National Association for Home Care & Hospice**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0811/attachment_2.pdf . https://downloads.regulations.gov/CMS-2023-0113-0811/attachment_1.pdf	See attached. NAHC Comment letter and Appendix A Complaint
CMS-2023-0113-0822	CMS-2023-0113	llw-rd1t-pa7a	2023-09-14T04:00Z				**National Association for Home Care & Hospice**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0822/attachment_1.pdf . https://downloads.regulations.gov/CMS-2023-0113-0822/attachment_2.pdf	See attached comments and Appendix A Complaint
CMS-2023-0113-0806	CMS-2023-0113	llw-qlnm-prmm	2023-09-14T04:00Z				**National Association for Home Care & Hospice**	Association - Other	https://downloads.regulations.gov/CMS-2023-0113-0806/attachment_1.pdf	See Attached
CMS-2023-0113-0354	CMS-2023-0113	llm-kumu-l8mv	2023-09-11T04:00Z				**National Black Nurses Association**	Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0354/attachment_1.pdf	See attached file(s) for a letter from the National Black Nurses Association, Inc
CMS-2023-0113-0779	CMS-2023-0113	llw-p1dm-auiq	2023-09-14T04:00Z				**National Committee for Quality Assurance (NCQA)**		https://downloads.regulations.gov/CMS-2023-0113-0779/attachment_1.pdf	The National Committee for Quality Assurance (NCQA) thanks you for the opportunity to comment on this rule. Our detailed comments are attached.
CMS-2023-0113-0474	CMS-2023-0113	llq-t3vj-xw0u	2023-09-12T04:00Z				**National Comprehensive Cancer Network**		https://downloads.regulations.gov/CMS-2023-0113-0474/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0857	CMS-2023-0113	llw-uncz-55hl	2023-09-14T04:00Z				**National Council on Aging**		https://downloads.regulations.gov/CMS-2023-0113-0857/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0712	CMS-2023-0113	llw-gvnt-34aw	2023-09-14T04:00Z				**National Home Infusion Association (NHIA)**		https://downloads.regulations.gov/CMS-2023-0113-0712/attachment_1.pdf	Attached please find comments filed on behalf of the National Home Infusion Association (NHIA).
CMS-2023-0113-0635	CMS-2023-0113	llv-gyru-iajf	2023-09-14T04:00Z				**National Hospice and Palliative Care Organization**	Health Care Provider/Association - Hospice	https://downloads.regulations.gov/CMS-2023-0113-0635/attachment_1.pdf	The National Hospice and Palliative Care Organization is pleased to submit these comments on the hospice proposed regulations.
CMS-2023-0113-0832	CMS-2023-0113	llw-s3vg-8qti	2023-09-14T04:00Z				**National Lymphedema Network**		https://downloads.regulations.gov/CMS-2023-0113-0832/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0678	CMS-2023-0113	llw-9mwq-jm2y	2023-09-14T04:00Z				**National Medical Assoiciation**	Health Care Provider/Association - Hospice	https://downloads.regulations.gov/CMS-2023-0113-0678/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0736	CMS-2023-0113	llw-k6ac-8uwx	2023-09-14T04:00Z				**National Multiple Sclerosis Society**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0736/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0567	CMS-2023-0113	llv-2han-qfwr	2023-09-14T04:00Z				**National Patient Advocate Foundation**	Consumer Group	https://downloads.regulations.gov/CMS-2023-0113-0567/attachment_1.pdf	See attached letter
CMS-2023-0113-0350	CMS-2023-0113	llm-k11m-pib3	2023-09-11T04:00Z				**National Rural Health Association**		https://downloads.regulations.gov/CMS-2023-0113-0350/attachment_1.pdf	See attached file for the National Rural Health Association's comment.

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CMS-2023-0113-0452	CMS-2023-0113	llq-n8et-ohw3	2023-09-12T04:00Z				**New Jersey Hospital Association**		https://downloads.regulations.gov/CMS-2023-0113-0452/attachment_1.pdf	Please see the attached document for NJHA's full comments.
CMS-2023-0113-0869	CMS-2023-0113	llw-wxf0-3myz	2023-09-14T04:00Z				**New Mexico Association for Home & Hospice Care**	Other Association - AS020	https://downloads.regulations.gov/CMS-2023-0113-0869/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0624	CMS-2023-0113	llv-eha8-su8k	2023-09-14T04:00Z				**New Mexico Caregivers Coalition**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0624/attachment_1.pdf	See attached letter
CMS-2023-0113-0180	CMS-2023-0113	lle-coct-yiyx	2023-08-29T04:00Z				**NHPCO, NAHC, NPHI, LeadingAge**	Health Care Provider/Association - Hospice	https://downloads.regulations.gov/CMS-2023-0113-0180/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0154	CMS-2023-0113	lll-19wj-jtfi	2023-08-22T04:00Z				**North Central Independent Living Services,**	Individual		My name is Shyla Patera. I am an independent living specialist employed by and representing North Central Independent Living Services Inc. in Black Eagle, Montana. Our center for independent living helps north central Montanans with disabilities and seniors navigate services in order to allow many to stay in their communities of choice. I also write this answer to the request for information and proposed rule on home health aides and Medicare as someone who has had lived experience as a dual eligible person or member under Montana Medicaid and Medicare. I also write this as a daughter of someone who is seeking home health care services for family members who is solely rely on Medicare and Medicare advantage plans for services. As someone who will rely on home health care services and hopefully self-directed services in Montana throughout my lifetime due to Cerebral palsy and glaucoma, I can testify that home health services have increased my independence and ability to live in the community. As part of my work as an independent living specialist and community advocate for Medicare ,Medicaid , community living services, I can reiterate what the request for information and proposed rule says regarding home health services the need and desire is great for home health care services for Montanans with disabilities and seniors. One of the issues that I see is the fact that we have to spend down to Medicaid levels in order to gain home health services in our state as in many others. I always advise people to seek home health services to study their Medicare Advantage plans .For those that are dual eligible and can pay their SLMBor QMB plans or receive assistance This can be beneficial. For those that cannot pay or do not wish to pay their QMB, SLMB or spend downs incurments it is very hard to track if people are receiving home health services as a center because Montana designed home health care and CFC services for Medicaid eligible members only. This is what has been done historically and for other states as well I'm sure but people have to be completely eligible for Medicaid in order to receive the levels of homecare and self-directed CFC services that may be needed by all. It only seems as if PACE programs cover the most Medicare responsible services. Often times, the pay service is added as a demonstration project where one community or a service demonstrates this. When the demonstration project ends, the services just seem to go away and services are not enfolded into any state plan amendment regarding home health care services for Americans on any insurance type.If Medicare is to expand home health coverage and service packages throughout the United States, CMS must provide guidance which expands Medicare coverage for home health beyond hospice diagnosis and need. CMS should outline guidance and best practices on how to implement home healthcare as a mandatory Medicare service. States, Stakeholders and those with lived experience must decide what community services and coverage packages will cover and how they will serve all Americans either on private insurance, Medicaid and Medicare. Regarding the discussion around home healthcare aides and needing the solid workforce that is requested or and. needed by states I think training needs to be provided to all and to ensure that we have a strong community healthcare workforce who understand about agency base and self-directed programs I am in favor of allowing spouses and family caregivers to work as personal care attendance for family members who are on Medicare and Medicaid as well. I don't know how to increase numbers in our healthcare work force. I know CMS,ACL states and other stakeholders are working diligently through these dilemmas every day. I know I have an answered fully the eight questions that are outlined in this proposed rule regarding home health but in my work life, I don't deal with all issues outlined in the proposed rule I have heard fromMontana DP HHS senior long-term care division that they do not have enough staff power to apply for discretionary grants unless they see the benefit for citizens of the state of Montana. I hope there is a way that we can make home and community based services mandatory for all insurance types. Q for allowing me as a consumer citizen as well as North Central Independent Living Services Inc.(NCILS) to comment on this proposed rule.

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CMS-2023-0113-0143	CMS-2023-0113	llc-nj8h-itng	2023-08-22T04:00Z				**Northern Light Home Care & Hospice**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0143/attachment_1.pdf	Northern Light Home Care & Hospice Comment on CMS 1780 P attached.
CMS-2023-0113-0757	CMS-2023-0113	llw-nduz-5g5x	2023-09-14T04:00Z				**NVNA and Hopsice**	Health Care Professional or Association - HC001		Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). NVNA and Hospice provides home health services in 29 towns across Massachusetts. Specifically, we serve Norfolk, Plymouth and Suffolk County. We have been a Medicare participating home health agency since 1989 and currently have a patient census of 650 patients. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Thank you for your time and consideration, Renee McInnes, MBA,RN

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CMS-2023-0113-0340	CMS-2023-0113	llm-hggy-y47i	2023-09-11T04:00Z				**Ohio Valley Manor Home Health LLC**	Home Health Facility - HPA25		Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Ohio Valley Manor Home Health provides home health services in Ohio. Specifically, we serves Rural community of Adams, Brown, and Ripley We have been a Medicare participating home health agency since [year] and currently have a patient census of almost 5,000 lives. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. While there have been a number of factors contributing to the decline in care availability, the reimbursements under PDGM are definitely a major factor. In 2019, we had a patient/referral acceptance rate of 88%. In 2023, that rate has dropped to 64%. Staff shortages have been a big factor in that decline with our inability to compete for staff with other health sectors greatly affected by reduced Medicare reimbursements is the main reason. We see most payors refusing to authorize care, pay claims, and lower reimbursement that does not support the cost of care. Without a fair Medicare rate we will not be able to continue and support quality services. 1. We have seen our labor costs rise at a level that is unprecedented. For example, our cost of nursing staff in 2021 and 2022 increased by 35% over 2020. In 2023, while the cost increase may have slowed, it has done so in the context of the past increases staying in place while reimbursement has not correspondingly increased consistent with our cost increases. Likewise, non-labor costs have also increased far beyond any change in payment rates. We have seen increase in use of PPE cost, vaccines cost, insurance cost, and almost every other supply we use has gone up including rent. 2. To address these and other financial stresses, our agency has had to take steps to reduce costs. However, our only real cost reduction options come at the expense of reduced care access. Over the last two years, we have not been able to continue accepting Medicaid due to decrease staffing and increased cost so only taking the most favorable payors. We have been unable to get advantage plans to authorize care which has caused a delay in care and then they also refuse to pay claims and we spend an increase amount of time chasing them down to get our reimbursement due. The current financial stresses will be greatly exacerbated by the proposed 5.63% rate cut for 2024. 3. If the proposed rate cuts are implemented in 2024, this organization will be faced with the difficult decision on whether we remain open at all. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Thank you for your consideration. We are seeing our area grow from a 50% Medicare to now less than 35% Medicare and the advantage plans are not fair with pricing or reimbursement practice. If you want to help us reform the insurance industry then you can pull the plans in line with the true intent of advantage plans. Get them to not refuse to approve the next level of care. And until you can get this fixed the industry cannot stand any additional decrease in revenue as proposed or you will see a shift in less and less qualified providers. Respectfully submitted, Ohio Valley Manor Home Health

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CMS-2023-0113-0400	CMS-2023-0113	llo-9k09-g78i	2023-09-11T04:00Z				**Omnitherapy Center, LLC**	Government - Federal	https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_3.pdf . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_3.jpg . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_1.docx . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_1.pdf . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_4.jpg . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_4.pdf . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_2.docx . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_2.pdf . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_8.docx . https://downloads.regulations.gov/CMS-2023-0113-0400/attachment_8.pdf	Providing Lymphedema, Lipedema, and Phlebo-Lymphedema Treatments for over 20 years
CMS-2023-0113-0187	CMS-2023-0113	llg-q1i0-qynm	2023-08-29T04:00Z				**Oncology Nursing Society (ONS)**	Health Care Professional/Association - Nurse	https://downloads.regulations.gov/CMS-2023-0113-0187/attachment_1.pdf	See attached.
CMS-2023-0113-0352	CMS-2023-0113	llm-k85d-uckf	2023-09-11T04:00Z				**Orthotic and Prosthetic Alliance**	Health Care Professional/Association - Other Practitione	https://downloads.regulations.gov/CMS-2023-0113-0352/attachment_1.pdf	The Orthotic and Prosthetic Alliance (“O&P Alliance”) appreciates the opportunity to submit the attached comments on the Centers for Medicare and Medicaid Services’ proposed definition of a brace (orthosis) under the Medicare orthotic benefit.
CMS-2023-0113-0435	CMS-2023-0113	llp-snky-nx91	2023-09-11T04:00Z				**P & H Services, LLC**	Health Care Provider/Association - Other	https://downloads.regulations.gov/CMS-2023-0113-0435/attachment_1.pdf	Thank you for the opportunity to provide comments on the LTA. We are a DME provider in Central Texas with 20 years of experience that specializes in compression garments. Commercial insurances set their standards based on Medicare guidelines. It is very important CMS takes into consideration the trickle-down effect this policy will have on all commercial policy holders that currently have coverage for lymphedema garments. Missteps in this bill could have a detrimental effect and reduce coverage for those patients. Please see the attachment for our comments.
CMS-2023-0113-0607	CMS-2023-0113	llv-camg-oamj	2023-09-14T04:00Z				**Parachute Health**	Health Care Industry - PI015	https://downloads.regulations.gov/CMS-2023-0113-0607/attachment_1.pdf	Please find attached Parachute Health’s comments on the CY 2024 Home Health Prospective Payment System Rate Update proposed rule.
CMS-2023-0113-0389	CMS-2023-0113	llo-3msv-gwwm	2023-09-11T04:00Z				**Paradigm Rehab and Healthcare LLC**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0389/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0388	CMS-2023-0113	llo-3kqz-6z59	2023-09-11T04:00Z				**Paradigm Rehab and Nursing LP**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0388/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0830	CMS-2023-0113	llw-rvaf-5ywc	2023-09-14T04:00Z				**Partnership for Quality Home Healthcare**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0830/attachment_1.pdf	See comment letter attached.

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CMS-2023-0113-0029	CMS-2023-0113	lkm-s9mk-t2xx	2023-08-10T04:00Z				**Partnership for Quality Home Healthcare (PQHH) and National Association for Home Care and Hospice (NAHC)**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0029/attachment_1.pdf	See comment letter attached.
CMS-2023-0113-0836	CMS-2023-0113	llw-s9mb-gn5i	2023-09-14T04:00Z				**Pennant Group**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0836/attachment_1.pdf	Please see attached.
CMS-2023-0113-0485	CMS-2023-0113	llq-yotu-2pjs	2023-09-12T04:00Z				**PHI**	Other - OT001	https://downloads.regulations.gov/CMS-2023-0113-0485/attachment_1.pdf	Please see attached.
CMS-2023-0113-0418	CMS-2023-0113	llp-ce12-dmrj	2023-09-11T04:00Z				**Premier Inc.**		https://downloads.regulations.gov/CMS-2023-0113-0418/attachment_1.pdf	Please find attached comments from Premier Inc. in response to the Proposed Rule titled “Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements,” which was published in the July 10, 2023 Federal Register.
CMS-2023-0113-0385	CMS-2023-0113	llo-0g5t-le6k	2023-09-11T04:00Z				**Press Ganey**		https://downloads.regulations.gov/CMS-2023-0113-0385/attachment_1.pdf	Please see the attached comment letter. Thank you.
CMS-2023-0113-0833	CMS-2023-0113	llw-s429-75ea	2023-09-14T04:00Z				**PUERTO RICO HOSPITAL ASSOCIATION**		https://downloads.regulations.gov/CMS-2023-0113-0833/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0386	CMS-2023-0113	llo-368u-vp8m	2023-09-11T04:00Z				**PURPOSE DRIVEN HOME HEALTH**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0386/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0818	CMS-2023-0113	llw-r5lu-5tb8	2023-09-14T04:00Z				**Research Institute for Home Care**		https://downloads.regulations.gov/CMS-2023-0113-0818/attachment_1.pdf	Please see attached comment letter from the Research Institute for Home Care for complete response. Thank you, Jennifer Schiller Executive Director Research Institute for Home Care
CMS-2023-0113-0795	CMS-2023-0113	llw-px8x-m2ur	2023-09-14T04:00Z				**ResMed Corp.**		https://downloads.regulations.gov/CMS-2023-0113-0795/attachment_1.pdf	ResMed Corp. appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the Calendar Year (CY) 2024 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; etc.(CMS-1780-P). ResMed's comment letter is attached.
CMS-2023-0113-0226	CMS-2023-0113	llm-g9mv-isqc	2023-08-29T04:00Z				**ReWalk Robotics**	Private Industry - Device	https://downloads.regulations.gov/CMS-2023-0113-0226/attachment_1.pdf	See attached file.
CMS-2023-0113-0453	CMS-2023-0113	llq-nlnp-31if	2023-09-12T04:00Z				**SC Home Health NFP**	Home Health Facility - HPA25		Our Medicare population needs access to home health care. Access to care has become a problem since the pandemic. One reason is staffing; a second and problematic reason is agencies are shutting down. They can't meet their margins today. Salary and wages have exponentially grown, and supplies cost much more. Now facing revenue cuts, access to our elderly to stay safely in their home will suffer. The focus be on managing our seniors. That can be done by managing them at home with the proper care team. Use palliative care to prevent that last hospitalization before the patient passes away. Focus on decreasing deaths in the hospital. Focus on decreasing unnecessary hospital stays by putting more resources IN THE HOME. i

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CMS-2023-0113-0884	CMS-2023-0113	llx-2ofm-ha3f	2023-09-14T04:00Z				**Seraphic Springs Health Care**	Health Care Provider/Association - Home Health Facility		Seraphic Springs Health Care provides home health services in Massachusetts. Specifically, we serve the Greater Boston Area, Central, North, and South Shore of Massachusetts We have been a Medicare-participating home health agency since 1996 and currently have a patient census of 1000. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024, as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. As a result, we have already instituted or a facing in the near term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high-quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access have extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.
CMS-2023-0113-0618	CMS-2023-0113	llv-dozj-avk6	2023-09-14T04:00Z				**Southwestern Illinois Visiting Nurse Association**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0618/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0338	CMS-2023-0113	llm-gpx0-ovel	2023-09-11T04:00Z				**Stay Well Home Health LLC**			Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program: Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Stay Well Home Health provides home health services in Ohio. Specifically, we serves Cincinnati/Dayton. We have been a Medicare participating home health agency since [year] and currently have a patient census of almost 5,000 lives. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. While there have been a number of factors contributing to the decline in care availability, the reimbursements under PDGM are definitely a major factor. In 2019, we had a patient/referral acceptance rate of 88%. In 2023, that rate has dropped to 64%. Staff shortages have been a big factor in that decline with our inability to compete for staff with other health sectors greatly affected by reduced Medicare reimbursements is the main reason. We see most payors refusing to authorize care, pay claims, and lower reimbursement that does not support the cost of care. Without a fair Medicare rate we will not be able to continue and support quality services. 1. We have seen our labor costs rise at a level that is unprecedented. For example, our cost of nursing staff in 2021 and 2022 increased by 35% over 2020. In 2023, while the cost increase may have slowed, it has done so in the context of the past increases staying in place while reimbursement has not correspondingly increased consistent with our cost increases. Likewise, non-labor costs have also increased far beyond any change in payment rates. We have seen increase in use of PPE cost, vaccines cost, insurance cost, and almost every other supply we use has gone up including rent. 2. To address these and other financial stresses, our agency has had to take steps to reduce costs. However, our only real cost reduction options come at the expense of reduced care access. Over the last two years, we have not been able to continue accepting Medicaid due to decrease staffing and increased cost so only taking the most favorable payors. We have been unable to get advantage plans to authorize care which has caused a delay in care and then they also refuse to pay claims and we spend an increase amount of time chasing them down to get our reimbursement due. The current financial stresses will be greatly exacerbated by the proposed 5.63% rate cut for 2024. 3. If the proposed rate cuts are implemented in 2024, this organization will be faced with the difficult decision on whether we remain open at all. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Thank you for your consideration. We are seeing our area grow from a 50% Medicare to now less than 35% Medicare and the advantage plans are not fair with pricing or reimbursement practice. If you want to help us reform the insurance industry then you can pull the plans in line with the true intent of advantage plans. Get them to not refuse to approve the next level of care. And until you can get this fixed the industry cannot stand any additional decrease in revenue as proposed or you will see a shift in less and less qualified providers. Respectfully submitted, Kimberly Tilley COO Stay Well Home Health 4000 Executive Park Dr ST 225 Cincinnati, OH 45241 513-247-3070 ktilley@staywellhomehealth.com

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CMS-2023-0113-0611	CMS-2023-0113	llv-db7s-1g2w	2023-09-14T04:00Z				**Summit Home Health and Hospice**			I am commenting in support of the corrective action proposed by the National Association for Home Care & Hospice (NAHC) and the Partnership for Quality Home Healthcare (PQHH) to reduce or eliminate the proposed cut to Home Health reimbursement. The cuts as currently proposed will reduce access to this care setting for vulnerable home-bound older adults.
CMS-2023-0113-0741	CMS-2023-0113	llw-ku4r-2h0t	2023-09-14T04:00Z				**Sunmed Medical**	Device Industry - PI005		Fitting rules for lymphedema garment compression fitting. I agree with a non clinical person needing to be certified through some sort of program, either manufacturer or independent body. What I would like to see is the ability for clinicians (lymphedema therapists, OTs, PTs) also be able to do fittings and be compensated for those efforts. Those clinicians know the patient best, how they change during their treatments etc. An non clinician sees that patient just one time and they don't know how they change due to mobility, temperature, foods ingested, etc. Easiest way would be to allow for a code for therapists to use to received direct compensation from Medicare as part of their treatment regimens. More complicated would be as the USMCA is recommending, to create a safe harbor for fittings to be paid back to the clinician for fitting the garments. Fee Schedule: The proposed 20% above Medicaid rates is highly unrealistic, especially when measuring is to be included in the rates. USMCA has provided pricing guidance which I believe is necessary for us to continue to provide patients with these garments. I have provided USMCA many examples of fee schedules from varying Medicaid states. If those are the rates established, our company will in no way be able to provide this service to patients. It is simply too low. CODING: As one of the largest billers of these custom garments in the US, establishing proper coding is critical. While laborious for sure, having specific codes for each item will streamline the process greatly and will also reduce any fraudulent practices since the descriptions will ensure compliance to the code. This is a must. I fully support the USMCA's suggestions for this.
CMS-2023-0113-0685	CMS-2023-0113	llw-bjoy-ri07	2023-09-14T04:00Z				**Sunnyview Rehabilitation Hospital**	Private Industry - Device	https://downloads.regulations.gov/CMS-2023-0113-0685/attachment_1.pdf	Please see attached file
CMS-2023-0113-0852	CMS-2023-0113	llw-u0wi-jy20	2023-09-14T04:00Z				**Support For People With Oral And Head And Neck Cancer (SPOHNC)**	Association - Device	https://downloads.regulations.gov/CMS-2023-0113-0852/attachment_1.pdf	On behalf of Support For People With Oral And Head And Neck Cancer (SPOHNC) we are writing regarding support of "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items." Head and neck cancer patients are experiencing increasing rates of survivorship. This also means many patients are living with the side effects of head and neck cancer treatment. Common side effects include and can be traced to a condition called lymphedema. When cancer infiltrates a lymph node or when a node is removed during surgery lymphatic flow is interrupted, which can begin a cycle of swelling and inflammation. It is proven that 75% of head and neck cancer survivor will suffer from lymphedema after HNC treatment. There have been a number of studies that have analyzed the patients' symptoms and have concluded that the compression device showed significant improvements in ability to control lymphedema. SPOHNC has heard from many of its patients and survivors that this compression device is currently not being covered by insurance and yet they heard from others who can afford this device how successful it is in their quest for a better outcome of treating this condition. Reseach shows that 90% of head and neck cancer survivors will suffer from lymphedema one year out of treatment. It is crucial for patients to be able to access this device for a much better quality of life. The regulations need provision for patients suffering from this terrible side effect. Aggressive and early treatment of lymphedema is critical for the best long-term patient outcomes. Please consider passing this legislation that will help to support many undergoing this challenging and very debilitating condition.
CMS-2023-0113-0887	CMS-2023-0113	llx-2ll7-yful	2023-09-14T04:00Z				**Susan G. Komen**		https://downloads.regulations.gov/CMS-2023-0113-0887/attachment_1.pdf	See attached comments from Susan G. Komen.
CMS-2023-0113-0619	CMS-2023-0113	llv-dslg-qe4z	2023-09-14T04:00Z				**Sutter Health**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0619/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0778	CMS-2023-0113	llw-ozxm-gknj	2023-09-14T04:00Z				**Symbii Home Health and Hospice**		https://downloads.regulations.gov/CMS-2023-0113-0778/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0776	CMS-2023-0113	llw-p3lk-9u5s	2023-09-14T04:00Z				**Symbii Home Health and Hospice- Bear River**	Health Care Provider/Association - Home Health Facility		As a Home Health and Hospice Administrator with Symbii in Utah the rate cuts proposed are not taking into account the high costs of inflation requiring us to pay higher wages to retain staff. In recent years we have also been faced with an increased shortage of licensed clinical staff including nurses, physical therapists, and CNA's. There has also been an increase in overall staff turnover, decreased retention, and increased labor stresses that home health providers are facing. My fear that country wide by combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. The proposed permanent rate reduction of 5.653% vs the cost inflation of 2.7% (which does not come close to actual cost inflation) will result in an overall reduction in reimbursement for all Medicare patients. It was not long ago that our clinicians and healthcare providers were heralded as heroes for going to the front lines to provide life changing care during the COVID-19 pandemic. The effects of this pandemic are ongoing still, with increased costs of infection control, labor, and medical supplies. These additional costs are what is required and needed to keep our patients safe, and have added to the cost of providing patient care. This reduction in reimbursement is significantly more than other health care providers. Home health has proven its effectiveness in reducing costs by effectively caring for patients outside of a skilled nursing/hospital setting. There are also parameters set in place for lower-performing companies to receive reduced reimbursement based on their annual outcomes. As an agency that serves a large geographical area, with may patients residing in rural and underserved areas, reducing reimbursement will inhibit us from providing care to some patients in outlying areas. The reimbursement for these patients already does not cover the expenses, but as a healthcare provider we have found ways to provide the best care possible under the current rate structure. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures that have been laid out. These measures have been highly scrutinized, and have required many hours of focus and training to ensure we are meeting all expectations set for us. Now 8 months into the year CMS is changing the rules and regulations mid-year, which puts all participating providers at a severe disadvantage. CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. If the goal is to provide better care for patients there are many more ways to do this over a rate reduction. After surviving the pandemic and keeping patients safe in their homes a significant rate reduction will impede our ability to provide this care to patients in the future.
CMS-2023-0113-0630	CMS-2023-0113	llv-fnxb-4j3z	2023-09-14T04:00Z				**Tactile Medical**	Device Industry - PI005	https://downloads.regulations.gov/CMS-2023-0113-0630/attachment_1.pdf	See attached file(s) in regards to Section VII.B Scope of the Benefit and Payment for Lymphedema Compression Treatment Items
CMS-2023-0113-0579	CMS-2023-0113	llv-5kdk-1wu0	2023-09-14T04:00Z				**Team Gleason Foundation**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0579/attachment_1.pdf	The Team Gleason Foundation Responses to RFI Addressing Access to Home Health Aide Services.
CMS-2023-0113-0817	CMS-2023-0113	llw-r5ke-0io2	2023-09-14T04:00Z				**Tennessee Association for Home Care (TAHC)**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0817/attachment_1.pdf	See attached letter
CMS-2023-0113-0707	CMS-2023-0113	llw-gakt-h4j4	2023-09-14T04:00Z				**Tennessee Hospital Association**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0707/attachment_1.pdf	Please see the Tennessee Hospital Association's comments in the uploaded file.

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CMS-2023-0113-0637	CMS-2023-0113	llv-ho6a-1aro	2023-09-14T04:00Z				**Teton Healthcare, Inc**	Home Health Facility - HPA25		I am writing today to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A -4.26% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration.
CMS-2023-0113-0748	CMS-2023-0113	llw-lgqw-v97f	2023-09-14T04:00Z				**The American Medical Association**	Health Care Professional/Association - Physician	https://downloads.regulations.gov/CMS-2023-0113-0748/attachment_1.pdf	On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide our comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed CY 2024 Home Health Prospective Payment System Rate Update. The AMA supports the proposed Hospice Enrollment Provisions and other Provider Enrollment Provisions outlined in the notice of proposed rulemaking (NPRM).
CMS-2023-0113-0841	CMS-2023-0113	llw-smx5-0nr3	2023-09-14T04:00Z				**The American Occupational Therapy Association**	Health Care Professional/Association - Occupational Therapis	https://downloads.regulations.gov/CMS-2023-0113-0841/attachment_1.pdf	Please consider AOTA's attached comments on the CY 2024 HH PPS Proposed Rule.
CMS-2023-0113-0801	CMS-2023-0113	llw-q68m-7qpx	2023-09-14T04:00Z				**The Coalition to Transform Advanced Care**	Consumer Group	https://downloads.regulations.gov/CMS-2023-0113-0801/attachment_1.pdf	Please see attached comment letter
CMS-2023-0113-0755	CMS-2023-0113	llw-mv2p-eh8y	2023-09-14T04:00Z				**The Commonwealth Fund**	Academic - OT005	https://downloads.regulations.gov/CMS-2023-0113-0755/attachment_1.pdf	See the attached PDF with the Commonwealth Fund's response to the Request for Information (RFI) on Access to Home Health Aide Services.

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CMS-2023-0113-0384	CMS-2023-0113	lln-zal4-1nmo	2023-09-11T04:00Z				**The Evangelical Lutheran Good Samaritan Society**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0384/attachment_1.pdf	Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). The Evangelical Lutheran Good Samaritan Society provides home health services in central Iowa. Specifically, we serve: Polk, Jasper, Warren, Marion, Story, Marshall, Dallas, Madison, Lucas, and Clarke Counties. We are a Medicare participating home health agency and currently have a patient census of 64 combining skilled and non-skilled clients. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state's citizens. Sincerely, Kara Kasischke, HCBS Administrator, Indianola & Ottumwa IA.
CMS-2023-0113-0693	CMS-2023-0113	llw-dvzp-7f3w	2023-09-14T04:00Z				**Therap-ease, Inc**	Health Care Provider/Association - Home Health Facility		I'm commenting on the proposed file code CMS–1780–P. I am a certified fitter for lymphedema garments. I'm glad that Medicare is proposing to pay for lymphedema garments but the pricing needs to be realistic. We also need to be compensated for our time. I've had patient's that have had to come in up to 3 times to make sure the garment fits properly. The first initial time could take up to an hour or two, then the ones after that 15 minutes to 30 minutes. The cost of some of the garments can cost the patient $200.00 for a custom made toe cap to $800.00 for a capri garment, or more depending on the garment. Also, the senior population doesn't usually have the mobility to put these garments on. Helping to pay for donning and doffing aids would benefit them tremendously. Try putting on a 20-30mmHG regular compression stockings and see what it's like!! Having a custom garment is a lot harder! This is a life long disease and if they don't wear compression garments, they are more prone to getting cellulitis, ulcers, etc. The cost of going into a wound care center or a hospital to take care of these problems is probably a lot more expensive than putting the money into compression garments. Women that have had a mastectomy really need these garments. It's traumatic enough to loose a breast, but then get lymphedema on top of it, is another travesty. The follow up care is just as important and they shouldn't have to worry about paying for an arm sleeve, glove or gauntlet. Plus any other part of their body that is affected by lymphedema. We are running a business and need to be compensated correctly, for the garments, and our time to take care of our patients. If you compensated realistically for these garments you will find businesses will stay in business, and not leave Medicare like I have seen in other areas of DME. Thank you for your time.

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CMS-2023-0113-0764	CMS-2023-0113	llw-nmk8-9k2p	2023-09-14T04:00Z				**Thuasne Therafirm**		https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_9.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_7.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_3.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_5.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_2.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_6.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_1.docx . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_8.pdf . https://downloads.regulations.gov/CMS-2023-0113-0764/attachment_4.pdf	Our comment is in reference to
CMS-2023-0113-0810	CMS-2023-0113	llw-qw1d-gcuq	2023-09-14T04:00Z				**United Spinal Association**	Consumer Group - CG001	https://downloads.regulations.gov/CMS-2023-0113-0810/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0786	CMS-2023-0113	llw-pes8-0vvp	2023-09-14T04:00Z				**United States Medical Compression Alliance**	Association - Device	https://downloads.regulations.gov/CMS-2023-0113-0786/attachment_1.pdf	On behalf of the United States Medical Compression Alliance (USMCA), we are pleased to offer comments on proposed changes to the CY 2024 Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies proposed rule, published in the Federal Register on July 10, 2023 (CMS-1780-P). USMCA member companies manufacture FDA registered, medical, gradient compression products in ready-to-wear and custom forms. For the reasons detailed in the attached document, USMCA humbly requests that CMS adopt its recommendations, because USMCA's recommendations will lead to better patient access to lymphedema compression treatment items for Medicare beneficiaries. Please know that we are available to discuss these comments and provide any other information that would be helpful.
CMS-2023-0113-0367	CMS-2023-0113	lln-0ga1-ozhy	2023-09-11T04:00Z				**University of WA Medicine**	Other - OT001		Compression bandaging and compression wearing are essential to reducing swelling and lymphedema; and reduce the risk for cellulitis which is a very costly infection. Thank you for working on reimbursement issues for compression garments. We need reimbursement to be strong in order for compression garment vendors to stay in business and serve our lymphedema patients. Thankyou!
CMS-2023-0113-0725	CMS-2023-0113	llw-ir77-8otd	2023-09-14T04:00Z				**Vicki's Mastectomy Boutique**	Health Care Industry - PI015		DME suppliers should NOT BE REQUIRED to participate or contract with medicare in order to provide upper & lower compression garments for patients. Both par and non participate DME providers should be able to supply these products
CMS-2023-0113-0444	CMS-2023-0113	llq-m40a-mdos	2023-09-12T04:00Z				**Visiting Nurse & Community Care**	Health Care Industry - PI015		Please reconsider the impact this will have on independent agencies who have provided Home Health Care for longer than 115 years. Each year, we are forced to provide the same quality of care and reimbursement has declined. Staffing has become almost impossible with the amounts of Requirements.

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CMS-2023-0113-0399	CMS-2023-0113	llo-6c80-06ea	2023-09-11T04:00Z				**Visiting Nurse and Hospice Care of Santa Barbara, dba VNA Health**	Health Care Provider/Association - Home Health Facility		Centers for Medicare & Medicaid Services Department of Health and Human Services CMS–1780–P, P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 Dear CMS, Thank you for the opportunity to provide comments on the proposed rule: “Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). VNA Health provides home health services in California. Specifically, we serve patients in Santa Barbara and Ventura Counties. We have been an approved Medicare home health agency since 1966, with a current patient census of 313. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to care for individuals who need home health services. We understand that CMS has the authority to determine the time and manner of applying a rate adjustment under the PDGM payment model. We respectfully ask that CMS withhold the imposition of the proposed rate cuts schedule for 2024. Our services are valuable to the patients that we serve. However, in recent years, VNA Health has experienced a significant reduction in its ability to serve home health patients. We have undertaken unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. We have experienced a reduction of our service area, restrictions on patient admissions, elimination of important community programs, and the adoption of new technologies that require significant financial investment. In addition, we have financial barriers to participating in innovative programs that would benefit patients because payers are not sharing the monetary risk needed to establish and maintain these important programs. The result of these reductions is decreased patient access to care, extended patient stays in hospitals, patients pushed to institutional care, and individuals left without care. In the end, the reduction of home health services increases the negative consequences for Medicare, which must pay for patient care at more costly facilities. We request that you not institute the proposed rate cuts in 2024. Please work with us to solve the problems associated with patient access to home health care. Sincerely, Kieran A. Shah President & CEO VNA Health

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CMS-2023-0113-0339	CMS-2023-0113	llm-gs35-7kuf	2023-09-11T04:00Z				**Visiting Nurses and Hospice dba Sutter Care at Home, San Mateo**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0339/attachment_1.pdf	Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comments on the proposed rule:"Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Visiting Nurses & Hospice dba Sutter Care at Home, San Mateo provides home health services in California. Specifically, we serve San Mateo and Santa Clara counties. We have been a Medicare participating home health agency since 1985, and currently have a patient census of 850. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce access to care in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or are facing in the near-future the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Sincerely, Rebecca Boodt, P.T. Administrator Sutter Care at Home, San Mateo 1700 S Amphlett Blvd, suite 300, San Mateo, Ca 94402
CMS-2023-0113-0598	CMS-2023-0113	llv-aarz-q4b8	2023-09-14T04:00Z				**VITAS Healthcare**	Health Care Provider/Association - Hospice	https://downloads.regulations.gov/CMS-2023-0113-0598/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0188	CMS-2023-0113	llh-34h3-td3t	2023-08-29T04:00Z				**VNA Health Group**		https://downloads.regulations.gov/CMS-2023-0113-0188/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0815	CMS-2023-0113	llw-r19e-sb7t	2023-09-14T04:00Z				**VNS Health**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0815/attachment_1.pdf	Thank you for the opportunity to comment on CMS–1780-P. Attached please find comments from VNS Health CEO Dan Savitt.
CMS-2023-0113-0223	CMS-2023-0113	llm-d8ug-r6h6	2023-08-29T04:00Z				**Wel Home Health of Red Oak**	Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0223/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0882	CMS-2023-0113	llx-1v7w-mx83	2023-09-14T04:00Z				**Well Care Health**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0882/attachment_1.pdf	On behalf of Well Care Health, see the attached comments regarding the CY2024 Home Health Proposed Rule. Well Care is a family-owned and operated Home Health, Hospice Home Care, and Home Care provider that currently serves a Home Health patient census of more than 4,000 patients across 40+ counties in North Carolina and South Carolina. Well Care has been repeatedly recognized as a national leader in quality of care with a Five-Star rating in Quality of Patient Care by CMS, a designation that corresponds to the top 4-5% of home health providers nationwide. Our comprehensive service offerings provide critical support for patients in their path to independence and self-care in the comfort of their own homes, and our top priority is placing the needs of our patients first. With 35+ years of experience in home-based care, including 23+ years as a Medicare-participating provider, we are well-positioned to share valuable insights with CMS in relation to the foreseeable negative repercussions of the Proposed Rule on our organization, as well as the patients and communities we serve across North Carolina and South Carolina. Well Care is a proud member of the National Association for Home Care and Hospice (NAHC) and the Association for Home and Hospice Care of North Carolina (AHHC).
CMS-2023-0113-0391	CMS-2023-0113	llo-3qpq-8ok6	2023-09-11T04:00Z				**West Texas Healthcare LLC**	Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0391/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0612	CMS-2023-0113	llv-dcu5-2zm9	2023-09-14T04:00Z				**Western Illinois Home Health Care**	Home Health Facility - HPA25		CMS-2023-0113 Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Western Illinois Home Health Care provides home health services in Illinois Specifically, we serve ten, largely rural, counties within West Central Illinois. We have been a Medicare participating home health agency since 1981 and are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.

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CMS-2023-0113-0717	CMS-2023-0113	llw-hw1p-q4bp	2023-09-14T04:00Z				**Western Illinois Home Health Care**	Home Health Facility - HPA25		Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Western Illinois Home Health Care provides home health services in Illinois Specifically, we serve ten, largely rural, counties within West Central Illinois. We have been a Medicare participating home health agency since 1981 and are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.

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CMS-2023-0113-0782	CMS-2023-0113	llw-pjty-0h4u	2023-09-14T04:00Z				**Western Illinois Home Health Care**	Home Health Facility - HPA25		Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Western Illinois Home Health Care provides home health services in Illinois Specifically, we serve ten, largely rural, counties within West Central Illinois. We have been a Medicare participating home health agency since 1981 and are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Allison Bernhardt Director of Operations
CMS-2023-0113-0781	CMS-2023-0113	llw-p4ry-u3bw	2023-09-14T04:00Z				**WHBoutique Inc. dba Women's Health Boutique**		https://downloads.regulations.gov/CMS-2023-0113-0781/attachment_1.docx	As a supplier of DMEPOS for over 30 years, with multiple locations that provide products to Medicare beneficiaries with lymphedema, WHBoutique Inc, dba Women's Health Boutique sincerely applauds CMS for the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. Thank you for the Public Comment Phase allowing professionals, organizations, DME suppliers, manufacturers, and beneficiaries the opportunity to be an integral part of this process as the future of Medicare coverage of these items for beneficiaries with lymphedema is shaped. Our comments are attached.
CMS-2023-0113-0004	CMS-2023-0113	lk2-ljkh-3dr3	2023-08-10T04:00Z				**William Allen Company (aka Allen's Medical)**	Private Industry - Health Care	https://downloads.regulations.gov/CMS-2023-0113-0004/attachment_1.docx, https://downloads.regulations.gov/CMS-2023-0113-0004/attachment_1.pdf	RE: Document 88 FR 43654 Thank you for taking our comment regarding DME Compression Garments. We are attaching more thoughts and considerations from the DME supplier perspective. We hope this will help inform policy decisions regarding the dispensing of compression garments. In this document we inform on the following: 1. Standard (ready to wear) vs. custom garments, our request for your consideration of the types of garments that should be covered and how we currently work with patients, providers and therapists to treat patients over the course of their Lymphedema treatment & therapy. 2. Our recommendations regarding confirmed refills and why automatic refill's should not be allowed if over one year.

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CMS-2023-0113-0790	CMS-2023-0113	llw-q5ho-cdae	2023-09-14T04:00Z				**Wisconsin Association for Home Health Care**	Health Care Provider/Association - Home Health Facility		August 28, 2023 Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comments on the proposed rules within “Medicare Program; Calendar Year 2024 Home Health Prospective Payment System Rate Update” 88 Fed. Reg. 43654. The Wisconsin Association for Home Health Care (WiAHC) and our members are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to provide home health care for individuals in our communities. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, our members have experienced a significant reduction in our ability to serve home health patients. While there have been numerous reasons contributing to the decline in care availability, the reimbursements under PDGM are a major factor. Staff shortages have also been a big factor in that decline. We are often unable to compete for staff with other health sectors, with reduced Medicare reimbursements being the main reason. WiAHC would also urge CMS to consider the following: • Home health care labor costs have increased at an unprecedented level. While the cost increase may have slowed in 2023, it has done so in the context of the past increases staying in place while reimbursement has not correspondingly increased consistent with our cost increases. Likewise, non-labor costs have also increased far beyond any change in payment rates. • To address these and other financial stresses, WiAHC member agencies have had to take steps to reduce costs. However, our only real cost reduction options come at the expense of reduced care. The current financial stresses will only be exacerbated by the proposed 5.63% rate cut for 2024. • If the proposed rate cuts are implemented in 2024, many of our members will be faced with the difficult decision on whether we remain open. Our services are very valuable to the patients we serve. Reduced access to home health care has extended hospital stays, pushed patients to institutional care, and left individuals without care. We ask that you not institute the proposed rate cuts and work with us to solve the growing access to care challenges. Sincerely, Jayne Thill, MSN, BSN, RN – Board Chair Wisconsin Association for Home Health Care

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CMS-2023-0113-0649	CMS-2023-0113	llv-m0e8-0qps	2023-09-14T04:00Z				**Women's Health Boutique**	Health Care Provider/Association - Other		I am a certified mastectomy and compression fitter for a DME Boutique and offering my public comment in regard to the proposed draft rules for VII. Proposed changes regarding Durable Medical Equipment, Prosthetics, Orthopedic, and Supplies (DMEPOS) Many of my customers are on Medicare benefits and are on fixed income every single month. They are unable to afford their needed compression garments to manage their chronic Lymphedema. This is disheartening since Lymphedema is not curable only manageable, so customers should be able to purchase those allowed yearly compression garments, whether they are custom made or over the counter lymphedema garments. If Lymphedema is not managed properly, it can cause infections, impaired independence in all daily living skills, depression, discomfort/pain, deficits in their social interactions, and a poor quality of life. Also commenting on the specific codes or grouped codes needed for these compression garments. I measure and fit my customers for various compression garments being prescribed by their physicians. Including arm sleeves, gloves, gauntlets, toe caps, compression bras, compression swell spots (used for lymphedema on their chest wall). These compression garments need to be dispensed every 6 months as the elasticity only last the 6 months. Customers usually buys one to wear and one to wash. Dorsal pads used in conjunction with their compression gloves. Nighttime garments to be dispensed 2 a year as they have to wash and wear them. Compression Velcro Wraps customer also is part of the compression garments customers are having to pay for them as well. Washing and wearing these garments daily to promote optimal Lymphedema management, improving every facet of a customer's life who is suffering from this condition.
CMS-2023-0113-0721	CMS-2023-0113	llw-i0am-xajg	2023-09-14T04:00Z				**Wound Ostomy and Continence Nurses Society**	Health Care Professional/Association - Nurse	https://downloads.regulations.gov/CMS-2023-0113-0721/attachment_1.pdf	Please find attached comments from Wound Ostomy and Continence Nurses Society
CMS-2023-0113-0495	CMS-2023-0113	llr-6d4x-jiwx	2023-09-12T04:00Z				**Zion's Way Home Health and Hospice**		https://downloads.regulations.gov/CMS-2023-0113-0495/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0062	CMS-2023-0113	ll3-tqqu-fmfx	2023-08-10T04:00Z	**Lela**	**A Albert**	NJ		Consumer Group		My comment is regarding the Lympedema Compression Coverage benefit in regards for medical coverage for compression garments, to thank you for passing this law and that now those who are living with lympedema with have a better medical treatment to address the patients who use compression garments on a daily basis. As a Lympedema advocate and supporting a close friend living with Lympedema, he is now going to able to have better and improve treatment which I am happy for his better quality of life.
CMS-2023-0113-0110	CMS-2023-0113	ll8-gk9u-qle0	2023-08-22T04:00Z	**Diana**	**Abbett**	CO		Health Care Industry - PI015		I am a lymphedema patient with a child who also has lymphedema. I also am a lymphedema patient. Because lymphedema supplies are very expensive, especially for those on a fixed income, I would like to see the following implemented in billing for such lymphedema garments, as well as the time spent with the individual lymphedema patient. *Lymphedema garments are to be worn around the clock, 24 hours a day, 7 days a week. For this reason, garments need to be replaced every 6 months. This includes one garment/garment set per affected area/body part per six months. *Day wear, by and large, is very expensive. It is particularly so for the patient who needs a custom fit combination of garments. The patient who lives on a fixed income, even 20% of the full price can be quite a stretch of the budget. Since the lympheedema specialist cannot work without the required supplies, the price of the garments, whether day or night garments should be part of the global payment of going to see the specialist. Once the patient is on their own, the supplier or qualified may bill the approproate insurance. Even at an 80% discount, lymphedema supplies are expensive for the patient on a fixed income. I would like to see the patient get billied for no more than $200 for each combination of garments. *Lymphedema garments do wear our rather quickly. I would like to see the patient receive from 3-5 garments/garment combination per affected area for daytime wear. I would like to see 2 garments/garment sets for night wear. Garments need to be replaced every 6 months to be billied as separate garment/garment combinations. *I would like to see a lymphdedma specialist for an annual check up, much like a patient would do for their primary care physician. *A qualified lymphedema specialist, and the clinic they work in should be allowed to have an ongoing prescription from a provider with prescription authority that will last up to 6 months. This potentially saves time between the specialist and the provider to acquire a prescription for every individual garment.

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CMS-2023-0113-0456	CMS-2023-0113	llq-olh4-r1al	2023-09-12T04:00Z	**Brian**	**Adams**			Physical Therapist - HC045		I am writing today as a home health physical therapist to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement at my agency by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs particularly with the average wages for health care personnel fluctuating since COVID-19. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. Particularly since many of these patients require home health care that goes beyond the current reimbursement under the PDGM system. We have about 5-10% of our patients that we lose money on with PDGM rules. We would need to assess the patient need for disciplines and frequency and say no to multiple people every month so we could avoid the extra cost that previously we have been able to bear. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. As I said above we would need to send referrals elsewhere if we determine the costs involved would surpass the PDGM reimbursement. We have been able to charitable in the past, but would need to adjust our charity down if theses cuts go into place. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. CNA observations: You chose the year of a public health emergency to determine the need for CNAs? Many patients refused CNA workers? Many CNAs realized they could make more money at local fast food agencies and either left the company of demanded higher wages. Inflation and real estate has significantly affected my area, Saint George Utah. We already are having trouble holding onto workers since other health industries are able to pay more. We will need to increase reimbursement from Medicare in the coming years in order to support our staff. In fact just 30 minutes away is Nevada where employees can get 20% more money just because Nevada home health reimbursement is better. Please consider what this payment adjustment would do to hundreds of home health agencies and thousands of employees, tens of thousands of patients. A few questions for you to reflect on: What is your current program for adjusting reimbursement based on a region's cost of living? Could you be as proactive and quick with cost of living assessments (the following year) as you are with reimbursement reductions? Why not? Why is the comparison year for CNA care chosen to be a public health emergency? Does that make sense to use that year? With the heroic status of our nurses during COVID what payment adjustment is fair? A 5% cut? With real estate costs up, rent up, food costs up, staggering inflation, is this the best time to propose to decrease reimbursements. We will lose health care personnel to other industries. Please reconsider. The changes to increase Lymphedema treatment options and IVIG treatment would help dozens of our patients. Thanks for considering that. Thank you for your time and consideration.
CMS-2023-0113-0583	CMS-2023-0113	llv-6x5r-moou	2023-09-14T04:00Z	**Nancy**	**Adsem**	MN				This comment is in response to “Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items”. It is important to remember that different types of products may be used in different stages of the disease. So bandages may to used primarily in the reduction phase of the disease and compression garments in the maintenance phase. But often times items (i.e. bandages, etc) are ALSO used in maintenance phase. Different products may be used after surgery is another example. Reimbursement rates will be critical to encourage an adequate number of vendors willing to supply the necessary products- and do so in a timely manner. Timing is critical to maintain health improvements. If timeframes to provide products, or replace lost items, take too long - status of the disease will decline, and will be difficult, if not impossible, to restore.

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CMS-2023-0113-0221	CMS-2023-0113	llm-cck0-fjvy	2023-08-29T04:00Z	**Jean**	**Alexander**	TN		Association - Device		To whom it may concern: Lymphedema in my legs was caused by the removal of many lymph nodes during surgery for uterine cancer. Without compression garments for my legs, I would not be able to live a normal life. Even with them I spend an hour and a half morning and night performing lymphatic massage and elevating my legs to keep the swelling under control. I am seventy-six years old and I'm not sure how much longer I can keep up this routine. I wear 30-40 compression garments which are expensive. Having them covered by insurance would be very helpful.
CMS-2023-0113-0472	CMS-2023-0113	llq-t5zy-jw6p	2023-09-12T04:00Z	**Ross**	**Alexander**	CO				I support the endorsement of the US Medical Compression Alliance in regards to changes we want to see in the proposed bill. Thank y
CMS-2023-0113-0430	CMS-2023-0113	llp-r2q2-oaty	2023-09-11T04:00Z	**Melinda**	**Allred**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0719	CMS-2023-0113	llw-hw49-8d1n	2023-09-14T04:00Z	**Amy**	**Alsop**	IL		Government - Federal	https://downloads.regulations.gov/CMS-2023-0113-0719/attachment_1.pdf	See attached file.
CMS-2023-0113-0713	CMS-2023-0113	llw-hhlt-olsr	2023-09-14T04:00Z	**Balamuruhan**	**Amurthalingam**	MI		Home Health Facility - HPA25		The proposal to cut rates for HHS will signaficanty reduce the ability of our organization to provide care for the much needed population. HHS have not fully recovered from the pandemic with staff shortages and wage hikes with inflation. With the proposed rule it will hamper any further movement in hiring an increase strain on the existing staff.
CMS-2023-0113-0730	CMS-2023-0113	llw-jikm-9txw	2023-09-14T04:00Z	**David**	**Anderson**	IN		Health Care Professional/Association - Other Health Care Professional		We pay for surgery for these conditions, and we pay for drugs for these conditions, why not pay for compression garments, that are non-invasive, without side effects? Duh?
CMS-2023-0113-0059	CMS-2023-0113	ll2-xo1x-kd7j	2023-08-10T04:00Z	**Merrilee**	**Anhalt**	IL		Individual		It would be financially very helpful to have coverage for my compression garments which now cost me over $2,500 a year.
CMS-2023-0113-0723	CMS-2023-0113	llw-i8zu-02z5	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0723/attachment_1.pdf	See attached
CMS-2023-0113-0034	CMS-2023-0113	lks-imku-az6a	2023-08-10T04:00Z	**Anonymous**	**Anonymous**				https://downloads.regulations.gov/CMS-2023-0113-0034/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0363	CMS-2023-0113	llm-smow-driw	2023-09-11T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0363/attachment_1.pdf	To all interested parties, Please see attached letter. We are hoping you understand just how important Home Health Care is to patients. I have been in Home Health since 1985, Advantage plans are detrimental to patients health and well being. The continued reimbursement cuts will continue to close agencies which is cost effective health care. I was working in Home Health when 250 agencies in the State of Missouri closed in 1997. I hope that History does not repeat itself. Thank you for your consideration, Sherry Evans RN,BSN,Admin. CRMC Home Health
CMS-2023-0113-0545	CMS-2023-0113	llu-wyxh-he6m	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0545/attachment_1.pdf	Please see the attached letter. Thank you in advance for your consideration.
CMS-2023-0113-0682	CMS-2023-0113	llw-aq0r-rgmd	2023-09-14T04:00Z	**Anonymous**	**Anonymous**				https://downloads.regulations.gov/CMS-2023-0113-0682/attachment_1.pdf	My mother's nightmare
CMS-2023-0113-0032	CMS-2023-0113	lkr-uoz0-1p28	2023-08-10T04:00Z	**Anonymous**	**Anonymous**					ask that administative procedure act be instituted here. The government rolled back requirements for vaccine mandates in healthcare shouldn't force poor people on Medicare and Medicaid to take vaccine or anyone. There is date suggests vaccine harmful. We need to remove these mandates and stop data collection. The pandemic is over. Don't put surveillance on anyone.
CMS-2023-0113-0054	CMS-2023-0113	ll2-cdu9-3lbv	2023-08-10T04:00Z	**Anonymous**	**Anonymous**			Individual		My life has changed forever. Constant fear of infection. Limited ability in all areas of my life. My Lymphedema was cause by a nurse 2 years after my double mastectomy and lymph node removal surgery for breast cancer. I was not educated or given a bracelet to inform the hospital or nurses that my arm could not be touched by blood pressure or blood draw. I have had numerous medical issues with cellulitis infection in my arm. I can't financially afford these expensive garments. I'm on a compression machine every day to control my condition. The compression sleeves are not optional, they are a necessity.
CMS-2023-0113-0089	CMS-2023-0113	ll6-wnrn-elf4	2023-08-22T04:00Z	**Anonymous**	**Anonymous**			Health Care Professional/Association - Other Health Care Professional		I work with a DME supply company and Medicaid plans will pay for custom compression garments, but we have to jump through multitudes of hoops, working and re-working denials and appeals, even with prior authorizations in place. There are many issues that we have to work around - Manufacturers aren't consistent with how they invoice us (the supplier) for each item - sometimes they are broken down by part (silicone band, y-knitting, knee high, closed toe, base garment - each having its own number of "units" and separate pricing for each option listed - one garment could have 16 units, for example) and sometimes they are all bundled as one garment with the customizations listed with no pricing. It causes confusion for payers and delays payment to us, which means we have to limit the availability to patients. I would ask that we get extremely clear guidelines on how to bill these (pairs vs units) and education regarding this for supplies, the claims processing personnel (CMS AND HMOs), as well as for the manufacturers, so everyone is on the same page and speaking the same language. I would also request very clear LCDs regarding documentation requirements - many patients had their initial evaluation with a referral to a therapist years ago and have only seen a therapist for management since then - will they need a new face-to-face, how frequently do they need to see a physician, which physicians may prescribe, how often are chart notes required, etc. How do we prove medical necessity for custom vs ready-to-wear - A6549 in particular. Also, clarification on whether a stand-alone diagnosis such as ICD-10 I89.0 is sufficient, or if it would require a secondary diagnosis code. I feel like these reasons are a large part of the reason CMS has avoided allowing coverage for such a long time - it's extremely complex and many suppliers refuse to provide these services because it comes at a very high risk due to the lack of consistent rules across payers (can of worms when you add in HMOs), and because you have to invest a significant amount of time and resources to just these specific items in order to receive payment. But we provide them because they are vital to patient care, regardless of the expense we put into it.

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CMS-2023-0113-0113	CMS-2023-0113	ll9-7nxo-69vp	2023-08-22T04:00Z	**Anonymous**	**Anonymous**			Other Health Care Provider - HPA70		i be disables have medcares. it extreme hurtful that lincare be no respects treat me propers when come my home. i be told only one option only for my supplys yet it no propers fit me to helps. lincare be false charge me for equipments and supplys i no have my home. i be tell doc office and tolds well after year no more charges i own yet still charges. there be no service provider resource program to helps me with understands propers the medicare lincare relations and my EOB especials when it show 5 things when i be no have 5 things my house. as i continue lives and age and as i be told by a case worker - stats show more health concerns issues - how i be stay safe and get respects my homes when lincare visits never the mind no over charge and charge for services and equipment i no have in home. also how it legal that lincare only carry one option adult cannula supply no make since. another - when i be have medcaid and got switch to the medicare i be told by resource person to keep using cause the system be delay and will eventuals correct self. just like with the doctor that tell me the lincare charges be stop - here another hurtful disgusting no proper helps abuse the system. a doctor tell me that i no pay for it. yet that no true. i pay for medicare and medigap and out of pocket charges to. who be review audit anything especials when there be no proper check in maintenance for medical equipment function level and clean - like filter changes and stuff. despite service resources programs many them no check in follow ups or take action when ask for helps or be alerted to scope of what they in place to do for qualty life function.
CMS-2023-0113-0131	CMS-2023-0113	llb-fv3q-1iaw	2023-08-22T04:00Z	**Anonymous**	**Anonymous**					I would like to offer my comments on the proposed Scope of benefit for lymphedema compression treatment items (file code CMS–1780–P). I appreciate all efforts put forth in this document and the opportunity to add my comments to change the current system of regulations and help the people who face this horrible disease on a daily basis. Reference to proposal of adding 414.1680 section 1834(z)(2) subpart Q: 2 daytime garments replaced every 6 months is a great start. However, 1 nighttime per year is not enough. I request consideration for 2 nighttime garments provided and replaced every year. Nighttime garments are indeed more sturdy and last longer than their daytime counterparts. However, the nighttime garments are subject to more wear and tear can become frayed just as quickly. Washing the heavier material on a regular basis also shortens the lifespan of the garment by pulling less refined stitching and lessening effective compression. Concerning the pricing, availability and general structuring of this proposal, I emphatically support your efforts to improve an industry of care that has left so many in need. From government legislation, thru doctors, lawyers, insurance providers, suppliers, manufacturers, all the way down to patients, it is a daunting task to balance the myriad requirements of all. Ultimately to provide affordable quality care to those that suffer is the challenge. To that, I offer this. These people need this to work. We need help. This is a large country this very few quality care providers. This proposal should make it easier to provide a quality product. We have suffered thru inferior and downright greedy manufacturers. Suffered thru doctors with no clue on treatment or prevention, delays in delivery from overwhelmed providers, legislation that favors profit over people... At the risk of becoming emotional, I digress. I will thank you for hearing my comments and look forward to the future.
CMS-2023-0113-0147	CMS-2023-0113	llc-rczn-27pf	2023-08-22T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		The proposed Home Health reimbursement cuts could be devastating to operations throughout the country. Home Health is one of the most crucial levels of care and it is already very challenging. Operating on an even smaller margin will only exacerbate recruiting and staffing challenges.
CMS-2023-0113-0155	CMS-2023-0113	lll-1rkg-u8sr	2023-08-22T04:00Z	**Anonymous**	**Anonymous**			Long-term Care - HPA45		Compression garments should be totally covered as they are necessary !!!!!

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CMS-2023-0113-0156	CMS-2023-0113	lll-1x03-md4n	2023-08-22T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		The payment changes proposed will likely bankrupt many homecare agencies. This will make obtaining care more difficult for patients and the patients will suffer. The healthcare system as a whole is broken, and there is a severe nursing shortage. Further cutting reimbursement will hurt the people who need these services and will not help the nursing shortage at large.
CMS-2023-0113-0185	CMS-2023-0113	llf-oimu-sgdf	2023-08-29T04:00Z	**Anonymous**	**Anonymous**			Health Care Industry - PI015		I hope my comment could be of help. But from what I have seen is that many agencies are staffing the clients that offers more hours than those individuals that are spproved for six hours a week. A HHA would prefer to have 6 to 8 hours in one home than to drive around town to different individuals homes for 2 hours of services and of course the cycle repeats itself. The cost of gas is high righ now, by the time they get their checks, it's basically gas money. Therefore, many HHAs preference would be to work somewhere that they can get their 40 hours a week without having to drive all over town to get the hours they need to make ends meet. I don't understand why Medicare provides funding to the most expensive care such as Home health and nursing homes, but does not give a dime to Adult Day Care Centers??? It's the most cost efficient resource that offers showers and some centers wash their clients' clothes and they get out of their isolated homes. An active senior is a healthy senior. Keeping them in their homes is a good thing but it does not solves loneliness, isolation and depression that most seniors feel.
CMS-2023-0113-0191	CMS-2023-0113	llh-zzuq-w6wf	2023-08-29T04:00Z	**Anonymous**	**Anonymous**					Compression garments are a life time necessity! They should be covered by all insurance coverages with no exceptions or exclusions. Deductibles should be capped at maximum of $25.00. Lymphedema affects people of all ages and all races, it does not discrimate. Coverage should include all bandages, machines and whatever is necessary for dealing with this unsightly and uncomfortable condition. As a lymphedema patient for over twenty years I have always had to pay out of pocket for Custom made day and night bandages because insurance would not cover the cost.
CMS-2023-0113-0209	CMS-2023-0113	llk-3nja-4dz8	2023-08-29T04:00Z	**Anonymous**	**Anonymous**					Lymphedema is a chronic lifetime disease. I purchased $800 worth of compression garments and most need replacing after six months. My yearly income is $22,00. That has effected my life style especially being a senior citizen. I made healthy choices and exercised daily throughout my life but cancer has a genetic component that I couldn't control. Cancer survivors need these garments to be able to function daily. Medicare needs to approve costs for the garments. Doctors need to be educated on the signs of lymphedema to diagnose this disease early as well.
CMS-2023-0113-0364	CMS-2023-0113	llm-tq2o-9fw5	2023-09-11T04:00Z	**Anonymous**	**Anonymous**			Health Care Professional/Association - Occupational Therapis		I am concerned about these proposed changes due to the following: Reduced the number of OT visits to clients- OT is known to reduce readmission and improve functional outcomes for the patient population served by CMS. The predictive analytic tools that use algorithms to determine how many therapy visits (if any) should be provided based on diagnosis- while diagnosis can be telling, it is one aspect of the context of those that OT practitioners serve. The skilled OT should determine the number of visits, using their full scope to address all needs, decreasing potential readmission risk and improving functional outcomes. The delay of OT to later in the Home health process or patients being told they can wait to get therapy after discharge when they are outpatient- again, the skilled therapists working with the client should be making this decision in collaboration with the client. Waiting for therapy to begin may decrease strength, and ROM impacts safety within the home, increases the risk of falls, and limits functional progression, potentially leading to readmission and secondary health issues, including mental health, which impacts one's physical well-being. Physician orders for OT are ignored, revised, or deleted, and nursing or Physical Therapy is determining when and if OT services are needed. This is inappropriate- while nursing and PT serve an essential role, the OT practitioner's lens vastly differs from the disciplines mentioned above. The OTP considers not only the current diagnosis but the context in which the individual exists, their mental well-being, and safety, which impact potential readmission or decline in health. Agencies are shifting OT visits to PT or nursing colleagues- Again, a PT and nurse cannot replace or make up the skills that the OT practitioner provides. While PT has goals, so too does OT that are different than the PT; The OTP is focused on activities of daily living and function beyond the current diagnosis, as well as one's mental well-being. OTPs have to do more, with less support, and therapists' clinical judgment is overridden or ignored; the above provides more detail. OT plays an important role within the healthcare system, including home health, and the agency of the OTP should be held in the same regard as PT and nursing.

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CMS-2023-0113-0410	CMS-2023-0113	llp-3xbm-2umj	2023-09-11T04:00Z	**Anonymous**	**Anonymous**					I have been a full time OT working in home care for 19 years. I am extremely concerned about the proposed payment cuts and the detrimental effect it will not only have on an entire profession but the patients who are in dire need of the services. Patients are coming home earlier and earlier but NOT getting the services they need. There is such pressure in home care - and such potential !- to keep patients at home but there is already such a lack of resources. I am not sure how this is all supposed to result in quality care. I am witnessing low staffing across all disciplines over the past several years in an area of healthcare that has been burdened with nearly impossible productivity requirements, due to the high level of documentation, travel time, and amount of information that is expected from staff in home care during the short amount of time we have in the home. I have noticed the job becomes less about EDCUATION but more about date entry and note taking as a result of all of the documentation expectations. True quality patient education is being lost in all of this. OTs PTs, nurses have all been grateful for this job, and it is a field like no other, with being able to care for people in their homes, as a truly multidisciplinary team. HOME CARE is ultimately, where care is transitioning to, yet, there are LESS and LESS resources. The agency I work for has already lost so much : Advanced palliative NP director, telehealth program, respiratory therapist, wellness nurse that would make phone calls to patients that are high risk. The list goes on. Patients are already experiencing long wait times on phones to make appts with MDs.. 2-4 weeks for DME to be approved- if Medicare even approves it.. My agency does not have HHAs available leaving patients even more vulnerable to falls, UTIs, poor care..poor outcomes.. My agency is also low staffed with nurses, and patients are lucky if they get a nurse 1 time a week. How is this supposed to be " quality care"? OTs, PTs who have also recently transitioned into what I call, a new profession, that consists of being a nurse/ SW/ PT and HHA, often asked to even go outside our scope of practice, due to low staffing. Yet, we are diminishing in value and this thought absolutely frightens me. And, does not make any sense. Again, how is this "quality care?" How are we supposed to keep up quality outcomes, makes patients happy, and keep patients out of the hospital, not fall, prevent pressure ulcers, etc...when the agency regulating it all is putting in place restriction after restriction, cut after cut, rule after rule , that does not facilitate QUALITY CARE AND BETTER OUTCOMES? I am truly hopeful the proposed payment cuts are reconsidered and removed. Thank you for taking my comment and please consider all of our comments, from a very concerned, yet, truly hopeful OTR/L.
CMS-2023-0113-0450	CMS-2023-0113	llq-nhk3-9mg8	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		Home health care is extremely critical for all Americans especially with shorter hospital stays, lack of vital discharge planning, higher skilled needs in the home, and an aging population. Reducing payment for home health will be extremely detrimental. Skilled nurses, Physical Therapists, Occupational Therapists, Speech Therapists, and Home Health Aides are the vital staff that will need to be employed in home health in order to meet the demands for patients due to shorter hospital stays and because of this reimbursement for home health needs to be taken into account. We need to be able to pay these skilled health care staff a fair wage in order to ensure quality, integrity, and compassion to carry out the care plan during the home health episode which in turn will impact the overall health and safety for the patient and reduce rehospitalizations.
CMS-2023-0113-0457	CMS-2023-0113	llq-oows-x4va	2023-09-12T04:00Z	**Anonymous**	**Anonymous**					We are already struggling to manage out payments and provide the care our patients deserve. This is America. Our elderly and disabled deserve to be taken care of.

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CMS-2023-0113-0462	CMS-2023-0113	llq-pywd-lv27	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		To whom it may concern: I am writing to comment on the proposed rule concerning the 2.2% payment reduction and the inclusion of the COVID-19 vaccination measures. I strongly oppose the 2.2% reduction in payments to home health agencies. As someone with nearly a decade of home health experience, I can attest to the growing challenges faced by agencies. They are caring for patients with complex, high acuity conditions that require specialized, resource-intensive care. Agencies are already operating on thin margins, and any reduction in payment would only strain their ability to provide quality care. Wellsky data also suggests we are taking care of 6% more acute patients on average than in 2019. A payment cut during this time will harm patients. Furthermore, the pandemic has increased costs across all departments. I wish to voice my opposition to the new HHVBP measures concerning collecting data on COVID-19 vaccination compliance. While I understand the intent behind these measures, the complexities involved in compliance are immense. Home health agencies are already required to manage influenza and pneumonia vaccinations, which we are already seeing a reluctance in our patients in obtaining. This is an area we think our patient's primary care provider should be overseeing because it's more appropriate. Because of the controversial nature of the COVID-19 vaccines and the discussions that will have to take place in a patient's home, this could impede the efficiency and effectiveness of our healthcare organization. I request CMS take these concerns into consideration and reconsider the proposed rule changes. I believe that maintaining the current payment structure and reviewing the vaccination requirements could significantly improve the quality of care provided by home health agencies and mitigate the challenges they face. Thank you for your attention to these matters.
CMS-2023-0113-0483	CMS-2023-0113	llq-y4sc-88pw	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Physical Therapist - HC045		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration

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CMS-2023-0113-0497	CMS-2023-0113	llr-8rdv-0hsp	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		Dear CMS, I am writing today to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a 32 year career home health nurse, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. In my 32 years of experience in the home health industry I have seen year over year cuts and program updates designed to reduce payments to home health, all the while the Home health industry continues to save Medicare monies by helping to reduce hospitalizations and provide life changing care to our aging population. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. Some are expected to see as much as 7.5% cut. A negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows and could be extremely detrimental to our elderly population. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for us to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Dee Minor Home Health Clincian
CMS-2023-0113-0500	CMS-2023-0113	llr-dlbb-lc5n	2023-09-12T04:00Z	**Anonymous**	**Anonymous**					Home health agencies cannot continue to operate with continued cuts to reimbursement. Increased cost of living, health insurance premiums and school loan payback continues to increase requiring agencies to increase salaries to employees. Agencies cannot retain qualified staff if they are not able to provide salaries to allow their staff to afford these costs. Agencies are also required ti spend more and more time in documentation, audits, quality assurance, authorizations and overhead costs which does not allow adequate pay to their staff.
CMS-2023-0113-0501	CMS-2023-0113	llr-dlbe-4zac	2023-09-12T04:00Z	**Anonymous**	**Anonymous**					Home health agencies cannot continue to operate with continued cuts to reimbursement. Increased cost of living, health insurance premiums and school loan payback continues to increase requiring agencies to increase salaries to employees. Agencies cannot retain qualified staff if they are not able to provide salaries to allow their staff to afford these costs. Agencies are also required ti spend more and more time in documentation, audits, quality assurance, authorizations and overhead costs which does not allow adequate pay to their staff.
CMS-2023-0113-0502	CMS-2023-0113	llr-dzey-75jz	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Individual		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients.

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CMS-2023-0113-0506	CMS-2023-0113	lls-102h-mdys	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Health Care Industry - PI015		regarding: payment rates for home health agencies (HHAs) for CY 2024. Patients need more care at home than ever before. Not less. It is the most cost effective and efficient method of care for our older patients. Our seniors will need more support going forward and if you want to ensure we have the capacity to care for patients in a dignified fashion then home care needs to be fully funded.
CMS-2023-0113-0512	CMS-2023-0113	lls-k160-p5cd	2023-09-12T04:00Z	**Anonymous**	**Anonymous**					Home health cuts making it impossible to pay competitive wages and attract staff. This takes away from patient care and increases hospital utilization
CMS-2023-0113-0520	CMS-2023-0113	llt-toos-9xtr	2023-09-12T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		Dear CMS, I am writing today as an registered nurse for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 5% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, BR at BSN, RN Home Health Clinician Hospice RN Case Manager
CMS-2023-0113-0547	CMS-2023-0113	llu-xrat-22nr	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Professional/Association - Nursing Aide		CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. There is already a caregiver shortage this will only increase that. The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas.

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CMS-2023-0113-0559	CMS-2023-0113	llv-1006-euky	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Industry - PI015		• CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. • The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. • Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. • The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. • CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. • The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year.
CMS-2023-0113-0588	CMS-2023-0113	llv-8cab-1pbx	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					Home health care is vital for patient's who are in need of care. Many people, especially the elderly are unable to leave their homes or have a family member/neighbor to help with their daily needs or care. The nurses, therapist and aides are able to help the clients get strong, manage their medications, assist with wound care and bathing. Patient's going in for surgery, like the ability to come home and be admitted for home health versus going to a nursing home. Home health care is able to save Medicare a lot of money. With the cuts all home health care organizations have received over the years, this is making it harder to give the care that is appropriate while running a successful, and dependable business.
CMS-2023-0113-0589	CMS-2023-0113	llv-8f1k-fx6d	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		We are a rural non profit home health agency. Many of our patients have voiced their preference to be admitted to Home health care in their home instead of a nursing home or a hospital. Statistics show 94% of Medicare patients & 86% of adults prefer being cared for in their home versus a facility such a nursing home or facility. By providing the patient home health care in a patient's residence, we save Medicare money. The HH Value Based Purchasing model is estimated by CMS to save the government roughly $3.37 billion over five years because of avoiding additional hospitalizations and or being admitted to a skilled nursing facility. Home Health allows hospitals to discharge patients sooner. This allows the patient to recover in the comfort of their own surroundings, not an institution. Many of our patients are grateful for this and express their appreciation for their care.

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CMS-2023-0113-0591	CMS-2023-0113	llv-8ve8-ed6g	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Nurse - HC065		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0592	CMS-2023-0113	llv-9uxf-8p3l	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Physical Therapist - HC045		Lymphedema Treatment Act - Lymphedema is a persistent, chronic condition. It can occur in almost any body part, although it is most commonly associated w/ arm/hand swelling after breast cancer treatments. I treat clients w/ primary lymphedema, lymphedema secondary to cancer related treatments (surgical lymph node removal & radiation therapy) and chronic venous insufficiency. After lymphedema treatment, each client MUST wear compression garments to maintain the results of treatment, prevent recurrent cellulitic infections and prevent hospitalizations. These compression garments are absolutely necessary to help the client manage their lymphedema independently and prevent the client from returning to PT for repeat treatment. All clients require daytime compression garments and many clients require night time compression garments which are different in fabric and compression for the affected/lymphedematous body part. Many insurance companies assist their clients in obtaining/sharing the cost of these garments that must be replaced yearly for proper management of lymphedema. Medicare has not provided assistance to date but the Lymphedema Treatment Act should ensure that all clients with this chronic condition receive the products they need to keep them out of treatment and the hospital! I am a PT and board certified lymphedema therapist (CLT-LANA) practicing in California.

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CMS-2023-0113-0600	CMS-2023-0113	llv-bnt7-lr50	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					Per the Lymphedema Treatment Act there are several concerns, we as a DMEPOS Supplier have. The professional services of applying compression garments is not covered. Suggestions have been made to provide a set fee for the fitting of the compression garments/products, requiring DME providers to reimburse these therapists. We are strongly against that suggestion. As a DME provider we find that would be cost prohibitive. Many times, when orders from therapists are submitted, and the custom garments are manufactured, the garments are ill fitting and returns occur. Therefore, who would be reimbursing for that? While we understand therapists are not able to bill for the fitting as they are not a DMEPOS supplier, the facility in which they are employed bill for various services and treatments the therapists provide. We suggest a code be created so the facility can bill for their time of fitting/measuring the patient. It is much too time consuming to be required to pass off payment from Medicare to the therapist. There are a lot of logistics involved in order to reimburse a set number of therapists. We provide DME products nationally. We would need to hire additional staff just to process payments to therapists, which would not be feasible. Another item listed in the Lymphedema Treatment Act applies to Competitive Bidding. We, as DME Supplier, are against that suggestion. This would cause more harm than good to the patient. By engaging in Competitive Bidding, the patient will most likely have limited access to suppliers. The reason for this is the number of DME Suppliers will be reduced due to not being able to participate. It's economically not feasible for a provider to competitively bid on custom compression garments. The cost of custom garments is unique and fluctuates for each individual garment based on options that may be needed for the treatment. The suggested solution by many to this is to have a reimbursement set based off of the Medicaid and Tricare reimbursement rates. Or, to base it on the average retail rate. What is not taken into consideration is the average retail rates do not factor in the overhead costs associated with DME Suppliers that have Brick and Mortar locations. These costs are something Retail Providers do not carry. If a reimbursement is set based off of the average retail rate, these rates do not even cover the cost of the actual garment from the manufacturer, let alone the costs associates with Brick and Mortar locations. Proposing to put the coverage of all lymphedema product into the control of the Federal Government's Medicare is the absolute worst thing to do! This is going to introduce a ton of government oversight, audits due to over utilization, scrutiny of the codes fee schedule by Medicare as to how much they would be paying forcing DME suppliers to go out and find the cheapest product possible so they can stay afloat with the poor coverage that Medicare is notorious at offering. Once a claim is processed by the DMAC and the EOB is processed by the DME supplier, asking the supplier to turn around and writing a check to a clinician is not only ludicrous it would be downright wrong as any transaction with the Medicare patient has a code associated with it, not just a supplier making a payment. The proposed would force the suppliers into more tax records by states (we work with therapist nationwide), the clinician would have to report a second income, favoritism would be introduced into the lymphedema world as far as who uses what DMEPOS, and the secondary/tertiary insurance would be cut out of the equation that look for the Medicare denial to pay accordingly. Following a Matrix type house of cards approach like a certain pump manufacture has setup where kickbacks are passed quietly violate stark laws and is not the way to get lymphedema items covered.

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CMS-2023-0113-0602	CMS-2023-0113	llv-bvyh-5s6l	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		Please don't allow CMS cuts for home health care. Cutting home health care program spending would jeopardize the care of those who choose to remain safely and as comfortable as possible in their own homes during critical illness / injury recovery. Patient care in their own homes is a much more cost effective than hospitalizations and placements in skilled nursing facilities - saving Medicare dollars and providing individuals a choice for remaining safely at home, which a vast majority strongly prefer. Individuals can be discharged from hospitals sooner knowing they will be well-cared for in their own homes. Home Health Agencies provide skilled nursing care, therapy care, doctor visits; with nursing availability 24x7. Again, please don't allow CMS cuts for home health care, we deserve an equitable choice when it comes to our health care recovery. Thank you for your consideration in this very important initiative.
CMS-2023-0113-0610	CMS-2023-0113	llv-cwrs-48ho	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Western Illinois Home Health Care provides home health services in Illinois Specifically, we serve ten, largely rural, counties within West Central Illinois. We have been a Medicare participating home health agency since 1981 and are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.

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CMS-2023-0113-0614	CMS-2023-0113	llv-drsg-fv15	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). CHC provides home health services in Illinois. Specifically, we serve Cook, Dupage and Lake Counties. We have been a Medicare participating home health agency since 1996 and currently have a patient census of 30. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.
CMS-2023-0113-0622	CMS-2023-0113	llv-ei8k-1wsr	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Individual		I have lymphedema of my chest wall and torso secondary to mastectomy with lymph node removal. As part of the treatment of this condition my lymphedema therapists recommend that I wear a foam filled channeled breast and chest wall pad to stimulate and support the movement of lymphatic fluid through this area with the goals of reducing swelling and discomfort and preventing infection. This type of pad is an accessory held in place by compression supportive garments. Will these pads, necessary accessories in the treatment of my lymphedema be covered ? If so what codes would be established to cover them?
CMS-2023-0113-0645	CMS-2023-0113	llv-j9h0-n9kn	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		As an RN and Director of Home Care for over 5 years, I am very concerned over what will happen if the payment cuts CMS has proposed are implemented. I have seen firsthand the vital role home care plays in providing continuity of patient care. We are the key component needed to transition patients from acute care settings back into their preferred home environment. We all know patients are discharged home from hospital settings as quickly as possible. Discharge planning starts from admission. Many times, home care services are ordered at discharge to ensure a safe transition home, allowing an earlier discharge from the hospital or SNF setting. I am fearful the cut in MCR payments will lead to less home care agencies and a greater decrease in the already scarce availability of home care services. A decrease in home-based care will only lead to lengthened hospital stays; resulting in more Medicare dollars spent. Patients will also be more likely to be re-admitted to the hospital, after discharge, or have lengthier SNF stays. It is no doubt that patients prefer care at home over any inpatient setting. With the potential for additional MCR payment cuts, there will likely be a decrease in the number of agencies available to care for the expanding needs of our MCR population. Agencies are already struggling to make ends meet due to high acuity patients and a decrease in medical staff. I am asking you to please reconsider the proposed MCR payment cuts for home care agencies.

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CMS-2023-0113-0650	CMS-2023-0113	llv-m2k6-k4bw	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Provider/Association - Home Health Facility		Dear CMS, I am writing today as a nurse and a Director of Clinical Services for a home health agency to express my opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have over 20 years of experience in the home health industry, and it is from that experience that I am basing my assessment that access to home health care will suffer, and home health agencies ability to provide quality care will be reduced if the proposed cuts are put into place. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. Considering other elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 3% cut is anticipated with internal data for my agency and we serve Medicare beneficiaries in a rural area with very limited access to healthcare, limited specialty providers, and limited clinicians in several key roles which are already a struggle to provide (specifically speech therapy, occupational therapy, and social work). The ability to adequately staff these disciplines in a rural area, while meeting CMS compliance guidelines for timeliness of care is a constant struggle. How can we hire, train, and keep the best clinicians, as we continue to operate under cuts that affect our ability to offer competitive wages in the healthcare arena? This is especially true in rural areas where we have smaller candidate pools from which to recruit clinical staff. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to decrease quality of care, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? We have worked very hard and diligently to understand quality metrics already put in place in recent years and make sure we are meeting quality criteria that CMS has put in place. The potential for changing the game with new requirements is unfair, exhausting, and leading to burnout of the best people in the industry. We understand the need to adapt and meet the changing needs of our community, but the time and attention changes in quality metrics this frequently require is unsustainable. I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. Thank you for your time and consideration. Sincerely, Melissa Nelson, MSN, RN Home Health Clinician
CMS-2023-0113-0670	CMS-2023-0113	llw-3sdv-bwe7	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					I share my deepest concerns regarding being a lymphedema patient. I was diagnosed in 2022 with lymphedema at age 60. I had no idea what this disease was. No individual asks to become ill with a chronic disease in their lifetime. I was terrified. My first thought was that I wasn't ready to leave this world. I have too much to do and live for. Medicare/Medicaid is extremely crucial and needed in helping to maintain proper management of this disease that has affected so many individuals of all ages. It is a major concern for all lymphedema patients who suffer daily regarding severe swelling and pain that is out of our control in the upper and lower parts of the body to be provided with the necessary treatment that will bring some comfort. Having access to both lower and upper compression garments for those individuals who must deal with this at the same time will be a huge step moving forward in their condition of giving us some type of hope of living a close to normal life. Everyone deserves to have the best treatment possible. Without lymphedema compression garments and supplies it is impossible to manage the disease properly. I am fortunate to be able to manage the disease by using compression garments for my lower body through my private insurance that must be connected to a controller pump device twice a day. I am also experiencing pain and swelling in my upper body as well and this concerns me because I am not certain whether my insurance is going to cover the upper body garments. I had to pay the cost for a pair of compression hose that I must wear daily because my insurance does not cover them, and I am not able to purchase another pair. I am unable to wear compression hose's at night on both legs due to the lack of funds. Having more than one pair of compression hose's daily and nightly will help lymphedema patients tremendously. Most of the patients and myself are on a fixed income due to our age, and can't afford the high cost of compression garments, supplies, etc. that will help us to manage this disease.
CMS-2023-0113-0691	CMS-2023-0113	llw-doj9-m5bz	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. Home health services save medicare/medicaid dollars by reducing hospitalizations and ER visits, and should not receive unfair cuts.

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CMS-2023-0113-0715	CMS-2023-0113	llw-hsny-9buc	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Individual		I am very Concerned and Strongly Disagree with any type of fitting fee for garments to any Physician, Physical or Occupational Therapist. This fee will turn into a "Kickback Referral" fee. Garments, whether Custom or Off the Shelf, are clearly a part of the Treatment Program for Lymphedema. Fiitting fees are not being paid to any other type of Medical Professions. Therapists realize the Garments may be a challenge for very involved patients and they have the Support of the manufacturers providing the garments if assistance is needed. There are a lot of DME Providers and Hospitals that measure and fit patients with garments with no added Fitting Fees and to consider paying a Therapist to fit patients would not be appropriate. I do not believe Medicare provides a fitting fee for Lymphedema Pumps nor a referral fee and they should not either. Please reconsider NOT paying anyone a fitting fee and considering part this of the Treatment Plan. Section VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items.
CMS-2023-0113-0728	CMS-2023-0113	llw-j2lj-gcx1	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					Home health care is a valuable asset to our senior citizens. Often times they are alone without family and we help them remain independent in the community and provide services in their final days with hospice care. Please keep in mind when changing the regulations that these are available services that should not be cut. It's important that we honor our seniors and provide with compassionate care throughout their lives.
CMS-2023-0113-0742	CMS-2023-0113	llw-kypz-1zsu	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		Home health provides such a valuable resource for patients. Cutting resources to this life saving service is a mistake.
CMS-2023-0113-0743	CMS-2023-0113	llw-lexa-2rtk	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					I have Lymphedema in the Right Arm and Hand as well as my Right Leg Due to breast cancer treatment and side effects. I rely on compression garments to allow me to sufficiently care for myself and be ambulatory while coping with the disability of lymphedema. I am on disability and have gone into debt purchasing the proper compression garments to help manage this permanent disability. Without the upcoming Medicare coverage of compression garments I would have increased hospitalizations and increased overall costs to Medicare due to my inability to manage lymphedema. The garments are critical in keeping me out of the hospital with infections and septic shock. The ability to have a daytime garment covered, a nighttime garment covered helps lower healthcare costs long-term.
CMS-2023-0113-0745	CMS-2023-0113	llw-lhnh-hzbc	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Individual		Will Medicare reimburse for Compression Bras, Compression Camisoles and Swell Spots. Will Medicare address the need for compression in the head and neck areas. Section VII.B. - Scope of the Benefits and Payment for Lymphedema Compression Treatment items.

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CMS-2023-0113-0754	CMS-2023-0113	llw-mizh-xmyy	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Individual		SECTION VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items I have dealt with lymphedema for 20+ years. Compression garments are intrusive in life. Nonetheless, they make everyday life possible and keep me out of the hospital. Thank you for the obvious work and thoroughness that you have put into moving the LTA from words on paper to real life help for people like me with lymphedema. Thank you especially for recognizing that it takes more than the compression garments alone to make treatment effective. Comments Exceptions in Replacement Frequency To “significant change in weight” add “or in size of limb or other area affected by lymphedema.” Significant changes in limb size can happen quickly with lymphedema surgery, compression therapy, or, hopefully, one day, with medication. Nighttime Garments Without Straps The nighttime garments recommended for me by my therapist do not have adjustable straps. Instead, a separate sleeve covers the basic garment. The sleeve provides additional pressure and a non-slip cover on the bottom of the foot to help prevent falls. These types of nighttime garments allow the appropriate night-time gradient pressure to be designated by the therapist. I do not think that night-time garment approval should be limited to garments using adjustable straps. Additional Item for Bandaging Using compression garments and bandages is a time-consuming process. I have found that a bandage roller helps re-roll washed and dried bandages better than re-rolling them by hand. The bandages are re-rolled more compactly and evenly, which means they can be applied with more consistency in pressure and placement. In short, the mechanical roller results in a more effective re-roll of the bandages. Effective Use of Gradient Compression Garments and Coverage of Accessories From personal experience I can attest to the need in some cases for liners in areas such as the top of the ankle area, where the compression garment may rub the skin and cause it to chafe and break open the skin. I can also attest to the need for the changing in the stitching of the garment behind the knee to keep that area from chafing and becoming irritated. These changes to garments have made a tremendous difference in my being able to wear compression garments without having areas where my skin breaks down. Reimbursement Codes for Application of Compression Garments I do not have a specific recommendation because I do not know the mechanisms of costs, payments, and responsibilities between therapists, the medical facilities for which they work, and the vendors of compression garments. However, I urge you to keep asking questions until you have the information you need so that you can make decisions that do not handicap lymphedema patients’ ability to get the compression garments they depend on every day to live productive lives. In my geographical area, the “supply chain” of lymphedema garments is very limited.

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CMS-2023-0113-0761	CMS-2023-0113	llw-nvay-wtbt	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Private Industry - Health Care		Dear CMS, I am writing today as an administrator for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 1.31% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Administrator of a home health agency

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CMS-2023-0113-0785	CMS-2023-0113	llw-pqfz-smz9	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					Comments regarding the proposals contained within CMS-1780-P. Our goal with these comments is to protect patient access to care. 1. Product Coverage & Qty. Limitations - CMS-1780-P proposes to cover 2 daytime compression garments every 6 months, and 1 nighttime garment/year. Wearing unclean compression garments could lead to complications (disease state exacerbation, infection, cellulitis, etc.) resulting in hospitalization. Under the proposed coverage quantities outlined above, patients would be required to launder their garments daily. We propose: 3 daytime garments/affected body part/6 months, & 2 nighttime garments/affected body part/6 months. 2. Adequate & Appropriate HCPCS Codes- There are thousands of products that fall into the compression garment product category. While existing code sets already account for different garment lengths and compressions, there are other variables not accounted for, such as textile & technology differences (circular knit vs. flat knit, day vs. night, bandages, accessories, custom vs. off-the-shelf, etc.). Additional codes are needed to accurately represent all product variations while both ensuring access to all products as well as being good stewards of the Medicare benefit. The variance in cost from product to product are too great to lump them all into existing codes and still avoid either over-paying or under-paying for them. We recommend CMS create additional codes to reflect all variations within this product category. A detailed proposal regarding coding was submitted by USMCA (US Medical Compression Alliance), and we encourage CMS to evaluate that proposal when considering all possibilities & combinations. 3. Payment Methodology - Since there are not currently very many compression products that have both a designated HCPCS code & a payable allowable amount assigned to them, many of the products will default to a pricing methodology other than a published fee schedule. CMS-1780-P proposed that items that don't have a HCPCS code & a Medicare allowable will have their pricing assigned by looking at some combination of Medicaid, Tricare, and internet pricing. The internet pricing does not account for the service component that is in integral part of supplying compression garments. Internet retailers are not measuring or fitting products. If beneficiaries order products from these online retailers without proper measurement and fitting procedures, it could lead to wasteful spending by Medicare & its beneficiaries, due to receiving products that are not appropriate for them. Several state Medicaid programs publish rates for only a few of the compression garment codes that will be covered by Medicare. There is also quite a bit of fluctuation from one state to another in terms of allowables. One state may have sufficient allowables to protect access to the most appropriate products, while another state may not. Medicaid and Tricare pricing are relevant benchmarks for certain products, but there are several products on the market that are not available to patients covered under those respective programs in certain states because the allowable currently in place is not sufficient to cover those products. As an alternative methodology, we recommend that CMS consider a pricing proposal that was submitted by the USMCA, which is a formula based on 120% of the specific product manufacturer's Minimum Advertised Price (MAP), with adjustments for pressure and custom factors and an allowance for the necessary fitting services. This proposal appears to be fair, well thought out, and will help accomplish the goal of protecting access to care, assuring that beneficiaries have access to the most appropriate and beneficial product for their condition. 4. Fitting Fee and Product Cost – We support a single payment amount that covers the fitting fee & the compression garment. We do not support separating the fitting fee from the product reimbursement. We believe the fitting process to be an integral part of the process for both off-the-shelf & custom fitted garments. The person responsible for the fitting process would preferably be a clinician, but we would support a non-clinician being responsible for the fitting process, provided they meet certain qualifications. We believe those requirements should be similar to what is currently required of mastectomy fitters. 5. Documentation Requirements for DMEPOS Refills to the Original Order Section 1893(b)(1) - CMS is proposing that the beneficiary confirmed the need for the refill within the 30-day period prior to the end of the current supply, and to require delivery of DMEPOS items (date of service) be no sooner than 10 calendar days before the expected end of the current supply. VGM supports this proposal.

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CMS-2023-0113-0803	CMS-2023-0113	llw-qp9i-lg3g	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. It's very sad that the most vulnerable populations that rely on our high-quality care will have their access to care restricted due to these cuts. We serve a rural area and each year it gets harder and harder because of continued cuts. For years home health has been the industry that receives the cuts in health care. No other health care providers have seen such significate rate cuts, despite home health care providing higher costs savings. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year.
CMS-2023-0113-0804	CMS-2023-0113	llw-qpo2-j9d2	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		Home Health Care and Private Duty Services are vital to our communities. As a provider for over 38 years, I have seen the many changes and challenges to reimbursement for such services and could see the value at a higher level. The changes proposed or made over the last 4-5 years has crippled the local agencies; providing care that patients need, particularly in the rural communites, with a smaller reimbursement. Caring for a more chronic patient population that frequent the E/R and/or inpatient hospital care and has multiple problems, ie wound, etc.is difficult for those agencies that are willing to take these patients. The larger regional/national agencies will not take them. The episodic payments from Medicare or other episodic payers does not cover the cost of staff and wound care supplies. In addition, patient outcomes do not always reflect excellent care because of the likelihood that many patients cannot improve and do not qualify for other types of care. The pandemic created a workforce shortage beyond anything we have seen in the last 38 years. Those licensed professionals that want to work, will only work for a 20% increase (or more) in pay. Home health and privated duty services compete with hospitals and nursing homes for staff and those facilities generally pay more than most home health companies can afford. Regulations increase but we can't afford to hire more staff. Hospice rates usually increase annually but home health does not. As the population of home health recipients increases, and more chronically ill and critically ill patients increase and get referred to the agencies whose mission is to care for ALL patients, an increase in episodic payment is necessary to adquately care for these patients and pay much higher salaries for licensed professionals. This is not a complaint, it is reality. Please do not decrease our payments. Thank you
CMS-2023-0113-0814	CMS-2023-0113	llw-rcxy-bt0r	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Individual		Presently, Medicare/Medicaid has a fee schedule for all supplies, equipment and services they provide. I understand Medicare/Medicaid does not allow upgrades on supplies provided i.e. mastectomy bras. Thus, with so many Manufacturers providing garments and supplies at all different quality and pricing I am interested to learn if Medicare/Medicaid will provide what meets the definition of "Medically Necessary" and not a better quality garment or supplies that will be more effective for the patient. Will Medicare Claims be submitted Non-Assigned or Assigned.... Section VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment.

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CMS-2023-0113-0820	CMS-2023-0113	llw-rnbb-zyck	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		Dear CMS, I am writing today as a Branch Manager for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Kristen Dalton Home Health Admin
CMS-2023-0113-0827	CMS-2023-0113	llw-s4c5-aijh	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Health Care Professional/Association - Occupational Therapis		If the proposed budget cuts go through, our company will be forced to make cuts to our patient care. There is already not enough money to go around. Patients will suffer, not to mention that this threatens the livelihood of people who take care of them. Please do not make budget cuts for home health. It's already a struggle to stay in the industry.
CMS-2023-0113-0851	CMS-2023-0113	llw-uatf-ydzc	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Home Health Facility - HPA25		This proposal will be detrimental to the rural underserved community where I work. The people in these communities already have limited resources and many are unable to leave the home. They depend on HH and cutting back on the reimbursement will make it near impossible to hire competitively. It is so hard to find qualified staff in rural areas and now we will have less money to work with to hire people to fill these roles. It has been increasingly difficult to provide the care these patients need. HH agencies are penalized for elderly patients that decline, we are penalized when they go the the ER or hospital even though many of our communities don't have an urgent care or open clinic hours. We are penalized if our hardworking farmers and vets don't take the time to fill out a survey and now we are just going to be cut funding across the board. The end result will be less HH agencies able to stay open. less HH nurses willing to work for less than market value and more communities falling through the cracks.

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CMS-2023-0113-0865	CMS-2023-0113	llw-wh8a-9yyg	2023-09-14T04:00Z	**Anonymous**	**Anonymous**					Dear CMS, I am writing today as an administrator for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have 14 years experience in the home health industry, and it is from this experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. Just a few of my concerns: • CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. • The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. • Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. • The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. • The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year. Thank you for your consideration.
CMS-2023-0113-0897	CMS-2023-0113	llx-75hv-hq1b	2023-09-14T04:00Z	**Anonymous**	**Anonymous**			Occupational Therapist - HC050		Home health occupational therapy has prevented significant amounts of falls and hospitalizations, saving Medicare money and allowing elders to age safely at their own home. I have seen it first hand, patients become able to take their own showers after home modification recommendations and appropriate training and education. I have seen people go from having multiple falls at assisted livings, to stopping having falls, after environmental modification recommendations and appropriate frequency of training to adhere to safety precautions; such as safety using a walker during several different daily care and social activities within the building . For patients with dementia, it requires increased repetition to adhere to safety training consistently. As occupational therapists we use the skill of tapping into implicit memory to compensate for decreased short term memory. Safety and independence with self cares, and fall prevention save Medicare money and appropriate frequency of visits for occupational therapy is required, in order to meet that goal. Taking away benefits that keep our elder population safe and at home is not dignifying to them. And it may cost more money in hospitalizations, hip replacement surgeries and nursing homes. Without appropriate frequency of occupational therapy the goal of aging in place and saving Medicare money can't be accomplished. I ask that CMS does not go through this cut proposal and instead, allow our elders their basic right of dignity of living safety and independently at home.
CMS-2023-0113-0826	CMS-2023-0113	llw-rxji-p621	2023-09-14T04:00Z	**Stephanie**	**Arnold**	ID		Home Health Facility - HPA25		This proposed rule would be detrimental to the Home Health and Hospice field. Home Health Care has become a vital role in caring for our community with excellent outcomes. Please consider the wellbeing of the homebound in our local community. There are gaps in Healthcare, please don't create another one.

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CMS-2023-0113-0033	CMS-2023-0113	lks-7l3f-yj9l	2023-08-10T04:00Z	**Geraldine**	**Artale**	NC				In February 2001 my foot began to swell. Within four months my entire left leg was swollen. After seeing countless doctors in NYC and Charlotte who could not provide a proper diagnosis, I was seen by a lymphedema doctor who was able to diagnose my condition within minutes. Prior to being diagnosed, I had experienced severe pain in my groin as a result of cellulitis (a bacterial infection of the deep layer of skin that often affects people with lymphedema). I was hospitalized to receive IV antibiotics. The Lymphedema diagnosis came nine months after symptoms first started to appear. Dr Stewart set me up with a rehab clinic and eventually with a compression specialist. During that time I had two additional bouts of cellulitis (both requiring hospitalization) before I completed the rehab program in early January. That was almost 22 years ago. I completed my rehab, starting wearing a custom-fit compression stocking during the day and a Reid Sleeve at night until recently when I switched to a custom-fit compression stocking at night due to hip issues. In 2007, I was able to purchase a Flexitouch machine for just my 20% copay which I use at least once a day and sometimes twice a day. Fortunately I had excellent insurance through my employer which made compliance a lot easier, therefore minimizing complications from Lymphedema. In 21 1/2 years, I have had the same number of cases of cellulitis as I did in the nine months I was without a diagnosis. I credit that with my ability to have access to the proper compression supplies necessary for Lymphedema. I have been on Medicare for 4 1/2 years and these supplies are cost prohibitive. Why is something that is a covered medical expense pre-Medicare not so after age 65? It is clear having access to compression garments and other lymphedema compression aids does make a difference. The number of compression garments should not be limited to two daytime and one nighttime If they are worn every day, they stretch out and do not provide the proper amount of compression necessary to avoid complications. My experience from having worn custom-fit compression garments for over 20 years is that at least six to seven daytime garments are needed per year as they begin to wear out between 60-75 days of continued daily use. Also, one nighttime garment every six months is definitely not sufficient. Most importantly, having access to compression garments is extremely necessary for minimizing complications and the costly hospitalizations which result from such.
CMS-2023-0113-0428	CMS-2023-0113	llp-qo2c-9wqm	2023-09-11T04:00Z	**TAYLOR**	**AVON**	UT		Individual		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0647	CMS-2023-0113	llv-knt8-3u2g	2023-09-14T04:00Z	**Debra**	**Axness**	MN		Individual		I am a breast cancer patient, 10 years post-treatment. I have chronic Stage II Lymphedema in my left arm, as the result of my surgery and treatment for cancer. For my lymphedema, I am being treated with custom Jobst Elvarex sleeve and gauntlet, worn all day, and Tribute night garment overnight. This has been very successful in keeping my lymphedema from progressing, and I have not had cellulitis or hospitalizations for my lymphedema. Over the past ten years, insurance coverage for my lymphedema garments has been spotty. Some years it has been very good and other years have been beset by claims denials and I have had to spend hundreds of hours in claim rejection appeals. My doctor has been prescribing two sets of custom Elvarex garments per quarter (8 sets per year) and one Tribute garment per year. I have not always been able to obtain this number of garments, due to insurance limits and time-consuming insurance denials. When I have been able to get 8 sets per year, my lymphedema has been very well controlled. I would encourage CMS to expand their limit on garments to be set by the patient's doctor (rather than restricting the number of garments to a set number per year for all cases). For the table of covered items and codes, I commend CMS for its thoroughness. It looks like the items I will need (custom compression arm sleeve, medium and heavy weight; and custom compression gauntlet) will be covered. I would like to urge CMS to re-examine the payment amounts, as my experience has been that my custom garments are much more expensive than the "Example Payment Amounts". Thank you to everyone at CMS for a thorough dive into this issue.
CMS-2023-0113-0423	CMS-2023-0113	llp-nudd-tibg	2023-09-11T04:00Z	**Kathryn**	**Ayoob**	CA		Health Care Professional/Association - Physical Therapist		Stop making cuts to coverage that people pay for throughout their lifetimes. Let providers do their jobs and give people access to services that we spend years and hundreds of thousands of dollars studying to provide.
CMS-2023-0113-0543	CMS-2023-0113	llu-w71q-xdn6	2023-09-14T04:00Z	**Rosie**	**B**	ID		Health Care Industry - PI015		Please do not reduce Medicare reimbursements in a time when everything else is going up. I serve as a registered nurse at HORIZON HOME HEALTH and already make less than most hospitals pay. Our most vulnerable populations will be impacted by not being able to afford homecare after surgeries and hospitalizations. Consider struggling families and individuals already barely surviving. Thankyou for continued consideration and good sense. Rosemary Barfuss RN

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CMS-2023-0113-0829	CMS-2023-0113	llw-s6a5-1plv	2023-09-14T04:00Z	**Jamie**	**Baber**	TX		Individual		COMMENTS SUBMITTED RE: FILE CODE CMS-1780-P I have worked for Women's Health Boutique for 13 years, providing products to Medicare beneficiaries with lymphedema. I applaud CMS for the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. My owners have supported the passing of this bill for the past 12 years and we all celebrated when Congress passed the LTA bill. Over the years, I can't even begin to count the number of Medicare beneficiaries needing compression garments that couldn't afford them out of pocket, so they went without. It has been heartbreaking. Thank you, Medicare, for the Public Comment Phase allowing me the opportunity to be an integral part of this process for the coverage of lymphedema garments for women who suffer from post-mastectomy lymphedema. Here are my comments and suggestions, as solicited by Medicare: Title VII. (B)(3) Pg. 271/392 COMMENTS: Compression Accessories – I hear the compression fitters in our boutique say, "no garment works in the drawer or closet!" We see how our customers cannot get the compression hose on without assistance. They live alone so they don't wear them. Their legs or arm get worse and worse and worse! My father was one of them. The fitters here gave him a pair of donning gloves so he could get his hose on. In fact, they give a pair of complimentary donning gloves with every pair of hose or arm sleeve they sell, to help our customers get them on and off. My dad developed non-healing open wounds. When he started wound care and debridement, he finally got compression wraps covered by Medicare. I am so thankful Medicare beneficiaries will no longer be financially suffering because of the cost of mandatory compression garments. I believe allowing coverage for donning and doffing aids is vital for Medicare to include because it enables a positive outcome and truly will help keep compression worn daily as prescribed and as needed. Accessories that I believe also need to be covered include: Donning aids Doffing aids Donning Gloves Chipped Foam Padding, such as swell spots in various sizes, S, M, L, XL Dorsal Hand Pad Silicone Padding (could be covered under existing HCPCS code A6425) Liner with light (10 mmHg) compression, upper extremity arm Liner with light (10mmHg) lower extremity, Liners for upper or lower extremities with no compression or elastic (could be covered under existing HCPCS code A6457, cotton stockinette) Hybrid socks Thank you for working with Congress to get lymphedema garments covered by Medicare. This has been much needed, and I am proud to see it come to fruition. Respectfully submitted, Jamie Baber Executive Assistant Women's Health Boutique
CMS-2023-0113-0538	CMS-2023-0113	llu-tpxb-066m	2023-09-14T04:00Z	**Donna**	**Bakke**	MO		Association - Device		Hello this comment is in regards to Section VII.B. - Scope of the Benefit and Payment for compression aids forLymphedema Compression As a cervical cancer survivor this daily treatment helps for pain and mobility but can be expensive for the patient. Please consider including this vital piece under Medicare Part B. Thank you. Treatment Items"

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CMS-2023-0113-0024	CMS-2023-0113	lkj-x3r1-tgza	2023-08-10T04:00Z	**Claudette**	**Banholzer**	WI				Thoughtful proposal-thank you. There doesn't seem to be category for custom gradient compression pantyhose of any compression amount (30-40mg, 40-50mg, etc). There doesn't seem to be category for nighttime gradient compression garment for torso/thigh. For example, I use a Jovipak Boxer Capri and a JoviPak Right/Left lower leg set. Over these I use JoviJackets-a type of nylon/spandex Super Powernet garment. You need both parts to achieve the correct nighttime pressure. Also, the replacement schedule is different for the parts of this system. The JoviPak garments are replaced after one year, but the JoviJackets are only good for 6 months. I do not believe that this type of issue is addressed in the draft. Finally, Provider payments to fitters/suppliers as proposed seem very low per the reimbursement schedule listed. For example, my six month use custom pantyhose are over $1000 a pair. My yearly nighttime compression garments cost ~$4000. This doesn't include the cost of the PT fitter time. Thank you for your work on this very important issue. Since being diagnosed with cancer and then experiencing lymphedema as a consequence of treatment, I can honestly say that this disease has had a significant negative impact on my life. Keeping it under control as much as possible avoids further medical complications, promotes lower overall health care costs, and gives me the opportunity to continue as a productive member of society.
CMS-2023-0113-0733	CMS-2023-0113	llw-ka9x-xxv0	2023-09-14T04:00Z	**LINDA**	**BARBER**	MD		Health Care Industry - PI015		I would like to comment on the rule for payment of Lymphedema Products. My husband was diagnosed with leg lymphedema in 2022. His treatment included therapy and the purchase of compression garments for both legs. His garments for both legs cost $1200 per leg out of pocket. I was diagnosed with a different type of leg lymphedema in 2022. My treatment included therapy and the purchase of compression wraps at the cost of $1000 per leg out of pocket. These garments only have a life expectance of 6 maybe 8 months and then they need to be replaced. There is NO cure for Lymphedema only preventive measures. Before treatment my husbands legs swelled and burst open and seeped fluid so bad we could see his footsteps as he walked across the floor and he was not able to wear shoes. After therapy and application of compression garments, he has no more seepage and we have bought special shoes he can wear and he can now leave the house safely. Before treatment he was unable to leave the house for anything besides doctor appointments. My leg lymphedema was the type where your legs turn black and they hardened so that your ankles don't move. My edema was up to my knees and I could barely get from room to room. I could not go up steps and could not get into my bathtub. After treatment and application of compression garments I can now go upstairs, I have full range of motion in my ankles and most of the black is gone from my legs. The total cost of our garments was $3400 out of pocket. We both wear these garments everyday. When you live on a set monthly income it is extremely difficult to come up with $3400 a year extra (they could be higher next year) out of your monthly income. This bill will be extremely helpful to everyone that has this illness. Everyone we met during therapy were all senior citizens and we all had to choose what we could afford to buy or if we could afford to buy anything. We sincerely hope this bill gets passed.
CMS-2023-0113-0441	CMS-2023-0113	llq-3gzf-ctt1	2023-09-12T04:00Z	**Katrina**	**Barlow**	UT				I am writing as a home health employee to express strong opposition to CY 2024 budget cuts. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly. They depend on home health to make it possible to live with dignity in their own homes. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration. Katrina.barlow
CMS-2023-0113-0626	CMS-2023-0113	llv-f6b6-u574	2023-09-14T04:00Z	**Brayden**	**Barnes**	TX		Individual	https://downloads.regulations.gov/CMS-2023-0113-0626/attachment_1.pdf	See attached file
CMS-2023-0113-0183	CMS-2023-0113	llf-gc2h-exzx	2023-08-29T04:00Z	**Ashley**	**Barnes**	TX		Individual	https://downloads.regulations.gov/CMS-2023-0113-0183/attachment_1.pdf	See attached file

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CMS-2023-0113-0627	CMS-2023-0113	llv-fq92-gsw5	2023-09-14T04:00Z	**Tyler**	**Barney**			Health Care Professional/Association - Nurse Practitioner		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0095	CMS-2023-0113	ll7-aho2-bi31	2023-08-22T04:00Z	**Edwyna**	**Batiste**	MI		Health Care Provider/Association - Other		Please expand Medicare benefits to cover additional healthcare cost related to lymphedema. Your support is greatly appreciate it.
CMS-2023-0113-0563	CMS-2023-0113	llv-1lcy-wy1t	2023-09-14T04:00Z	**Kate**	**Battenfeld**	CA		Individual		I've had chronic, idiopathic bilateral lower lymphedema since I was 10 years old. I'm now 60, and the only way that I've learned to manage it is through daytime and nighttime compression. During the day I wear compression stockings, and at night I wrap using a combination of bandages that I purchase as full leg sets from a medical supply company. As I draw close to retirement, I worry that when I no longer have insurance coverage through work, I will lose my ability to purchase these life-altering supplies. Knowing that I will have coverage through Medicare is absolutely a medical necessity for me and for many others who live with this incurable disease. I am an active and healthy individual and I'm able to live life to the fullest in large part, due to the fact that I maintain 24-hour care of my lymphedema through the use of compression garments. It I were to lose access to these items, my quality of life would greatly suffer. In fact, without Medicare access to compression garments, my life could potentially be cut short, if my lymphedema were to worsen and lead to catastrophic infections and loss of mobility. This is truly a life and death issue for me, and for so many others. Thank you for your consideration.
CMS-2023-0113-0422	CMS-2023-0113	llp-npox-9zp7	2023-09-11T04:00Z	**Drew**	**Bechler**	IA				Please reconsider the proposal for the codes, coverage and payment of the Lymphedema Treatment Act. As it stands now, this ruling would destroy the marketplace and make it very difficult for patients to get compression garments.
CMS-2023-0113-0526	CMS-2023-0113	llu-3lg4-9qca	2023-09-12T04:00Z	**John**	**Beckwith**	OR		Physical Therapist - HC045	https://downloads.regulations.gov/CMS-2023-0113-0526/attachment_1.pdf	Please submitted document

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CMS-2023-0113-0427	CMS-2023-0113	llp-qlg1-jcc3	2023-09-11T04:00Z	**April**	**Beebe**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0028	CMS-2023-0113	lkl-wjut-loks	2023-08-10T04:00Z	**Susan A**	**Beecher**	MI				As a person who has breast-cancer related chest lymphedema and one who is unable to get my Medicare Advantage insurance to cover my medically necessary compression brassieres (“bras") covered, I would like to make a suggestion for this bill. Let me explain, before I had Medicare coverage, my Blue Cross insurance did cover my compression bras which I got through the University of Michigan Hospital's prosthetics department. However, once I became old enough to be covered by Medicare, then the bras were no longer covered. I should explain that the best bra that is specifically designed for women with breast and underarm lymphedema is the Belisse Compression Bra now made by Jobst. These bras cost $200. There are other bras on the market ostensibly for lymphedema and I have tried a number of them, but the Belisse is the best. After my Blue Cross (BC) Medicare Advantage plant denied my request for coverage of a compression bra in 2021, I appealed the decision with much supporting evidence (my appeal letter attached). Blue Cross agreed to cover a fitting with a durable medical equipment company (Wright and Fillipis). I was fitted by Wright and Fillipis and they submitted a claim to BC for the bra. The claim was denied and the reason was that Medicare had no procedure code for a compression bra. It has procedure codes for other types of compression garments but not for bras. So my request is that the language in this new regulation be very specific about the kinds of compression garments that are covered. I do not see bras specifically mentioned in the language in the new rules. I believe that bras should specifically be listed so that there are no issues later about them being covered. Breast lymphedema is a medical condition. It is included under this ICD-10 code: 2021 ICD-10-CM Diagnosis Code I89.0 Lymphedema, not elsewhere classified. I appreciate your consideration of my request for more specific listing of compression bras specifically designed for patients with breast lymphedema.
CMS-2023-0113-0100	CMS-2023-0113	ll7-eqtt-ieon	2023-08-22T04:00Z	**Krista**	**Beheler**	VA		Occupational Therapist - HC050		I have been a Certified Lymphedema Therapist since 2016. Many of my patients are unable to afford their needed compression garments to manage their chronic Lymphedema. So, some are unable to procure rheur Lymphedema garments for management. This is disheartening since Lymphedema if not managed can cause infections, impaired independence in all daily living skills, depression, discomfort/pain, deficits in their social interactions, and a poor quality of life. It is my hope that laws will be passed to cover payment for compression garments to promote optimal Lymphedema management, improving every facet of a patient's life who is suffering from this condition.

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CMS-2023-0113-0433	CMS-2023-0113	llp-spso-87q7	2023-09-11T04:00Z	**Jessica**	**Behunin**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0446	CMS-2023-0113	llq-mzfx-bgsx	2023-09-12T04:00Z	**Valerie**	**Belisle**	NY		Individual		I believe that compression thigh, highs, for example, should be covered by insurance. When I spoke to my insurance company, they said that they weren't because they were considered expose a bowl like a Band-Aid. I understand that they don't last forever, but I usually get more than the recommended six months out of each pair. The reason being is I have multiple colors so I switch, they should at least give some kind of allowance towards them. It's not like I want to wear them I need to.
CMS-2023-0113-0220	CMS-2023-0113	llm-5sll-yluy	2023-08-29T04:00Z	**Sherilyn**	**Bell**	GA				I am retired and have lymphedema most of my life.Since retirement I have been paying for my own compression garmemts, co pays for treatment and services medical insurance nor merdicare pay towards the garments. Because I am on a fixed income the number of garments,(day and nightime) are limited. It would be beneficial to me and others in my situation to have financial support in paying for garments, treatment and supplies. The proposed guidelines outlined in this bill for the number of garments, types of garments based on patients condition, and percentage of patient obligation would be helpful provided pricing with suppliers is regulated.

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CMS-2023-0113-0117	CMS-2023-0113	ll9-tkyh-g374	2023-08-22T04:00Z	**judy**	**bellin**			Federal Government - G0005		Re Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items The proposed rule is sorely needed by lymphedema sufferers, especially those who face financial barriers to their use. In general, CMS is to be recommended for this proposed rule., but I am greatly concerned for the inadequacy of its proposed method for calculating reimbursement. CMS proposes that 2024 reimbursement rates will be determined based on existing reimbursement amounts used by Medicaid and Tricare, and when necessary, average online retail pricing. This is a major flaw in the proposed rule, for it is unrealistic. The proposal could result in too low reimbursement rates and price discrepancies. the average Medicaid fee schedule amount plus 20 percent represents what other government payers such as the VHA and TRICARE consider an appropriate payment basis for these items and a slightly higher payment basis than the average payment rates established by Medicaid state plans that have fee schedule amounts for these items. This is unrealistic in the real world. Folks with lymphedema differ in the kind and number of sleeves they need. For some, a simple compression sleeve suffices; others need more sophisticated even customized sleeves. A simple internet search shows that daytime sleeves can cost $50–$300 for manufactured sleeves with much higher prices for custom-made sleeves. Nighttime sleeves are even more costly, ranging in price from $200 to more than $1,000. Average prices are skewed low by commercial giants like Amazon. Many private insurance plans do not cover the costs of compression sleeves for lymphedema. Medicare does not include compression sleeves for lymphedema on its list of durable medical equipment or provide coverage for them. Medicaid provides some coverage, although this varies by state. The costs of compression sleeves for lymphedema is way too high for many people, especially since doctors recommend having at least two sleeves. I urge CMS to establish a more realistic real world method for establishing reimbursement rates and frequency, and ensure that the category of covered lymphedema items be broadened.

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CMS-2023-0113-0118	CMS-2023-0113	ll9-z1iz-s9w1	2023-08-22T04:00Z	**Peter**	**Bellin**			Individual		FROM: Peter Bellin, Phd, CIH TO: Centers for Medicare & Medicaid Services, Re CMS–1780–P. Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items I am writing to comment on this proposed rule. I am greatly in favor of adding compression treatment devices to the list of durable medical equipment. Such items are essential for proper care of lymphedema patients. The proposal falls short in the proposed method for calculating reimbursement. CMS proposes that reimbursement rates will be determined based on existing rates used by Medicaid and Tricare, and when necessary, average online retail pricing. I am concerned that the proposal could result in low reimbursement rates and price discrepancies. Lymphedema patients differ in the kind and number of compression items they need. For some, a simple compression sleeve suffices; others need more sophisticated even customized devices. Prices for daytime sleeves can cost $50–$300 for manufactured sleeves with much higher prices for custom-made and specially fitted ones. Nighttime sleeves are even more costly, ranging in price from $200 to more than $1,000. Average prices are skewed low by commercial the widespread availability of compression sleeves that are not designed for treating lymphedema. I urge CMS to establish a more realistic method for establishing reimbursement rates and frequency, focused on the needs of the range of patients needing this treatment. Thank you for providing the opportunity to comment on this important regulation.
CMS-2023-0113-0126	CMS-2023-0113	llb-51ir-lcij	2023-08-22T04:00Z	**David**	**Bellin**	NC		Government - Federal		Re Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items The proposed rule is sorely needed by lymphedema sufferers, especially those who face financial barriers to their use. In general, CMS is to be recommended for this proposed rule., but I am greatly concerned for the inadequacy of its proposed method for calculating reimbursement. CMS proposes that 2024 reimbursement rates will be determined based on existing reimbursement amounts used by Medicaid and Tricare, and when necessary, average online retail pricing. This is a major flaw in the proposed rule, for it is unrealistic. The proposal could result in too low reimbursement rates and price discrepancies. the average Medicaid fee schedule amount plus 20 percent represents what other government payers such as the VHA and TRICARE consider an appropriate payment basis for these items and a slightly higher payment basis than the average payment rates established by Medicaid state plans that have fee schedule amounts for these items. This is unrealistic in the real world. Folks with lymphedema differ in the kind and number of sleeves they need. For some, a simple compression sleeve suffices; others need more sophisticated even customized sleeves. A simple internet search shows that daytime sleeves can cost $50–$300 for manufactured sleeves with much higher prices for custom-made sleeves. Nighttime sleeves are even more costly, ranging in price from $200 to more than $1,000. Average prices are skewed low by commercial giants like Amazon. Many private insurance plans do not cover the costs of compression sleeves for lymphedema. Medicare does not include compression sleeves for lymphedema on its list of durable medical equipment or provide coverage for them. Medicaid provides some coverage, although this varies by state. The costs of compression sleeves for lymphedema is way too high for many people, especially since doctors recommend having at least two sleeves. I urge CMS to establish a more realistic real world method for establishing reimbursement rates and frequency, and ensure that the category of covered lymphedema items be broadened.

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CMS-2023-0113-0214	CMS-2023-0113	lll-agn5-3e5h	2023-08-29T04:00Z	**Christine**	**Bender**	PA		Health Care Professional/Association - Nursing Aide		A human life has worth. Home health aides are responsible for keeping people alive. Their salaries should reflect that level of responsibility. How is a home health agency able to compete in recruitment when they are offering a salary less competitive than food service work. A human life is worth more than a hamburger in a bag. Recruitment and retention is a wasted effort when there is no financial incentive for a home health aide. Keeping people in their own homes is less costly than 24/7 inpatient care. Those dollars should be moved to the in-home care sector designated for salaries, training, and bonuses for home health aides.
CMS-2023-0113-0503	CMS-2023-0113	llr-ilqx-0xv7	2023-09-12T04:00Z	**Israelia**	**Benjamin**	FL		Individual		My comment is kind of inappropriate, whereas, some may find it offensive. I have both, CVI & Lymphedema (combined). Growing up, I never really studied the issue. My family never showed the same symptoms as I did (mine being the worst/ most noticed). Certain ethnicities are more prone to vein issues, than others. I can easily recognize veins issues without diagnoses now (I am not a doctor). In my family, one member has not been diagnosed, but I'm certain I know what condition the person has. They described their symptoms to me , and I knew. Will compression, or, pneumatic compression be available do to genetics? If so, it would help a lot (severely early family / people prevention). Anything dealing with Lymphedema is all self help I'm thankful for all education on the topic. Thank you to all for advocating for lymphedema. The L.T.A is milestone/ triumph/ appreciated.
CMS-2023-0113-0565	CMS-2023-0113	llv-1nzg-mrn2	2023-09-14T04:00Z	**Frances**	**Berg**	PA		Individual		I am a patient at the Hodi Lymphatic Center in Edwardsville Pa. There is no DME for lymphedema within 100 miles. I am fortunate that Farrow trim to fit strong wraps and Jobst hybrid compression liners are working for me. I am able to purchase these items when on sale on the web. Will I be able to be reimbursed for these purchases? Will replacement Velcro tabs covered for the Farrow wraps?
CMS-2023-0113-0641	CMS-2023-0113	llv-io3h-2shl	2023-09-14T04:00Z	**Christina**	**Berry**	NY		Health Care Professional/Association - Occupational Therapis		This is in reference to “Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” I am an Occupational Therapist and an NLN CLT. I have been treating patients with Lymphedema for over 20 years. My understanding is that Medicare will now pay for all gradient compression garments; standard, custom (does this include zippers and padding to address fibrosis and difficult to address areas?)garments with straps, sets instead of individual garments, daytime and night-time. Wooooooo hoooooo!!! Thank you!! I do have concerns/suggestions; Will the garments covered include the accessories sometimes needed; chip packs to address fibrosis, shelf straps to address lobules,, liners that cover velcro straps so they don't stick to sheets/pants/other garments, liners, toe caps Will the benefit cover; multiple garments per year. Think of it, the person needs a garment for each leg 7 days /week day and night. 2 gamrents per day and i per night doesn't cut it. They will spend all their time washing the garments which usually have to air dry. I usually recommend 6-8 gamrents /year by day and 2-3 by night. Are additional garments covered in the instance of theft, damage, lost, change in status? Sometimes we layer garments 2* patient's comorbidities/tolerance/status of lymphedema. This means the need 2-3 garments/leg..... Will the patient be receive benefits for wound care supplies? creams, foams, alginates etc as well as the basics non-adherent pads, gauze pads, abdominal pads, tape, roll gauze..... Bandaging Sets; I hope will include; cream, stockinette, artilfex/cotton roll, gray (open cell) foam, orange (closed cell) foam, isoband/fixing bandage to hold foam, short stretch compression bandages, chip packs to address fibrosis Coding changes specific to Manual Lymph Drainage, Gradient compression bandaging - bandaging 2 legs toes - thigh definitely takes more time than 1 arm fingers to axilla. Bandaging toes can often include padding the underside of each toe as you go to prevent rubbing/friction sores, if there are lobules you have to pad these prior to putting foam on. All takes time. The first day of bandaging when you have to custom cut the foam to fit takes more time than subsequent visits, except when you've made so much progress you have to cut the foam down to a smaller size. Constant re-adjustments. nothing is cookie cutter style. ALso need codes for measuring. Again a lobular leg takes more time than an arm or a mild edema calf. DME companies that provide the garments are few and very far between where I live. Please make this process easy.

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CMS-2023-0113-0524	CMS-2023-0113	llu-1zbj-6vu1	2023-09-12T04:00Z	**Susan**	**Bertram**	WA		Individual		Section 1834(z)(2) discusses frequency limitations for lymphedema compression treatment items and specifies that no payment may be made for lymphedema compression treatment items furnished other than at the frequency established in accordance with this provision of the Act. Lymphedema Custom Garments and non custom garments - I disagree with limiting the number of daytime garments covered to two (2) every six (6) months. I believe patients should have the option of three (3) garments every six (6) months. Having the extra garment allows patients to have sufficient garments in the case of unknowns. These are not fashion items, but necessary items that allow lymphedema patients some sort of normalcy in life. I only wear these garments because I have too. Lymphedema Garments - Night Time: While correct that there are various night time compression garments, they typically are similar to the Jovi Pak system which is a two component system. The first layer is a garment with chipped foam sewn into channels in the garment. The second layer is a compression layer, that only last six (6) months. The assumption that they last for one (1) year is does not take into account the elastic outer layer (second layer). The second layer which is elastic needs to be replaced more often and should be covered. I have a Jacket style garment that covers both arms, full back, chest and abdominal area. I need a new outer elastic jacket piece and the cost quoted this spring was $1,000. This needs to covered with a minimum of 2 replacements per year, one (1) every 6 months. Set up a separate code for a replacement outer elastic compression garment for these night time garments. The under garment can last one (1) year, but in that time frame I need two (2) outer elastic garments to provide the benefits of night time garments breaking up fibrotic tissue and keeping the volume of lymphatic fluid at a lower level than if I don't wear the night time garment. Lymphedema is a chronic condition, that can progress every year. The garments and lymphatic treatments allow me to continue working. Custom garment coverage is essential to keeping me working and having enough covered custom garments every six (6) months will help keep me working longer. Regarding proposed codes for lymphedema compression garments, please make sure you provide a code for patients like me that have bilateral lymphedema that is also in the chest, back and abdominal area. It's also important to figure out a payment amount so when items are ordered in early 2024, patients like me will have an idea how much the garments will cost us out of pocket.
CMS-2023-0113-0440	CMS-2023-0113	llq-133k-fu6c	2023-09-12T04:00Z	**Maggie**	**Bistline**					I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0086	CMS-2023-0113	ll5-nydc-xfoh	2023-08-22T04:00Z	**Judith**	**Blackburn**	NY		Health Care Industry - PI015		My main concern is that 6 months is too long before you are able to reorder stockings. 4 months is more reasonable.

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CMS-2023-0113-0026	CMS-2023-0113	lkk-649o-ty6h	2023-08-10T04:00Z	**Elizabeth**	**Blankenstein**	NH		Individual		I appreciate the opportunity to enter comment in support of CMS-1780-P, specifically to address the new rule to implement the new Part B for Lymphedema treatment items. I appreciate the challenges in rulemaking where a broad spectrum of compression garments and treatments for both daytime and nighttime administration exists for a complexity of lymphedema patient needs. I am a Stage 3 Lymphedema patient who has suffered with chronic lymphedema of my right arm and hand for over 12 years, as a result of cancer surgery and radiation. I have had extensive lymphedema drainage treatments through physical therapy and I have learned to compression wrap my effected limb nightly to control swelling. I also wear compression garments at 20-30 Hg in the form of a gauntlet, glove, and sleeve. These two processes are critical and the most effective means to control the swelling and avoid the possibility of infection of the affected limb. Every patient is unique, and I applaud the agency's decision to cover a broad spectrum of compression supplies. I agree with the proposed daytime compression garment frequency of replacement, permitting two garments per every six month period. Our daytime compression garments are rated most effective at providing adequate compression for six months and to permit two garments allows for daily laundering without an interruption in compression treatment and wear. For nighttime compression and bandage wrapping, I am concerned that these systems should also be covered for patients who need and rely upon them. I use compression wraps, also known as short stretch bandages, and these are critical for my nightime compression treatments. In addition, I am concerned that more should be done to assure that there is no interruption or delay in compression treatment should an immediate replacement be needed for a lost or ineffective garment or bandaging. Patient compliance is critical to ensure that lymphedema stays in check. The risk for infection cannot be underestimated if treatment compliance fails, as is the risk to the patient for painful swelling and irreversible lymphedema symptoms. Thank you.
CMS-2023-0113-0863	CMS-2023-0113	llw-weyp-h8dh	2023-09-14T04:00Z	**Alicia**	**Bowman**	WA		Home Health Facility - HPA25		Good Afternoon- I would like to comment on CMS's proposed rate reduction. This change does not take into consideration the high costs of inflation, staffing shortages, turnover, and labor stresses that we face in the home health setting. It is difficult to recruit, train and retain staff to care for our patients and growing home health need alone. With the proposal of significant reduction in reimbursement this challenge will be overwhelmingly devastating to our communities. The Proposed Rule ignores the ongoing Covid-19 pandemic and the significantly impacts home health care, including increased costs of infection control, labor, and medical supplies. The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year. Please take these comments into consideration.

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CMS-2023-0113-0574	CMS-2023-0113	llv-58ge-qrxb	2023-09-14T04:00Z	**Claudia**	**Boyle**	IL		Health Care Professional/Association - Other Technician		Thank you for the opportunity to provide input and express concerns. I know that many, if not all of us in the Med compression garment have serious concerns about how Medicare coding and pricing will affect this industry. The decisions made will have a major impact on reimbursements from private payors and almost certainly there will be unforeseen consequences as providers try to work with the new rules of the game. I have been involved in compression garment fittings for 40 years. During that time I have witnessed the difference a properly garment in a well selected material can make in patients health and quality of life. I have also seen the negative consequences of poorly fit or inappropriate garments. AND I have seen how even a beautifully fit garment can provide no medical benefit if the patient has not been trained to put it on and take it off. Fitting and educating takes time and money and a level of expertise. Measuring for a compression stocking is only the beginning of the process. Much more of our time is spent assessing the appropriate material and type of garment. Even more time is spent demonstrating/training in application and removal of these garments For many seniors this process can take an hour or more. Having to return and refit garments is a regular part of the trial and error process. This can take many weeks and several office visits- even for the most skilled fitters. We simply can't know what a patient can manage or how a garment will feel until we try it on. This process costs providers in labor, shipping and materials. Without allowing funding for this entire process providers will be unable to provide the level of service that assures that patients are actually getting the medical benefits of their garments. I ask you to please approach reimbursement for compression garments more like Orthotics & Prosthetics than DME. If treated as a commodity, like something you can purchase from Amazon- you will have succeeded helping the lymphedema community in name only. Providers will have to figure how to jettison service and customer care in exchange for volumes. There is no room for dedication to a good fit or comfort or education or assurance of ability to wear when high volumes are required to make the bottom line work out. It is our greatest hope that we will be able to continue to serve this community and provide our Medicare patients with the garments they need. We ask you to consider all of the costs involved in doing that, and the cost to both patients and out industry if you choose not to.
CMS-2023-0113-0687	CMS-2023-0113	llw-cmtq-yg5n	2023-09-14T04:00Z	**MELINDA**	**BRADEN**	TN		Health Care Industry - PI015		As a certified O&P fitter for 18 plus years I have measured and supplied both lower and upper compression garments successfully. I feel it is in the best interest of the beneficiaries to allow a Certified Fitter of Mastectomy to continue to measure and dispense the compression garments.
CMS-2023-0113-0860	CMS-2023-0113	llw-vcit-xah0	2023-09-14T04:00Z	**Sarah**	**Bramblette**	FL		Individual	https://downloads.regulations.gov/CMS-2023-0113-0860/attachment_1.pdf	As a Medicare beneficiary living with lymphedema, and caretaker for my mother until she passed away last October, I have comments regarding several sections of the Calendar Year 2024 Home Health Prospective Payment System Rate Update Proposed Rule. Please see the attached document. Thank you for your time and the opportunity to share my thoughts. Sarah M. Bramblette, MSHL
CMS-2023-0113-0788	CMS-2023-0113	llw-pne7-ey0o	2023-09-14T04:00Z	**Robert**	**Brandon**	NY			https://downloads.regulations.gov/CMS-2023-0113-0788/attachment_1.pdf	See attached file(s) - I would like to provide more feedback and reports in the future. Please keep me in mind when you wish for more feedback regarding all these issues and concerns. This attachment is brief feedback on my experience as a case manager helping the Aging Population navigate the health care system and I help people through the Medicaid process.

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CMS-2023-0113-0043	CMS-2023-0113	lkx-1mo7-x6qs	2023-08-10T04:00Z	**Christina**	**Brewer**	MD		Individual		I am commenting specifically on the new Medicare coverage of lymphedema garments specified in CMS–1780–P. I have had lymphedema for 20 years now. Using compression garments has keep my condition under control and, therefore, allowed me to continue a normal life. I am fortunate to be covered by both Medicare and a comprehensive secondary insurance which has covered the cost of these garments, one of them custom made every couple years. I support this change to Medicare rules allowing coverage of these garments as it will help those only covered by Medicare to purchase the needed support for their chronic lymphedema condition.
CMS-2023-0113-0740	CMS-2023-0113	llw-ktve-qfxp	2023-09-14T04:00Z	**Sue**	**Briggs**	VA		Home Health Facility - HPA25		Home Health remains the most cost effective setting to provide the needed care to our aging population. Every year home health is hit with reductions in reimbursement creating a burden on the agencies to be able to provide the quality of care that our patients deserve. If these reductions continue, there will not be agencies available to take care of your grandparents and parents or any other loved ones. The lack of care will lead to deterioration of quality of life, falls, social isolation and/or premature death. Please reconsider further reductions to home health reimbursement. Please think of your loved ones.
CMS-2023-0113-0351	CMS-2023-0113	llm-kiv9-melt	2023-09-11T04:00Z	**Kalina**	**Brinning**			Home Health Facility - HPA25		Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care, LLC. provides home health services in Iowa. Specifically, we serve the counties of Polk, Jasper, Dallas, Lee, Van Buren, Davis, Appanoose, Wayne, Lucas, Monroe, Wapello, Jefferson, Henry, Des Moines, Louisa, Washington, Keokuk, Mahaska, Marion, Warren, Madison, Greene, Boone, Story, Marshall, Tama, Hardin, Hamilton, Webster, Calhoun, Pocahontas, Humboldt, Wright, Hancock, Kossuth, and Palo Alto, and we are always looking to expand our service areas. We have been a Medicare participating home health agency since 2004 and currently have a patient census of 700-800. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare; therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state’s citizens. Sincerely, Kalina Brinning, RN, MSN Pediatric Program Manager Iowa Home Care Des Moines, Iowa

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CMS-2023-0113-0572	CMS-2023-0113	llv-4jmu-g3r4	2023-09-14T04:00Z	**Rachel**	**Brown**	NC			https://downloads.regulations.gov/CMS-2023-0113-0572/attachment_1.pdf	I am pleased to see that new codes will be created specifically for compression of non-limb areas of the body. Coverage for non-gradient compression of the torso, back and breast are however, greatly needed also. This is especially true for women who have had a breast cancer related surgery as they are at high risk for developing breast or torso lymphedema. Covered supplies should include standard fitted compression garments for the chest and back, such as compression bras which are able to hold a breast prosthesis/L8030, as these are deemed medically necessary by CMS. Both compression and breast prosthesis accommodation are often needed for patients who have had breast cancer surgery unilaterally or bilaterally. For surgical breast reconstruction, using tissue transfer, abdominal compression wraps with adjustable straps; compression bandaging systems; and other items should be covered. These are not able to be designed as gradient due to the many unique shapes of the female treast orso. The method proposed for calculating reimbursement rates will result in very low reimbursement rates. This means many vendors will not be willing to supply these products. Reimbursement rates should be based on retail prices of a variety of compression garments, including mastectomy, compression bras which currently can only be billed as L8000. The cost of a compression bra is higher than average, daily use mastectomy bras. The expense of these garments should not be the burden of a patient trying to treat or prevent lymphedema as she also battles cancer.
CMS-2023-0113-0479	CMS-2023-0113	llq-vwjn-acco	2023-09-12T04:00Z	**Bonni**	**Brown**	NY		Individual		I am commenting on Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I was diagnosed with Stage Two Lymphedema of my right arm In 2001, four years after treatment for aggressive breast cancer. Over the past 22 years I have purchased more than 90 compression sleeves. Because I was lucky that my lymphedema was identified and treated very early, my arm swelling has been limited and successfully controlled by the use of compression garments only. I was very surprised when I qualified for Medicare that fitted compression garments, which were part of my required medical treatment, weren't covered as Durable Medical Equipment (DRE). I'm happy that finally those of us with lymphedema will no longer be left out in the cold. I'm now 79, on a fixed income, and the cost for a standard fitted compression garment has doubled over the years. Under item 3. Current Issues: Scope of the Benefit for Lymphedema Compression Treatment Items, TABLE FF-A 2: EXAMPLE PAYMENT AMOUNTS FOR LYMPHEDEMA COMPRESSION TREATMENT ITEMS lists S8424 Gradient pressure aid (sleeve), ready made with the suggested reimbursement of $58.10 which is very outdated. The current cost for a standard fitted compression garment purchased online is now about $80. Since the swelling of my effected arm has remained stable I have been able to consistently purchase my standard compression garments, in the same size without need of a new fitting, via the internet. I'm confused as to whether the current proposal is to deduct a professional fitting fee from the reimbursement rate for the garment. If so, it will negatively effect those of us who are able to purchase compression garments online. I think the fee for fitting, if necessary, should be separate from the reimbursement cost per garment. Thank you for addressing the needs of those of us who have suffered silently with Lymphedema for many years.

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CMS-2023-0113-0378	CMS-2023-0113	lln-wg4b-0s5a	2023-09-11T04:00Z	**Amanda**	**Brylinski-Jackson**	NY		Health Care Provider/Association - Other		As a community social worker in Western New York working with older adults and caregivers, I have noticed an escalating need for home health care aid professionals. However, due to the declining number of home health aids, many older adults are left without the care they need in the home. Most people are aware of the home health care crisis, and might rely more heavily on informal caregivers including children, grandchildren, family members, and neighbors. These informal caregivers have the best intentions, but often are forced to choose between time caring for their loved one, their employment, their family/other responsibilities. We are seeing a significant increase in caregiver burnout, financial and health complications for the caregivers and clients we serve. People just simply cannot do it all, but are being asked to fill in the gap in services that cannot be provided by professional agencies. People who are adversely impacted by these factors are people who are living in poverty, speak a language other than English, living in a rural residence, and those who need a greater amount of care due to chronic health conditions. Home health care aids are not being compensated at a competitive rate to those working in long term care facilities, often not compensated for commute time (getting from one client to another) and not offered other benefits such as sick time/PTO, childcare. These and other reasons make recruiting and retaining home health aids a tall task. It would be in the best interest of home health care agencies and the clients looking for these services, to recruit home health aids that have a variety of life experiences and speak languages other than English (including ASL). To do this, they will need the infrastructure to provide support to these employees (alternative communication methods, variety of training times, etc). When considering people who are eligible for Medicare and Medicaid, and trying to access home health aids paid by Medicaid, New York Independent Assessments often create barriers to access to these services by only offering telemedicine visits for the assessment, and offering appointments that are over a month in the future. People who have trouble navigating technology, do not have access to a computer, have a hearing impairment, or speak another language, often have trouble accessing the necessary support they need to be connected to Managed Long Term Care. We are doing a disservice to older adults, family members, and home health care professionals, if we do not begin to address some of these important barriers. In fact, I would assume that we will continue to see a decrease in professionals drawn to this line of work, burn out in family members and informal caregivers, increased health decline in older adults who are unable to access services (increasing likelihood they will end up moving to a higher level of care facility), people leaving their career/employment to care for a family member, and greater depression among older adults. Most people want to live their lives in their home, not in a health care facility. Please let me know if I can provide any further information regarding these concerns.
CMS-2023-0113-0368	CMS-2023-0113	lln-3df7-5glq	2023-09-11T04:00Z	**Julia**	**Burdine**	VA				Medicaid coverage for Lymphedema treatment and supplies is absolutely essential. While I agree with previous commenters that coverage should be provided for more frequent MLD sessions and periodic home care check ins to help patients maintain their rigorous care schedules, providing coverage for diagnosis, CDT and custom compression is paramount. Early treatment is so crucial to reducing disease severity, and preventing complications, challenges, functional limitations in the patient population— and the high expenses to patients, healthcare institutions, and taxpayers that are all associated with them. I have had primary lymphedema of my left leg since I was 23 years old. It occurred out of the blue, with no family history or known cause. I was, and am, a healthy, active young woman, now 35 years old. I have always lived below the poverty line, with no family health insurance. At the time I lived in Georgia, a state where I was ineligible for Medicaid, despite my income level and great need for treatment. I have been hospitalized with sepsis from my Lymphedema at least 5 times. Social workers never suggested petitioning for Medicaid coverage, instead encouraging me to apply to a historically black college where I might receive scholarships as a white student. The absurdity of these experiences in healthcare is traumatic enough in its own right, let alone how dehumanizing it is to be denied medically necessary treatment to keep you from becoming physically disfigured, functionally impaired, and at risk for life threatening infection. The advancement of this disease, untreated for ten years, has become a struggle for me in so many ways that I can hardly fully describe here. It weighs heavily on me, physically, emotionally, psychologically. Since moving near family in Maryland, it astounds me that accessing Medicaid is an entirely different experience than in Georgia. Sadly, my disease advanced so far from being without treatment while living impoverished in Georgia for a decade. Now, even with my pump, 3 years of summers undergoing CDT, and garments, there is a plateau that my swelling does not reduce from. My entire left leg is affected. My active lifestyle and my ambitions are very difficult to integrate with the realities of my condition. It discourages me that there are others in this nation that are also having the prime of their life impeded by this disease and its financial burdens. At any age, Lymphedema patients deserve access to medically necessary care and assistance to help with the numerous issues they face with this lifelong diagnosis.

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CMS-2023-0113-0344	CMS-2023-0113	llm-j6u5-29b1	2023-09-11T04:00Z	**Sydney**	**Burgardt**	IA		Health Care Industry - PI015		To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in HHA, SN, RN, OT, PT, HMK. Specifically, we serve Greene, Boone, Stroy, Dallas, Polk, Jasper, Madison, Warren, Marion, Lucas, Wayne. We have been a Medicare participating home health agency since 2004 and currently have a patient census of 704. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state's citizens. Sincerely, Sydney Burgardt Client Care Coordinator Iowa Home Care West Des Moines, IA 50266
CMS-2023-0113-0105	CMS-2023-0113	ll8-14e4-laqb	2023-08-22T04:00Z	**Kimberly**	**Byle**	FL		Individual		Pertaining to the Lymphedema Treatment Act. My compression stockings cost around $275 each, and are necesary due to the size of my leg (from lymphnode dissection of the groin). The extensive swelling requires extreme compression, and the "OTC" stockings just don't work. They are only effective for 3-4 months, and my insurance pays nothing. However, if my lymphedema was the result of breast cancer, they would pay a portion of the costs under the Breast Cancer Act (or something similar). Why is lymphedema caused by the removal of lymphnodes due to breast cancer, different from lymphedema caused by lymphnode removal from other parts of the body, due to other types of cancer? I've been fighting with my insurance company for 3 decades and I just don't have the time or money (lawyer) to fight. Which is just what they hope will happen! And due to the burdon of paying for the stockings, I try and stretch their use way past their usable limit, thus negating the exact reason why I wear the stocking in the first place! Compression!!! My insurance company is more than willing to pay for the in-hospital treatment of cellulitis and other serious maladies that can affect lymphedema patients, but refuses to pay for inexpensive and proven treatment methods! It's time the medical community treats lymphedema as the serious illness/disability that it is and compression therapy becomes an insurance-covered medical expense.
CMS-2023-0113-0544	CMS-2023-0113	llu-wfvw-1x7c	2023-09-14T04:00Z	**Brice Brian**	**Cacayan**	ID		Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0544/attachment_1.png . https://downloads.regulations.gov/CMS-2023-0113-0544/attachment_2.png	See attached file(s)

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CMS-2023-0113-0613	CMS-2023-0113	llv-die6-im7k	2023-09-14T04:00Z	**Mary**	**Calys**			Physical Therapist - HC045		As a physical therapist and certified lymphedema therapist, specializing cancer survivorship, I see and treat patients suffering from lymphatic disease on a regular basis. I have been a practicing clinician in oncology rehabilitation and lymphedema for over 22 years. I am offering my expertise in the public comment for “Section VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” in the 2024 Medicare Home Health Prospective Payment System Proposed Rule. I want to ensure my patients have access to the various lymphedema treatment compression items needed for long-term successful management of their disease. Treating patients with lymphatic disease is complex. Their plan of care often includes multiple treatment modalities to help mitigate their symptoms. This may include a prescription for both static compression and pneumatic compression, as well as a referral to rehabilitation services for wound care, physical or occupational therapy or lymphedema therapy. This all requires a coordinated effort by multiple disciplines and commitment to provide optimal treatment to the patient. I am happy to see both Congress and Medicare recognizing the gaps in reimbursement of treatment modalities for lymphatic disease; I am supportive of coverage and reimbursement. Compression levels Attaining unique codes for compression levels may ensure reimbursement for garment manufacturers. However, this should not be considered a staged treatment approach in coverage policies with patient's required to start with lower compression progressing to higher levels before obtaining the appropriate compression needed for successful management of their disease. I will prescribe the appropriate mmHg level of compression for my patients based on the stage and severity of their condition as well as other comorbidities impacted by compression. For instance, if 20-30mmHG does not prove to be efficacious, a higher pressure, such as 30-40mmHG, is not an automatic next step in standard of care. The mmHg pressure I will prescribe will be based on the stage 0-3, symptoms, patient tolerance, and other factors dependent on the patient. CMS should not interpret or assume that lower pressure garments are a starting point for treatment and higher-pressure garments are an end point or that a patient should utilize all pressure ranges, at some point, in their treatment plan. New HCPCS codes are unnecessary for compression stockings used as surgical dressing in treatment of open venous stasis ulcer because multilayer adjustable wraps or bandages are used instead. Phlebolymphedema is lymphedema secondary to chronic venous insufficiency. All patients with CVI (CEAP scores C3-C6) should be considered lymphedema patients. When treating ulcers, stockings are not typically worn, rather multilayer bandages (or adjustable wraps with Velcro) are used as patients usually are not able to don stockings over open ulcers. In addition, if a patient has a diagnosis for CVI with ulcers and a diagnosis for lymphedema, this separation of wraps and bandages in the HCPCS descriptor may lead to unanticipated denials when comorbidities are documented in the medical record. Similar documentation complexities already exist when prescribing pneumatic compression devices for these patients. My staff and I spend a lot of time complying with these requirements to support our patients, without reimbursement. It would be unfortunate to see unnecessary administrative burdens carry over into this new benefit category. Mary Calys, DPT, CLT, CES, FDNS, TPS Sr. Clinical Specialist Tactile Medical Member, American Physical Therapy Association Member, American Vein and Lymphatic Society
CMS-2023-0113-0791	CMS-2023-0113	llw-q68j-k7ta	2023-09-14T04:00Z	**Phyllis**	**Cammack**	TX				The number one issue that I hear daily from my customers is they can't don and doff their compression garments. It can be difficult to don and doff compression socks, especially over the heel and ankle. Unfortunately, when people struggle to don and doff they become discouraged, and they don’t wear them consistently or don’t wear them at all and the swelling in their lower legs and ankles tends to get worse rather than better. I spend time showing them all of the tricks to put them on, but they still need donning and doffing devises, and they should be considered medically necessary.

LTA Proposed Rule Public Comments

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CMS-2023-0113-0777	CMS-2023-0113	llw-p8st-bzxy	2023-09-14T04:00Z	**Michael**	**Cannon**	NC		Individual		My name is Michael Cannon and I have been involved in the compression & lymphedema industry for over 23 years. I first called on CMS to provide coverage back in 2009 & 2010. I was told that CMS could not help me that an act of congress would be necessary. That's when I met Heather Ferguson. Here are my thoughts: Custom garments – I can tell you as someone who represents a manufacturer and has been in hundreds of therapy clinics and worked with hundreds of compression garment fitters that not all custom-made compression garments are the same. It is imperative that when it comes to elastic custom-made garments that the material be a flat knit product and not a circular-knit compression garment. Flat knit is specifically woven for maximum containment, which is essential for proper containment of an edematous limb. A circular knit custom-made garment will not offer the proper knit structure to contain lymphedema and therefore will prove ineffective. I also believe the need for custom-made garments is needed to come from a doctor or therapist after examining and treating that individual. Most lymphedema patients will require custom-made garments as the edema puts them outside the window of ready-made / tradition size and shape patients. Nighttime compression – I believe a patient will be better able to properly launder a set of nighttime garments if given 2 sets per year. This would mean that the patient can receive one every 6 months or two per year. These garments are thicker than daytime garments and will certainly need 24 hours (or more) to completely dry. Other body part garments –We also need to include garments for the head, neck, chest, torso and genital areas. These are difficult areas to treat, and lymphedema exists here. Toe cap – A toe cap is necessary for patients with edema in their foot or foot and toes. It is no different than a glove which is needed for edema in the hand or hand and fingers. Please include this item and create a HCPCS code for it. Efficacy Tools / Accessories – Coverage is needed for tools to help with application, removal, and more. These items include but are not limited to butlers, butler off, 2N1, zippers, hook & loop (Velcro), handles, liners, relief areas, non-skid segments, lymphpads, digital spacers, support straps, nighttime compressive covers, etc. Qualifications for Measuring and Fitting – I firmly believe that all fitters for compression garments reimbursed by Medicare should be certified by a manufacturer that will provide these products or an independent organization that is approved by the manufacturers. This is the only way to ensure that their products fit properly and meet the warranty requirements for life expectancy and replacement requests. All of this is covered in a certification course. We also need to have many options for getting measured and fitted as people turn over and move on. It is very important that we not limit the number of dealers or therapists that can provide this service. Reimbursement / Payments for Fittings - I believe it would make sense to have one fee for the product to include the measuring and fitting. If a therapist will measure for a DME provider, then the DME can pay the therapist for that service. It is important to consider the fact that some custom-made compression garments need to be remade and that will be best served if it goes through the DME provider. A therapist will not want to handle the remake of a garment and a DME provider will not want to if the measurements come from someone else. HCPCS Codes – It is very important to expand & update the codes for each type of material (circular knit, flat knit, inelastic wraps) and whether it is ready made or custom made. I agree with the plan to change the current codes for garments covered by Medicare for surgical dressings for the treatment of open venous stasis ulcer (A6531, A6532 & A6545). Reimbursement rates for Garments – The formula for determining reimbursement rates for garments does not take into consideration several factors. Using Medicaid plus 20% or Tricare / Retail Internet pricing average does not consider that much of those prices are based on ready to wear compression garments which are much simpler to fit and also mass produced at a much lower cost. Medicaid does not cover the cost of flat knit and that pricing, and those patients never see flat knit products. People lose money on providing those garments for those reimbursement rates. A more appropriate reimbursement structure should be used to match the type of material and whether it is ready-made or custommade. Competitive Bidding – I am opposed to this as it will certainly limit access to qualified fitters and suppliers for patients. Keeping a broad group of certified fitters should provide the best possible care for patients. Limiting the number of locations and suppliers will prevent many patients access to necessary professional care.

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CMS-2023-0113-0885	CMS-2023-0113	llx-2utw-1sh1	2023-09-14T04:00Z	**Christine**	**Capehart**	OK		Occupational Therapist - HC050		As a Certified Lymphedema Therapist and Occupational Therapist I often measure and fit patients with off the shelf and/or custom garments. Many factors play into this decision including but not limited to availability of help, range of motion, strength,coordination, pain levels, continence, ability to use assistive donning/doffing devices, compliance with overall care, cognition, etc. Patients in my area have limited access to qualified DME providers and physicians who understand the need for reduction of limbs prior to garments being recommended. We often rely on National DME provider who do not have fitters that are accessible in our area. It would be better to have the fitting fees separated from the garment fees so that the therapist who knows/understands the patients the best can check fit of garments recommended and make the most appropriate recommendations for changes.
CMS-2023-0113-0886	CMS-2023-0113	llx-2uty-wipl	2023-09-14T04:00Z	**Christine**	**Capehart**	OK		Occupational Therapist - HC050		As a Certified Lymphedema Therapist and Occupational Therapist I often measure and fit patients with off the shelf and/or custom garments. Many factors play into this decision including but not limited to availability of help, range of motion, strength,coordination, pain levels, continence, ability to use assistive donning/doffing devices, compliance with overall care, cognition, etc. Patients in my area have limited access to qualified DME providers and physicians who understand the need for reduction of limbs prior to garments being recommended. We often rely on National DME provider who do not have fitters that are accessible in our area. It would be better to have the fitting fees separated from the garment fees so that the therapist who knows/understands the patients the best can check fit of garments recommended and make the most appropriate recommendations for changes.
CMS-2023-0113-0509	CMS-2023-0113	lls-89tq-jhvh	2023-09-12T04:00Z	**RoseMarie**	**Carey**	NY		Individual		I had a mastectomy and I have had lymphedema for 2 years. I wear compression garments all the time and have purchased two out of pocket including swell pads. The pads are more expensive than the shirts. I think I need at least three shirts and pads during the week because they need to be laundered and I don't think hand washing is that effective. In the summer I sweat profusely wearing these garments and could easily wear two a day, I have had to purchase them out of pocket and one set costs $250. I would benefit from nighttime garments especially. Right now I wear my daytime garments at night because I need constant compression. I have not purchased nightime garments due to cost. Help from Medicare is critical to prevent my lymphedema from getting worse.
CMS-2023-0113-0490	CMS-2023-0113	llr-3ez5-n4cy	2023-09-12T04:00Z	**Joseph**	**Carlock**	TX		Health Care Industry - PI015	https://downloads.regulations.gov/CMS-2023-0113-0490/attachment_1.pdf	Board-Certified Spinal Cord Injury physician here with letter wholeheartedly supporting this rule change to allow funding for powered braces.
CMS-2023-0113-0148	CMS-2023-0113	llc-u42w-pc5p	2023-08-22T04:00Z	**Jennie**	**Carpenter**	CA				As a lymphedema patient and Medicare beneficiary, I am very appreciative of the work CMS has done to move the Lymphedema Treatment Act towards full implementation. However, I'm concerned that potentially inadequate reimbursement rates for vendors, may result in too few entities willing to supply garments to patients. These concerns are prompted by my experience with a California insurer that repeatedly denied coverage of my compression garments when I had employer-provided health insurance. Compression garments/supplies, etc. for the treatment of lymphedema were included in California's implementation of the Affordable Care Act, and items were fully covered under prosthetics and orthotics, rather than DME, which would have required a 50% co-pay. The historical parallel to this experience, and my concern about CMS' proposed rules, is that my former health plan's network of authorized therapists to fit patients for garments, and then order them was nearly nonexistent. Because I had a PPO plan, I was required to use vendors authorized within the insurer's network. I was provided with a list of 20 in-network providers in the greater Bay Area. However, none of the providers were contracted with the health plan. The common response when I contacted each of the vendors, was that they didn't provide this service because of insurers' low reimbursement rates. In addition to failing to ensure an inadequate supply of its in-network vendors, the insurer did not understand the coverage process, know the applicable billing and treatment codes, and was unaware of California's inclusion of compression garments under the ACA. I had to file multiple complaints against the insurer with the California Department of Managed Health Care to resolve the matter. After a 2-year battle, the insurer finally agreed that I had been denied coverage for which I was eligible, reimbursed me for my out-of-pocket costs, and subsequently covered additional necessary items. It also had to arrange an agreement with an out-of-network provider in another city to fit and order the custom and off the shelf items I needed. With respect, I ask that CMS carefully re-evaluate its proposed method for calculating reimbursement rates to ensure there won't be price discrepancies and/or low reimbursement rates that risk having too few vendors willing to supply patients with the products they need to optimally manage this condition.

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CMS-2023-0113-0634	CMS-2023-0113	llv-ha9c-160j	2023-09-14T04:00Z	**Sharon**	**Carroll**	ID		Health Care Professional/Association - Nurse		Dear CMS, I am writing today as an nurse for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A5% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Sharon Carroll Home Health Clinician
CMS-2023-0113-0702	CMS-2023-0113	llw-g4lr-15fp	2023-09-14T04:00Z	**shelley**	**Cassel**	IL		Nurse - HC065		I HAVE BEEN A HOME HEALTH NURSE FOR 29 YEARS AND HAVE SEEN MANY CHANGES. I AM MORE CONCERNED ABOUT THESE CHANGES THAN ANY IN THE PAST. WHILE I THINK THAT ACCOUNTABILITY FOR BEST CARE AND WISE USE OF RESOURCES IS GOOD, I AM WORRIED THAT THESE CUTS IN PAYMENT AND OTHER RESTRICTIONS WILL ONLY HURT PATIENTS. IF HOME CARE AGENCIES ARE RECEIVING MORE ACUTELY ILL PATIENTS FROM HOSPITALS, WHICH WE ARE ALL THE TIME, AND BEING FORCED TO LIMIT RESOURCES FOR CARE, WHILE IN THE MIDST OF A STAFFING CRISIS, THE ONLY OUTCOME I SEE IS LESS AVAILABLE CARE FOR SICK PATIENTS, POORER OUTCOMES BASED ON SAME, MORE RECURRENT HOSPITALIZATIONS AND MORE EXPENSE FOR THE MEDICARE/MEDICAID SYSTEM. I ALSO WORRY ABOUT FAILURE OF AGENCIES DUE TO FINANCIAL CONSTRAINTS, FURTHER EXACERBATING THIS ISSUE. LOOK AT THESE CUTS AND OTHER CHANGES AS IF YOU OR YOUR LOVED ONE WERE THE RECIPIENTS OF THE CARE YOU ARE AFFECTING. THANK YOU, SHELLEY CASSEL RN

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CMS-2023-0113-0890	CMS-2023-0113	llx-3wua-0dvm	2023-09-14T04:00Z	**Pamela**	**Cassidy**	MD		Individual		Hello, I developed lymphedema 16 years ago, after surgery for breast cancer. My sentinel node was cancerous and so my breast surgeon had to remove all the lymph nodes to try and insure my cancer wouldn't come back. The diagnosis of lymphedema was a crippling experience for me. And it continues to be that on a daily basis. I have suffered a serious infection, cellulitis 3 times, requiring hospitalizations and aggressive medications to kill the infection. No one understands the lifelong impact lymphedema has on a breast cancer survivor. After treatment for breast cancer everyone is happy for you, you've survived surgery, chemo and radiation (at least that's what I went thru). But lymphedema is with me EVERY day. I have to see a physical therapist for manual lymph drainage. I am extremely lucky that I have had the best therapist for the past 15 years. She is become a 'member of my family' and has helped me survive this awful condition. But this treatment is only partially covered by insurance so the amount not covered is an expense I must pay. Once your lymphedema is diagnosed, you have to wrap your fingers and arm, first with a layer of gauze, then layers of artiflex, sometimes a layer of foam and finally short stretch bandages (anywhere from 3 or 4 layers in my case). This has to be done EVERY night! Bandaging supplies are not covered by insurance and bandages must be replaced every 3 months. My arm swells more in the summer due to heat and humidity so I can't go to the beach anymore. Bug bites can trigger an infection. It's a constant problem! Other things that people don't know is how frustrating it is to try and find coats, sweaters or long sleeved tops to fit your arm. There are no clothes designed for women (and men) with lymphedema. While I'm very grateful to have survived breast cancer, living with lymphedema has been and continues to be an extremely frustrating condition to live with. Please help and get reimbursement for bandages. Thank you. Pam Cassidy
CMS-2023-0113-0087	CMS-2023-0113	ll5-sw3r-u9o8	2023-08-22T04:00Z	**Sarah**	**Chase, LCPO**	WA		Health Care Professional/Association - Other Health Care Professional		I am a Orthotist that has fit custom and off the shelf compression garments for the last 20 years. This proposal does not even include Orthotics in the mix. The fitting fee vs measurement fee is unusual- and clunky at best. Perhaps involving Orthotists in the discussion would be beneficial.
CMS-2023-0113-0838	CMS-2023-0113	llw-schm-mht5	2023-09-14T04:00Z	**Carolyn**	**Chastain**	CA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0838/attachment_1.pdf	As a 24 year gynecologic cancer survivor, who developed bilateral lower extremity lymphedema immediately after surgery, I greatly appreciate the new compression garment and bandage benefits under Medicare included in the proposed rule. My recommendations are outlined in the attached document.
CMS-2023-0113-0432	CMS-2023-0113	llp-s91l-ls9u	2023-09-11T04:00Z	**Quinn**	**Christensen**	UT		Individual		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0416	CMS-2023-0113	llp-ab85-z5f2	2023-09-11T04:00Z	**Venus**	**Chupuico**	MO		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0416/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0149	CMS-2023-0113	lld-wfoh-mxhw	2023-08-22T04:00Z	**Melissa**	**Clark**	NY				“Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” As a therapist who works with people with lymphedema, I have found that many of my patients cannot afford bandaging or compression garments. This severely hinders their ability to treat and manage their lymphedema- which is a chronic and progressive condition. By not having insurance coverage for compression garments, this is the number one barrier for my patients being able to manage their lymphedema effectively and independently. Having the proposed coverage for off the shelf and custom garments, along with bandaging supplies will be very advantageous for therapy and improve people's quality of life
CMS-2023-0113-0855	CMS-2023-0113	llw-usjo-du0c	2023-09-14T04:00Z	**Marilyn**	**Clarke**	NY		Individual		My comment is in reference to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items: I have had SeconaryLymphedema of the left arm since 1997, in 2018, I developed Lymphedema of my left hand, and in 2023, I developed Lymphedema of the right breast and trunk area. I need to buy multiple compression sleeves, gloves and bras, as well as bandages, gauze, foam, padding and tape because I bandage my left hand and left arm every single night. I wear a compression bra 24/7. These treatment items must be replaced at least every 6 months. This adds up to a lot of money! As a retired kindergarten teacher on a fixed income, this places a burden on my retirement and small savings. I ask that Lymphedema treatment items be included in coverage.
CMS-2023-0113-0816	CMS-2023-0113	llw-rfji-qbjz	2023-09-14T04:00Z	**Sandra**	**Clayton**	ID		Home Health Facility - HPA25		Dear CMS, I am writing today as a registered nurse for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A -4.08% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS’s stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Sandy Clayton Home Health Clinician

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CMS-2023-0113-0551	CMS-2023-0113	llu-zwpq-j1bz	2023-09-14T04:00Z	**Martha**	**Cloninger**	TN				I have lymphedema after two bouts of cancer and lymph node removal. I have paid out of pocket for wrappings and garments over the past 12 years which is very expensive. I feel these garments should be covered by Medicare as they are so necessary to protect and control the swelling of lymph fluid retention. This topic has been submitted so many years to be covered and yet nothing has been done. Lymphedema is very painful and puts so much strain on your body and heart. I am among thousands that have this problem and I hope after this vote, we can be treated and not worry how much money we have to pay out of pocket. . . Thank you for your time and hopefully your vote. Martha J. Cloninger Mcloni@aol.com 423-367-1699 4117 Winfield Dr. Kingsport, Tn 37663
CMS-2023-0113-0139	CMS-2023-0113	llc-hoc0-8rnr	2023-08-22T04:00Z	**Carter**	**Colby**	WI				Hi, First I would like to give thanks to Heather Fergusen and all the people who have work years to bring LTA to life. I also must thank all the physical therapist that work with us to keep our body's functioning. I have had Lymphedema for 60 years. It started in my left leg and thigh and has progressed to my left arm and chest. The diagnosis cost my parents over $13,000 back in 1965. Over the years I have spent 10's of thousands on garments. All of these were out of pocket. I am sure the LTA is not perfect at this point, but it is a beginning for all of us.... give it time. Thank all of you again. Carter J.
CMS-2023-0113-0623	CMS-2023-0113	llv-eahq-9yev	2023-09-14T04:00Z	**Millard**	**Collins**	TN		Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0623/attachment_1.pdf	I believe in assurance of high-quality service in the field of medicine. I have reviewed the SFP initiative and feel that there some concerns with its heavy-weighted consideration of the CAHPs, which has an unfavorable propensity when assessing underserved and underprivileged populations. I am submitting this letter for your consideration.
CMS-2023-0113-0518	CMS-2023-0113	llt-seu8-9q9e	2023-09-12T04:00Z	**Frances Coty**	**Colquitt**	SC		Individual		In reference to Secion VII.B.- Scope of benefit and payment for lymphatic compression treatment items and accessories, I suggest the coverage for assisting pads, sheets, donning gloves and sleeves that are used with compression garments. These items and accessories assist the patient to use their garments effectively without the assistance of a physical therapist or physician. If these are not covered, a patient cannot address areas of their lymphedema that may change and need car. For example, if a knee area changes and retains lymphatic fluid, the patient can place a pad in that area under their compression garment and maintain self care; if they don't place a pad under their knee (in this example), that area continues to accumulate fluid and can be at risk for infection or further compromising surrounding areas.
CMS-2023-0113-0184	CMS-2023-0113	llf-kyub-0bl1	2023-08-29T04:00Z	**Lisa**	**Cooley**	CA		Home Health Facility - HPA25		Make it easier for states to meet home health care payment requirements.

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CMS-2023-0113-0663	CMS-2023-0113	llv-ul1g-6nvq	2023-09-14T04:00Z	**Clare**	**Copenhaver**	PA		Health Care Professional/Association - Physical Therapist		My comments are in reference to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I am a nationally certified lymphedema therapist and regularly treat patients who are dealing with lymphedema. These proposed changes are going to greatly help these people in obtaining the products that they need to reduce their edema and to help them with long term management of this disease. I work in outpatient therapy in a specialty that covers treatment of lymphedema, and the professional services that I provide such as applying bandages, providing manual lymph drainage, and measuring for garments is covered under physical therapy services. However, as a certified lymphedema therapist, I have had to undergo additional training to be able to provide these services. If a separate billing code is available for the specific treatment of lymphedema to reflect our more specific and extensive training and ongoing education, it would more accurately reflect our more specific physical therapy treatment. In addition, the fitting services that we provide in order to provide proper garments for our patients, both custom and standard-fit, is also a reflection of our extensive training and education, so a more specific code to convey this would be beneficial. The proposed rule that the suppliers receiving payment for a garment would have to be responsible for paying the therapist for the fitting component would be challenging. Since we are not DME providers, we have to use multiple garment providers for our patients depending on preference and location, and to arrange for a separate payment for fitting from those providers would be demanding and time consuming. With regards to the proposed rule for coverage of supplies for treatment of lymphedema, I agree with the need to cover a broad spectrum of compression supplies and accessories to ensure that the individual need of each patient is met. I agree that specific base sizes should be added to the code for items used in a compression bandaging system. I agree that there should not be a specific limit to what is necessary as each patient is different in their needs. A person with Stage 2 Lymphedema would require fewer short stretch compression bandages and related padding, etc when compared to a person with Stage 3 Lymphedema with more pronounced lobules and skin folds and increased girth size. Daily care which includes laundering of supplies helps to lengthen the life of these products but knowing that additional supplies can be ordered as needed due to wear or damage will be a big sigh of relief for these people. I urge CMS to ensure that compression bandaging systems are also covered during the maintenance phase of treatment, as many patients use these items instead of or in addition to day and/or night time garments, not only during the intensive/reduction phase of treatment. I am satisfied with the proposed rule covering two daytime garments every 6 months, and one nighttime garment each year per affected body part, and that both day and nighttime garments can be replaced sooner due to damage or if they are lost or stolen, or if their needs change due to medical or physical condition. I am very pleased to see that new or additional codes will be created specifically for non-limb areas of the body. This will ensure that supplies needed to treat these areas of the body are included in coverage. I am a bit concerned that your proposed method for calculating reimbursement rates could result in price discrepancies and/or very low reimbursement rates. This could possibly result in an inadequate number of vendors that are willing to supply these products. As a treating therapist, I am pleased overall that coverage for the supplies needed during the intensive treatment time and the compression garments needed for the long- term management of lymphedema is being addressed. I thank you for the opportunity to make my comments.
CMS-2023-0113-0437	CMS-2023-0113	llp-xu38-3a8m	2023-09-11T04:00Z	**Camree**	**Cox**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. If you could see how much people appreciate in home health assistance you would see the value in it. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. If we are to prevent patient's from more expensive hospital care, then we need to be funded enough to care for patients. Thank you for your time and consideration.

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CMS-2023-0113-0208	CMS-2023-0113	llj-wtq1-xbaa	2023-08-29T04:00Z	**Deb**	**Cozzone**	GA			https://downloads.regulations.gov/CMS-2023-0113-0208/attachment_1.pdf	I have attached my comments in a PDF document.
CMS-2023-0113-0893	CMS-2023-0113	llx-4ezg-52fs	2023-09-14T04:00Z	**Myra**	**Craig**	IN		Individual - I0001		Pertaining to the Lymphedema Treatment Act, it is important for a member of my family that costs of compression garments and any related professional services be covered. This should include all kinds of compression garments including custom garments, day and nighttime garments and accessories such as liners for as often as necessary to control the lymphedema condition and maintain our patient's health. The expense of these garments is too much for my family to afford otherwise. Garments that wear out or are lost should be replaceable at no cost. The continued use of these garments has been and will continue to be essential in preventing more serious medical complications that require expensive treatment or hospitalization.
CMS-2023-0113-0114	CMS-2023-0113	ll9-ducw-33yy	2023-08-22T04:00Z	**Walter**	**Cranston**	NJ		Individual		I have primary severe lymphedema. I'm a very large person, 6 foot 3 inches tall and size 17 shoe, therefore, I need to wear custom-made compression garments. I am now retired and on Medicare but for decades when I was working, my commercial insurance covered my compression garments as a benefit exception. The quantity of two garments per body part every six months isn't insufficient. I wear a pair of custom thigh high leg garments daily. With my commercial insurance benefit exception, my allotment was five pair every six months. Even with five pairs of garments, the ability for these garments to properly compress would fail before the end of the six month period. My recommendation, from years of personal experience, is six garments per body part every six months.
CMS-2023-0113-0204	CMS-2023-0113	llj-nfqz-45px	2023-08-29T04:00Z	**Walter**	**Cranston**	NJ		Other - OT001		I have primary severe lymphedema. I'm a very large person, 6 foot 3 inches tall and size 17 shoe, therefore, I need to wear custom-made compression garments. I am now retired and on Medicare but for decades when I was working, my commercial insurance covered my compression garments as a benefit exception. The quantity of two garments per body part every six months is insufficient. I wear a pair of custom thigh high leg garments daily. With my commercial insurance benefit exception, my allotment was five pair every six months. Even with five pairs of garments, the ability for these garments to properly compress would fail before the end of the six month period. My recommendation, from years of personal experience, is six garments per body part every six months.

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CMS-2023-0113-0031	CMS-2023-0113	lko-cltu-9mpy	2023-08-10T04:00Z	**Kim**	**Craven**	CT				VII. Proposed Changes Regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items "We are proposing to add § 414.1680 and the following frequency limitations for lymphedema compression treatment items established in accordance with section 1834(z)(2) of the Act under new subpart Q: • Two daytime garments or wraps with adjustable straps for each affected limb or area of the body, replaced every 6 months. • One nighttime garment for each affected limb or area of the body, replaced once a year." The implementation of the Lymphedema Treatment Act will bring great peace of mind for me, as I have had Lymphedema in my upper right quadrant for 17 years (caused by surgery and radiation for early-stage breast cancer), and I worry about managing the ongoing expense caused by this disease. I'd like to give feedback on the coverage for garments and bandages: Daytime garments: I would recommend that the quantity be increased from two sets every six months to four or five sets every six months because if one exercises and/or gets sweaty they have to change into a clean set of garments. In the summer, I can go through two-three sets of garments a day. Two sets every six months puts a burden and stress on those of us who are dealing with this high-maintenance lifelong illness and also risks burdening the health service systems. We know that exercise is especially good for people with lymphedema to help keep the disease from progressing to advanced stages, and to minimize the risk of life-threatening cellulitis infections (which we are more prone to because we have lymphedema) when we are sedentary because of lack of activity causes lymph fluid to stagnate in the compromised areas. If we want people to exercise to maintain (or improve) their health we need to give them the garments to do so. By covering the cost of more garments, we give people the necessary tools to take better care of themselves and minimize the risk of cellulitis, which also reduces the financial load and strain on the hospital and emergency care systems. It is less expensive to give patients an adequate quantity of garments to maintain their lymphedema health than to cover emergency and hospital care required by cellulitis when IV antibiotics are needed to prevent the body from going septic. Nightime garments: Two per year is great. Bandages: I use a set of three bandages over my night garment every night for added compression. It would seem equitable to cover the costs of bandages because it is something every patient needs initially and forever after. I'd also like to comment on my experience in the fitting of custom garments: I highly recommend compensating therapists for garment fitting. In my 17 years with lymphedema, I have had fittings done by multiple therapists and DME fitters. By far, the therapists have been more accurate in providing me with properly fitting wearable garments, which promotes patient compliance, minimizes waste of a new garment that does not fit properly and is discarded by the manufacturer, and the back and forth with the garment manufacturer to get a wearable garment. If a garment is ill-fitting, it can cause chaffing leading to an open wound making one susceptible to infection, or pooling of lymph fluid in an area which can cause discomfort and over time can cause the area to become fibrotic and more prone to infection.

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CMS-2023-0113-0899	CMS-2023-0113	llx-7g3z-9xai	2023-09-14T04:00Z	**Amber**	**Crist**	ID		Health Care Professional/Association - Nurse		Dear CMS, I am writing today as an RN Case Manger for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A -4.69% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Amber Crist, RN-BSN Home Health Clinician
CMS-2023-0113-0093	CMS-2023-0113	ll7-350e-clad	2023-08-22T04:00Z	**Pat**	**Critchfield**	CO		Individual		My comment is in reference to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I am very grateful that garments will now be covered under Medicare. I have been using custom garments for lymphedema of my left arm and hand for several years as a result of breast cancer. I need to replace the garments every 5 months as they stretch out and get very worn as I am religious about using during waking hours every day. I understand the proposal is for replacement every 6 months and I hope the process for exceptions is not overly burdensome. When my garments do not fit properly, my lymphedema worsens and increases my risk of complications. The custom garments are expensive running $248 for the custom sleeve and $460 for the glove. I hope the reimbursement rates will be adequate so that competent providers will continue to order them for us who need them.

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CMS-2023-0113-0218	CMS-2023-0113	lll-m5ak-l7su	2023-08-29T04:00Z	**Cindy**	**Cronick**	WI		Individual	https://downloads.regulations.gov/CMS-2023-0113-0218/attachment_1.pdf	My comments are in reference to Section VII.B.-Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I am 57 years old, a 16 year survivor of breast cancer, and have been a lymphedema patient for the past 11 years. I am a board member of the Lymphedema Advocacy Group and am very grateful for passage of the Lymphedema Treatment Act. Thank you for allowing me to comment on the proposed rules. I am pleased that the proposed rules allow for custom garments to be covered. I started with standard fit garments, which did not allow me to manage my lymphedema, and led to progression of my lymphedema in my arm that also progressed into my hand. I then was prescribed weeks of complete decongestive therapy, followed by a prescription for custom fit garments and have managed my lymphedema much more successfully with their use. I do want to stress how important it is to have a streamlined process for acquiring additional garments beyond a set of two every six months if they are required for your condition and prescribed by your medical provider. This is the case for my compression garments which do not last for 6 months. I have previously worn two types of gloves, before finding a glove that would fit my hand properly and contain my lymphedema swelling. Even these gloves, as they stretch out, slide down my fingers and bunch up between my fingers and cause an abrasion that is not only painful, but dangerous, since a break in the skin can be a source of infection and can cause a serious cellulitis infection. This was the case in 2013 when my private insurance company limited the number of garments that I could receive under my plan, and I had to wear worn out garments that needed replacement sooner than what they allowed. They refused to authorize the additional garments that my physician prescribed, and during the time that it took to appeal their decision, I had to return to physical therapy to try to manage the additional swelling in my hand. After several levels of appeal which took several months, I won my appeal and received the additional garments that my physician had prescribed, but the delay caused my condition to become worse. I've attached the letters written by my physician explaining the need for additional garments that I used in my appeal. Since this appeal, I have had access to the quantity of garments that I need to properly manage my lymphedema and have not had to return to physical therapy. There can be various reasons why a patient would need additional garments. In my case, I am a pharmacist who works with my hands all day long and even with meticulous care of my garments, which includes gently washing the garments and then air drying them, the fingers of the gloves still stretch out before the 6 month mark. Due to the high amount of movement of my fingers, there is more demand on a glove than garments worn on other areas of the body. Please consider the consequences to a patient's health, if there is a cumbersome and slow system for receiving additional garments that are medically necessary and doctor prescribed. We need to have a simple and quick process for covering additional garments. I appreciate your consideration of my comments. Thank you,
CMS-2023-0113-0408	CMS-2023-0113	llo-lkdp-3air	2023-09-11T04:00Z	**John**	**Crosby**			Physician - HC005	https://downloads.regulations.gov/CMS-2023-0113-0408/attachment_1.pdf	See Attached File

Document ID	Docket ID	Tracking Number	Posted Date	First Name	Last Name	State	Organization Name	Category	Attachment Files	Comment
CMS-2023-0113-0749	CMS-2023-0113	llw-lva4-2cgj	2023-09-14T04:00Z	**Deborah**	**Crow-Petree**	OK		Health Care Provider/Association - Ambulatory Surgical Center		Subject: (1) Coding and (2) Toe Caps R/T Scope of the Benefit and Payment for Lymphedema Compression and Treatment Items Sixty-five years ago, I was born puffy-footed, with "piggy toes" and upsloping toenails, a consequence of primary lymphedema that had already begun to show itself while I was in my mother's womb. Physicians told my parents there wasn't much to be done for me and to "get on with life." Following their advice, I pursued my best life, marriage and motherhood, a long nursing and nursing education career, and, eventually, a doctorate in educational psychology. I hiked in the American wilderness, traipsed through nine European countries with my veteran spouse, grew a beautiful garden at home, cared for my elderly parents until they died, and now enjoy playing with seven beautiful granddaughters. Compression garments have enabled the depth and breadth of my life experiences. I wish my parents were alive to see that the United States of America will finally fulfill the Medicare promise to me and close the coverage gap for compression garments, a critical treatment that will help me to avoid disability, depression, and even life-threatening infections and, hopefully, to live a long, active life. Developing separate billing codes for measurement, fitting and patient education, and product will facilitate access to compression garments in my state. Oklahoma has no comprehensive "lymphedema center" that provides expert services to those with the condition. One result is that few of our durable medical providers are willing to maintain the measurement expertise required to purchase the broad array of compression garments available to meet the unique needs of all individuals. Thankfully, the number of certified lymphedema therapists in our state is growing. They can be certified to measure for compression garments and fit and educate us about the wearing of those garments so that we can place our orders for garments fully guaranteed for fit. Toe caps are a must for me. When the development of my lymphatic system went awry, fewer and fewer lymphatic vessels budded in the more distal parts of my lower limbs. I suspect there is no lymph uptake in my toes. Decongestion occurs only with elevation and compression of each toe, around the full girth of each toe, to move collected lymph out of my toes and up my legs where it can be taken up. Toe caps have been a godsend for me, saving me much time and comfort over the onerous task of wrapping each toe with gauze bandages at least once or twice a day. I believe the soft, well-fitted toe caps have caused less wear and tear on the skin of my toes than do gauze wraps that are difficult to secure in place. The skin of my toes became compromised with fibrosis when they went uncompressed as a child. Toe caps help me to avoid injury and infection in that vulnerable skin. As lymphedema goes, I've been fortunate and possess the financial ability to manage my disease well without comprehensive insurance coverage for compression. Admittedly, at my age, I'm much more likely to become disabled and even die from a different, more common chronic disease(s) or cancer. Nevertheless, continuing to manage my lymphedema well enables me to do the things I must do to prevent disability and death from those diseases.
CMS-2023-0113-0005	CMS-2023-0113	lk2-rqc4-aoef	2023-08-10T04:00Z	**Michele**	**Cruz**	FL		Association - Other		It would greatly help me if my medical compression garments were covered by Medicare. I spend about $100 every 2-3 months; which is excessive for me. I collect disability & can only work part time. I feel lymphedema is an illness & should be considered the the same as other medical covered issues.
CMS-2023-0113-0006	CMS-2023-0113	lk2-rqc6-jhvu	2023-08-10T04:00Z	**Michele**	**Cruz**	FL		Association - Other		It would greatly help me if my medical compression garments were covered by Medicare. I spend about $100 every 2-3 months; which is excessive for me. I collect disability & can only work part time. I feel lymphedema is an illness & should be considered the the same as other medical covered issues.

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CMS-2023-0113-0573	CMS-2023-0113	llv-57m5-pg80	2023-09-14T04:00Z	**Alexis**	**Cutler**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0443	CMS-2023-0113	llq-ifza-jqe6	2023-09-12T04:00Z	**Robyn**	**D'Aquila**					I am a nurse and on my feet all day. I am using compression stockings from 5 years ago, five days a week; some with holes in them, bc I cannot afford new ones. Especially five pairs to cover my five days a week working. If I do not use them my feet, ankles and legs become so swollen it hurts to walk let alone stand on them.
CMS-2023-0113-0877	CMS-2023-0113	llw-zoau-rhfb	2023-09-14T04:00Z	**Elizabeth**	**Daane**	TX		Individual	https://downloads.regulations.gov/CMS-2023-0113-0877/attachment_1.pdf	See attached file
CMS-2023-0113-0445	CMS-2023-0113	llq-m31r-3s90	2023-09-12T04:00Z	**Joanne**	**Dallas**	PA		Individual		How do we handle end of life care? My Mother died 9/20/23 (age 89). The attached photos are her lymphatic legs as a result of radiation for endometrial cancer in 2000. She spent thousands of dollars on lymphatic massage, garments and as she aged, between hiring help and my help to continually get these garments on and keep skin clean and dressed. In the end there were no options left other than to treat open wounds and skin. So it's not only compression items but treating open wounds, transport when you can no longer walk or get in a car plus in home help. Unfortunately, she eventually went into skilled nursing which we paid out of pocket for.
CMS-2023-0113-0513	CMS-2023-0113	lls-nnam-rr8a	2023-09-12T04:00Z	**Christopher**	**Daly**	AZ		Health Care Professional/Association - Occupational Therapis		Home Health Agencies cannot tolerate further pay cuts and greater administrative burden. Previous pay cuts and PDGM adoption has decreased necessary access to Occupational Therapy services for home health patients, creating greater risk of patient falls, re-hospitalization, and less favorable clinical outcomes. Further pay cuts and the proposed removal of M2200 Therapy Needs will further negatively impact medically necessary Occupational Therapy utilization. Please do what is right for patients and clinical practitioners.
CMS-2023-0113-0141	CMS-2023-0113	llc-jz79-yl0a	2023-08-22T04:00Z	**Donna**	**Daniels**	PA				I am 62 years old and not currently on Medicare. However, I have primary lymphedema in both my lower extremities. I have been diligent since 28 years old, when I was finally diagnosed, in wearing my 30-40 compression stockings every day so my condition does not worsen and cause further complications in my health and a greater burden to the system and my family. Every year I spend over $2,000 on stockings as they are $140 for one hosiery. Currently, my insurance will only pay for one half as they will only pay for one leg! Further, they repeatedly deny coverage. The time it take to fight them is exhaustive and leads to nowhere, so I pay for this out of pocket. It is atrocious that I have a birth disorder that insurance will not help defray the cost but will pay for other things if my condition progresses. Where is the logic in that?!?! In the long run, I save the insurance companies money by wearing my compression stocking and my condition not progressing. So I ask, why are the insurance companies not supporting my proactive care?
CMS-2023-0113-0053	CMS-2023-0113	ll2-bxa0-k7vs	2023-08-10T04:00Z	**Lauren**	**Darby**	NY				I was diagnosed this year, went through four months of therapy. I now have a set of the neoprene compression garments that I use for sleep and for travel. They cost me $2100. They are good for six months. I was measured for them. I also have a set of thigh high compression stockings that cost $763 , also good for only six months. Thankfully I was able to come up with the money but it is a strain on my budget. I have to wear garments 23 1/2 hours a day for the rest of my life. I would really appreciate Medicare paying for them. It is a necessary medical supply.
CMS-2023-0113-0153	CMS-2023-0113	lll-0wt0-p1tm	2023-08-22T04:00Z	**Paden**	**Davis**			Individual	https://downloads.regulations.gov/CMS-2023-0113-0153/attachment_1.pdf	Please see attached letter.

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CMS-2023-0113-0529	CMS-2023-0113	llu-ahph-0hlc	2023-09-12T04:00Z	**Katherine**	**Davis**	AZ				I am a home health occupational therapist (OT). I have almost 30 years of exeperience as an OT and have been working in home healthcare since 2019. I have been told many inaccuracies about reimbursement for OT HH services since Jan 2020. I was working on the east coast then. I have relocated to Arizona and continue working for a HH agency. OT continues to be phased out of home health by agenicies. We have to fight for every visit. I've heard a plethora of reasons such as; OT is repetitive OT only needs 1-2 visits then PT can do the rest Medicare won't pay for that much OT Medicare doesn't cover HH OT services any longer OT's can't do SOC's Medicare likes strengthening by PT Due to CMS HHVBP, Medicare has reduced OT visits Medicare allocates the visits and we can't change it Medicare determines how many visits per discipline This is very frustraining and demeaning to hear comments like those stated above. Being devalued by an entire industry if baffling. Pts should not be denied their right to OT services. Unfortunately HH agencies nationwide are systematically phasing OT out of homecare. What that the intention of PDGM?
CMS-2023-0113-0137	CMS-2023-0113	llc-b80u-vo7f	2023-08-22T04:00Z	**Darby**	**Dawson**	IA		Health Care Professional/Association - Occupational Therapis		Good morning. Thank you for your time and effort in reading this comment on behalf of those who I serve that deal with the issue of lymphedema on a daily basis. As being a CLT for only a short period of time, I have had several patients that are in need of some form or other of compression garments to manage this life long pain as it doesn't go away. Compression stockings are expensive, not to mention the lymphedema pumps to help in keeping it at bay. These patients suffer everyday, some with back pain due to excessive pain in their BLE due to excess fluid, they become sedentary because of this which then ends up causing more health issues. This health condition causes a significant decrease of their ability to function and perform in their daily activities. Providing easier access to compression garments would greatly improve their ability to maintain their daily activities and improve their overall health and wellbeing while also maintaining their health, physical, mental and emotional health as a whole. Which in turn will help to reduce the stress and risk of developing chronic diseases and illnesses and take burden off health care workers and the system. As you can see, providing necessary garments to those suffering from lymphedema will greatly benefit and remove burden from our already stressed health care system. Thank you for listening Darby Dawson COTA, CLT

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CMS-2023-0113-0013	CMS-2023-0113	lke-bizh-dlx0	2023-08-10T04:00Z	**Nancy**	**DeLuca**	FL		Individual		Pertaining to the Lymphedema Treatment Act (CMS-1780-P), I do not see "custom" compression stockings for the leg included in the "example payment rate" list. I must wear custom stockings, because I have long legs, to treat lymphedema (as a result of having had extra lymph nodes removed during surgery to treat uterine cancer in 2011). In addition to not being long enough, the off-the-shelf compression stockings for the leg are very difficult to get on and off whereas the custom stockings are made of a different fabric and weave and are actually comfortable to wear as well as easy to get on and off. I currently pay $350-$400 per stocking out of pocket. I hope you will include "custom" compression stockings for the legs in your payment rate schedule. Also - I wear a custom night garment, chap style. I hope you will include the "custom" night garment for the legs in your payment rate schedule as well. I currently pay about $1000 for the custom night garment and it is effective for about 3 years (no more than 5 years). Thank you for consideration. I do not purchase the compression stockings as often as I should because of the out of pocket cost.
CMS-2023-0113-0510	CMS-2023-0113	lls-g89s-p9h7	2023-09-12T04:00Z	**Kush**	**Desai**			Health Care Provider/Association - Hospital		As a dedicated, board-certified physician specializing in vascular and interventional radiology, I see and treat patients suffering from lymphatic disease on a regular basis. I have been in practice for 10 years in a primarily academic practice. I am offering my expertise in the public comment for “Section VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” in the 2024 Medicare Home Health Prospective Payment System Proposed Rule. I want to ensure my patients have access to the various lymphedema treatment compression items needed for long-term successful management of their disease. Treating patients with lymphatic disease is complex. Their plan of care often includes multiple treatment modalities to help mitigate their symptoms. This may include a prescription for both static compression and pneumatic compression, as well as a referral to rehabilitation services for wound care, physical or occupational therapy or lymphedema therapy. This all requires a coordinated effort by multiple disciplines and commitment to provide optimal treatment to the patient. I am happy to see both Congress and Medicare recognizing the gaps in reimbursement of treatment modalities for lymphatic disease; I am supportive of coverage and reimbursement. Compression levels Attaining unique codes for compression levels may ensure reimbursement for garment manufacturers. However, this should not be considered a staged treatment approach in coverage policies with patient's required to start with lower compression progressing to higher levels before obtaining the appropriate compression needed for successful management of their disease. I will prescribe the appropriate mmHg level of compression for my patients based on the stage and severity of their condition as well as other comorbidities impacted by compression. For instance, if 20-30 mmHg does not prove to be efficacious, a higher pressure, such as 30-40mmHg, is not an automatic next step in standard of care. The pressure I prescribe will be based on the stage 0-3, symptoms, patient tolerance, and other factors dependent on the patient. CMS should not interpret or assume that lower pressure garments are a starting point for treatment and higher-pressure garments are an end point or that a patient should utilize all pressure ranges, at some point, in their treatment plan. New HCPCS codes are unnecessary for compression stockings used as surgical dressing in treatment of open venous stasis ulcer. Phlebolymphedema is lymphedema secondary to chronic venous insufficiency. All patients with CVI (CEAP scores C3-C6) should be considered lymphedema patients. When treating ulcers, stockings are not typically worn, rather multilayer bandages are used as patients usually are not able to don stockings over open ulcers. The separation of stockings for treatment of lymphedema verse treatment of open venous stasis ulcers, is not recommended, and may lead to unintended administrative burdens and misinterpretation of medical necessity by Medicare claim reviewers. This recoding could cause unanticipated denials based on diagnosis coding and comorbidities documented in the medical record. There are already existing complexities with documentation requirements in prescribing pneumatic compression devices for these patients. My staff and I spend a lot of time complying with these requirements to support our patients, without reimbursement. It would be unfortunate to see unnecessary administrative burdens carry over into this new benefit category.

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CMS-2023-0113-0603	CMS-2023-0113	llv-bkcg-g6rq	2023-09-14T04:00Z	**Lisa**	**Dietsch**	IL		Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0603/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0055	CMS-2023-0113	ll2-fhlb-6fs4	2023-08-10T04:00Z	**Lisa**	**Domby**	NC		Individual		In reference to “Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items,” I support benefit and payment for custom fitted compression treatment items. As a breast cancer survivor with chronic left arm lymphedema for the last 6 years, I can attest that I needed multiple costly lymphedema treatment blocks until I was fitted for a custom compression sleeve with flexible elbow. Prior to receiving a custom fitted compression sleeve, each time my lymphedema was "resolved" with high frequency intensive physical therapy, it would then exacerbate again due to poorly fitted compression sleeves. Fitted compression garments save money, prevent symptoms from advancing, improve productivity, and support quality of life.
CMS-2023-0113-0374	CMS-2023-0113	lln-rqpb-mlmt	2023-09-11T04:00Z	**Nancy**	**Dooley**	RI		Occupational Therapist - HC050		As an occupational therapist I am writing to express my concerns with the proposed rule and input on OT's role in quality measures and other policy proposals for Home Healthcare. I urge CMS to adopt safeguards to protect patient access to medically necessary OT services. Agencies must rely on the therapist's clinical judgment to determine the type and amount of therapy services an individual patient needs. To that end, I oppose the removal of item M2200 Therapy Needs from the OASIS because it is an important item to help track the need for therapy, and removing the item could contribute to a further decrease in the provision of therapy services. Please consider the input of the American Occupational Therapy Association and the facts about how occupational therapy helps clients improve their functional independence and keeps people out of the hospital! Thank you, Nancy R. Dooley, PhD, OTR/L, CDP, FAOTA Professor and Program Director Occupational Therapy Doctorate Program Johnson & Wales University Providence, RI
CMS-2023-0113-0580	CMS-2023-0113	llv-64s5-4xkv	2023-09-14T04:00Z	**Cassandra**	**Dowtin**	NC		Health Care Professional/Association - Physical Therapist		I'm a physical therapist, and have been treating lymphedema patients since 1998. We try to reduce their swelling and teach them self-management. The biggest limiting factor in independence is not have the financial means to purchase the compression garments needed to keep their swelling under control. This is such a crucial element in decreasing their infections, decreasing wound formation, decrease hospital stays, and limit the need to return to PT for reduction. I work in an outpatient setting and get consulted frequently for what garments would be most beneficial in reducing swelling. For the elderly population, if their swelling is present even after a good night's sleep, they do best with the inelastic velcro garments that they can manage and will accommodate to fluctuation in swelling, but help them reduce their swelling. I hate that I can help them bring the swelling down with insurance covering my PT services, but they don't have the insurance coverage to cover the compression garments needed to keep swelling down. I also use compression low stretch bandages and teach my patients and their families how to help themselves. I can train but I need the right tools for the patients to keep the swelling down. Please expand their coverage to allow for bandage supplies, inelastic velcro compression garments, and compression socks/sleeve/gloves/gauntlets/pantyhose/thigh highs to help them keep their swelling well controlled.
CMS-2023-0113-0660	CMS-2023-0113	llv-rrjz-6guy	2023-09-14T04:00Z	**KELLY**	**DUARTE**	ID		Health Care Professional/Association - Occupational Therapis	https://downloads.regulations.gov/CMS-2023-0113-0660/attachment_1.pdf	I'm opposed to the CMS 2023-0113-0002 Home Health Prospective Payment System Rate Updated as it will have a negative effect on consumers. Please see the attached letter.
CMS-2023-0113-0219	CMS-2023-0113	lll-nrqn-9htv	2023-08-29T04:00Z	**Brittney**	**Duley**	CO		Health Care Professional/Association - Nursing Aide		Home health agencies have got to start hiring CNA’s for people who need daily care people who are paraplegic and have a hard time doing their daily care independently we shouldn’t have to wait for hours just to get our daily routine taking care of our parents shouldn’t be responsible for our daily routine when we have CNA’S available
CMS-2023-0113-0676	CMS-2023-0113	llw-9om4-pkdu	2023-09-14T04:00Z	**Elaine**	**Eaton**	FL		Health Care Professional/Association - Nurse		I am an RN and work in a Vascular Vein Center. We see n number of patient with secondary lymphedema related to their chronic venous insufficiency. Not only are compression not covered for vein disease which is a chronic inflammatory process, the garments are not covered for patients with chronic secondary lymphedema. This is an injustice to both venous and lymphedema patients as those garments are required to control edema, improve symptoms and quality of life. In addition, compression garments are a stipulation for conservative management of vein and lymphedema treatment, however, are not a covered benefit. This must change.

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CMS-2023-0113-0601	CMS-2023-0113	llv-bv4z-m5v8	2023-09-14T04:00Z	**Maria**	**Efstratiades**	NJ		Individual		Thank you for the proposals to revise § 414.210(g)(9)(v) based on the "… Current Medicare Part B, which does not include coverage for lymphedema compression treatment items other than compression pumps and accessories that meet the definition of DME covered under the DME benefit category under section 1861(n) of the Act. Section 4133 of the CAA, 2023 amends the Act to establish a new Part B benefit category for lymphedema compression treatment items…" I commend your dedication to implementing new codes that ensure quantity limits based on sets rather than the number of individual pieces. Furthermore, the introduction of these revised codes ensures that non-limb areas of the body receive the same coverage. Regarding the limits on quantities, in my specific situation, ordering a combination of shorts and thigh-high custom-fit gradient compression garments signifies meeting my allocation of five garments. The methodology employed by the insurance company to calculate these orders is as follows: 1 Shorts are considered as three separate components: one for the abdomen section and two for the leg segments of the shorts. 2 Thigh-high garments are considered as two separate pieces, with each piece designated for one leg. Regarding covering non-limb areas, I wear thigh-high compression stockings on both legs, along with shorts that offer coverage from the abdomen down to the knee region. These thigh-high compression stockings are classified as class 3 custom-fit gradient compression garments. Conversely, the shorts are also custom-fit gradient compression garments but consist of two separate compression classes. The abdominal section garment is constructed with class 3 compression, while the leg section of the shorts is constructed with class 2 compression. It's worth highlighting that the leg portions of the shorts are worn as an additional layer on the upper thigh over the thigh-high custom-fit gradient compression garments. My other concern with the new proposals is with the daytime quantities. The rule suggests coverage for two daytime garments every 6 months per affected body parts. Drawing from my experience over the past 11 years of wearing custom-fit gradient compression garments, I've noticed that after three to four months, the elasticity of the garments diminishes, reducing their effectiveness in delivering medically necessary support. Another point I'd like to address is the introduction of codes describing the services provided by the therapists who perform garment measurements. In my view, it would be beneficial to establish codes that compensate therapists for their measurement services in addition to compensating the vendor or supplier for the actual garments.

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CMS-2023-0113-0596	CMS-2023-0113	llv-ab8s-tgtg	2023-09-14T04:00Z	**Susan**	**Ellenson**			Health Care Professional/Association - Physical Therapist		As a Certified Lymphedema Therapist, I see and treat patients suffering from lymphatic disease on a regular basis. I have worked both in an outpatient clinic, as well as a clinical educator on lymphedema. I am offering my expertise in the public comment for "Section VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items" in the 2024 Medicare Home Health Prospective Payment System Proposed Rule. I want to ensure patients have access to the various lymphedema treatment compression items needed for long-term successful management of their disease. On a personal note, I too have lymphedema due to treatment of malignant melanoma in 2009. I have suffered with lymphedema in my left trunk/abdomen and lower extremity since then. I manage my lymphedema both through compression garments as well as intermittent pneumatic compression. This is very expensive as my daytime garments need to be replaced every 3-6 months and my custom nighttime garment yearly. Unfortunately, often my decisions as to what type of garment I get is based more on what I can afford, and not what would provide the best management, in order to keep the cost down. Treating patients with lymphatic disease is complex. Their plan of care often includes multiple treatment modalities to help mitigate their symptoms. This may include a prescription for both static compression and pneumatic compression, as well as a referral to rehabilitation services for wound care, physical or occupational therapy or lymphedema therapy. This all requires a coordinated effort by multiple disciplines and commitment to provide optimal treatment to the patient. I am happy to see both Congress and Medicare recognizing the gaps in reimbursement of treatment modalities for lymphatic disease; I am supportive of coverage and reimbursement. Compression levels Attaining unique codes for compression levels may ensure reimbursement for garment manufacturers. However, this should not be considered a staged treatment approach in coverage policies with patient's required to start with lower compression progressing to higher levels before obtaining the appropriate compression needed for successful management of their disease. Prescription of the appropriate mmHg level of compression for patients should be based on the stage and severity of their condition as well as other comorbidities impacted by compression. For instance, if 20-30mmHG does not prove to be efficacious, a higher pressure, such as 30-40mmHG, is not an automatic next step in standard of care. The mmHg pressure prescribed is based on the stage 0-3, symptoms, patient tolerance, and other factors dependent on the patient. CMS should not interpret or assume that lower pressure garments are a starting point for treatment and higher-pressure garments are an end point or that a patient should utilize all pressure ranges, at some point, in their treatment plan. New HCPCS codes are unnecessary for compression stockings used as surgical dressing in treatment of open venous stasis ulcer because multilayer adjustable wraps or bandages are used instead. Phlebolymphedema is lymphedema secondary to chronic venous insufficiency. All patients with CVI (CEAP scores C3-C6) should be considered lymphedema patients. When treating ulcers, stockings are not typically worn, rather multilayer bandages (or adjustable wraps with Velcro) are used as patients usually are not able to don stockings over open ulcers. In addition, if a patient has a diagnosis for CVI with ulcers and a diagnosis for lymphedema, this separation of wraps and bandages in the HCPCS descriptor may lead to unanticipated denials when comorbidities are documented in the medical record. Similar documentation complexities already exist when prescribing pneumatic compression devices for these patients. Providers spend a lot of time complying with these requirements to support their patients, without reimbursement. It would be unfortunate to see unnecessary administrative burdens carry over into this new benefit category. Susan Ellenson PT, CLT-LANA, CWS
CMS-2023-0113-0037	CMS-2023-0113	lkv-6e8p-qbo8	2023-08-10T04:00Z	**Kathy**	**Elliott**	MD				Home Health coverage is positive and welcomed to the current plan. Lymphedema care requires an abundance of therapist's guidance. Workers need to be adequately paid and the Medicare system needs to be safeguarded against abuse and fraud. Updates should be required on a regular basis.

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CMS-2023-0113-0581	CMS-2023-0113	llv-67r0-ydx3	2023-09-14T04:00Z	**Brenda**	**Emerson Harmon**	MN		Association - Other		I have lymphedema in both feet, ankles and calves. I have to wear custom made to measure compression toe caps during the day. They stretch out within 3-4 months and must be replaced more 4 times a year (every calendar year.) This year they increased in cost from $420.00 to $750.00. I also wear custom made open toe compression knee highs. And require ankle compression pads and pads for the top of my feet to keep the lymphedema from becoming permanent there. I also have wraps for my legs at night, Thanks for your understanding of this issue. Brenda
CMS-2023-0113-0568	CMS-2023-0113	llv-31wt-gu06	2023-09-14T04:00Z	**Elaine**	**English**	FL		Individual		I am a Florida State Licensed Orthotic Fitter and the only Licensed Profession mandated by Florida Law to measure and fit for Custom Lymphedema, Burn Velcro and other Garments. I am also a Licensed Physical Therapist Assistant and Lymphedema Therapist. I have been measuring for over 18 years My Credentialing allows me to submit billing to Private Insurances. I understand Medicare requires Licensing for Orthotics and Prosthetics. Will Medicare require Licensed Orthotic Fitters (that require Biannual CEU's to maintain Licensure) to measure and fit for these custom and Off the Shelf garments? Will the Facility require Accreditation too?There is a lot more that goes into measuring and fitting Custom and Off the Shelf Garments. My comment is in reference to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment items.
CMS-2023-0113-0558	CMS-2023-0113	llv-0vmh-1lev	2023-09-14T04:00Z	**Susan**	**Eoff**	MO		Religious Nonmedical Health Care Institution - HPA60		I am commenting on the VII Proposed Changes Regarding Durable Medical Equipment. I am thrilled to hear that proposed changes will help me and others deal with the problems that lymphedema causes and our quality of life. If lymphedema isn't controlled it can cause multiple problems such as infection, mobility issues, depression, and quality of life. All these problems can cause even more costs to the health care system. Thank you so much for FINALLY addressing this issue. Lymphedema patients, pay thousands of dollars to try and help their condition. I am able to pay some toward my treatment but I'm not using all the compression that I really need because of cost. I feel for the people who can't afford any treatment because of cost. I see people every day that I know have lymphedema but can't get diagnosed and the treatment that they need. YES! we definitely need enough garments to be able to wash and dry them and replace them as needed to get full benefit of the garment. We also need to have the option to buy multiple items to layer compression. Hopefully, you have seen pictures and heard testimonies from people who suffer from lymphedema so you understand how this affects us. Thank you for your attention to this problem.
CMS-2023-0113-0039	CMS-2023-0113	lkv-fk2z-bxq4	2023-08-10T04:00Z	**Paul**	**Erickson**	VA				I support the Lymphedema Treatment Act. Please fully fund all the components of this act, and consider widening the scope of allowing 2 daytime garments and 1 nighttime garment per 6 month period. I wear a new garment for my leg lymphedema every day so as to avoid other problems i.e. athlete's foot, etc. I usually buy at least 14 garments. People need to be able to wear a new garment every day without having to do laundry every day as well. Consider raising the daytime allotiment to 5-7 instead of 2. Thank you.
CMS-2023-0113-0585	CMS-2023-0113	llv-7a4y-popz	2023-09-14T04:00Z	**Cheryl**	**Erpelding**	AZ				I encourage Medicare to provide all of us lymphedema patients the compression garments they need to prevent complications like cellulitis which I have gotten several times and had to be hospitalized for. Under Kasier's care, I received three custom sets of thigh highs, two biker shorts, and two sets of toe caps to manage the terrible swelling that comes from lymphedema. I need these custom measured compression garments every 6 months.
CMS-2023-0113-0130	CMS-2023-0113	llb-aiui-n300	2023-08-22T04:00Z	**Alberto**	**Esquenazi**	PA				The use of exoskeletons for ambulation are of great value to patients, CMS and the public at large. Reducing complications that are expensive to treat by allowing increase assisted functional ambulation. As a rehabilitation physician I believe in the use of technology to advance healthcare

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CMS-2023-0113-0677	CMS-2023-0113	llw-9z4g-7c5w	2023-09-14T04:00Z	**Amy**	**Ewell**			Occupational Therapist - HC050		Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items I have been a Certified Lymphedema Therapist for more than 20 years working with patients in a variety of settings from acute care, outpatient and home health. From my experience the patient needs to have options for their care. The option to have 2 night-time garments would be beneficial as these garments need to be washed and properly cared for to maintain the effectiveness until another is allowed. Putting the garments in a dryer is not always recommended and they can take more than a day to dry especially in humid climates. Another reason for allowing 2 would be that patients need various tools to manage their edema. A different type of night-time garment allows for days that there is increased edema or skin issue which may need more or less support to the body part. Many patients have the need for garment layering or breaking the garment into components to be able to manage toileting or to be able to get the garments on. Layering allows the patient to achieve the targeted compression for maintenance. The garments can be difficult to apply especially for those with comorbidities and limited range of motion. Reimbursement options to have multiple garments on 1 extremity would be extremely important. Another option to assist patients would be the addition of accessories such as assistive devices to put the garments on. There are a variety of tools available to help and coverage would increase the success and challenge for patients unable to wear the proper garments due to physical challenges. (gloves, donning aids, pull straps etc) As a therapist one of the most challenging and time consuming tasks is measuring and education on use of the garment or adjusting the garment for proper fit. A code for therapist to use for fitting and or followup would be most beneficial to the fitters (if going to a DME), the patient and the therapist. It is a team effort as patients are fitted in a variety of settings and the feedback from therapists once the garments are made is crucial to the effectiveness. For those unable to be seen by a fitter especially in rural areas it is sometimes the therapist that measures and sends to a fitter that may or may not be near by. There needs to be codes that a therapist can use for fitting of the garment. Measuring and fitting/education are 2 separate things and should not be lumped together. Bandaging is utilized in a variety of situations from the maintenance phase to ongoing treatment. It can require skilled adjustment by a medical provider especially in the more advanced cases as the skin quality, changes in shape and changes in texture of the skin are all taken into account. The bandages and or bandage systems are adjusted as clinically needed to get the patients ready for self maintenance. This is done by adding liners, foam, or a variety or skin treatments. There must be application options for providers to continue coverage of these patients to ensure patient safety.
CMS-2023-0113-0402	CMS-2023-0113	llo-au16-qdcb	2023-09-11T04:00Z	**Molly**	**Falkner**	WA		Individual - I0001		My comment is in reference to "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items". I have suffered from lymphedema since 2001, as a result of breast cancer treatment (surgical removal of lymph nodes, radiation and chemotherapy). I am very grateful that the Lymphedema Treatment Act was passed, and that compression garments to help manage the condition, will now be a covered benefit by Medicare. I need to wear custom, flat knit garments, due to my specific arm measurements, the specific level of gradient compression required by my condition to reduce swelling and pain, and accommodate irregularities and complications in my arm from surgery. I wear compression arm sleeves and gloves. I feel that more than two gloves every six months is not a sufficient quantity. With germs and the Covid situation, I need to change my glove each time that I return home after going out into the Community (gym, grocery store, errands, medical and other appointments, events), being exposed to germs. People wash their hands more than two times per day. I feel like I need a minimum of 3-5 gloves per day. When you wash them, they take overnight to dry, as they have to be hung to dry, and cannot go into the dryer to dry. Also, the propose two nighttime garments every two years, should be revised to two Nighttime garments every year, in my opinion. They also take overnight to dry. Please ensure that the reimbursement rates are sufficient to support vendors within the community to supply the compression garments. The reimbursement rates should include the Suppliers costs for measuring and fitting both custom and over the counter garments. Again I am very grateful for this proposed coverage. Compression garments are so very essential in controlling and managing this debilitating disease (lymphedema).
CMS-2023-0113-0198	CMS-2023-0113	lli-aqo4-zru2	2023-08-29T04:00Z	**Maura**	**Fallon**	WA		Individual		I am a constituent in 98121 zip code. I support the proposed coverage rules for lymphedema compression supplies. Are used both daytime and nighttime compression leg garments because I have lymphedema. Without it my legs are incredibly achy and I have big challenges with my movement. Many thanks for your support!

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CMS-2023-0113-0562	CMS-2023-0113	llv-1g0z-x2gg	2023-09-14T04:00Z	**Kim**	**Faulk**	AZ				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0651	CMS-2023-0113	llv-muvx-5dnc	2023-09-14T04:00Z	**Heather**	**Ferguson**	NC		Individual		I am commenting on section VII-B of the proposed rule. I am the Founder and Executive Director of the Lymphedema Advocacy Group, but first and foremost, I am the mother of a 16-year-old son, Dylan, who was born with primary lymphedema. He was prescribed his first set of compression garments when he was seven-months-old. It's always been a struggle to get our insurance to cover these supplies. We are so grateful that Medicare will soon set a precedent for private insurance coverage, and hence why the details of this rule are important, not only to Medicare beneficiaries, but to all Americans with lymphedema. Dylan's daily treatment includes wearing custom-fit flat knit knee highs and standard-fit circular knit toe caps during the day. At night, he uses compression bandaging, which for him is more effective and comfortable to sleep in than a nighttime garment, and is also less costly. I have the following concerns about the proposed rule, as it relates to my son: 1.) I do not see any proposed code for toe caps, which could also be referred to as a foot glove, as they provide compression to each individual toe. 2.) While most of Dylan's life we have been able to get by with two sets of garments replaced every six months, there have been a few times when they required replacement sooner, so I am relieved to see that exceptions will be granted when necessary. Please note, however, because Medicare rules set a precedent for private and other public policies, I think that it is important that the list of qualifying exceptions include not just a change in weight, but also a change in size. Especially with children, they sometimes grow taller/longer without a change in body weight, and this can cause their compression garments to no longer fit properly. Even in adults, body parts can change size and shape without there being a significant change in body weight. 3.) My son's disease state requires a flat knit compression garment on his legs to control his swelling. We have tried circular knit compression garments and they do not provide the level of containment he needs. I hope that, thanks to this expanded coverage, the flat knit standard-fit garments currently sold in Europe will become available here, as those would be a fantastic and more cost-effective option for patients like my son, who can fit into a standard-fit size but require the containment of a flat knit garment. 4.) As stated, my son uses compression bandaging to sleep in rather than a nighttime garment because he finds bandaging more comfortable and effective. It is also far less costly than a nighttime garment. I am concerned that the proposed rule only speaks about compression bandaging in the context of the intensive/reduction phase. Please make sure that compression bandaging supplies are also covered during the maintenance phase for patients who need those supplies. 5.) And lastly, I am worried about the reimbursement rates. Medicare rates will set a precedent for other plans, so this matters to every patient across the country. Even with insurance coverage, we still pay a percentage through copays and deductibles. It is crucial that the reimbursement rates be fair to all parties - they must be high enough that vendors are willing to sell these items and can stay in business doing so, but not so high that patients are being gouged. In my son's 16 years of life we have seen both extremes. Thank you so much for considering my comments and for all your work to improve coverage and access to care for this chronic disease!

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CMS-2023-0113-0699	CMS-2023-0113	llw-fkxr-2nfn	2023-09-14T04:00Z	**Dylan**	**Ferguson**	NC		Individual		I am commenting on section VII-B of the proposed rule. I am 16 years old and was born with primary lymphedema. I began wearing compression garments when I was seven months old. My current treatment includes wearing custom-fit flat knit knee highs and standard-fit circular knit toe caps during the day, and using compression bandaging at night. By faithfully wearing my compression garments I am able to be an active teenager and my lymphedema does not prevent me from pursuing my interests. I maintain excellent grades and have a 4.00 GPA, have been practicing Brazilian Jiu Jitsu for 11 years, serve in a leadership position on a FIRST Robotics Team, and look forward to attending college and leading a full life. All of these things are possible only because I am able to manage my lymphedema effectively. It will be many years before I am on Medicare, but for my entire life it's been a struggle to get our insurance to cover my compression garments because Medicare did not. I'm so glad that will be changing soon. I also look forward to new treatments, and maybe even a cure, and it will be important for those things to be covered by Medicare and other insurances as well. Thank you!
CMS-2023-0113-0494	CMS-2023-0113	llr-6ec4-u1yk	2023-09-12T04:00Z	**AMY**	**FLINN**	CA		Health Care Professional/Association - Physical Therapist		Thank you for submitting the proposal for comment. I am commenting as a lymphedema therapist and as an owner of a compression garment fitting DME office. Compression garments for lymphedema are of concern for me as they represent the greatest cost for people with lymphedema. I agree the codes need to be updated as too many garments fall under the A6549 code currently. After discussing with my biller, I am concerned about the wording "affected limb or area of the body" as 2 or more garments sometimes are required for an affected region. Examples: 1) armsleeve and glove are 2 items, but only represent one of the 2 sets needed. 2) thigh high and toe caps are 2 items, but only represent one of the 2 sets needed. The section recommending the DME clinic reimburse the therapist who is measuring for the garment is complicated and conflicts with established Stark anti-kickback rules. I am not sure the best solution, but the current proposal will not work. Proposed reimbursement rates fall below the minimum amount for our office to break even on compression garments. Therefore, if unchanged, we will remain non par to allow us to provide necessary garments to Medicare beneficiaries at the lowest cost possible to allow us to stay in business. Lastly, compression bandaging materials are substantially more expensive than traditional bandaging materials. Using the same codes as traditional bandaging materials will provide about 10% of the reimbursement necessary for those items. I recommend looking at different codes for lymphedema bandaging and improved reimbursement rates for those items.
CMS-2023-0113-0621	CMS-2023-0113	llv-dxsc-wfuu	2023-09-14T04:00Z	**Mary**	**Foelster**			Individual	https://downloads.regulations.gov/CMS-2023-0113-0621/attachment_1.pdf	Please see attachment for my comments on aspects of CMS–1780–P related to lymphedema and related coverage by Medicare.
CMS-2023-0113-0517	CMS-2023-0113	llt-q8hp-c651	2023-09-12T04:00Z	**Kari**	**Formsma**	MI		Individual	https://downloads.regulations.gov/CMS-2023-0113-0517/attachment_2.docx https://downloads.regulations.gov/CMS-2023-0113-0517/attachment_2.pdf https://downloads.regulations.gov/CMS-2023-0113-0517/attachment_1.docx https://downloads.regulations.gov/CMS-2023-0113-0517/attachment_1.pdf	Public Comment on Proposed rules CMS-2023-0113-0002 Introductory remarks: I am a retired physician (obstetrician/gynecologist) and medical school/residency faculty member. I also spent many years in private practice and am well acquainted with billing and coding issues. I required cancer treatment that resulted in significant left lower extremity edema, which I have lived with for 9 years so far. I served as the co-chair of the Michigan Chapter of the Lymphatic Education and Research Network (although am submitting these comments as an individual.) It is through my various perspectives in these roles that I submit these comments and recommendations in the hope that Medicare beneficiaries can maximally benefit from the newly congressionally authorized coverage for medical compression garments, supplies and services for lymphedema and continue to be healthy enough to be contributing members of our American society. Please review my specific comments in the attachments below.

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CMS-2023-0113-0199	CMS-2023-0113	lli-ba1q-7pv6	2023-08-29T04:00Z	**Herbert**	**Forsberg**	NJ		Individual		Hello, I was born with congenital lymphedema. I'm 74 years old, born in 1949. At that time and where I lived, physicians didn't know what my condition was nor even the term 'lymphedema'. In those days, you didn't complain about your problems – you just got on with life. By the time I was 15 years old, I had had cellulitis so many time that my parents decided they needed to take me to Cleveland Clinic, since the doctors in my hometown of Jamestown, NY had thrown their hands up so many times, and had told my parents they could do nothing more, and that they should call the minister. My parents no longer had any faith in our local docs. At Cleveland Clinic we heard the term lymphedema and congenital lymphedema for the first time. After a week of review by doctors of varied specialties, Dr. Jess Young, head of vascular medicine, described my condition and recommended a newish therapy of compression therapy. This was 1962. First they removed an infected large toenail on my affected foot which had been causing recent bouts of cellulitis. Then we started the compression therapy. Miss Rose, in the physical therapy department, would pump my leg with a Jobst compression pump for 3 hrs, send me back to my room for lunch, then pump my leg again for 3 hrs. After a week of this she measured my leg and ordered a combination of made to measure Jobst compression garments as ordered by Dr. Young. I've been wearing Jobst/Elvarex made to measure garments every day since then. That was 60 years ago. I'm now retired. I spent my career as a freelance cinematographer in the NYC market. I've worked for ABC, CBS, NBC, PBS, CNN, FOX, worked with Julia Childs, Lydia Bastianich, Jacque Pepin. I've worked with Bill Moyers, Barbara Walter, Diane Sawyer, Brian Williams, Dan Rather, Morley Safer, Ed Bradley, and many other broadcast figures. I've worked for many Fortune 500 company, on national commercials, and more. I've photographed many famous dignitaries and celebrities and traveled to dozens of countries on work assignments. I would never have been able to have this level of success without the aid of compression therapy and custom compression garments from Jobst. It wasn't without difficulty, but the compression garments made it possible. I now wear a series of garments which address my lymphedema from my toes to my butt on my right-hand lower quadrant. I wear a toe cap, a knee high, a full-length thigh high, and a Bermuda shorts garment. Because of the severity of my lymphedema, Dr. Young had always prescribed a double garment on my calf to reinforce the gradient compression strategy. My wife is retiring this September from CUNY as a professor of cinema studies. After that our income will consist of Social Security and our savings. Thus far, we've had insurance coverage through her work. Emblem Health/GHI has begrudgingly made partial payment for my garments. We'll be going onto Medicare as of 9/1/23. This new coverage will be most appreciated and helpful and enable me to continue my way of life.
CMS-2023-0113-0106	CMS-2023-0113	ll8-1597-0yeb	2023-08-22T04:00Z	**Jenn**	**Frees**	NE				On page 9, the line at the end of the page, it states such as outpatient physical therapist. Can we please also add occupational therapist alongside physical therapist?

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CMS-2023-0113-0487	CMS-2023-0113	llr-2h22-atwq	2023-09-12T04:00Z	**Ryan**	**French**	WA		Individual		I work at Jim's Pharmacy & Home Health, a retail DME provider that currently fits and provides ready-to-wear and custom compression garments for lymphedema. In general, I am writing to support the comments by VGM and USMCA, with the following specific comments. First, I support creating separate HCPCS codes for circular knit vs flat knit garments as they have different costs and are appropriate for different patients. If only one HCPCS code category is created combining both types of garments, and the fee schedule is priced to the cheaper circular knit fabrics, beneficiaries will be forced by cost pressures into the wrong garments and worse outcomes. Alternatively, if the fee schedule is set high enough to cover flat knit garments, then unscrupulous suppliers will bill Medicare higher prices in order to capture the entire fee schedule, resulting in waste and abuse. I also recommend that lymphedema sleeves and mastectomy sleeves not be artificially separated into different HCPCS codes. Lymphedema should be treated appropriately regardless of whether a patient has had a mastectomy. Please eliminate the HCPCS code L8010 (Mastectomy sleeve) when creating lymphedema sleeve HCPCS codes. However, I disagree with USMCA that the existing gradient compression garment codes in the surgical supplies LCD should be separated from newly established lymphedema garments HCPCS codes—I believe a HCPCS modifier is sufficient to differentiate these garments when used for different purposes. We already have other HCPCS codes that are covered differently based on modifiers, such as A4450 (tape) covered according to the ostomy supplies LCD when using the AU modifier vs the surgical supplies LCD when using the AW modifier. As a DMEPOS biller, I find this system far more accessible than having the same item belong to two different HCPCS codes depending on why it is being provided. It also makes DMEPDAC coding decisions simpler. Second, I support USMCA's pricing proposition of polling manufacturer Minimum Advertised Pricing, using multipliers for compression strength and garment material. Pricing needs to be based on objective data. Medicaid rates or internet sales for lymphedema garments are not reliable—our own state of Washington does not have a Medicaid fee schedule and instead requests the invoice. Other payors that we serve, when they cover these garments, either request an invoice or cover half of our billed charge. We have even seen third party administrators take our billed charge, double it, and pass that on to the plan for payment, keeping their half before paying us. We have seen internet retailers sell garments at prices barely above what we can get purchasing directly from the manufacturer. Prices derived from these sources do not include the properly-trained fitter services or the overhead costs of DMEPOS supplier standards. However, I support creating a separate HCPCS code for fitter services, similar to repair labor codes like K0739, and requiring fitters to document their time similarly. CMS should allow this HCPCS code to be billed by either DMEPOS suppliers or therapists, to the appropriate MAC, or create a CPT code for therapists providing fittings of lymphedema garments if a similar CPT code does not already exist. Forcing therapists and DMEPOS suppliers to enter into financial relationships would most likely serve to steer patients to remain within large corporate-owned provider networks rather than allow them to choose the best healthcare provider for them. Third, I support leaving coverage limits up to the DME MACs during the LCD drafting process. At the very least, the manufacturer warranties and estimated lifetimes of their products should be taken into account; most manufacturers suggest refitting every 6 months due not only to wear on the garment but also changes in medical condition and none that I know of support using the same garment for more than 1 year. Additionally, nighttime garments are difficult to wash and dry properly, so providing only 1 garment is not feasible as the patient would spend hours every day cleaning it. The most reasonable coverage would be as USMCA recommends: 3 daytime garments per 6 months and 2 nighttime garments per 1 year. Finally, I do not support adding lymphedema garments to the Competitive Bidding program. Medicare Competitive Bidding for DMEPOS is broken beyond repair. The initial system was not a fair auction, and attempts to fix its issues left the program unable to issue contracts for most product categories, because fair bids were obviously higher than the previous unfair bids. Competitive bidding has led to a 37% decrease in DMEPOS supplier locations since 2013, while Medicare enrollment has only grown. Adding more items to the Competitive Bidding program is a recipe for disaster, unless the goal is to provide lymphedema products only through mail-order suppliers after patients attempt to measure themselves. Thank you for considering my comments.
CMS-2023-0113-0051	CMS-2023-0113	ll1-j6aw-1zjl	2023-08-10T04:00Z	**Cynthia**	**Fuller**	IL				I am hoping that custom garments will be covered. I have to have therapy often and now going to a 30-40 compression sleeve and glove. I am happy to see something is going to be covered as I cannot afford my garments.

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CMS-2023-0113-0722	CMS-2023-0113	llw-iekj-g184	2023-09-14T04:00Z	**SUSAN**	**FURR**	MI		Individual		Thank you for the time, effort, and interest in supporting fair lymphedema treatment. Having had Stage 3 breast cancer with removal of 33 lymph nodes, 16 of which involved metastatic carcinoma, I am now a lifelong lymphedema patient. Because of custom day and night garments, the swelling and disability I experience is greatly reduced. Before receiving custom garments, the amount of swelling and disability was much greater. It is my hope that the provision for ALL lymphedema patients will make patients' daily lives just a bit easier, especially since this common but relatively little-researched condition is currently considered incurable. It is also my fervent hope that research will generate new, successful ways of treating lymphedema, giving people affected with it greater mobility and wellness. All people should be treated with equal regard to this chronic disease, especially since the compression supplies and garments are prohibitively priced, despite their necessity to deal with daily swelling and to avoid severe complications. Custom garments, where deemed beneficial to the patient, should be provided at reasonable intervals in order to maintain their effectiveness.
CMS-2023-0113-0898	CMS-2023-0113	llx-78w4-8386	2023-09-14T04:00Z	**Erin**	**Gallagher**	IA				CMS-2023-0113-0002 Comment Providing coverage for compression garments is very important and necessary. Each individual is very different in the types of garments that are effective for him/her and based on the cause of the lymphydema. Compression garments are very expensve to purchase in the stores, and often we are left to fit them ourselves and don't know which ones to purchase so it results in many trips to the store or mail service to purchase/return and finally receive a garment that works, We want all individuals to be able to continue working and/or enjoying their time. If limited by the high expense for compression garments it may limit people being able to work or enjoy their time with family and/or friends. The garment reimbursement should be at a set rate for each item, ie, $75 for sleeves, $50 for gauntlet. This will allow for the individual to know what is expected for him/her to pay when accessing a garment. It will also hopefully eliminate price gouging the consumer by some companies and/or in specific areas of the country. Replacing lost/stolen/items that have worn out before the six months should have an easy questionnaire for a Dr. or patient to fill out to receive another garment to replace it. People become frustrated when it becomes a lengthy process to request and/or receive an item or treatment and then forego the treatment which ends in less healthy people and longer health care costs as time goes on. Requesting a compression garment needs to be very easy for both the healthcare provider and the patient. Often time one is stumbling through forms not knowing exactly which form is needed or what elements need to be completed to receive what they are requesting. This causes unnecessary stress to patients which can add to their decline in health and rise in cost of healthcare. Being able to access the compression garments is a great thing for those suffering with lymphydema, but it must be an easy access and result in patients being able to receive the treatment measures....otherwise the treatment measures are not helpful to the patient.

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CMS-2023-0113-0674	CMS-2023-0113	llw-8e9o-q9ie	2023-09-14T04:00Z	**Marcie**	**Ganson**	IL		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0674/attachment_1.pdf	See attached file(s) Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Mason District Hospital Home Health provides home health services in rural central Illinois. Specifically, we serve Havana, Illinois and surrounding counties for a thirty-mile radius. We have been a Medicare participating home health agency since January 5, 1982 and currently have a patient census of 75. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Thank you, Marcie Ganson, PT, DPT, MBA
CMS-2023-0113-0537	CMS-2023-0113	llu-tcx8-7w2q	2023-09-12T04:00Z	**Renee**	**Garber**	NC		Device Industry - PI005		I believe more than two daytime garments should be covered every six months, if determined necessary. I am 42 years old with metastatic breast cancer. I’ve had lymphedema since my stage 3 diagnosis when I was 34. Exercise has been proven to be necessary in supporting cancer care, and after exercising, I cannot wear the same lymphedema garment. This means that each day I wear at least two daytime garments; further, these stretch out and are not as effective over time. I would like to see the option of additional coverage if warranted by the physical therapist (I work with one weekly) or the oncologist.

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CMS-2023-0113-0523	CMS-2023-0113	llt-wx4x-foc5	2023-09-12T04:00Z	**Lori ANGEL**	**Garza**	CO		Home Health Facility - HPA25		I , lori angel garza , writing today as a home health RN to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0461	CMS-2023-0113	llq-psz7-2xbs	2023-09-12T04:00Z	**Antonios**	**Gasparis**	NY		Health Care Professional/Association - Physician		Comment regarding: Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. As a dedicated, board-certified physician, specializing in Vascular Surgery, I see and treat patients suffering from lymphatic disease on a regular basis. I have been practicing for over 25 years and have a dedicated outpatient practice in the venous and lymphatic disease. I am offering my expertise in the public comment for “Section VII.B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” in the 2024 Medicare Home Health Prospective Payment System Proposed Rule. I want to ensure my patients have access to the various lymphedema treatment compression items needed for long-term successful management of their disease. Treating patients with lymphatic disease is complex. Their plan of care often includes multiple treatment modalities to help mitigate their symptoms. This may include a prescription for both static compression and pneumatic compression, as well as a referral to rehabilitation services for wound care, physical or occupational therapy or lymphedema therapy. This all requires a coordinated effort by multiple disciplines and commitment to provide optimal treatment to the patient. I am happy to see both Congress and Medicare recognizing the gaps in reimbursement of treatment modalities for lymphatic disease; I am supportive of coverage and reimbursement. Compression levels Attaining unique codes for compression levels may ensure reimbursement for garment manufacturers. However, this should not be considered a staged treatment approach in coverage policies with patient's required to start with lower compression progressing to higher levels before obtaining the appropriate compression needed for successful management of their disease. I will prescribe the appropriate mmHG level of compression for my patients based on the stage and severity of their condition as well as other comorbidities impacted by compression. For instance, if 20-30mmHG does not prove to be efficacious, a higher pressure, such as 30-40mmHG, is not an automatic next step in standard of care. The mmHG pressure I will prescribe will be based on the stage 0-3, symptoms, patient tolerance, and other factors dependent on the patient. CMS should not interpret or assume that lower pressure garments are a starting point for treatment and higher-pressure garments are an end point or that a patient should utilize all pressure ranges, at some point, in their treatment plan. New HCPCS codes are unnecessary for compression stockings used as surgical dressing in treatment of open venous stasis ulcer. Phlebolymphedema is lymphedema secondary to chronic venous insufficiency. All patients with CVI (CEAP scores C3-C6) should be considered lymphedema patients. When treating ulcers, stockings are not typically worn, rather multilayer bandages are used as patients would not be able to don stockings over open ulcers. The separation of stockings for treatment of lymphedema verse treatment of open venous statis ulcers, is not recommended. This recoding could cause unanticipated denials based on diagnosis coding and comorbidities documented in the medical record. There are already existing complexities with documentation requirements in prescribing pneumatic compression devices for these patients, and I don’t want to see that persist when prescribing lymphedema compression items. My staff and I spend a lot of time complying with these requirements to support our patients, without reimbursement. It would be unfortunate to see unnecessary administrative burdens carry over into this new benefit category. Antonios Gasparis Past President, American Venous Forum Professor of Surgery, Stony Brook Medicine

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CMS-2023-0113-0599	CMS-2023-0113	llv-aun8-lzyu	2023-09-14T04:00Z	**Carrie**	**Geibel**	MA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0599/attachment_1.pdf	I am writing in response to the proposed rule: Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I am an occupational therapist and certified lymphedema therapist, I work full time in a dedicated lymphedema clinic. The implementation of Medicare coverage for compression garments will have a profound impact on the medical well-being and quality of life of the patients I work with. I would first like to thank and commend CMS for their attention to detail and careful consideration of issues affecting the lymphedema population in writing these proposed rules. There are a few areas of the proposed bill I feel need to be added or adjusted to meet the needs of the patient population. Areas can be summarized into: reimbursement rates, categories of garment coverage, use of multiple or layered garments on the same limb, compression bandaging during maintenance phase of therapy, night garment replacement schedule, and reimbursement for garment measuring. Please see the attached document for details regarding my concerns in each area Thank you again for your attention to this very important topic
CMS-2023-0113-0419	CMS-2023-0113	llp-hjga-iohy	2023-09-11T04:00Z	**MARIANNE**	**GEOFFROY**	MA		Individual		Lymphedema Compression Treatment Items are essential to prevent acute incidence that would require hospital care. The changes proposed would bring Medicare in line with the standards of care that have been evolving over the past twenty years, since my original diagnosis. Without Medicare's impact, costs have soared beyond what is affordable for most retired persons. For example, my coinsurance for a single night garment was more than $1200 last year. The codes and descriptions in this legislation seem very fair. I have worked in the private health insurance industry, and for medical groups and hospitals. With all my experience, I have struggled to get my own compression garments covered by medical insurers. The prospective changes regarding Lymphedema Compression Treatment Items are necessary (and overdue).
CMS-2023-0113-0375	CMS-2023-0113	lln-u5fm-4wqy	2023-09-11T04:00Z	**Jennie**	**George**	MO		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0375/attachment_1.pdf	Please see attached letter. Thank you!
CMS-2023-0113-0578	CMS-2023-0113	llv-5q2g-cqa2	2023-09-14T04:00Z	**Susanne**	**Giannitti**	CT		Health Care Professional/Association - Occupational Therapis		The value of occupational therapy is being diminished in home health care agencies due to proposed budget cuts. Examples include: Agencies are applying pressure to reduce the number of OT visits to clients. Agencies are using predictive analytic tools that use algorithms to determine how many therapy visits (if any) should be provided based on diagnosis. Agencies are instructing staff to delay OT to later in the HH episode, or patients are told they can wait to get therapy after discharge when they are outpatient. Physician orders for OT are ignored, revised, or deleted. Nursing and Physical Therapy are determining when and if OT services are needed. Agencies are shifting OT visits to PT or nursing colleagues. OTs are having to do more, with less support. Therapists' clinical judgment is overridden or ignored.
CMS-2023-0113-0458	CMS-2023-0113	llq-owmr-55ux	2023-09-12T04:00Z	**sandy**	**giordano**	PA		Association - Device		It's been a long time coming, but let's hope it is worth it!!
CMS-2023-0113-0111	CMS-2023-0113	ll8-ivw3-t5de	2023-08-22T04:00Z	**Joleen**	**Gonser**	CA		Individual		“Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” The Lymphedema Treatment Act should address reimbursement to the patient for, or actual payment, to the caregiver who puts on and both the daytime and nighttime compression garments for people who cannot reach their feet or other parts of their body. I am a Medicare recipient with Social Security income only. I have compression wraps for both feet and lower legs, and for one arm. I cannot reach my feet and must hire a caregiver to come twice daily to put them on, which takes 15-20 minutes each time.
CMS-2023-0113-0125	CMS-2023-0113	lla-ynnz-nqoc	2023-08-22T04:00Z	**Carlos**	**Gonzales**	MA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0125/attachment_1.pdf	See attached file
CMS-2023-0113-0726	CMS-2023-0113	llw-iroa-jyfb	2023-09-14T04:00Z	**Allan**	**Goodin**			Health Care Professional/Association - Physical Therapist		It seems that every year health care is met with cuts from Medicare. The costs for care, however, are trending upwards. In light of recent changes in inflation and the effects on the general population in conjunction with these propositions goes against the balance of moral integrity. These cuts repeatedly threaten the viability of providing quality care due to the economic and emotional burden on providers. Repeated cuts in our industry reflects poorly on the authorities involved and illustrates their lack of commitment to the work done in healthcare. These discrepancies negatively impact not only patients but health care workers, their families, their livelihoods. It is not right. Please heed this call and better your actions accordingly. Thank you.

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CMS-2023-0113-0414	CMS-2023-0113	llp-8dmq-i5g3	2023-09-11T04:00Z	**andrea**	**gouaux**	LA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0414/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0025	CMS-2023-0113	lkj-x8az-qyig	2023-08-10T04:00Z	**Patti**	**Graybeal**	TN		Health Care Professional/Association - Other Health Care Professional		I work in a facility that provides orthotic and prosthetic devices . I have worked with Lymphedema patients for the past 20 years. I have witnessed first hand proper treatment for Lymphedema vs no or little treatment .Being a provider of compression I agree that 2 sets of garments per affected area per six months would allow laundering of garments and having a garment to wear . Six month replacement ensures garments maintain the affected area. As a provider proper reimbursement is imperative for our facility to continue to provide compression. Our type of facility cannot bill for office visits only item patient receives . Visit includes the measuring of garments , acquiring the garments and then fitting and any followup Currently many facilities have stopped providing garments due to the poor reimbursement
CMS-2023-0113-0215	CMS-2023-0113	lll-c845-3e78	2023-08-29T04:00Z	**Kathleen**	**Green**	NJ		Health Care Professional/Association - Nursing Aide	https://downloads.regulations.gov/CMS-2023-0113-0215/attachment_1.pdf	I am a registered nurse working as a staff educator for a home health agency. In response to your request for comments regarding the decline in home health aide utilization, I attached an article from United Disabilities Services. This article addresses the main reasons for the decline and makes recommendations to improve the pool of home health aides. I agree with everything the article states, especially the lack of pay and the lack of respect. At the home health agency where I work, the "professionals", SN, PT, OT, and ST, have their mileage reimbursement at a higher rate than the aides. This makes no sense to me since we all had to take the same drivers' test. I also want to say the shortage of caregivers is not just in the home but also in Assisted Living Facilities and Nursing Homes. In regards to the payment reductions, I agree with every thing the National Association for Home Care (NAHC) has already addressed and hope you seriously pay attention to what NAHC stated in their public comments. Thank you for your time and attention.
CMS-2023-0113-0460	CMS-2023-0113	llq-osry-g7ot	2023-09-12T04:00Z	**Jeremy**	**Green**	UT			https://downloads.regulations.gov/CMS-2023-0113-0460/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0486	CMS-2023-0113	llr-0hpk-3vfb	2023-09-12T04:00Z	**Julie**	**Green**	WI		Health Care Professional/Association - Occupational Therapis		In reference to Section VII.B. -Scope of the benefit and payment for lymphedema compression treatment items. It is imperative that coverage include custom stockings and off the shelf stockings as for most patients manage their lymphedema better with flat knit stockings/sleeves that are custom fit to their shape and size. This should also include any adjustable straps, bandaging systems, and night garments. Patients will need two sets of garments for each affected region of the body. Quantity should be based on actual "sets" and not number of pieces to successfully treat and manage their condition. The other important recognition and coverage needs to be for areas that have previously not been identified as having lymphedema such as head and neck, genitalia, trunk, abdomen, breast/chest both anterior and posterior as lymphedema can develop in any part of the body and cause a local inflammatory state, edema, tissue changes, risk of serious infection and poor quality of life.

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CMS-2023-0113-0492	CMS-2023-0113	llr-5zbm-r9f1	2023-09-12T04:00Z	**Jared**	**Green**	NV				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration. Jared Green RN, BSN Comfort Home Health and Hospice Mesquite, NV

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CMS-2023-0113-0800	CMS-2023-0113	llw-qhg4-flv7	2023-09-14T04:00Z	**Jeanie**	**Green**	TX				As a BOC certified mastectomy fitter (CMF), I am the lead mastectomy fitter for Women's Health Boutique, a DMEPOS supplier with multiple locations, I sincerely applaud CMS for the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. Thank you for the Public Comment Phase allowing me the opportunity to be an integral part of this process as the future of Medicare coverage of these items for beneficiaries with lymphedema is shaped. My support of this Act is relevant to the 12 years I have been a fitter in this industry, working with the challenges of post-mastectomy lymphedema that continues to plague the mastectomy population. I understand that years ago Medicare did allow coverage for L8010 and for some reason changed to a non-paid code. This has been devasting to women who suffer from post-mastectomy lymphedema for the remainder of their lives. Although I could comment on every section of this act, I included only comments about Chest/Torso compression garments that we refer to in our industry as a compression bra. It is my desire that Medicare recognizes the need for chest, torso, breast, axilla, and back compression post mastectomy, in addition to compression for the arm and hand. RE: FILE CODE CMS-1780-P VII. Proposed Changes Regarding Durable Medical Equipment, Prosthesis, Orthotics, and Supplies (DMEPOS) B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items Title VII. (B)(3) Pg. 271/392 "as well as comments on whether there are additional items other than the gradient compression garments, gradient compression wraps with adjustable straps, and compression bandaging supplies that could potentially fall under the new benefit category for lymphedema compression treatment items." COMMENTS: I propose the following gradient compression garments be included in this new benefit category: Chest/Torso Compression Garment, typically referred to as a "compression bra", but is not a bra. It generally covers the entire torso with compression on the chest wall, torso, back and underarm, sometimes extending to the waist and even to one or both arms. I recommend staging of the post-surgical garment. Existing HCPCS code L8015, post-surgical camisole, provides the "first stage" post-surgical needs including drain pouches and fiber-filled puffs appropriate for the first 2-8 weeks after surgery. The "second stage" could be a post-surgical compression garment, possibly HCPCS code L8016 and could be described as "second stage" post-surgical compression garment for post-surgical use, or for ongoing use as necessitated, covered for an indefinite period for residual lymphedema over the torso, chest, axilla, underarm, and back. This would most probably be chest length and could be described as: ~ Post-surgical compression garment, chest length, without arms, L8016 Depending on compression levels and length of garment, differentiating chest length from torso length, HCPCS codes could also include: ~ Chest/Torso length compression garment, without arms, L8017 ~ Chest/Torso length compression garment, with one arm, L8018 ~ Chest/Torso length compression garment, with bilateral arms, L8019 ~ Chest compression vest, without arms ~ Torso compression vest, without arms ~ Compression bodysuit with arms ~ Compression bodysuit with arms and legs I also propose these chest/torso compression garments have an allowed minimum of two garments initially, one to wear and one to wash, and with replacement at least every three months, as medical need dictates, up to eight per a year. In specific cases, the addition of swell spots, foam pads, or silicone pads as medically necessary might be indicated for use to effectively treat targeted areas of lymphedema, fibrosis, or scar tissue on the torso, chest wall, surgical site, breast, or back. I also propose these additional gradient compression garments be added under this new benefit, including: ~ Compression Arm Sleeve with Shoulder Attachment ~ Compression Arm Sleeve with Gauntlet Attachment Thank you for considering the inclusion of all the above compression garments and accessories in this Proposed Rule.

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CMS-2023-0113-0763	CMS-2023-0113	llw-nxdk-3dho	2023-09-14T04:00Z	**Nancy**	**Gregory**	MI		Health Care Provider/Association - Home Health Facility		CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year

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CMS-2023-0113-0347	CMS-2023-0113	llm-jk3t-1npt	2023-09-11T04:00Z	**Annette**	**Griffith**	NC		Individual		I am a lymphedema patient commenting on section VII-B of the proposed rule regarding coverage for the lymphedema compression supplies. Compression levels of garments Page 43772 last line of column 3 to the beginning of column 1 on page 43773 “For codes A6530 through A6541, we are soliciting comments on whether we should maintain the three level differentiations in the codes and whether these differentiations should be something other than 18-30, 30-40 and 40- 50 mmHg.” The stocking that I currently wear is an Elvarex CCL4 (49-70 mm HG) custom-fit thigh high sold by Jobst. This appears to be one step higher than what you are listing as the most common compression classifications. Higher classifications should be included in the new rules when prescribed by a physician (or a physician assistant, nurse practitioner, or clinical nurse specialist.) Replacement garment frequency and descriptions of the nighttime garment Page 43776 last 5 lines of column 1 “We are proposing to cover one nighttime garment per affected extremity or part of the body to be replaced once a year.” Also: Page 43771 paragraph one column 3 end of the second line “We are specifically soliciting comments on the topic of coverage of accessories necessary for the effective use of gradient compression garment or wraps with adjustable straps including what HCPCS codes should be established to describe these items, as well as comments on whether there are additional items other than the gradient compression garments, gradient compression wraps with adjustable straps and compression bandaging supplies that could potentially fall under the new benefit category for lymphedema compression treatment items.” My nighttime garment sold by Jobst comes with two parts: the JoViPak (padded leg) and a JoviJacket. Instructions from Jobst states: “The JOBST JoViJacket is worn on top of the JOBST JoViPak.” “Due to wear or slackening of the materials, the medical efficacy can be guaranteed for a wearing period of 12 months for the JOBST JoViPak compression garment (Standard option), 6 months for the JOBST JoViPak compression garment (cotton option), and 6 months for the JOBST JoViJacket.” Do you consider the JoViJacket an accessory to the JoViPak? The JoViJacket is necessary for the JoViPak to be effective. Presently the JoViPak and the JoViJacket are billed separately but are to be used together. This may be because the JoViPak lasts a year and the JoViJacket should be replaced twice a year. Both pieces together are needed medically for a nighttime garment to be effective. If they continue to be billed separately then the wording needs to be changed to: The JoViPak needs to be replaced once a year and the JoViJacket needs to be replaced twice a year. Replacement of sets of nighttime garments once a year vs 2 sets of garments every two years Page 3777 fifth paragraph of column 3 “We are soliciting comments on whether two nighttime garments should be allowed with both garments being replace once every 2 years, to allow for more than 1 day for washing and drying of the garment(s.)” I would rather there be a choice of replacing a garment once a year or two garments every two years. This gives those who are new to using these garments the option of changing style, manufacturer or description of the garment after one year instead of being locked into the garment for two years before the garment can be changed. This would be less important to those who are maintaining their condition and are more concerned with the time it takes to be able to wash and dry the garments. Please see my previous comment on how pieces of a nighttime garment are counted. The JoViPak needs to be replaced once a year and the necessary JoviJacket needs to be replaced twice a year.

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CMS-2023-0113-0729	CMS-2023-0113	llw-izgk-67mc	2023-09-14T04:00Z	**Karen**	**Grishaber**	WI		Federal Government - G0005	https://downloads.regulations.gov/CMS-2023-0113-0729/attachment_1.pdf	Thank you for considering attached comments regarding the Calendar Year 2024 Home Health Prospective Payment System Rate Update Proposed Rule (CMS-1780-P), respectfully submitted on behalf of Karen Grishaber and the Diabetes Leadership Council.
CMS-2023-0113-0182	CMS-2023-0113	llf-8cpq-k65j	2023-08-29T04:00Z	**Kara**	**Groenenboom**	IA				I have been a Certified Lymphatic Therapist for 16 years. I was diagnosed with lymphedema to my abdomen, thighs, and chest about 9 years ago. Somedays are harder than others for myself and treating patients. I hear on a regular basis how insurance doesn't cover compressions garments for patients. Most patients in rural area (where I work and live) can't afford their garments. Wearing good compression socks are important for their overall health. This will keep them out of the hospitals due to infections or fluid overload. Compressions garments such as sleeves, socks, wraps, pants, etc are all important for these patients and myself. There are times these patients can go through 2 per day due to drainage or other bodily fluids. They take time to dry and therefore more would be great if possible. The lymphedema treatment act is a big deal that this was passed after many years.
CMS-2023-0113-0668	CMS-2023-0113	llv-z9oj-854k	2023-09-14T04:00Z	**Fenton**	**Groff**	NJ		Other Health Care Professional - HC075	https://downloads.regulations.gov/CMS-2023-0113-0668/attachment_1.pdf	Greetings CMS, I have attached a PDF document in reference to "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items." Thank you for your time and consideration to my comments. Fenton G.
CMS-2023-0113-0560	CMS-2023-0113	llv-12cs-e8of	2023-09-14T04:00Z	**Shelley**	**Grosky**	NH		Other - OT001		I believe we as lymphedema patients need more than 2 pairs of compression stockings in any given year. During hot weather, we sweat in them and they need to be washes daily. Every time I wash them, they lose some of their strength. 6 or 7 pairs would be adequate for a year as that allows me to wear each pair once a week. I can't put them in the dryer, so they have to air dry after being washes in the washing machine. If I continue to wear sweaty compression stockings without washing them, I get sores on my skin. Your coverage of 2 pairs per year is unrealistic. That number definitely needs to be higher! Thank you.
CMS-2023-0113-0859	CMS-2023-0113	llw-vk8v-co88	2023-09-14T04:00Z	**Darcy**	**Guhl**	OR		Health Care Provider/Association - Home Health Facility		I am a home health physical therapist and have been doing this important work for over 20 years. I tell the folks I take care of that my job is to help keep them from going to the hospital by improving their function and overall health. The idea that there are proposed cuts to this service makes my heart ache. Not only does home health provide community medical care that helps to reduce hospital stays and overall health care costs, it also is an essential service, improving an individual's health and wellbeing, both mental and physical. Please do not reduce funding for home health care. It is essential care. Reducing costs will reduce/eliminate services in communities because these agencies will not be able to survive. Then everyone suffers. Ask someone you know if they have had home health and if it made a difference? I am sure the answer will be "It was lifesaving."

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CMS-2023-0113-0590	CMS-2023-0113	llv-8rod-1q8r	2023-09-14T04:00Z	**Joseph**	**Guppy**	WA		Individual		My comments relates to: Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items--In 1955, I was born with lymphedema in both legs and feet. I had my first cellulitis leg infection at 18 months. From that time, until the mid-1990's I suffered periodic infections, at random, but averaging about once a year, including several hospitalizations, when I was given intravenous antibiotic to control the infection. The infections were the most miserable aspect of my childhood--I ran a (sometimes high) fever for days, experienced painful redness and swelling in the infected leg, would be unable to walk for at least a week, miss school and fall behind. And it wasn't until 1989, when I was hospitalized in Los Angeles, that a doctor informed me that these infections were potentially life-threatening--"if you get red streaks up your leg, the infection is heading for your heart." My impression, up that that point, was that doctors either regarded the condition as no more than an unpleasant nuisance, or they didn't know what to do. In the 1990's I discovered the support of the Northwest Lymphedema Center and the National Lymphedema Network. I found out about compression garments, and eventually, in 2000, made a breakthrough by using toe gloves / toe caps to compress my toes. It turned out that this was a key to preventing the lymph fluid, under pressure due to my compromised lymph system, from breaking out through surface holes in my feet and legs, causing fluid leaking, which gave the bacteria the opportunity to infect. Since that time I have spent thousands and thousands of dollars out of pocket on compression garments, (also saving my insurance companies tens of thousands of dollars in hospitalization costs.) Sometimes I had insurance coverage for the garments, but paid out of pocket anyway, because I did not want to reveal that I had a "pre-existing condition" and be denied any coverage at all. Fortunately, the pre-existing condition mandate changed that, but only a few years before I went on Medicare. So being currently on Medicare, I am extremely grateful that, thanks to the Lymphedema Treatment Act, Medicare will go from zero coverage for my compression garments to, hopefully, full coverage. Here are the compression garment issues I advocate for: 1) We need "SETS" of garments, not individual garments. I was born with lymphedema in both my legs and both my feet. I require a set of garments, two garments per limb, not one garment. For me, a daytime set of garments is two leg compression leg garments and two toe caps, every three to six months. (And I need two sets-- see "WASHING" topic below.) If the LTA results in me being covered for, let's say, one garment, I would have to pay for 3/4ths of what I need. For example if the toe caps are not covered, the lymph fluid will return to leaking out my toes, resulting in infections, very expensive hospitalizations; eventually I would be permanently disabled, as successive infections creative additional damage. 2) I need NIGHT-TIME garments, two sets every three to six months. Again, I have paid thousands of dollars out of pocket for night-time garments. These keep the lymphedemous legs from hardening, becoming fibrous. Eventually, hard, fibrous, permanently swollen legs become useless. 3) WASHING--We need at least two full sets of daytime and nighttime garments so we can WASH the garments. The lymphedema does not take a break while the garments are being washed and dried. And you can't throw these garments in the dryer; they will be damaged. Thanks for taking my comments into consideration. I am fortunate that, although these out of pocket expenses have had a definite impact on my long-term financial security, I have been able to pay the costs. Now, as a senior citizen, financial pressure is increasing. Of course, for many other Americans, the emergency room and the hospital have been the only option, since they have not been able to prevent infection by using the compression garments. The policy of not paying for compression garments up to this point has, of course, been incredibly "penny-wise and dollar foolish," as there is nothing more expensive than repeated and prolonged hospital stays, which is the fate of those with chronic infections. Compression garments provide a simple, common-sense, extremely effective, alternative to hospitalization. Thanks for considering these comments.

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CMS-2023-0113-0019	CMS-2023-0113	lkf-koyw-x7ka	2023-08-10T04:00Z	**Stephen**	**Haire**	RI				I am writing as a caregiver and significant other for an individual who has lymphedema along with significant other medical issues impacting the useful life of compression garments. She has been using compression garments for approximately 20 hours per day for approximately 15 years, in addition to other treatments. Other conditions include being bedbound, spinal stenosis, 3 knee replacements with one broken but fused replacement knee, and urinary incontinence, all impacting compression alternatives and mobility. She continues treatment by her doctors and a physical therapist. While we have CNAs, I am the primary person who assists with compression. While the proposed rule has a nice summary of the condition, other conditions present needs outside the norm. I am limiting my comments to Section 1834(z)(2) as to frequency limitations for “nighttime” compression. The daytime limitations for compression are consistent with our use. We have to replace “nighttime” garments having Velcro fasteners more frequently than once per year (9 to 12 months) with respect to trunk compression. For arm and leg compression, the proposed Rule meets current needs. The Velcro closures have been the first component to fail due to washing frequency required. Velcro has proven necessary to maintain compression levels. Without fasteners, compression levels cannot be maintained in all affected areas and the degree of swelling on any particular day. The truck garment needs to be washed frequently which over time has reduced compression effectiveness. The “nighttime” truck garments have not lasted a full year before needing replacement. Please change the exception language to allow replacement of nighttime garments more often than once per year based on the beneficiary’s other or total medical or physical conditions that impact the effectiveness of the compression over time, rather than just a change in beneficiary’s medical or physical condition. The Rule includes “Such changes due to medical necessity will not be subject to the frequency limitations, as previously described.” Consideration must be given to all medical conditions and physical limitations of the beneficiary impacting compression. It is not just progression of other conditions that require more frequent replacement, it can be the totality of those other medical and physical limitations combined with compression construction. Thank you for your consideration.
CMS-2023-0113-0848	CMS-2023-0113	llw-tjma-a8m1	2023-09-14T04:00Z	**Laurie**	**Hamilton**	CO				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0413	CMS-2023-0113	llp-88cl-kit1	2023-09-11T04:00Z	**Margaret**	**Hancock**	DE		Consumer Group		In reference to “Section VII.B-Scope of the Benefit and Payment for Lymphedema Compression Items.” On page 24 of 30, the sentence “or a significant change in body weight”, there should be added after body weight, stature or size. Only having the words significant change in body weight does not address the needs of a growing child. A child may have grown in stature and limb size but not have a significant body weight change.
CMS-2023-0113-0747	CMS-2023-0113	llw-lfr1-hnvt	2023-09-14T04:00Z	**Abbe Buck**	**Hann**	VA		Government - Federal	https://downloads.regulations.gov/CMS-2023-0113-0747/attachment_1.pdf https://downloads.regulations.gov/CMS-2023-0113-0747/attachment_1.jpg https://downloads.regulations.gov/CMS-2023-0113-0747/attachment_2.jpg https://downloads.regulations.gov/CMS-2023-0113-0747/attachment_2.pdf https://downloads.regulations.gov/CMS-2023-0113-0747/attachment_3.png	I am in full agreement with the proposed documentation provided for Lymphedema Compression Treatment (under Medicare Part B, MM of Section 4133 (a) (2) of the CAA 2023 amendment. As a person suffering from Lymphedema, I was suffering from a disease from a disease I never knew I had contracted. In the course of several years my weight went from 223 to 410. I could hardly move my arms or legs, and was unsure on a daily basis if this had anything with two major spinal surgeries I had undergone. Our disease, as explained early in the document we are writing to here, is a chronic one, that if not treated correctly, can worsen through stages until our movement becomes rocklike until we can no longer move at all in some cases, as we are so full of lymphatic fluid, which is heavily made up of water. This is Lymphedema. The impact of our disease, and what it does without treatment, can ultimately lead to death. We must have compression stockings, and in the best way, made to fit us individually. I have been fortunate to finally find a doctor, in what I refer to is a “Happy Accident”. An endrocrynologist who happened to be in an area I was in took on look at my ankles and said “I believe you have Lymphedema. Is anyone treating you?” No. No one was. The doctor immediately sent me to a doctor that treated people for Lymphedema within the hospital to test me. I was tested and II had a significant case in my legs, thighs and tummy. I met with the Lymphedema doctor, and them was assigned to another branch of my hospital that had an Occupational Therapy practice specializing in Lymphedema. The first thing the therapists done was wrap my legs in brown bandages. The second thing they did was place my legs in leg pumps. I was very fortunate that my spouse had an excellent job for the past fifteen years. I was able to get compression stockings from a company my Occupational Therapists referred me to a stocking mfg called Juzo. I have been wearing them for five years now. They make a strong stocking and have excellent customer service should one run into a problem. I became involved in the Lymphedema Treatment Act in late 2018, as I became concerned that there so many people suffering from our disease, one that has no end. At least they could also be more comfortable and in less pain. Heather Ferguson, the president of the Lymphedema Treatment Act, had been as impassioned as much as she was twelve years before, when she co- founded #LTA lin honor of her two children. I wanted to help those who couldn’t afford their stockings, too. The day would be coming sooner than later when my husband would be retiring and we would be going off our Insurance and be on Medicare, Plan B. As this plan will be officially starting on January 1, 2024. By then, or shortly thereafter, we will be going through Medicare Plan B as well. I am very grateful that the Bill had passed through Omnibus. This enables millions of sufferers to receive their stockings. January 1, 2024 will be a very important day on my calendar,
CMS-2023-0113-0505	CMS-2023-0113	llr-wxrd-z95q	2023-09-12T04:00Z	**Judy**	**Hanna**	FL				RE: Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I have managed left leg and abdomen lymphedema for 10+ years following cancer surgery. Compression garments and wrapping costs me on average $1000+ per year out of pocket. Many times, I have delayed purchasing compression items because I did not have the money. Delay can mean a worsening of the lymphedema resulting in more intensive/more expensive treatment provided by a physical therapist which costs insurance more money. I applaud this legislation to begin covering some costs related to compression - thank you! I have a MediCare Part C insurance policy. I am concerned that the restrictive nature of the HMO formulary will not allow those of us on Part C to access to compression and/or night garments that are specific to our needs. Compression is very patient specific and varies over time. What treats lymphedema and wears comfortably for one individual is different from another. Please consider how those of us in Medicare Part C can continue to have access and to have a choice in collaboration with healthcare providers to the compression we know works vs. compression only on the HMO formulary.

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CMS-2023-0113-0091	CMS-2023-0113	ll7-187j-dawp	2023-08-22T04:00Z	**JR**	**Harding**	FL		Health Care Provider/Association - Home Health Facility		To Whom It May Concern, I am pleased to submit the following thoughts and observations to the CMS community-based home healthcare program. As a citizen advocate and a person living with quadriplegia, my comments and observations may not be in a formal format. However, I hope that you may take my lived experiences and apply them appropriately. 1. Persons with disabilities, specifically quadriplegics, continuously face hardships in recruiting and retaining personal care assistance. This challenge is made more difficult when the individual is self-funding and not relying on federal programs to cover costs. 2. Working quads are unable to save for retirement, cover medical co-pays, fund adaptive technology, and daily living expenses. 3. Working quads and others with significant disabilities should be able to receive a modest stipend to offset PCA expenses, while simultaneously working. The stipend threshold should be adequate to meet the above demands of life. Current SGA limits create handicapping outcomes because the earning limits are so low. 4. Reasonable Americans would support (actually think they exist now) a stipend to offset PCA expenses. 5. Access to durable medical equipment is a significant headache for the PWD community. The insurance company and CMS have the final word for product, cost, and need, rather than primary care doctors and the individual living with a disability. 6. Working through insurance companies and CMS can take months for durable medical equipment to be approved. During this timelapse, conditions and needs change, and often get exasperated because intervention tools come too slowly. 7. PWDs should be able to try products for 60-90 days before having to pay the retail or out-of-pocket costs. 8. CMS needs to encourage an environment in which competition drives innovation and service delivery. There are currently too few providers and individual services have been lost as a result of mega companies. Thank you. JR Harding
CMS-2023-0113-0448	CMS-2023-0113	llq-n573-whcm	2023-09-12T04:00Z	**Jamie**	**Hart**	MA		Individual		Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment My name is Jamie Hart and I have secondary lymphedema as a direct result of breast cancer treatment. Within several weeks after my first surgery to remove the tumor and lymph nodes I began to have symptoms. I have lymphedema in my left arm, wrist and hand. I was educated about Lymphedema at the Lahey clinic in Boston and prescribed compression garments immediately. For the past 17 years I have been using a daytime sleeve and glove as well as a night sleeve. I am using compression every day, all day. I am prescribed 2 arm sleeves and 2 gloves every 6 months as well as night sleeve once a year. This is a lifetime need. I was 46 years old when first prescribed and working fulltime. Over the past 17 years I have found the insurance coverage extremely challenging and getting more so. I am finding fewer resources that will measure and carry the product often driving for several hours to work with a resource. As I approach Medicare age, I am grateful that lymphedema garments will be covered. The implementation of coverage needs to address not only the needs of the patients but those of the providers as well. They need to be compensated appropriately throughout the process of diagnosis, measurement and dispensing . I am concerned that the method proposed for calculating reimbursement rates could result in price discrepancies and/or very low reimbursement rates, possibly resulting in an inadequate number of vendors willing to supply these products. We need to make this a win-win for both patients and providers so we can find the needed service close to where we live.

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CMS-2023-0113-0577	CMS-2023-0113	llv-5pfo-3bs7	2023-09-14T04:00Z	**Cheyenne**	**Harvey**	UT		Individual		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0012	CMS-2023-0113	lke-ay8f-bleg	2023-08-10T04:00Z	**Barbara Carmen**	**Hazera**	FL		Individual		From full time Respiratory Care Practitioner to disabled. The cost of lymphedema supplies is not the only cost. Retirement at 64 made my Social Security check much smaller. Life plan to retire at full retirement to support myself, a single woman, destroyed. Hope future lymphedema patients will have a better outcome.
CMS-2023-0113-0213	CMS-2023-0113	lll-adsb-62jv	2023-08-29T04:00Z	**Linda**	**Hedden**	NJ		Individual		My commets refers to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. Grateful for this new coverage that will help so many of us that suffer with this condition. The garments that we wear are very hard to apply to our bodies. Will this new benefit also cover the gloves, glue, stocking holders or what simply devise that helps us to apply our garments. These are a necessity too.
CMS-2023-0113-0092	CMS-2023-0113	ll7-1zxa-wxzs	2023-08-22T04:00Z	**Donna**	**Hedicke**	NM		Individual		Something truly needs to be done about the quality and availability of home healthcare. My spouse is wheelchair bound - entirely unable to bear weight because of CIDP. We have been able to obtain home healthcare, but the caregivers are usually (1) underpaid, (2) lack initiative, (3) not dependable, and (4) lazy. Perhaps that is because they are underpaid. We have found that the managers of the caregivers are not well trained in matching the skills of the caregiver to the needs of the patient. In our area, they often don't speak English. It has been very frustrating to us to make sure there is a responsible, caring adult present with my spouse when I go to work. If I don't work, we will be on governmental aid of some kind. My spouse needs to stay in his home and live with dignity and respect. We don't need a "caregiver" that sits on a chair, playing on their phone all day. If you raise the rates of pay to the actual caregiver (not the piggy business owner) it might attract people with better qualities sufficient for the work. Our caregiver makes only $9 an hour and still has to pay for benefits. That just isn't fair! Also, providing for SAFE and SANITARY IVIG infusions would help enormously. It is very difficult to transfer my husband from WC to car to WC to infusion chair and back again. Such a struggle for necessary treatment.

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CMS-2023-0113-0900	CMS-2023-0113	llx-7jw0-jww9	2023-09-14T04:00Z	**Andi**	**Heinemann**	TN		Health Care Professional/Association - Physical Therapist		Dear CMS Officials, I am a Doctor of Physical Therapy practitioner of 28 years, 23 of which I have been a CLT. I have earned certification from both Leduc and ACOLS schools and LANA certification in 2015. I have exclusively treated lymphedema since 2008. Since 2008, I have developed and manage a specialties clinic dedicated to patients with this disease. Our clinic has about 75-80 visits per week for lymphedema and swelling related disorders. We are in a rural setting and are a part of an independent, non-profit hospital system. I am submitting comments regarding the CMS proposed coverage of DME items for patients with lymphedema because this essential coverage is pivotal to achieve the long over due basic healthcare needed to manage lymphedema responsibly. I commend our legislators and CMS on recognizing this need and rising to the occasion for our affected citizens. In all of my years of healthcare service, this one shift to provide what is needed for our citizens suffering with Lymphedema may be the biggest “bang for the buck” CMS has ever achieved. The effect on improving mobility, quality of life, and consequently health, will be massive. For this reason I respectfully leave comment about the following proposed rulings regarding the prescription, purchase and regulation of providing compression garments. Most of our patients who suffer with lymphedema (and other forms of chronic swelling) have a more complex medical history, co-morbidities, or other impairments which already leave them pre-disposed to acute infection, DVT, decline in function or hospitalization. Garments make the difference between staying functional, independent and relatively well or the opposite. To do this compression wear MUST be worn most of the day, usually 23 out of 24 hours. To wear compression is to accept putting “skin over your own skin” which is at best, difficult to adjust to even when all aspects of the garment worn is a “perfect fit”. Most people, even those who may love glamour wear or parties, would openly revolt having to wear something that feels like “SPANX” most hours of the day, everyday. When you factor in all the variables required to “select” or “fit” a patient for a compression garment, you are having to integrate 20 or more variables which affect the success of that garment, not to mention how your patient will be able to receive the compression on their bodies, be able to put it on, and whether or not it will “hold the line” across the hours it is worn WITHOUT creating any damage or pain requiring removal. Of all the work me and my therapists do, finding the “right garment”, monitoring for proper fit and containment, as well as determining how it best fits into a home program is the hardest part of what we do. In phase 1, patients reduction is in the hands of the therapist. In phase 2, self management, the patient must navigate it’s use for any success. This may seem like a simple venture but it is not. the human body has innumerable variables that affect the body’s ability to respond to compression well. Venous congestion, BMI, activity level, body shape, skin sensitivity, patient flexibility, organ failure or insufficiency, scar tissue, radiation effects, etc all produce an outcome that requires a unique combination of items to both control lymph fluid refill and enable the patient to manage the garment ion their home environment. Yes, some cases are simpler, but most are not. No one knows my patients better me. The reduction process teaches me a lot about my patient’s particular case. It is through the patient-therapist alliance that I learn about their tolerances and personal limits. Often we must work with a patient to develop tolerances and make compression add/removals to arrive at an effective, manageable product. I want to address 2 key points. First, patients need their therapist to be actively involved in prescription and ongoing fitting of their compression wear systems. There is no way a fitter in an O&P or DME can adequately assess and provide the feedback needed to achieve optimal fit and function. Even if a DME has an excellent fitter, the therapist will likely have to collaborate. When this does not happen, the outcome is not what we are all trying to achieve here to improve our patient’s health. Fit informs fabric selection, style/components, revision and ultimately function and health. I suggest you establish the fee recommended by the USMCA for the garment price alone and allow the professional fee currently established for 97760 and 97763 to remain payable by CMS to therapists. If a DME provides a “fitting” by a fitter, a separate, lesser fee can be billed and paid to CMS for that fitting with appropriate guidelines. DME fitters do not provide the same expertise and knowledge as CLT providers. Second, 2 sets of garments is not enough. A person can go through 2 sets in a day given weather, sickness or accidents. I recommend 3 every 6 months.

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CMS-2023-0113-0343	CMS-2023-0113	llm-j5m3-spz7	2023-09-11T04:00Z	**Paige**	**Hellmann**	IA				Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in Iowa. Specifically, we serve the greater Des Moines Area along with Marshalltown, Ottumwa, Webster City, and Knoxville. We have been a Medicare participating home health agency for almost 20 years and have a current client census of over 700! We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state's citizens. Sincerely, Paige Hellmann Human Resources Assistant Iowa Home Care West Des Moines, IA

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CMS-2023-0113-0533	CMS-2023-0113	llu-g9uz-ayq7	2023-09-12T04:00Z	**Sandy**	**Henschel**	OR		Individual		To Centers for Medicare and Medicaid Services: Management of my secondary (to cancer) leg lymphedema requires multiple items. If I do not comply with daily use and nighttime use of a night time garment (Jovi Pak), then I am to expect major problems. My necessary items to manage lymphedema and to have a better quality of life outcome include the following: Medical grade Custom thigh highs (I have 2 so that when one is in the wash, I wear the other stocking) Medical grade Prescription (non-custom) thigh highs (open-toe in the summer months and closed-toe in cooler months) Note: I have color variations so that I can wear the colored thigh highs when I work out at my gym. I have 4 pairs of these particular thigh highs and I alternate between the 4 pairs of non-custom and the 2 pairs of custom thigh highs. I use both Medi and Jobst brands of the prescription thigh highs. I gravitate towards Medi for summer use as their stocking is more lightweight that the Jobst. I gravitate towards Jobst brand in the winter months as it is a heavier weight fabric. Circaid wraps: these are provided via prescription from my rehabilitation physical therapist who specializes in the treatment of Lymphedema. These wraps are used when flying on an airplane, when needing to reduce the size of my leg to ensure the best fit for custom thigh highs, when traveling. Ready wraps are also used when I am not using my Circaid wraps. (I alternate between the two). The leg wraps would have to include the thigh, knee, calf, and foot for my leg lymphedema. Circaid and Ready wraps are very important items for my leg to stay in good control. I consider these items to be a necessity. Night time garment: this was mentioned above, but the one that I use is the Jovi Pak by Jobst. I need one of these each and every year. They come with a cover to protect the garment as well. Wraps/Velcro bandage systems: Wraps have their importance in the management of Lymphedema and some of the better wraps are the velcro bandages/wraps used to prevent further swelling of the affected appendage. All items related to the management of my leg lymphedema are quality of life issues and if I am not compliant with using the recommended items, then I can suffer from dire consequences. It makes so much sense for Medicare to put money forth for the prevention of Lymphedema complications than for Medicare to have to pay for us suffering from infections like Cellulitis or Sepsis and having to be hospitalized or placed in a rehabilitation facility. I very much appreciate the fact that the Lymphedema Treatment Act passed and will be effective starting January 1, 2024.
CMS-2023-0113-0181	CMS-2023-0113	lle-k6ms-1gtl	2023-08-29T04:00Z	**Derek**	**Herrera**	CA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0181/attachment_1.pdf	See attached file.
CMS-2023-0113-0554	CMS-2023-0113	llv-028y-23dw	2023-09-14T04:00Z	**Sarah**	**Herzberg**	ID		Home Health Facility - HPA25		To Whom it May Concern with CMS, I am writing today as an administrative assistant for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 4.69% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Sarah Herzberg Home Health Administrative Assistant

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CMS-2023-0113-0134	CMS-2023-0113	llc-7rr3-9cy4	2023-08-22T04:00Z	**Gene**	**Hetz**	NY				My name is Gene Hetz and I am a Lymphedema Therapist working in the home health setting in NY. I support the maximum coverage amount for garments, and the chief obstacle to adoption of garments by my patients is the cost. When my patients learn of the cost of standard compression sleeves or inelastic adjustable compression garments they choose to forgo compression at the expense of disease progression. The prohibitive OOP cost directly results in irreversible trophic changes, decreased physical function, and increased risk of infections requiring hospitalization and increased utilization of healthcare services. I support the coverage of donning and doffing equipment, as the second biggest obstacle to garment use with my patients is the inability to don and doff garments due to decreased mobility and a lack of adequate social support in the form of having others who could apply these garments. Regarding Section 1834(z)(2), I support the coverage of two garments per limb for daytime use to allow for one to be washed and one to be worn. I believe that the same should be true to nighttime garments, as they typically should be air dried, which can take more than one day depending on the garment and would prevent the patient from wearing the garment during the drying process.
CMS-2023-0113-0122	CMS-2023-0113	lla-tv93-so7f	2023-08-22T04:00Z	**Carl**	**Higgins**	CA				This comment is in response to the solicitation from CMS if they should differentiate compression garments within THREE pressure levels other than the current Level 1 (18-30 mmHg), Level 2 (30-40 mmHg) and Level 3 (40-50 mmHg). It has been my personal experience as a Lymphedema patient for nearly 10 years that manufacturers like Medi and Jobst use FOUR classes of pressure levels in their custom compression garments as follows: CCL 1 (18-21 mmHg, CCL 2 (23-32 mmHg, CCL 3 (34-46 mmHg) and CCL 4 (49-60 mmHg). And, in fact, Jobst makes garments as high as 90 mmHg. If these changes are included then presumably additional code numbers and payment amounts may be required.
CMS-2023-0113-0127	CMS-2023-0113	llb-4pei-yi16	2023-08-22T04:00Z	**erik**	**himbert**	OR		Individual	https://downloads.regulations.gov/CMS-2023-0113-0127/attachment_1.pdf	*SEE ATTACHED FILE
CMS-2023-0113-0022	CMS-2023-0113	lki-br95-6v0j	2023-08-10T04:00Z	**Mary Jo**	**Hitz**	PA				Grateful for the opportunity to relay lymphedema compression needs that are shared by myself and other lymphedema patients. I have cancer related lymphedema in my left leg from toes to thigh. Vigilant care and compliance are taken, to prevent infection by wearing a standard soft flat thigh high stocking and a custom toe cap. In regards to the recommended quantities and replacement exceptions, alternating compression levels are necessary for me to maintain healthy skin. I require a pair of 20-30 mmHg and a pair of 15-20 mmHg every four to six months plus 2 custom toe caps. My skin displays an allergic reaction not to the fabrication but to compression alone. To boost my need to maintain lymphedema swelling my ankle is wrapped in Kinesio tape under my stocking. For the last ten years I have worked with a Certified Lymphedema Therapist. He guides my choice of garments, usage of garments as well as taking measurements for a custom toe cap. This regime of alternating compression levels has kept me free of infection, off disability, in the workplace until age 70 and an advocate for the Lymphedema Treatment Act. Thank you for your consideration in crafting the life altering Lymphedema Treatment Act.
CMS-2023-0113-0132	CMS-2023-0113	llb-iz4x-licf	2023-08-22T04:00Z	**mary**	**Hitz**	PA				Grateful for the opportunity to relay lymphedema compression needs that are shared by myself and other lymphedema patients. I have cancer related lymphedema in my left leg from toes to thigh. Vigilant care and compliance are taken, to prevent infection by wearing a standard soft flat thigh high stocking and a custom toe cap. Alternating compression levels are necessary for me to maintain healthy skin. I require a pair of 20-30 mmHg and a pair of 15-20 mmHg every four to six months. My skin displays an allergic reaction not to the fabrication but to compression alone. To boost my need to maintain lymphedema swelling my ankle is wrapped in Kinesio tape under my stocking. For the last ten years I have worked with a Certified Lymphedema Therapist. He guides my choice of garments, usage of garments as well as taking measurements for a custom toe cap. This regime of alternating compression levels has kept me free of infection, off disability, in the workplace until age 70 and an advocate for the Lymphedema Treatment Act. Thank you for your consideration in crafting the life altering Lymphedema Treatment Act.
CMS-2023-0113-0048	CMS-2023-0113	ll1-9c5e-6bzi	2023-08-10T04:00Z	**Linda**	**Hodgkins**	CT			https://downloads.regulations.gov/CMS-2023-0113-0048/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0667	CMS-2023-0113	llv-y4ol-cyjn	2023-09-14T04:00Z	**Jamela**	**Hodgson**	NC		Health Care Industry - PI015		Cms-1780-P -Finally coverage for lymphedema products! I am a certified fitter for over 15 years. Reimbursement rates must include allowance for fitting, overhead and cost of doing business. Using online retail rates do not cover a professionals time and expense. It can take an hour and a half to properly fit a garment, not including the time to file the claim. Garments should be replaced every 3 months. The client needs at least 3 a2 to wash and one to wear. They begin to lose elasticity and efficacy after 3 months. Certain garments (gloves for example) wear out very quickly in patients who work with their hands. Nighttime garments and I elastic wraps should be replaced every 6 months.
CMS-2023-0113-0530	CMS-2023-0113	llu-b7e6-toq5	2023-09-12T04:00Z	**Anette**	**Hogan**			Individual		I am writing to advocate for broader availability of, and financial assistance for personal exoskeleton coverage in the Medicare benefit category for braces. These devices can truly be life changing. 21 years ago, I was an active, athletic woman with a wonderful life ahead of me. Then I was diagnosed with multiple sclerosis. For several years my symptoms were mild and unnoticeable to anyone but me. By 2005, though, the disease was beginning to affect my balance and mobility. Within a few short years, I went from walking with the aid of a cane, to needing the support of a wheeled walker. Then, in September of 2014, I lost the use of my legs altogether. For the past 9 years, I have literally not taken a day off from various physical therapies, exercises, stretching and doing everything I possibly can to retain what upper-body mobility I still have. MS is a terrible disease that takes but, typically, does not give back when it comes to mobility. Especially walking. Then, in July of 2022, I began visiting an outpatient rehabilitation clinic in Pomona, California to use an Ekso Bionics computerized robotic exoskeleton device that helps me to stand and WALK! The emotional rush from once again being on my feet and taking steps was nearly overwhelming. But the best part is that—over the past 13 months—my legs have begun responding and I can actually take limited steps under my own power. I attribute this fully to the robotic exoskeleton device since, despite all of my previous continuous hard work and efforts—which I continue—nothing helped me regain leg mobility. The not so good news and pertinent reason for my exoskeleton advocacy is that, in my case, it is a 2-hour drive each way to the physical therapy center in Pomona. Four hours of driving for a single 45-minute session. Including personal exoskeletons in the Medicare benefit category for braces will induce more physical therapy centers to provide robotic exoskeleton therapy, helping to ensure broader access to the exoskeleton technology to many more patients like me. The cost/benefits of getting patients walking again are significant. The hope these devices can provide? Priceless.
CMS-2023-0113-0793	CMS-2023-0113	llw-q9at-9rla	2023-09-14T04:00Z	**Dawn**	**Honarvar**	KS		Individual		Section VII.B.-Scope of the Benefit and Payment for Lymphedema Compression Treatment Items 1. Stages of Lymphedema are important to list as has been done, however the stage numbering is not in alignment with medical industry. Stages should be Stage 0-3 for the numbering of the 4 phases. 2. Compression gradient levels vary by type of compression garment and body area. mmHg is the compression level, however the ranges for each level are not consistent and thus, either all body areas and related compression should be listed and included in codes or just the description, ie: low, moderate, high as not to delay approval of needed compression garments if vendors have varying ranges. 3. Billing for the measurement component of compression garments, whether standard or custom, is better served by the patient's trained physical or occupation therapist or physician prescribing as they have the most knowledge of the patients needs for specific size options as ranges overlap in some garments. It is proposed to bill as is currently done with prosthetics and orthotics and have a code for initial encounter and management and training that includes measurement and then fitting and adjusting as needed on an ongoing basis. 4.There do not need to be separate codes for mastectomy sleeves as the arm sleeves, gloves and gauntlets are not different than for other upper extremity patients 5. However, codes for combination sleeves currently include sleeve and glove currently, but sleeve and gauntlet are more common and should be added. Offering to include 2 daytime garments is good, however there should be 2 nighttime due to time needed for washing and drying. Also, for hands/fingers and feet/toes, these get dirty more often than other body parts and should be increased to 4.
CMS-2023-0113-0469	CMS-2023-0113	llq-scqo-wczo	2023-09-12T04:00Z	**Jennifer**	**Hood**	CO		Health Care Professional/Association - Other Practitione		I support the endorsement of the US Medical Compression Alliance in regards to changes we want to see in the proposed bill.

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CMS-2023-0113-0659	CMS-2023-0113	llv-rpeb-yq0n	2023-09-14T04:00Z	**Rebecca**	**Hood**	WA		Individual		I developed secondary lymphedema of the left leg in July 2003 as a result of a hysterectomy and radiation treatment for endometrial cancer in April – June of that year. I had 15 lymph nodes removed in my groin, and two had cancer. My right leg has been considered at risk since that time. I received Physical Therapy and was prescribed over-the-counter Jobst compression pantyhose of Medical Grade Class II 30-40 mmHg. While the OTC pantyhose were somewhat helpful in containing my lymphedema, by the end of each day, my left ankle would swell to the size of a grapefruit, due to the horizontal compression design, and the pantyhose were extremely difficult to remove. I used the OTC pantyhose until 2013 when I had the first of three occurrences of cellulitis of the left leg that resulted in hospitalizations. The first was in May 2013, and the subsequent occurrences were in November 2014 and August 2016. After the first instance, my Primary Care Provider referred me to the Lymphedema Clinic. At that time, I was prescribed custom compression garments. The vertical design of the garments and higher class of compression were deemed necessary to control my lymphedema. I was also prescribed a nighttime garment and a lymphedema pump. Each occurrence of cellulitis has further damaged the tissue in my left leg, particularly my ankle and calf, requiring increased compression. I now require Medical Grade Class IV of 49-70 mmHg in my lower leg. I am currently 62 years old and retired and have Individual insurance. The coverage for my compression garments has been challenging, unlike when I was covered by employer-based insurance. I was relieved when the Lymphedema Treatment Act was passed so that I can be sure to have coverage for the compression garments I require once I become eligible for Medicare. And I am hopeful that Individual insurance plans will follow suit in the meantime.
CMS-2023-0113-0442	CMS-2023-0113	llq-40du-ig76	2023-09-12T04:00Z	**Holly**	**Houston**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0878	CMS-2023-0113	llx-05gv-4xl9	2023-09-14T04:00Z	**Jennifer**	**Hovatter**	TN				I am the widow of a lymphedema patient. My dear husband Thomas passed away when he was only 43 years old due to complications from lymphedema. By the time he was properly diagnosed his condition was very advanced, so he was prescribed custom-made compression garments. Our insurance did not want to cover them because they followed Medicare guidelines, which caused a delay in him beginning treatment. Unfortunately, during that delay he developed a cellulitis infection, became septic, and died before receiving the compression garments he needed that could have prevented the infection and saved his life. I am so glad that this coverage gap will soon be closed, but I am concerned about patients who, like my late husband, need custom garments. Please make sure these patients do not experience a delay like my Thomas did. It can be a matter of life and death.

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CMS-2023-0113-0508	CMS-2023-0113	lls-6eur-mcmw	2023-09-12T04:00Z	**Laurie**	**Howard**	MN		Individual		As an Ovarian Cancer Survivor. I am grateful for the second chance in life. With my treatment for eradication of the mass, I was also left with Lymphedema of the left side of the abdomen. I now have to wear compression full time and do manual drains twice a day. These garments are crucial to curbing the buildup of fluid where I have lymphatic fluid that is trapped. This is affecting immunity and is a sometimes painful result of the lifesaving surgery . These steps to protect one's health are not optional. These garments are medical supplies just like any other supply item to maintain a quality of life and ward off ill health. The only type of garment I can use because of my size and body shape are of a lower compression level than the "standard" abdominal compression garments but are the only garment that works for me . A proper fit is vital or it can do more harm than good . Lymphedema is a chronic disease with no cure. It progresses over time and is something that lowers the quality of life. Special diets are necessary as well to avoid inflaming the lymph fluid from building up and backing up in the immune system. Inclusion of the garments has been long overdue. Some of them can cost at minimum $100.00 a piece. You need at least two per day since personal hygiene is crucial to the management of the disease. Adding up the total of having enough clean garments in the patient's rotation and getting the advised manual Lymphatic drainage every four to six weeks is staggering over time . This is a disability and the garments should be a covered part of patient care to manage the disease and seek a quality of life that is manageable. Some patients develop the disease with no discernable risk factors. Thank you for allowing my comments Sincerely, Laurie P Howard
CMS-2023-0113-0825	CMS-2023-0113	llw-rgbv-zfv0	2023-09-14T04:00Z	**Sydel**	**Howell**	CA		Other Health Care Professional - HC075	https://downloads.regulations.gov/CMS-2023-0113-0825/attachment_1.pdf	Please see attached document regarding the Lymphedema Treatment Act request for comments.
CMS-2023-0113-0030	CMS-2023-0113	lkn-2t7m-pqu2	2023-08-10T04:00Z	**Trina**	**Huber**	IA		Occupational Therapist - HC050	https://downloads.regulations.gov/CMS-2023-0113-0030/attachment_1.pdf	Please see attached.
CMS-2023-0113-0608	CMS-2023-0113	llv-cb9u-3pkx	2023-09-14T04:00Z	**Chris**	**Huber**	UT			https://downloads.regulations.gov/CMS-2023-0113-0608/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0211	CMS-2023-0113	lll-5xoo-28ic	2023-08-29T04:00Z	**Mary**	**Hughes**	TX		Individual		After 5 years in remission of Breast Cancer, with 2 scares in between, I have now experienced Lymphedema. I has taken almost 2 months and clearance through 4 doctors to finally get to see a Lymphedema Therapist. This gal is passionate and thorough in her explanations. I have already seen lots of improvement. I do foresee this reoccurring as I have had it explained there is no cure, just therapy. I foresee medical costs for this issue adding up quickly. It is my opinion that those of us on Medicare are already living on fixed incomes and need all the help we can get to help us with medical costs. I am a petite person, so finding medical garments for me has always been a challenge. I am NOT a person looking for a handout OR something my government can do for me! I am a United States Marine Corps veteran, spouse of a USMC AND United States Navy retiree, and only appreciate receiving what I feel I paid into all the employment years of my life.
CMS-2023-0113-0371	CMS-2023-0113	lln-mvyw-tvex	2023-09-11T04:00Z	**Eileen**	**Hunter**	PA		Health Plan or Association		Many people prefer to receive healthcare at home, and it saves hospital and rehab costs, so I would ask you to reconsider the budget cuts for home health agencies, thank you!

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CMS-2023-0113-0734	CMS-2023-0113	llw-kamf-0b4o	2023-09-14T04:00Z	**Aaron**	**Hwang**			Physical Therapist - HC045		To Whom It May Concern: As a Physical Therapist passionate about improving the lives of those affected by cancer, I must comment and advocate for cancer patients affected by lymphedema. I am requesting clarification on the six topics below: 1. Total Cap: I request no total cap on the dollar amount or number of medically necessary supplies. a. Changes in type and grade of compression cannot always be finalized before the person uses the compression. A no total cap policy allows the individual and their therapist flexibility to optimize the person's compression needs. 2. Medical Necessity: Timely review of medical necessity appeal is critical to support optimal lymphatic management. a. As mentioned, people may require compression bandaging until they can transition to a compression garment. A long appeal process will impact their ability to transition, resulting in less functional mobility, reduced independence, and financial and time toxicity. b. Additionally, an untimely appeals process can result in significant risks for other health problems such as infection as well as skin breakdown and falls due to immobility. Additionally, mental health concerns related to self-image could occur due to the individual having an enlarged limb and by having to wear prolonged compression bandages. 3. Bandages: Bandages and garments ideally would be separated into 2 categories without a cap. Each should be eligible for coverage. a. Based on the American Physical Therapy Associations Clinical Practical Guideline for Breast Cancer Related Lymphedema, bandaging is a critical part of lymphedema management for those with Stage II and III lymphedema (Davies 2020). It is required until a patient reaches maximal lymphatic decongestion before transitioning into an appropriately fitting compression garment. Supplying a garment too soon can negatively affect the person's maximal decongestion. 4. Garment Set Definition: The ruling states that 2 'sets' will be covered every 6 months. a. Two garments or garment sets, enable the person to wear compression while washing their other garment set. This is critical for skin hygiene and infection prevention. A complete wash cycle can take up to 24 hours. b. Further definition of sets as the 'garments an individual needs to wear over a 24-hour period' will provide coverage for those who use more than one garment type throughout the 24-hour period AND support skin hygiene. Allowing different products and combinations within a set would support the individual characteristics of garments to fit the individual characteristics of people with lymphedema. c. Many people with lymphedema have different needs and are at significant risk of declined mobility and lymphatic congestion, leading to more significant medical consequences and costs if they do not receive the necessary supplies. The LTA was designed to accommodate these needs of the population and should be included in the draft ruling. d. Coverage should be considered for those who need unique compression garments for activities such as swimming that promote lymphatic movement and further improve the health and independence of the person with lymphedema. 5. ICD-10 Codes: CMS states that only patients with 'lymphedema diagnosis' codes will be eligible for coverage. a. Different ICD-10 codes should be developed for the right and left sides of the body and each region of the axial skeleton (pelvic, abdomen, buttock, chest, back, breast, neck, head). 6. Optimal Care: A referral to a licensed clinician or certified lymphedema therapist is not required. A recommendation to see a qualified clinician when newly diagnosed or significant change in function or lymphedema status would be optimal to ensure the right type, size, compression level, and location will reduce potential harm and maximize the benefit of compression. Should individuals order these garments themselves before achieving optimal decongestion could result in additional financial and time toxicity. We urge you to consider these topics and clarify initial statements before 1/1/24, as the previously listed situations can be crucial to individuals living with lymphedema. Thank you for your consideration.

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CMS-2023-0113-0675	CMS-2023-0113	llw-9nwt-wzqf	2023-09-14T04:00Z	**Jan**	**Ireland**	ID				Dear CMS, I am writing today as an administrator for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A XX% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather Dear CMS, I am writing today as a Registered Nurse for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A -3.43% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Jan Ireland, RN, BSN, CM Horizon Home Health & Hospice

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CMS-2023-0113-0896	CMS-2023-0113	llx-723u-rnnc	2023-09-14T04:00Z	**Matt**	**Janes**	KY				Thank you for allowing an open comment period for the CMS CY 2024 Home Health PPS Proposed Rule. In consideration of the proposed payment adjustments included as part of the proposed rule, I would encourage CMS to adequately consider overhead costs and administrative burden as part of the total cost of care. As an example, since the implementation of the Patient-Driven Groupings Model (PDGM), gasoline and auto maintenance costs have continued to rise, placing an increased burden not only on the clinician but also on the agency. The home health care delivery model, provided in a patient's place of residence, varies significantly from patient to patient. This includes distance traveled especially in rural or economically challenged areas. This increased burden is either absorbed by the agency or directly by the practicing clinician. CMS should also consider the additional cost burden of delivering technologies to enhance patient care and help reduce potentially preventable hospitalization. Technologies such as the use of remote patient monitoring technologies aka telehealth and virtual care visits remain at the cost of the Medicare Part A provider to realize as no reimbursement for deploying these technologies for patient care benefits currently exists. Despite the prospective payment system methodology, there is no additional consideration for implementing and deploying this technology. This year's proposed rule remains silent on this evolving innovative patient care strategy despite recognition, billing, and reimbursement inclusion in other practice settings. CMS should also consider the increased oversight requirements, costs, and educational activities required to ensure agency and clinician adherence to regulatory requirements or conditions of participation. This includes but is not limited to OASIS routine updates, EMR integration, deployment, maintenance and improvement costs, data analytical software, HHCAHPS vendor fees, quality reporting, and monitoring activities including ensuring a comprehensive Quality Assurance and Performance Improvement (QAPI) program. With increasing labor costs, challenges with worker retention, and the indisputable nursing shortage now and for years to come, CMS should consider how to modernize the home health patient care model by promoting a more robust and responsive multidisciplinary care model. As an example, the dated approach of requiring a registered nurse to perform a comprehensive assessment when physical therapy is also ordered as part of the referral is an antiquated and inefficient collaborative care model. The flexibilities during the Public Health Emergency (PHE) addressed this issue to some degree, however, despite other disciplines ability to perform a comprehensive assessment appropriately, agencies are still faced with this antiquated approach to patient care assessment and management. I would highly recommend CMS take time to engage with industry stakeholders, but most importantly front-line clinicians. Further, I would recommend CMS better understand the capabilities of clinicians today and help foster an updated collaborative approach to comprehensive patient care. As a clinician for over 25 years with the majority served in home health practice, in consideration of other practice settings and assessing disciplines including physicians and other healthcare providers responsible for care oversight, the OASIS remains the most complex and comprehensive patient assessment instrument within the healthcare industry. Singularly the total amount of assessment questions and potential answers goes far above other healthcare practice settings. The inclusion and expectation of meaningful measures for the home health quality reporting program (QRP) are now misrepresented by an insurmountable number of questions and response options contained within the OASIS. Many measures would be best served by primary care or other healthcare providers directly managing and/or coordinating a patient's care. An example in the CY 2024 proposed rule is to include reporting on "COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine)" beginning in CY 2025. This measure is served to be assessed during a primary care visit. Further, I would encourage CMS to consider how to promote adherence to and opportunities for better patient care and management practices versus serving primarily as a data collector where the understanding of the intent and accuracy of the specific response drives outcome performance.

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CMS-2023-0113-0541	CMS-2023-0113	llu-v7gf-0dgr	2023-09-14T04:00Z	**Shana**	**Johannessen**	PA		Individual		I've been living with lymphedema post-breast cancer treatment since 2015. My situation became worse when I had a recurrence of my cancer and had to undergo more invasive treatment in 2018. That treatment included tumor removal, chemo, radiation, removal of my ovaries, oral chemo (still taking), and the following year I had my other breast removed to prevent getting lymphedema in my other arm. I've had two lymphatic infections over these years, and I've learned that my compression garments are not optional. I need them all day, every day. I've been through a lot, as many of us have. The thing that most messes with my head, though, is that the lymphedema could someday get away from me. More than the weird lumpy flat chest I've been left with, the sleeve on my arm is both humiliating and necessary. I wear my custom day and night garments religiously, for fear of something worse. I used to be able to get six custom day sleeves through my insurance at a time (annually), and for a time I did, until I had about a dozen, which is a comfortable situation in terms of laundry. It allowed me to exercise (necessary for lymphedema management), get a clean sleeve (sometimes you need more than one in a day!) and do laundry every five to seven days. However, in the last couple of years, I've only been allowed 2 sleeves per annual order. My sleeves are dwindling. I find some days I have to choose not to get sweaty in order to keep my schedule, because I cannot get to the laundry enough (I have two young kids with busy schedules that require my running them, and I work part time). I'm sacrificing self-care because of insurance limitations. I have about 9-10 sleeves now and the numbers keep going down as the elastic fails. Every time I launder them now I have a panic attack. What is going to happen when I am down to only two sleeves per the new coverage rules? What if my cat catches my sleeve and puts a pull in it (it's never happened, but it could) that makes it ineffective? What if something stains my sleeve and I have to wear a dirty garment in public until I am eligible for a new, clean sleeve? I feel like these rules do not take human beings into account in a way that recognizes the mental and physical toll the condition and its management take.
CMS-2023-0113-0056	CMS-2023-0113	ll2-j0ql-zfr1	2023-08-10T04:00Z	**Kathleen**	**Johnson**	FL		Other - OT001		Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items I'm 65 years old and I have had severe Lymphedema in my left arm for 10 Years. I can't afford prescription compression garments so Im forced to wear over the counter garments which I can no longer afford. There's times when I just want to cut off my arm. It is so heavy and the pain is overwhelming. I went to Physical Therapy but it didn't help at all. The anxiety and depression I am feeling just wont go away. I'm sure it would help if the garments would be paid by insurance.
CMS-2023-0113-0853	CMS-2023-0113	llw-ula7-whmp	2023-09-14T04:00Z	**Tim**	**Johnson**	CA		Home Health Facility - HPA25		CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year.
CMS-2023-0113-0876	CMS-2023-0113	llw-zwp3-0npb	2023-09-14T04:00Z	**Andreana**	**Johnson**	NC		Other - OT001		I propose that there be allowance for coverage for the cleaning/maintenance of durable equipment such as the Reid Sleeve, by Peninsula Medical,and the fabric attachment of the Flexitouch Machine. The manufacturer of the products offers such services and this would aid in the long term durability and service of equipment for the patient. In addition, allowances for skin care products for the patient and cleaning solution for the garments that are conducive with the wear and care of custom compression garments made by Jobst and Medi and will prevent the premature breakdown of the material the are made of because an incorrect but affordable accessible " workable " option was used.
CMS-2023-0113-0770	CMS-2023-0113	llw-o443-p69g	2023-09-14T04:00Z	**Travis**	**Jones**	TX		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0770/attachment_1.pdf	See attached file
CMS-2023-0113-0858	CMS-2023-0113	llw-uzs6-q5py	2023-09-14T04:00Z	**Vicki**	**Jones**	TX		Individual	https://downloads.regulations.gov/CMS-2023-0113-0858/attachment_1.docx	As a DME owner and Medicare provider for nearly 35 years, I have seen incredible changes in Medicare. Seeing inclusion of compression garments for the diagnosis of lymphedema for Medicare beneficiaries is one of the best changes witnessed through these years. Thank you for this Proposed Rule and the opportunity to comment on Medicare's proposal of coverage, including items, descriptions, HCPC codes, allowables, frequency and replacements, and suggestions for new product categories and items to be included. It has been my privilege to be a part of this. My comments are attached.

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CMS-2023-0113-0883	CMS-2023-0113	llx-25qx-eq6r	2023-09-14T04:00Z	**WARREN**	**JONES, MD, FAAFP**	MS		Physician - HC005	https://downloads.regulations.gov/CMS-2023-0113-0883/attachment_1.pdf	Please accept my letter of communication regarding the Helping Our Senior Population In Comfort Environments Act. I invite you to reach out to me if I may be able to provide any additional information. Respectfully, Warren A. Jones,MD,FAAFP
CMS-2023-0113-0535	CMS-2023-0113	llu-roe3-l2mp	2023-09-12T04:00Z	**Mary Ellen**	**Juliano**	WI		Individual - I0001		file code CMS–1780–P. I first want to take this opportunity to thank all who have advocated! I am a 23 year survivor of cervical cancer with right leg lymphedema. Cervical cancer affected my pelvis and the lymph nodes in my groin. It has grown to a gross enlargement of my right leg and thigh. Especially around the knee. I'm very grateful for the lymphedema treatment act. I don't agree with 2 sets per 6 months. While this may work for some, it won't be enough for me. Even though I have a heavy right leg, I refuse to stop doing things that bring me joy. I love the outdoors and all that it encompasses. I live in Wisconsin. In February, I travel to Florida. I'm there until the end of March. My days during this time are spent at the beach. I get up early so that I can watch the pelicans and dolphins do their feeding. No lawn chair, that's just extra weight I don't need. I throw a mat down in the sand, and there I sit. I'm an avid gardener. I begin in April with working in my greenhouse. I plant up nearly 75 hanging baskets and large pots, tend to many perennials and several fountains, all with help from my golf cart, which is great for dragging the heavy water hose! The only thing I have found that works for me is a circaid reduction kit. A reduction kit is thin foam that can be cut to size and has velcro straps. I can't wear compression stocking for any length of time as it affects a heel spur and another bone spur on my right foot. The composition of my leg can change drastically from one day to the next. There have been times I've ordered a custom stocking and 2 weeks after receiving it, it doesn't fit. Because my leg has grown. I'm not sure why it grows but I think It sometimes has to do with whether I have sat too long, or stood too long. In the summer I cut 2 acres of grass (riding mower). My concern with allowing 2 sets is: They get wet within a few hours of being outside. It's sweat. I don't know why but it must be sweat along with lymphatic fluid leaking from the leg. My reduction kit also gets wet if I urinate on myself when I am taking my water pills. To properly care for my leg and to avoid a rash which could lead to an infection. These are changed more often than once a day. This needs to be washed after wearing for a few hours, otherwise they tend to harbor bacteria get sour smelling. My second set of the day would goes on when I cant take the wetness any longer. That one gets drenched with sweat as well. I usually don't wear compression once I come in for the evening as I don't have enough. Each set is a little over $500. The first set I wore during the day wasn't dry. I don't dry them in the dryer as the Velcro straps get more worn as they turn in the dryer. I lay them flat to dry. If I go out for dinner or leave the house in the evening I wear no compression. Besides the sweat, sand, peat moss, soil, grass clippings, sticky burrs, pollen, chopped leaves, and concrete mortar mix sometimes gets on my reduction kit. If I don't pay attention and my cover slides down. That set goes in the wash and another one is put on. Each reduction kit set includes tubi grip for my calf, a separate size tubi grip for my thigh. Cotton behind my knee so that I avoid getting an open wound. Then I put on the calf part of the reduction kit, 2 knee pieces (as it takes 2 in order for the knee piece to stay up around my lobule), a thigh piece, then a cover so that they Velcro straps don't get caught on things and to keep soil, mulch, and sand off of the reduction kit as if strands of weeds or grass, lint or anything gets on the Velcro straps they stop working. I have tried picking things out of the straps with a needle, tweezers, and tape. It usually doesn't come out once it gets embedded in the Velcro. The covers are helpful. This is why 2 sets every 6 months would not be enough for me. I would need at least 5 sets every 6 months. I do my best to take care of them. With the frequency in washing and the type of outdoor work I enjoy, 2 sets every 6 months wouldn't be enough for me. It is a true financial burden to pay for my reduction kits in addition to the payment for my pump. All of my disability income is going for compression

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CMS-2023-0113-0109	CMS-2023-0113	ll8-erts-7g26	2023-08-22T04:00Z	**Deborah**	**Kalkstein-Lamb**	VT		Individual		Living with Lymphedema is a daily management effort of an incurable condition which when poorly controlled leads to increased health risks. I request comprehensive support of coverage of Lymphedema compression garments. In reading the proposal i am pleased that the coverage now refers to sets, rather than individual units. i would advocate for 3 sets per "body parts/unit" (rather than 2) every 6 months (imagine wearing just 2 pair of socks for 6 months). I would like to assure that this is per "set of Body Parts/Units" as i wear custom leg garments on both legs (lymphedema being caused by a traumatic injury) as well OTC compression sleeve and full glove (yet another "set") on one arm due to the removal of lymph node, and want assurances that both my legs and arm would all receive garments every 6 months. I utilize custom night garments for all as well and also have a pump to treat all which at some point would need replacement too. As a retiree having to pay for much of these out of pocket is prohibitive.
CMS-2023-0113-0115	CMS-2023-0113	ll9-ffi7-t267	2023-08-22T04:00Z	**Susan**	**Kehoe**	MA		Individual		I offer my support for the inclusion of lymphedema compression treatment items in Medicare Part B coverage. This support is long overdue and deeply appreciated. Measuring for all compression treatment garments to ensure correct fit is critical. This also means measuring again if/when limbs or affected areas change in size. There is no specific timeline for when or how many times measurements might be needed. It is also extremely important that measurements are completed by personnel who are knowledgeable about lymphedema and its treatment. I hope the rules will consider allowing reimbursement for lymphedema therapists to complete this task. The proposal to cover 2 daytime garments every six months is helpful but not adequate for some situations. Those of us who wear a garment all day, every day likely purchase at least 6 pairs of compression pantyhose every 6 months. Since I wear pantyhose everyday, they must be also be laundered before wearing again. The high level of use and laundering limit the efficacy of the product over time. I hope the process for exceptions for replacement will extend to a situation like this and will not be unduly challenging or cause lengthy delays. I hope the range of acceptable products and reimbursement rates will be adequate so current vendors of these products will choose to participate. I also wear a night time garment every night. The proposed rule to provide one garment per year is much appreciated. Again, I hope the range of acceptable products and reimbursement rates will be adequate so current product vendors will choose to participate.
CMS-2023-0113-0797	CMS-2023-0113	llw-qeuf-7440	2023-09-14T04:00Z	**Danielle**	**Kelly**	OR		Other - OT001		Regarding CMS–1780–P. Our Medical Systems in general are in distress. People are being discharged from acute care facilities earlier than is optimal and sicker than they had been discharged to home just a few years ago. Their medical comorbidities and wound care needs in the home are a higher acuity than in recent years. Home Health/ Hospice and Home Infusion Care services require highly skilled clinicians for best outcomes and reduced readmission rates. In Home Care is often more challenging than acute care- I know this first hand as I've had years of working in both types of care settings. In the home, you do not have the support of multidisciplinary team mates to assist you in a moments notice like you do in acute care settings. It takes years of practical experience as a professional to be able to discern the safest and most effective way to approach the myriad of circumstances, diagnosis and care needs that one may find in the home setting. Highly skilled clinicians require and deserve to be compensated for their skill sets and the risks taken when entering a persons home environment (or shelter). Home Care Services clinicians require exceptional administrative support. These requirements are not cheap. Especially in today's financial climate. Please know that how you reimburse our service lines directly effect who gets what type of quality service in the home - which can ultimately effect the cost of acute care stays …. Pay It Forward…. Spend MCARE funds on high quality in home care … it will be less expensive than acute care losses at the end of the fiscal year. Our citizens deserve that. Thank You, D. Kelly Us citizen, Tax payer and Seasoned Registered Nurse (who loves her community members and works hard to get and keep them healthy)

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CMS-2023-0113-0528	CMS-2023-0113	llu-8pfn-fw0a	2023-09-12T04:00Z	**Collette**	**Kennedy**	NJ				"…We are seeking comment on our proposal to cover and make payment for two garments or wraps with adjustable straps for daytime use (one to wear while another is being washed), per affected extremity, or part of the body, to be replaced every 6 months or when the items is lost, stolen, or irreparably damaged, or if needed based on a change in the beneficiary's medical or physical condition such as an amputation, complicating injury or illness, or a significant change in body weight. In order to maintain mobility, patients may require separate garments or wraps above and below the joint of the affected extremity or part of the body…" • I am appreciative that a category code is being established to provide reimbursement options for garments. Two garment pieces are more than what has been covered previously but with the significant impact the garments provide, removing any barriers to cause patients not to wear them is crucial. The research provided over the years led to the passing of the Act of Congress because it was proven with research the importance of having access to compression garments. Consistency is important in maintenance of affected body parts. Exercise is also a critical component of maintenance and sweating, especially during summer months for feet and hands, happens often in the heat in addition stains and dirt that do not come out with the recommended washing instructions. A patient may be embarrassed to wear one that appears to be dirty. This could cause the patient to stop wearing the garment causing a detrimental effect. Should a patient have several in their personal "maintenance toolkit" I believe the long-term goal is a better outcome overall. • In conclusion, two garments is better than none - but there really should be consideration given to not capping the amount of garments at all. I have yet to find anyone that would want to wear compression garments unless they had to medically, and I do not foresee an abuse of coverage occurring if a cap is removed. The reason patients need them is because they want to improve or maintain their status of lymphedema, so they are going to want to wear them. Therefore, having a reasonable number of garments accessible to wear that aren't waiting to dry from the day before is the most ideal situation. Please consider removing or even focusing on whether there should be two or one garments per year or two years and consider just listing that the products are covered without listing a limit amount. Thank you.
CMS-2023-0113-0007	CMS-2023-0113	lk4-02f1-qsbh	2023-08-10T04:00Z	**Cynthia**	**Kenyon**	VT		Physical Therapist - HC045		Regarding File Code CMS-1780-P, specifically the Part B benefit for lymphedema compression treatment items. I am a physical therapist working in rural Vermont with special training in lymphedema management. The most effective treatment requires the use of firm bandaging which is financially out of reach for many of my patients. Without treatment, the swelling is not controllable causing untold suffering with formation of ulcers and inability to mobilize. Insurance coverage of these items as well as some level of coverage for the wraps and garments that are used for long-term management would be very helpful. Thank you for your consideration.
CMS-2023-0113-0152	CMS-2023-0113	llk-e7pe-qpe5	2023-08-22T04:00Z	**Jane**	**Kepics**	PA		Health Care Professional/Association - Physical Therapist		RE: "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items". I am a retired PT/ Lymphedema therapist who worked with this specific patient population for for 34 years. My comments have to do with obtaining appropriate bandages and supplies ,then custom garments post treatment . The suggestion that therapists be enrolled as DMEPOS suppliers will be problematic. Hospital systems are trying to cut back on PT time with patients at increasing rates ,despite the fact that treatment is so labor intensive . Adding all that is needed to be a supplier will certainly affect the time we can spend with patients . Having a Lymphedema administrative assistant to do this work (ordering and tracking orders) has traditionally been rejected by the facility because they cannot be reimbursed for his/her time. Determining the bandage system a patient needs can be done as part of the patient evaluation , when we develop the plan of care. I choose the bandages and the DME provider fulfills the order. . But you must recognize that deciding on the right garment , measuring for it and then fitting is an art as much as a science . The therapist gets a feel for the limb as we work with the tissues - decisions I made when measuring (tightening up here, loosening up there) were based on my knowing that limb through the course of care . I know there are newer therapists who aren't aware of this and we made that part of this at my hospital's orientation and ongoing training for our therapists. We did ongoing mentoring and encouraged therapists to attend continuing education re: measuring and fitting which was often provided by garment manufacturers - Jobst, Medi , Juno , etc. I have a real problem with handing off the patient to a DME for custom measurements and fitting because it may cause delays in getting the appropriate garment -which can cause a reaccumulation of swelling while getting the appropriate garment. Having specific codes for the PT to use for measuring and fitting garment is helpful I am concerned that the method proposed for calculating reimbursement rates could result in price discrepancies and/or very low reimbursement rates, possibly resulting in an inadequate number of vendors willing to supply these products- there has to be a collaboration between therapist and DME supplier .

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CMS-2023-0113-0484	CMS-2023-0113	llq-yl7b-d5xi	2023-09-12T04:00Z	**Sarah**	**Kerr**	MO		Health Care Industry - PI015		STOP the cuts to Home Health Agencies. The proposed changes have a negative impact on our ability to provide the high quality of care that each person deserves AND that you expect! We continually are expected to do more and provide more with less reimbursement. I have worked in home care since 1982--so obviously believe this is the best place to provide care and hands down is where most people want to receive their services. Not to mention--home health is the most cost-effective place to provide/receive post-acute care. I am old enough to remember when home care was fun--not so laden with burdensome regulations and payment cuts. People accessing health care through their Medicare have worked to earn this benefit and deserve to be able to tap into it as they age and need the care! I am nearing retirement. I have loved providing home care services for many years--both in the field as a direct care provider as well as various roles in the office. At some point-hopefully not in the near future, I'll need these services--will they be there for me? Will they be there for you? Doesn't matter what your retirement benefits are if the workers aren't there to provide the care. We are struggling to recruit, hire and retain talented staff. Why would they choose to do this HARD work when there are so many other more attractive options. When it comes to hiring aides to provide personal care, they can go work as servers in restaurants and make more per hour--PLUS tips--Who can blame them? Yet you want us to improve our outcomes and if not improving you take away even more money which only makes it more difficult to hire staff. You have created a no win cycle. Having been in home care for these many years, do I agree that reforms were needed along the way--absolutely--but now you are cutting so deep--agencies cannot afford to stay in business--severely impacting access to care in certain areas--especially the rural areas. The patients we are seeing are much more ill than in the past--they need more care--yet you continue to cut our reimbursement--that just doesn't make any sense. You want us to keep them out of the hospitals (and if we don't you further penalize us and often times the hospital) but again--except us to care for more acutely ill people with less. This combined with the staffing shortages has led to delays in providing care as we cannot accept patients as we have no staff to provide the care. This is compounded by the fact that other agencies in the area closing as they simply cannot afford to do business any longer. I was just notified of another one in our area this morning. STOP the cuts--STOP all the waste going on up there. Hear the people you are supposed to be representing and protecting! Take a close look at these harmful proposals--STOP them while you have time!!
CMS-2023-0113-0040	CMS-2023-0113	lkv-fzsm-1137	2023-08-10T04:00Z	**Sandra**	**Kerwin**			Health Plan or Association		You are stating that this is for 2024 and Medicare, however, what about folks who had to have these compression stockings this year and are not on Medicare, regular working folks and the insurance companies will not cover them for this year? It may not be a lot of money, however, if a doctor prescribes them, why are they not covered by insurance?
CMS-2023-0113-0867	CMS-2023-0113	llw-x60l-xlxr	2023-09-14T04:00Z	**Susan**	**Kiffmeyer**	MN		Other Health Care Professional - HC075		I am a professional custom compression fitter. I have been measuring and providing compression garment to lymphedema patients for 17 years. I have provided garments to them throughout their years of employment of which their insurance covered for their custom compression vests, arm sleeve, gloves, pants, etc. I have had the misfortune of not being able to provide custom compression garments to Medicare clients as they could not afford them. I am pleased to hear that Medicare has made the decision to cover a broad range of lymphedema supplies to ensure that patients individual needs are met. When I say individual needs, I mean that there are no two people with the same needs. Everybody is built differently. Custom materials lay better on the odd shaped body parts and compress the fibrotic lymph skin tissue more effectively that the traditional circular knit compression stockings. Custom materials are measured for the body part that is affected. I applaud that the allowable quantiles are for the affected body part, ensuring that patients with lymphedema in multiple areas will have coverage for the number of garments they need. If the code used is A6549, the allowable cannot be capped at a certain dollar amount. It will need to be at the discretion of the body part affected. Traditional compression codes for sleeves and stockings do not cover the cost of the custom flat knit material needed for the lymphedema clients. The areas affected by the lymphedema need the custom measurements to fit the odd shaped limbs and body parts disfigured by lymphedema. The cost of the flat knit material is far more expensive than a traditional circular knit compression sleeve or stocking. The current code for custom is A6549 which can run from $400.00 to $2,000.00 depending on the areas affected. I am very pleased to see new additional codes will be created to cover the chipped foam nighttime compression garments needed for lymphedema clients. I am very concerned that the proposed method for calculating reimbursement rates could result in price discrepancies and/or very low reimbursement rates, possibly resulting in not being able to provide the products to the lymphedema clients as the cost is higher that the proposed reimbursement. I have worked closely with the Lymphedema Specialists, Physical and Occupational Therapist trained in Manual Decongestive Therapy to move the Lymph proteins out of the tissues and with the Wound Doctors that treat open ulcers resulting from the skin bursting after it as filled with lymph and had nowhere to go so it split the skin and drained. When that happens, most undergo cellulitis and have to be in the hospital on drip antibiotics. It is very expensive to be in the hospital and the damage it can do on the entire body is awful. I am hopeful that the lymphedema clients will now be able to get 2 sets of daytime garments for hygiene purposes and a nighttime chipped foam compression garment for the body parts that are affected.

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CMS-2023-0113-0843	CMS-2023-0113	llw-t16f-b3eb	2023-09-14T04:00Z	**Holli**	**Kiley**	AZ		Home Health Facility - HPA25		I would like to comment on the proposed rule as it pertains to Home Health rate reductions and changes to VBP measures. It was quite a shock to read this update and seems to reflect the growing disconnection between our lawmakers and the realities of the costs of caring for an increasingly acute population that we serve. The rate reduction is not considering the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. CMS continues to forget that home health is the most cost efficient and effective form of health care and our agencies save millions of MC dollars thru methods of keeping patients out of expensive hospitals and skilled nursing homes. Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. Additionally, CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year.
CMS-2023-0113-0620	CMS-2023-0113	llv-e986-p65q	2023-09-14T04:00Z	**Scott**	**King**	ID				The proposed payment system will damage the Home Health Industry. It will lead to shortages in healthcare providers and result in decrease in quality of care. This will put patients at risk some of which are the most vulnerable. This proposal should not be implemented.
CMS-2023-0113-0605	CMS-2023-0113	llv-but0-rptg	2023-09-14T04:00Z	**Guenter**	**Klose**	CO		Individual	https://downloads.regulations.gov/CMS-2023-0113-0605/attachment_1.pdf	See attachment.
CMS-2023-0113-0157	CMS-2023-0113	lll-453l-rvbx	2023-08-22T04:00Z	**Elizabeth**	**Knight**			Health Care Provider/Association - Home Health Facility		As a home health therapy provider for many years, the proposed decrease in payment across the board is very concerning. 1) Employing and retaining staff is increaingly expensive. The nummber of nurses graduating from school is less than the number who are leaving the profession or taking nonpatientt facing roles. The cost to attract experienced nurses to the homecare setting rises significantly every year 2) as a provider at a not for profit Cathlic health system, we are already unfairly bearing the cost of serving patients with complex diagnoses, or costly care whom for profit agencies refuse to provide care. Many agencies are declining patients with hea wound vacs, pluerex drains or complex wounds as the cost of the supplies to provide that care increase. we are also seeing agencies decline patients with heavy therapy needs as the LUPA threshold for a payment period may not even cover the amount of vsits to have all evaluations completed. 3) Inflation ad the cost to do business continues to rise as seen by market and interest rate adjustments made, the cost to provide home health care to our vulnerable citizens rises at least as quickly. When payments are cut, agencies may have to close their doors, leaving those patietns even more at risk

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CMS-2023-0113-0439	CMS-2023-0113	llp-z7ax-vmnt	2023-09-12T04:00Z	**Sheila**	**Knight**	UT		Health Care Professional/Association - Nurse		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0638	CMS-2023-0113	llv-hzjt-z4jp	2023-09-14T04:00Z	**Lisa**	**Konruff**	CO				For 17 years I've been the operations manager for an international lymphedema continuing education school that is based in the United States. The majority of our students (customers) are physical and occupational therapists in the US who attend our lymphedema therapy certification and advanced level classes. I'm not a healthcare practitioner, instructor or lymphedema patient...but I've talked with countless people living with lymphedema and countless Certified Lymphedema Therapists and family caregivers from my desk phone over the years. I know you're not looking for a vote, but I did want to take time (off the clock) to add my voice to the others affected by lymphedema and lymphatic disorders. A Compression Garment for Lymphedema, as I understand it, must be worn on the skin 24 hours a day, 7 days a week for effective containment. Garments must be kept clean (hand washed and air-dried) to maintain effectiveness. I know there is a balance to this...people who make the garments must be paid, people who measure and fit the garments must be paid, and the people who wear the garments should get the number of garments they need at a price that is reasonable for them. (I think about how many pairs of underwear I am privileged to own and how easy it is to launder them). We agree this a complicated problem. I am grateful to those working on this to help make self-care a little easier and more affordable for people living with an incredibly physically, emotionally/psychologically/socially challenging disorder.

LTA Proposed Rule Public Comments

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CMS-2023-0113-0564	CMS-2023-0113	llv-1nt5-wh2x	2023-09-14T04:00Z	**Cindy**	**Krafft**					August 28, 2023 The Honorable Chiquita Brooks-LaSure Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS-1780-P P.O Box 8013 Baltimore, MD 21244-8013 Re: CMS-1766-P: Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements Dear Administrator Brooks-LaSure, Thank you for the opportunity to participate in the comment period for this proposed rule. My initial comments are focused on the relationship between the data used to calculate payment adjustments and outcome measures relating to value-based purchasing. For the last several years, the primary focus of the annual rule update has been on the need to reduce payments to home health agencies. The recalibration of how points are awarded in the PDGM model is supported by data indicating that certain elements (functional impairments or coding) are being reported at different than expected patterns. This is being interpreted as the potential influence of the payment model on OASIS data collection and ICD-10 coding. In addition, the concepts of “behavioral adjustments” are now a cornerstone of the proposed rule and details related to both data collection and utilization changes, specifically related to therapy, are cited as supporting this plan. Concurrently, the Home Health Value Based Purchasing Program (HHVBP) has been expanded nationally based on the results of the demonstration project. Agencies received their preliminary reports during the open comment period for this very proposed rule. Some of the very same OASIS items that are being questioned in terms of accuracy for payment purposes are used to create 1/3 of that total measure. Agencies are seeing cohort rates that, at times, appear to be unrealistically high given the complexity of the patients we serve – yet the accuracy of this is not being questioned. How can CMS use the same data to support that questionable behavior is present to justify payment cuts on one hand and to support payment increases for some agencies tied to quality on the other? Given the amount of data CMS has access to at this point, the time has come to use it to identify SPECIFIC agencies who are generating OASIS data and/or coding that is an anomaly and investigate them further. Concerns about these behaviors need to be addressed by identifying and confronting the agencies that are confirmed to engage in them and stop punishing the entire industry. The mixed message that the data is problematic, and payment should be cut cannot be the same data used to potentially reward the very same agencies manipulating it to achieve outcomes. The second part of my comments is specific to the proposed changes to the HHVBP model. The suggested removal of the Total Normative Composite and replacing it with a subset of GG items is being driven by the Impact Act and the need to achieve cross-setting measures. I applaud the intent. As one of the home health representatives on the TEP (Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures July 14-15, 2021), I can confirm there was significant dissent from this setting regarding moving forward in this manner and at this speed. Home health agencies have not received any meaningful data analysis from CMS regarding any of the GG items as was evident by the fact that home health data was not made available to TEP participants. Data was available for the other three settings and used to make modifications to the discharge functioning measure. The home health representatives expressed concern about moving to change the model when home health had no data to consider and could not predict what the impact would be in this important setting. Based on this, it appears that implementation of the change should be delayed allowing home health agencies the opportunity to see their data, understand how the proposed measure works with real patients, and be prepared to participate before financial rewards or penalties come into play. Thank you again for taking the time to review my comments.

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CMS-2023-0113-0190	CMS-2023-0113	llh-zqki-c5ww	2023-08-29T04:00Z	**Kim**	**Krug**	IL		Association - Device		Lymphedema and lipedema patients need to be supplied elastic wraps new every 6 moths. To maintain the condition 2 pairs of custom garments every 6 months. Tactile lymph machine to keep lymph moving through body. Physical therapy as needed for deep compression therapy. Allow surgery at a Lymphedema center to improve limb health.
CMS-2023-0113-0417	CMS-2023-0113	llp-avah-4129	2023-09-11T04:00Z	**Debbie**	**Labarthe**	GA		Individual		I am submitting my Public Comment regarding the proposed draft rules for "VII. Proposed Changes Regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)". Particularly, "Scope of the Benefit and Payment for Lymphedema Compression Treatment Items". This is contained in the "Dept of HHS and CMS - 42 CFR Parts 409, 410, 414, 424, 484, 488, and 489 – Proposed Rules" document. I have been a Board Member of a local, non-profit lymphedema support group since 2004. Then, in 2016, I also became a member of the Lymphedema Advocacy Group, and subsequently joined their Board in 2022. It has been a tireless and rewarding journey to network with lymphedema patients, family members, and caregivers to advocate for the Lymphedema Treatment Act. What an amazing feeling it was to finally witness its passage in December 2022! This legislation finally closes the coverage gap as it pertains to doctor-prescribed compression supplies, thus impacting millions of lymphedema patients across the U.S. and improving their quality of life. In 2004, my then-13-month-old grandson was diagnosed with primary congenital lymphedema in his right leg, pelvis, abdomen, and genital area. Because of his delayed diagnosis and lack of treatment during those months, his swelling was severe. Within a few weeks of his diagnosis, he began his MLD/aquatic/compression therapy and had amazing results. The compression component was extremely effective in reducing and maintaining his swelling. He is now 20 years old and, fortunately, he has never developed cellulitis, nor has he ever been hospitalized for any other lymphedema-related conditions or complications. Since he will not be eligible for Medicare for many years to come, he will not be impacted by the LTA when it goes into effect on 1/1/2024. However, the LTA will have an impact on his current insurance coverage as he continues to successfully manage his lymphedema throughout his adulthood. When he becomes eligible for Medicare in the future, I am grateful that he will have the coverage he needs and deserves for his doctor-prescribed compression supplies. In addition, because he is affected by lymphedema in non-limb areas, I was pleased to read, in the Draft of the LTA Rules, that new/additional codes will be created to facilitate reimbursement, including codes specific to non-limb areas of the body (such as head, neck, genitals, torso) to ensure coverage for the supplies needed to treat these areas. Thank you for working diligently on the Draft of the LTA rules, providing the listening sessions for the stakeholder groups, and accommodating and collaborating with medical professionals, advocacy groups, and lymphedema communities to address the critical aspects of the LTA rules.
CMS-2023-0113-0049	CMS-2023-0113	ll1-arqa-vd0l	2023-08-10T04:00Z	**Victoria**	**Laibinis**	CO		Individual	https://downloads.regulations.gov/CMS-2023-0113-0049/attachment_1.pdf https://downloads.regulations.gov/CMS-2023-0113-0049/attachment_2.pdf	See attachments: My Lymphedema Story; and Regulation Comments
CMS-2023-0113-0738	CMS-2023-0113	llw-knoi-x3t2	2023-09-14T04:00Z	**Alexander**	**Lalov**	IN				Best LYMPHEDEMA Garments are made by BIOFLECT I have tried several different brands compression stocking. The one, that I am finding most effective is the BIOFLECT brand: https://www.therapygarments.com/ Please, take this in serious consideration. Thank you! Alexander
CMS-2023-0113-0369	CMS-2023-0113	lln-5dsq-pgsi	2023-09-11T04:00Z	**Caren**	**Landis**			Individual	https://downloads.regulations.gov/CMS-2023-0113-0369/attachment_1.pdf	See Attached File

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CMS-2023-0113-0356	CMS-2023-0113	llm-pbxj-i7hw	2023-09-11T04:00Z	**Mary Jo**	**Lane**	OH				First and foremost, thank you for all the thoughtful consideration that has gone into this new rule that will support Medicare patients with lymphedema. I have primary lymphedema in my right leg and rely on a variety of treatments to keep it under control: custom thigh-high, class 3 (40-50 mmHg) compression garments; knee-high off-the-shelf class 1 (18-30 mmHg) garment; night garment; bandaging; and a lymphedema pump. I would like to comment on these items: Nighttime Quantities For me, one nighttime garment per year would work because it doesn't get the workout that daytime garments get. So I have enough time to wash and dry it every few days. Coverage for Layering Garments I would recommend that layering be accommodated in the final rule. In addition to my daytime, class 3 garment, my doctor also recommended using an off-the-shelf, class 1 knee-high garment for added compression. Coverage for Bandaging During Maintenance Nighttime bandaging, alternated with my night garment, has been essential to keeping my lymphedema under control. I would urge you to include maintenance bandaging as an allowable item. Calculation of Reimbursement Rates Please know that I am extremely grateful that some of my treatment expenses will be covered under this new rule. However, the current reimbursement rate for A6535 is $68.45 – and I recently purchased just one custom, class 3 thigh-high garment for about $275. If it's possible to create a separate, more realistic reimbursement schedule for custom garments, that might encourage vendors to actually supply these products under the new rule.
CMS-2023-0113-0498	CMS-2023-0113	llr-b28s-x6y6	2023-09-12T04:00Z	**Celeste**	**Lane**	CA		Individual		I am commenting as a Lymphedema patient. I am mostly concerned with the issue of very low reimbursement rates. There is already a scarcity of suppliers of lymphedema garments. I doubt that the number of Medicare enrolled participating providers (those who accept assignment) will increase when the goes into effect and some might change to non-participating so that they can receive fair reimbursement. Because of the very low fee schedule it may be difficult for patients to find a supplier.
CMS-2023-0113-0694	CMS-2023-0113	llw-eaqz-o8md	2023-09-14T04:00Z	**Connie**	**Larson**	ID			https://downloads.regulations.gov/CMS-2023-0113-0694/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0135	CMS-2023-0113	llc-8brr-pexi	2023-08-22T04:00Z	**Martha**	**Leamman**	MD		Individual	https://downloads.regulations.gov/CMS-2023-0113-0135/attachment_1.pdf	See attached file(s) I am a lymphedema patient who will soon be on Medicare. Please see my attached comments that outline what compression supplies I need to maintain my leg and avoid extra unaffordable expense for myself and the health system.
CMS-2023-0113-0548	CMS-2023-0113	llu-xymg-g22z	2023-09-14T04:00Z	**Jennifer**	**Leavens**	CA		Individual		My comment is in regard to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I have lymphedema in my legs due to necessary surgery stemming from melanoma cancer. The cancer spread to the lymph nodes in my legs so they had to be removed. As a result, I have to wear medical-grade compression garments on my legs daily. Without them, my legs swell to painful proportions which limits my ability to function in daily life. Each pair of medical-grade compression garments cost $99. I rotate through 6 pairs weekly. I have to replace them every 3 months as the compression/elastic wears out through wear and washing. That is $2400 annually. The proposed rule would cover two daytime garments every 6 months per affected body part. (Two sets.) This would only partially cover my daily needs, but it would significantly cover my out-of-pocket costs. I support the proposed rule as it will help my situation. But it will also greatly improve the financial conditions of those that are born with lymphedema, those that need regular medical intervention for lymphedema, and those that have it in multiple extremities.

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CMS-2023-0113-0405	CMS-2023-0113	llo-ixgu-4x50	2023-09-11T04:00Z	**Esther**	**Leon**	OR		Health Care Professional/Association - Physical Therapist		My name is Esther, and I am a home health physical therapist full-time. The proposed budget cuts to Medicare reimbursements for home health services are not the solution for the expanding need for home, health access, as the baby boomer generation ages. Currently, clinicians are strapped with massive amounts of paperwork, which was significantly increased this year with the roll out of the new OASIS. This has resulted in at least 30 ADDITIONAL minutes needed within start of care visits, with the start of care, OASIS, taking me, a clinician, with three years of Home Health experience And eight years of healthcare experience, two hours to complete. This already impacts our ability as clinicians to provide quality care in the home, and I am happy to see that CMS is considering decreasing the amount of data collection. However, by decreasing the overall reimbursement, the net result will be that clinicians will need to either spend less time in the home, which means less quality of care, or they will need to see more clients Within a standard work week to get the same amount of income. This will lead to higher healthcare provider burn out rates, which are already severely elevated since the COVID-19 pandemic, and will ultimately result in poor quality of care. The expectation of CMS in altering value based purchasing is that home health agencies will be incentivized to provide a better quality of care. However, this will not be the case when budget cuts are also occurring at the same time. Clinicians will be incentivized to spend less time in the home, or else will receive pay cuts, be in the form of actual decrease in annual salary, or in lack of raises. This will result in poor quality of care due to less time in the home and higher burnout rates, which will only lead to increasing hospitalization rates. Clinicians who work with Medicare and Medicaid clients are already subject to limited amount of salary, increases due to reimbursement costs not adjusting to the current rate of inflation. With a further budget cut, salaries can expect to remain stagnant for healthcare providers in the home health sitting over many more years. This comes at a time when we are seeing record-breaking inflation rates, record-breaking amounts of student loans among healthcare provider and new graduates, which already make it difficult to meet the cost of living as a healthcare provider. The net result will be that less people will want to go into healthcare, since it is poorly reimbursed. We are already facing a severe, healthcare shortage, particularly with nurses. CMS is making a grave mistake in introducing budget cuts at this time. The solution is not to pay healthcare providers less while piling on more work with paperwork, as well as more work onto the current providers while the healthcare system is strapped with a staffing shortage. As a provider, I hear constantly from the patients I serve that they do not feel they are getting enough services. Budget cuts are creating a perfect storm for citizens to have even less care at a poorer quality. CMS presented a chart of average visits spent per discipline in the home over the past five years. It is no surprise to me that average visits spent in the home have decreased over the past five years when workload has only increased, reimbursement has decreased, or become harder to get with the value-based purchasing system, And there is a nationwide healthcare shortage. It seems that CMS takes the decreased use of visits as decrease in fraud, waste, and abuse by showing a decrease in unnecessary visits. I beg to differ. Visits are decreasing because we live in a for-profit, healthcare economy, and, as inflation rises, the only answer is to take on more clients, with less visits to go around for everyone. Please reconsider these budget cuts. This is not the solution. This will only make Home Health a much more difficult experience for home health providers, and be a massive disservice to our patients, who will suffer with decreased quality care and decreased availability of clinicians.
CMS-2023-0113-0045	CMS-2023-0113	lky-6rlc-7txp	2023-08-10T04:00Z	**Cecelia**	**Lester**			Physical Therapist - HC045		To CMS I am a person with Lymphedema secondary to breast cancer. My husband and I are retired. We are both on Medicare. I noticed when I was being treated for breast cancer then for Lymphedema that my hospital submitted three different claims for one compression garment and two sleeves which I did receive. The amount was almost $400.00 for each item. I was told by my physical therapist that the medical community said those having to wear the sleeves needed two (2) new ones every six (6) months. Two new ones every six comes to a figure in the neighborhood of $1,600 every year. Because of the cost, I have chosen to keep my sleeves for as long as I could. Sleeve #1 is 16 months old. Sleeve # 2 is right at twelve months old. I received the second sleeve because I had a hole in the first one. What I DID NOT know was that the two times I got measured when I was in physical therapy was that those therapists were paid, beyond their wages, to measure my arm. All I knew was that the hospital sent those claims in for an EXORBITANT amount of money. I would like to know that in the future, that each patient be informed of the fees involved in their treatment.

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CMS-2023-0113-0112	CMS-2023-0113	ll8-w2ml-ztdt	2023-08-22T04:00Z	**Keisha**	**Lewis**	MD		Health Care Provider/Association - Other		• Why is the use of home health aides declining even though there's still strong need for those services? Home health aide services are declining due to low pay and increasing physically demanding jobs (often home health workers have limited training and the physical demands of assisting with mobility is a challenge. • To what extent are people eligible for Medicare who have multiple or more severe impairments having more difficulty accessing home health care services, specifically home health aide services? Eligible Medicare recipients are unable to find qualified assistance (someone who understands their condition and how to assist them). Also Medicare recipients have had unfavorable encounters with aides who are not equipped to manage their care. • What are notable barriers or obstacles that home health agencies (HHAs) experience in recruiting and retaining home health aides? What steps could HHAs take to improve the recruitment and retention of home health aides? o Ability to offer premium pay o Lack of training personal o Lack of qualified aides HHA need to offer better pay, benefits (including time off), Health insurance, offer training (transfer, mobility, communication, dementia care), work with high school and college students who wish to go into healthcare fields, offer to pay students to provide care • Are HHAs paying home health aides less than equivalent positions in other care settings and if so, why? I have been told HHA pay aides lower wages; online resources such as Angies List, Caregiving.com, etc, allow aides to market themselves and make more money. Individual families hiring personal aides are willing to pay for qualified, highly skilled aides. How effective is the coordination between Medicare and Medicaid to ensure adequate access to home health aide services? I can not personal speak to this, as I have not seen this in action. • What are the consequences of beneficiary difficulty in accessing home health aide services? Consequence is that individuals lose their functional independence (mobility, ADL's, cognition) which leads to the inability to age in place or age well in place. This will cause an increase in hospitalizations and institutional placement (SNF) for Medicare and Medicaid recipients.
CMS-2023-0113-0465	CMS-2023-0113	llq-r9in-r50h	2023-09-12T04:00Z	**Monica**	**Longoria**	CO				I support the endorsement of the US Medical Compression Alliance in regards to changes we want to see in the proposed bill.
CMS-2023-0113-0136	CMS-2023-0113	llc-axww-kf6o	2023-08-22T04:00Z	**Maria**	**Lukas-Asbury**	KY		Home Health Facility - HPA25		I am happy to see that there is plan to improve the payment system for Home Health Aides. However, I believe this is another example of too little, too late. With this said, I do not believe increasing payment is worthless but if it is not accompanied with the following changes, the public will never see the increase in the number and quality of home aides needed to meet the current, let alone future needs as we baby boomers grow older. - The increase in payment needs to be funneled into the hands of the actual, individual home aid. If it stops at the point of company/corporate greed and profit, availability of this resource will continue to lag and get worse with time. - Licensed, monitored programs need to be developed/expanded and licensure and on-going skill and performance standards must be developed and evaluated. Individual aides must be afforded the opportunity to be licensed and awarded appropriately for achieving licensure, developing new skills and maintaining practicing standards. You must know after years of failed and successful programs that any program, such as this, requires on-going evaluation and development in order for any further investment will just be more money spent for no return on that investment. I hope HHS improves its policies to meet industry and population needs and builds in quality and on-going evaluation and improvement requirements and rewards. Please don't tease this tax-payer, with the need for a Home Aid in my future again by asking for input that is ignored. If you cannot do this right, please don't waste your time or our tax dollars.
CMS-2023-0113-0145	CMS-2023-0113	llc-orow-nccd	2023-08-22T04:00Z	**Penny**	**Lutsi**	AZ		Individual	https://downloads.regulations.gov/CMS-2023-0113-0145/attachment_1.pdf	Please see attached file.

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CMS-2023-0113-0377	CMS-2023-0113	lln-v1df-1wp9	2023-09-11T04:00Z	**H**	**M**			Occupational Therapist - HC050		I am an Occupational Therapist and I am writing in opposition to the removal of M2200 Therapy Needs from the OASIS. Therapy is one of the greatest tools in order to allow patients to stay safely in the home (vs skilled nursing facilities or full-time caregivers/etc). With use of a skilled nursing facilities or a full-time caregiver, there is increased cost for the family and/or the government / Medicare/Medicaid. By further removing therapy needs assessment from the OASIS, you will drive up overall spending, falls, injuries, and cost of care - which is probably the opposite of the goal. Occupational Therapy focuses on improving safety, quality of life, and panoramically addressing the needs of the patient - no other discipline does this quite like OT. We address cognitive, physical function, disability, home assessment and modification, compensatory strategies and adaptive equipment (and that is just scratching the surface). Occupational Therapy (OT) treats the person holistically. With using therapy services more, you could decrease caregiver burden and injury, prevent falls and injuries /etc. I understand that cost reduction is vital - and I agree - but I strongly disagree with how you are going about it. On of the greatest problems with healthcare in America is the focus is - we must shift from trying to put band-aids on huge issues and shift to preventative medicine to achieve the cost savings we desire. Therapy and therapists are an excellent resource and need to be utilized more (not less). Additionally, therapists need to have opportunities for pay increases. Therapists have been getting decreases in pay cuts or been on pay freezes for a while and cost of living and inflation keeps rising. Therefore, my closing point is not to reduce reimbursement for therapy services. Thank you for your time!
CMS-2023-0113-0679	CMS-2023-0113	llw-a0zi-ywgy	2023-09-14T04:00Z	**S**	**M**			Association - Device		Very important. People can't afford these garments and leads to less carryover to home care which increases cost when they need to return to therapy. Would save money in the long term
CMS-2023-0113-0088	CMS-2023-0113	ll6-0wie-7qk9	2023-08-22T04:00Z	**MaryTherese**	**MacConnell**	WA		Individual		Comments on Part B: Scope of the Benefit and Payment for Lymphedema Compression Treatment Items I have had lymphedema in my right leg for over 40 years as a result of an accident. I wear custom compression garments (40-50 mmHg) during the day and a night garment and/or bandages at night. I have seen many improvements in the awareness of, knowledge of, and treatment of lymphedema as well as an increase in the number and quality of garments and accessories over the years that have greatly helped with self-treatment and maintenance. I have read the proposed rules related to the Lymphedema Treatment Act that passed late in 2022 that caused the creation of this section of the rules. I sincerely thank those who wrote these rules. They are very comprehensive and seem to indicate a real wish to help those with lymphedema. Following are a few comments/suggestions that might help with some of the details. • I wear toe-caps (similar to the gauntlets that are used to cover fingers). I don't see them mentioned in the rules and I hope they will be added. • I see non-elastic gradient wraps mentioned in some areas (section 4 and elsewhere) for "below the knee." They are used on other areas such as knees, ankles, and thighs. Perhaps that needs to be modified. • Coverage for bandages during the initial treatment phase is mentioned in several places. Some of us use or have used bandages for maintenance. Some prefer or have better results with bandages. I sometimes use bandages even now over my compression stockings to provide extra compression for my ankles and/or knees if they seem to need a little extra support especially when I have worn a garment longer than the recommended six months. I have also used bandages at night. • Non-elastic wraps OR garments is a phrase that I saw a few times (section 7 and elsewhere). Again, wraps are sometimes used in conjunction with garments. I frequently wear a non-elastic wrap in addition to my compression garment to provide a rigid support that helps to contain my swelling. In addition, there are other times that compression might be layered on the same part of the body. • I think the cost of fitting needs to be separate from the cost of the garment. Once lymphedema is stabilized, the patient might not need to be measured each time a new garment is ordered. In addition, measuring might be provided by a physical therapist, an occupational therapist, a fitter associated with a supplier, or possibly others. • Fitters and physical therapists are listed as those who can be compensated for measuring. Occupational therapists should be added to that list. • Coverage for accessories (section 7 and elsewhere) is very important. I have used liners, donning and doffing helps, padding, and other accessories over the years. Thank you for including them. • And finally, I hope reimbursement rates are realistic. There is one particular custom compression stocking that works best for me. There is one particular non-elastic wrap that works best for me. These choices among different brands/products are important to individuals once we find what works best. I would not want to have to choose price over quality. Thanks again for your concern and thoroughness in writing these rules. Having my lymphedema supplies reimbursed, will help me to care for my lymphedema more effectively.

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CMS-2023-0113-0780	CMS-2023-0113	llw-pfbp-sve1	2023-09-14T04:00Z	**Kameron**	**Magnuson**	UT		Health Care Professional/Association - Physical Therapist		Dear CMS, I am writing today as an administrator for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A -6.83% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, and hospices). The cuts to home health do not help to accomplish CMS's stated goal, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. To summarize, please consider the following points: -CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. -The Proposed Rule ignores the ongoing COVID-19 pandemic and its significant impacts on providing home health care, including increased costs of infection control, labor, and medical supplies. -Other healthcare providers have not seen such significant rate cuts, despite home healthcare providing higher cost savings. -The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. -CMS relies on flawed data and methodology regarding behavioral adjustments and those flaws should not form the basis for the rate cuts. -The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue our great progress and focus and do not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year Thank you for your time and consideration. Sincerely, Kameron Magnuson, PT, DPT

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CMS-2023-0113-0101	CMS-2023-0113	ll7-f7i2-mrai	2023-08-22T04:00Z	**ElizabethRene'e**	**Mallett**	TN				"Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items Asking for !00% coverage of compression wraps, gauze, stockings, socks etc. Lymphedema patients have had the burden of cost of their supplies to maintain health. I feel these garments are as necessary as a gauze to apply compression to a bleed. These garments are worn daily and with the wear they need to be replaced to maintain the correct elasticity required for the correct compression every 3 months. This enables the person to do the tasks they can still maintain. Fluid accumulation without correct compression compromises optimal health and activities of daily living. As a RN I take care of lymphedema patient daily and the differences I see when wearing the correct compression garment that is of optimal condition is a must for maintaining the best health of this disease. Intermittent pneumatic compression pumps (IPCP) make a huge difference in maintaining the health of lymphedema and should also be 100% covered. I have followed daily and twice daily of IPCP treatments with documented decrease in popliteal, ankle, calf and thigh measurements post IPCP. IPCP and compression garments are prevention measures that decrease the hospital lymphedema admissions for those that has this available to use daily. My personal experience patient prior to using compression garments and IPCP hospitalized twice per year with acute lymphedema episodes and multiple physician visits. Last 4.5 years with compression wrapping and wearing compression socks no hospital admissions and decrease physician office visits. Its a win win for these patients and decrease cost for insurance. Thank you for taking the time to read and thank you for your voting yes for all those deserving this coverage. Rene'e ND,RN

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CMS-2023-0113-0342	CMS-2023-0113	llm-j3wj-hjsw	2023-09-11T04:00Z	**Angela**	**Maring**	IA		Health Care Provider/Association - Home Health Facility		Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in West Des Moine, IA Specifically, we serve Des Moines Metro, Urbandale, Waukee, Marshalltown Area, Bondurant Area, Webster City Area, Ottumwa Area, Boone, Knoxville and others. We have been a Medicare participating home health agency for 20 years and currently have a patient census of 705. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state’s citizens. Sincerely, Angela Maring Iowa Home Care 4312 Mary Lynn Dr Urbandale, IA 50322

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CMS-2023-0113-0429	CMS-2023-0113	llp-qs3c-g5ed	2023-09-11T04:00Z	**Matthew**	**Maris**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0129	CMS-2023-0113	llb-ag38-ohx3	2023-08-22T04:00Z	**Nancy**	**Martin**			Health Care Industry - PI015		Since all edema has some basis in lymphedema, I would like to see compression coverage extended to chronic venous insufficiency. Many venous wounds could be prevented if compression (wraps or garments) would be covered for those with venous insufficiency.
CMS-2023-0113-0521	CMS-2023-0113	llt-w049-mmwz	2023-09-12T04:00Z	**Leslie**	**Martin**	WA		Individual		My comments are in reference to “Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” • I am writing in support of the proposed guideline for two (2) Daytime garments every 6 months and one (1) Nighttime garment each year, but there is a more practical need for the allocation of two (2) Nighttime garments every two years. The fact is that Nighttime garments don’t always dry completely in one day. Having two Nighttime garments available will ensure that patients will have a dry Nighttime garment to wear each night. Reference: Page 29, line 1 • It is imperative to include coverage of compression bandaging systems not only for the proposed Intensive/Reduction Phase of Treatment, but also for the Maintenance Phase of Treatment as well, because patients often use bandaging in combination with compression garments in both of these phases of treatment on a regular basis. Reference: Page 12, line 9 • I ask that you include a more frequent replacement allowance for compression gloves, which wear out more quickly because they are always exposed and receive more wear and tear due to the many demands on the hands in carrying out the tasks of daily life. Reference: Section 1834(z)(2), Page 23

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CMS-2023-0113-0532	CMS-2023-0113	llu-czn8-qu4n	2023-09-12T04:00Z	**Jane**	**Martin**	ID				Dear CMS, I am writing today as a registered nurse for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A XX% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Jane Martin Home Health Clinician
CMS-2023-0113-0556	CMS-2023-0113	llv-0sjg-bcw9	2023-09-14T04:00Z	**Rachel**	**Martin**			Health Care Professional/Association - Occupational Therapis		Additional payment cuts could further decrease therapy utilization. Agencies must rely on the therapist's clinical judgment to determine the type and amount of therapy services an individual patient needs. To that end, I oppose the removal of item M2200 Therapy Needs from the OASIS because it is an important item to help track the need for therapy, and removing the item could contribute to a further decrease in the provision of therapy services.

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CMS-2023-0113-0631	CMS-2023-0113	llv-g46i-81h7	2023-09-14T04:00Z	**LAURA**	**MARTIN**	WA				I am commenting on the Medicare Proposed Rule to implement Part B Coverage for Lymphedema Compression treatment Items. I have lived with lymphedema for 8 years. The “garments” discussed are supplies to help my body move fluid that accumulates after surgery. I cannot work or sleep without compression. I am in compression 23 hours a day. I was first wrapped by specialized physical therapists, and then techniques were taught to me to use at home. I use the following products to do this, and I need ALL of them: • 2 sets of nighttime garments • 2 sets of daytime garments with 2 additional gloves ordered separately because your hands do a lot and they stretch out. • A bandaging undergarment called a Caresia glove and sleeve that I use 3 short stretch bandages on – sometimes used to increase the pressure on my arm during sleep, at a higher level than my sleeping sleeve and glove • Layered liner, foam, and short stretch bandages. Coverage of Supplies and garments: • I am happy to see that Medicare will cover ready-made and custom supplies. I believe that all kinds of existing and future forms of compression should be covered – ready-made and custom. Whether wraps, with or without straps, the sleeves and gloves or one-piece gauntlet systems, layered wrapping with short stretch bandaging for both acute and maintenance phases of treatment should be covered. I use both; custom daytime and custom night-time and ready-made sleeves and gloves for short stretch bandaging for day or night. It is very important to realize that care of the limb or body part changes from time to time because the body does. We need options! • Please include coverage of wrapping supplies including rolls of gauze bandaging, short stretch bandaging, foam rolls, padding, and accessories that support the individual’s home bandaging routine, even during the maintenance part of care. Measurements: • Measurements must be taken for custom and for ready-made products. A trained person is the one responsible for making sure the item will work for a patient. Please include reimbursement for measuring of both kinds of measurement. • Measurements in my home town are NOT done by therapists or physicians. There are not enough PT, OT or MDs to see patients in the initial stage of LE as it is, let alone in the maintenance phase. Most PTs or Ots are not trained to take measurements and deal with the prospect of ordering compression garments, billing for them, handling the insurance, sending bills, making sure they fit, returning them when the companies don’t create what is ordered, interfacing with regional managers, and more. They see the patient through the intensive reduction stage and offer periodic checkups or help with acute problems. There are limited numbers of dealers who measure, order, deal with the billing, receive the completed custom orders, and provide them to the patient. These people are trained by the companies who make the products. Each company has different ways of measuring, different materials, different manufacturing methods, different geographical sources for their products. These people are the professionals who make my compression work. If this kind of process is not included in the coverage, I will not be able to get garments. These are qualified practitioners. Allowable quantities and replacement frequency and exceptions: • I agree with covering 2 daytime garments in sets per calendar year with exceptions you have listed. • I would propose that you increase the nighttime garment limit to 2 per year, including all forms of the garment, because these garments take a LONG time to dry unless you bake them in the dryer which shrinks them to a useless size. If one is drying, you need the other. Reimbursement levels: • I pay out of pocket for all my compression needs and it costs in the thousands of dollars every year. I have Medicare and a supplement but until now, no help from either. If Medicare and the departments associated with payment for services don’t pay the folks who measure, order, and supply my compression enough money to stay in business there will be a disaster for many people; myself included. Based on existing reimbursement rates for services in other areas of healthcare, it may not make sense for them to stay in business. I would recommend that businesses be allowed to not accept assignment at their discretion.
CMS-2023-0113-0206	CMS-2023-0113	llj-trbs-d8bx	2023-08-29T04:00Z	**Renee**	**Martinelli**	TX		Health Care Industry - PI015		I have lymphedema and have been wearing a compression arm sleeve since 2013. They are very expensive and medically necessary. My comment is that Medicare should cover these compression garments at 20%. You should be able to order them from any company even ones on the internet and any color or pattern. As long as it is the correct compression that the doctor ordered such as mine is 20-30 mmg. Also, I have varicose veins and believe Medicare should cover compression stockings at 20% as well. Thank you for receiving my comments.

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CMS-2023-0113-0362	CMS-2023-0113	llm-sqej-lfvr	2023-09-11T04:00Z	**Melissa**	**Mattner**	CO		Health Care Professional/Association - Occupational Therapis		Decreasing funding and support for occupational therapy in Home Health is going to be detrimental to those who need to utilize Home Health services. Occupational therapy is the epitome of a therapy that can help patients become more independent in the home environment so that they can A)Keep from returning to the hospital B) Age in place, and C) Keep from having funds being spent in an environment such as SNFs, where often patients are also required to apply for Medicaid funds to afford to live there. We have a large Boomer generation population that is aging quickly. We will have severe and very serious issues if we decrease reimbursement to help people stay and rehabilitate at home. Why is this even being considered? Physical therapy can help people become more mobile, but they aren't the ones that are working on independence in activities of daily living. Neither is nursing. Do the right thing. Do not decrease funding. It's so incredibly vital to our aging population.
CMS-2023-0113-0018	CMS-2023-0113	lke-rml5-yyjj	2023-08-10T04:00Z	**William**	**McCann**	MO				I am offering my Public Comment in regards to the proposed draft rules for "VII. Proposed Changes Regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)". Particularly, "Scope of the Benefit and Payment for Lymphedema Compression Treatment Items". This is contained in the "Dept of HHS and CMS - 42 CFR Parts 409, 410, 414, 424, 484, 488, and 489 – Proposed Rules" document. I am a 55 year old male who survived Synovial Sarcoma cancer in my early 20s. I have lived with Lymphedema in my leg for many years. I am a Board member of the Lymphedema Advocacy Group. As you can imagine, I was absolutely thrilled with the passage of the Lymphedema Treatment Act! Also, I have been fighting stage 4 metastatic Synovial Sarcoma for the last two years. Getting the LTA passed and implemented appropriately has become even more important given my circumstances. I have reviewed the proposed rules. I very much appreciate that the following has been included in the proposed rules: • Full spectrum of treatment items included in coverage. • Quantity limits based on sets of compression garments and not the number of pieces. • Recognition of Lymphedema in all areas of the body, including non-limb areas. On page 288/392, "We are soliciting comments on whether two nighttime garments should be allowed, with both garments being replaced once every 2 years, to allow for more than 1 day for washing and drying of the garment(s)." My feedback is that you should allow for 2 nighttime garments every 2 years in the final draft. I use a nighttime garment. Generally, they are much thicker than a daytime garment and a challenge to dry. Patients are told to air dry, but that can take an entire day as you need to dry on both sides. Often, we end up putting into a dryer. Even with no heat drying, that can be hard on the nighttime garment. Having two would allow for a more reasonable amount of time for washing/air drying and the nighttime garments would last longer. Also, I was pleased to see proposed wording that garments could be replaced sooner if the item is lost, stolen, irreparably damaged, or if needed based on a change in the beneficiary's medical or physical condition (again, page 288/382). I do know patients who wear compression garments on their hands and other "high usage" areas. They will no doubt need garments more frequently and my hope is the process is made simple for them. If not - I predict there will be increased swelling, difficulty working, infections, and hospital days. As an example of my advocacy for Lymphedema patients, here is a piece I did with KCTV5: https://www.youtube.com/watch?v=A2h3dHoVb4E. I look forward to the final wording and implementation. Hopefully, private insurance will follow Medicare as a beacon for guidance on this very important health issue. Thank you so much for your time, hard work, and consideration.

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CMS-2023-0113-0348	CMS-2023-0113	llm-jg04-txzu	2023-09-11T04:00Z	**Cherie**	**McClelland**			Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0348/attachment_1.pdf	Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in Iowa. Specifically, we serve Palo Alto, Kossuth, Hancock, Pocahontas, Humboldt, Wright, Calhoun, Webster, Hamilton, Hardin, Greene, Boone, Story, Marshall, Tama, Dallas, Polk, Jasper, Madison, Warren, Marion, Mahaska, Keokuk, Washington, Louisa, Lucas, Monroe, Wapello, Jefferson, Henry, Des Moines, Wayne, Appanoose, Davis, Van Buren, and Lee counties. We have been a Medicare participating home health agency since 2004 and currently have a patient census of 705. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state’s citizens. Sincerely, Cherie McClelland Assistant Billing Manager Iowa Home Care West Des Moines, Iowa
CMS-2023-0113-0142	CMS-2023-0113	llc-loqx-so0y	2023-08-22T04:00Z	**Jody**	**McClenny**	OR				Commenting on response to the language used in lymphedemas description and areas affected. (page 3) "Additionally, according to the National Lymphedema Network, this swelling commonly occurs in the arm or leg, but it may also occur in other body areas including the breast, chest, head and neck, and genitals.151" Although the abdomen could be considered part of the "other body areas" specially naming the abdomen would be appropriate in order to address the effects of central lymphatic dysfunction that occurs, goes under diagnosed and affects the abdominal region. The lower abdomen is also part of the lymphatic territory we know that is affected with the lower body region which includes genital and leg lymphedema, which was appropriately specifically named out. The added language might help future clarifications if garments are needed for the specific abdominal region. Thank you.
CMS-2023-0113-0709	CMS-2023-0113	llw-gt7d-73ak	2023-09-14T04:00Z	**Alexander**	**McCulley**	OR		Home Health Facility - HPA25		A quick look around the country and the closing home health agencies should be a yellow flag that further cuts to this industry will result in even more closures. I work for an agency that routinely loses money given the complex and severely sick population that we serve, with a payment model under PDGM that does not cover the cost of their care. Further cuts by CMS to home health reimbursement will only facilitate the decline in care for the most at risk in our community. This is a short sighted approach as these individuals will seek care within the emergency department, at a much greater cost to CMS. Please reconsider another round of cuts to home health reimbursement. If I understand correctly, reimbursement is roughly on par what it was 10 years ago, with cost of serving our community greatly increasing since that time.

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CMS-2023-0113-0643	CMS-2023-0113	llv-iuos-g9wy	2023-09-14T04:00Z	**Virginia**	**McElvain**	TX		Individual		When I retired nursing I was an RN, BSN, CWOCN, which means I was board certified in wound care, ostomy care and incontinence care. I had many patients that had lower leg edema and leg ulcers that I treated. I have had lymphedema of my right arm for 25 years. I developed lymphedema basically 1 year after my breast cancer surgery. I was working I had several patients with sever lymphedema in there arm and hand that has allowed me many incites. I worked as the night charge nurse in a community hospital for 4 years immediately following my breast cancer surgery. One of my most motivating experiences in all my years of nursing has been two elderly women that had breast cancer and then developed lymphedema. One lady could not move her arm, hand or fingers. The other lady could not move her arm, hands or fingers and could not feel anything in them either. Many times when I did not have energy or money to manage my lymphedema, I remember those ladies. They had no treatment or choices for their lymphedema. Most people have not had these older ladies to inspire us to do all we can to mange lymphedema; My treatment has changed over the years that has allowed me what I needed to manage my lymphedema. I started out with a compression sleeve for my arm. Then I found a certified lymphedema specialist who taught how to better manage my lymphedema. I was lucky to find her as this was a very new specialty. I now wear a compression sleeve during the day. It is higher compression then what I started with. I do manual lymph drainage nightly and then pump with my Lympha Press Optimal pump. This takes two hours every night. At night, I wear a custom compression sleeve which an additional custom garment over that. I then wrap that with a short stretch wrap. When I fly I have to wrap my arm. I have to do the same when my arm is getting more edema than usual. To wrap my arm I start with a cotton sleeve. Next, I use a foam wrap.. Then I use at least 5 short compression stretch wraps. You must have the greatest pressure at the bottom near the hand and gradually decrease the pressure going upward. The wraps have to be wrapped in alternating directions. My certified lymphedema specialist taught me this. If done incorrectly it increase the lymphedema. I am most thankful for what is I got started with these products while I had them covered by private insurance. Hopefully Medicare will cover all the products used to manage lymphedema . HOPEFULLY YOU WILL COVER PRODUCTS FROM WHERE A PERSON IS AT AND YOU WILL NOT MAKE US GO BACK TO THE INITIAL LEVEL OF CARE. You would not make someone who is diabetic go back to a baseline when there diabetes is being managed successfully or someone with hypertension to go back to ground level treatment. A doctor's prescription for the products we need should be all that is needed. If you get an area with edema, it is there forever and if you go back on your treatment you will have more edema you cannot get rid of.
CMS-2023-0113-0107	CMS-2023-0113	ll8-8nzq-n5p9	2023-08-22T04:00Z	**Elizabeth Susan**	**McHenry**	MD		Association - Other		After a double mastectomy with lymph node axillary dissection, I developed lymphoedema in my left arm. Medicare will not pay for the daily compression sleeve and glove that I must wear to keep my lymphoedema from getting worse. Worsening lymphoedema can spread and affect other areas of my body if I cannot keep it controlled. The cost of the sleeve and glove at this time is $165.00, and they wear out fast and need to be replaced every few months. I cannot afford constant expenses like this, and my research about my condition has proven that this is a widespread problem in our population and seems to be getting more common. Please vote to have Medicare cover these compression garments and other medical supplies or equipment needed to help patients fight this incurable disease/condition.

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CMS-2023-0113-0353	CMS-2023-0113	llm-l3bt-i3pu	2023-09-11T04:00Z	**Diane**	**McKibben**	IA		Government - Federal		Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in Iowa. Specifically, we serve 36 counties. We have been a Medicare participating home health agency since 2004 and currently have a patient census of 705. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state’s citizens. Sincerely, Diane McKibben Administrative Assistant Iowa Home Care West Des Moines IA
CMS-2023-0113-0872	CMS-2023-0113	llw-y7bn-vuza	2023-09-14T04:00Z	**Tyler**	**Mears**	UT		Health Care Professional/Association - Occupational Therapis		Home Care Occupational Therapist should be allowed to be Case Managers. With out education with a Masters degrees and experience we are just as qualified to be Case Managers as a Physical Therapist or a Nurse. Thank you.
CMS-2023-0113-0525	CMS-2023-0113	llu-2e4y-am1n	2023-09-12T04:00Z	**Linda**	**Mele**				https://downloads.regulations.gov/CMS-2023-0113-0525/attachment_1.pdf	With more than 70 years of trying to manage my lymphedema I am grateful that this coverage will happen. Please read my comments in the file attached below.
CMS-2023-0113-0752	CMS-2023-0113	llw-mckk-tcsx	2023-09-14T04:00Z	**Caroline**	**Melgarejo**	TX		Other Health Care Provider - HPA70		Hello, I am a Certified Compression Fitter (CFCS) and I've been working with lymphedema patients for a bit over a year. I witness the dire necessity for these garments, DAILY. I encounter some who cost for out of pocket due to lack of insurance coverage, may not cause a dent in their pocket. However, there is a much larger population, specifically Medicare patients, that cannot afford to pay for their compression garments. These garments are vital to maintenance of their edema/lymphema, preventing further lymphatic damage. This also allows for better quality of life, as having swollen limbs/extremities can limit activities in the day, enjoying life with loved ones, and mental health. These are also garments that require to be replaced frequently, at least twice a year, in order to get the best function out of them and quality. After some wear and tear, the garments lose their ability to contain swelling. During my fittings, I describe garments as canned goods; good for a long time but eventually they go "bad." That all being said, I disagree that “average internet pricing” should be used in determining allowable prices under this new Rule. I propose Medicare use 130% of average internet pricing, as current internet providers of these products have no brick-and-mortar costs, no accreditation costs, no billing services costs, and no stock inventory costs built into their pricing, as do DME suppliers. I recommend Medicare use manufacturers MAP pricing to determine allowable pricing, or a percentage of manufacturers MSRP which has been commonly requested by Medicare in CERT requests for medical records. And that is only considering over the counter garments; their ability to contain is best for anyone with Mild to Moderate swelling, but if they have Moderate to Severe swelling (unable to keep swelling down while NOT wearing garments), they need a Custom containment. The cost for Customs can range from $500-$1000 +, of which CANNOT be purchased online/website. For the best quality of compression, Customs are the best route, but some customers chose to deter from purchase due to price/cost of garments. I recommend considering the cost of the garments and the frequency to replace them, as part of the financial allowability insurance will have. I've had too many patients leave without garments because of the cost, and their condition worsens.

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CMS-2023-0113-0787	CMS-2023-0113	llw-ptle-ya67	2023-09-14T04:00Z	**Elaine**	**Melton, CFCS, CMF**	TX		Other Health Care Provider - HPA70		Title VII. (B)(3) Pg. 271/392 “We are specifically soliciting comments on the topic of coverage of accessories necessary for the effective use of gradient compression garment or wraps with adjustable straps, including what HCPCS codes should be established to describe these items.” In regard to accessories, I would like it to be recognized that an outer jacket or sleeve almost always accompanies a foam chip, inelastic night garment. Although considered "light compression" it is an integral part of the garment and is sometimes sold and billed separately as a replacement. This could be billed as a separate light compression custom sleeve, however it is only ever an accessory to a night garment. It should have a companion code to whatever code is decided upon for the night garments. Thank you for your consideration!
CMS-2023-0113-0823	CMS-2023-0113	llw-rqqz-82ov	2023-09-14T04:00Z	**elaine**	**Melton, CFCS, CMF**	TX		Other Health Care Provider - HPA70		Title VII. (B)(3) Pg. 271/392 “as well as comments on whether there are additional items other than the gradient compression garments, gradient compression wraps with adjustable straps, and compression bandaging supplies that could potentially fall under the new benefit category for lymphedema compression treatment items.” In regard to the above suggestion of possible new category, I propose a new code/category for the compression garments and accessories that are used following breast surgery, specifically after the initial 8 weeks. As a compression fitter, it has become routine for patients to be sent by therapists to be fitted for very specific compression bras and swelling pads to be worn for months or indefinitely after the first post-surgical garment (L8015) is no longer needed. These garments can vary in strength and construction and can be costly. And, of course they should be dispensed at least 2 at a time. They are often recommended to sleep in these torso garments.
CMS-2023-0113-0202	CMS-2023-0113	llj-72dd-42ct	2023-08-29T04:00Z	**Linda**	**Mendenhall**	AL		Congressional		Compression is lifesaving for those with lymphoma and lipedema and daily compression and evening compression and work compression and travel compression is vital. it's about health to avoid death AND costly excessive medicare in lieu pf compression GARMENTS unique and measured per individual health needs.
CMS-2023-0113-0639	CMS-2023-0113	llv-i4aa-9gqf	2023-09-14T04:00Z	**Beth and Laurence**	**Meyer**	MD		Individual - I0001		We are writing in regards to draft rule 2023-14044, specifically about the Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. This is a subject of great concern for our family. We have two daughters with primary lymphedema in their lower legs. Our younger daughter developed lymphedema at 9 years-old and our older daughter developed it at 18. They are now 19 and 23 respectively. Since the initial diagnosis, our daughters have been undergoing lymphedema treatment and wearing custom fitted compression garments on a daily basis. We are thrilled to see that compression garments and associated supplies are finally going to be covered by Medicare. We agree that “two daytime garments…for each affected limb or area of the body, replaced every 6 months” is an appropriate coverage amount. Likewise, one night time garment replaced annually seems sufficient. These quantities and time frames are generally consistent with our usage. We also appreciate the availability of “replacements of garments or wraps that are lost, stolen, irreparably damaged, or when needed due to a change in the patient’s medical condition.” We would like to be sure that the frequency of replacement proposed in § 414.1680 of, “two daytime garments” per limb does not limit coverage to a single garment for a given limb, As stated elsewhere, coverage should cover, “multiple garments used on different parts of the body when the multiple garments are determined to be reasonable and necessary.” We have seen benefit from having a set of garments for a limb, as opposed to a single piece. For example, our daughters have swelling in their feet too and have used a full leg garment, with a separate toe cap used in conjunction. As such, language to support a set of garments for a limb may be more inclusive. Please include toe caps as covered garments. In addition to gradient compression garment coverage, we are thankful to see compression bandaging supplies addressed. We have always had to supply our own bandaging for decongestive therapy sessions. The proposal states, “We are proposing that determinations regarding the quantity of compression bandaging supplies covered for each beneficiary during phase one of decongestive therapy would be made by the DME MAC that processes the claims for the supplies”. We are concerned that this proposal may limit bandaging coverage to initial decongestive therapy. We have found that wrapping with compression bandaging is helpful as part of the overall care of lymphedema. Bandaging is more disruptive to everyday life than a compression garment but it is the only way to actually reduce the swelling. Hose just maintains the swelling. For example, after a long airplane trip or in extremely hot weather our daughters' legs swell and they might choose to wrap rather than wearing garments for a few days.

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CMS-2023-0113-0744	CMS-2023-0113	llw-l31c-vdzb	2023-09-14T04:00Z	**Nicole**	**Meyers**	IA		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0744/attachment_1.pdf	Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in Iowa. Specifically, we serve West Des Moines, Webster City and Ottumwa with surrounding counties. We have been a Medicare participating home health agency since [year] and currently have a patient census of 750. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state's citizens. Sincerely, Nicole Meyers Authorization/Billing Specialist Iowa Home Care West Des Moines, IA 50266

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CMS-2023-0113-0447	CMS-2023-0113	llq-mzya-mk9t	2023-09-12T04:00Z	**Amber**	**Michael**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0636	CMS-2023-0113	llv-hcx0-zrz9	2023-09-14T04:00Z	**Becky**	**Miles**	ID		Home Health Facility - HPA25		Dear CMS, I am writing today as a Director of Clinical Services for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 4.08% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Becky Miles RN - Director of Clinical Services

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CMS-2023-0113-0373	CMS-2023-0113	lln-pc5g-w6ub	2023-09-11T04:00Z	**Allison**	**Miller**	IN		Health Care Professional/Association - Occupational Therapis		Home health patients needs occupational therapy services now more than ever. Please do not allow other allied health professions to override the clinical judgment of occupational therapists, as they are not qualified to decide whether or not a patient needs occupational therapy services. The following is quite alarming: Since the adoption of PDGM, AOTA has heard from numerous OTs and OTAs about PDGM's negative impact on their ability to treat HH patients who need their services. These reports include: Agencies are applying pressure to reduce the number of OT visits to clients. Agencies are using predictive analytic tools that use algorithms to determine how many therapy visits (if any) should be provided based on diagnosis. Agencies are instructing staff to delay OT to later in the HH episode, or patients are told they can wait to get therapy after discharge when they are outpatient. Physician orders for OT are ignored, revised, or deleted. Nursing and Physical Therapy are determining when and if OT services are needed. Agencies are shifting OT visits to PT or nursing colleagues. OTs are having to do more, with less support. Therapists' clinical judgment is overridden or ignored. If this is ALREADY happening, I fear for the future of the people we serve and our profession.

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CMS-2023-0113-0489	CMS-2023-0113	llr-2ni7-83rx	2023-09-12T04:00Z	**Diane**	**Miller**	CT		Health Care Provider/Association - Home Health Facility		Thank you for your work in an arena that must be daunting related to balancing the provision of quality care within fiscal limitations. As someone who has been a front line clinical provider in home health as well as working in management and operational leadership for more than 20 years, I have seen first hand the difference that the provision of services in the home can make to individuals and families. Caring for people in their homes has been shown to be significantly more cost effective than within a facility. For that matter, one ER visit can end up being more costly than a 30 day period of home health services that might prevent that ER visit or a longer hospitalization, so I am perplexed why this sector of health care would be a continued target for cuts. I have tried to diligently read through the rationale for the decrease in payments, but the descriptions that are included do not line up with my day to day experience. The homecare providers that I interact all tell a similar story related to challenges just in trying to be able to "break even" financially. Agencies are unable to hire sufficient clinical staff to meet demand both because of inability to compete with other settings salary wise and because of the burdensome nature of home health documentation requirements. Referrals are being declined due to inability to provide all needed services. Trying to keep up with the regulatory requirements and changes requires continual training and retraining, in addition to staffing on the office side in order to be able to follow all needed steps to hopefully be reimbursed for the care provided. I am not naive about understanding that there have been "bad actors" within the home health setting and agencies that have been driven only by profit, but to my knowledge, these are very much in the minority. I fear that the continued proposed changes and cuts punish the entire industry and in fact, threaten the ongoing existence of a critical link in the healthcare system for some of our most vulnerable people. With the continued changes and cuts that have occurred combined with staffing shortages, home health patients are often receiving services for a shorter than needed period of time, resulting in poorer outcomes and unnecessary rehospitalizations. Some patients can benefit from just a few visits to transition well from an inpatient setting to self-management at home, but research in a variety of different areas (falls for example) shows that longer term treatment is often needed to effectively mitigate future risks and the current reimbursement system does not support best practice. I do understand and support the need for home health to demonstrate their value and am generally support of the move towards value based purchasing, but am concerned that instituting ongoing payment cuts at the same time as also decreasing reimbursement to a significant portion of providers found to be in the lower percentages will decrease access to patient care even more. I would also ask for reconsideration in the use of (and reimbursement for) telehealth for home health services when appropriate. Telehealth can be a cost effective way to provide heath care services and can mitigate some of the staffing challenges currently facing the industry. We as a nation should be looking to invest in home health as a health care sector that can help us provide better, cost-effective care in the place most people want to be - home. Thank you for your time and consideration.
CMS-2023-0113-0586	CMS-2023-0113	llv-7f7w-q656	2023-09-14T04:00Z	**Jeff**	**Miller**	NC		Individual		I offer the following comments with regard to the proposed Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. The proposal to allow Medicare Coverage for necessary compression garments for passive treatment of Lymphedema is a critical matter. These compression garments are the ONLY available relief from the swelling that is experienced by Lymphedema patients, as no medications exist for treatment of the condition. These garments MUST be worn daily, and each pair may only last 60-90 days maximum, when well cared for by the patient. For the high compression ratings required (30-40 hg), the cost runs about $150 per pair (thigh high stockings). Obviously multiple pairs (3-4) are required for any given week. If 4 pairs are purchased quarterly, that is still a minimum of $2,400 per year. This is completely beyond the household budget of most recipients of Medicare Disability. Please consider this critical matter to provide assistance for the many Americans on Medicare Disability.

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CMS-2023-0113-0098	CMS-2023-0113	ll7-ecio-mcyk	2023-08-22T04:00Z	**Phyllis**	**Monahan**	GA				I was diagnosed with lymphedema four years ago after uterine cancer surgery. I have paid out of pocket over $20,000 in made to order compression garments as prescribed by my physician at MD Anderson Cancer Center in Houston, Texas. Pertaining to the Lymphedema Treatment Act (CMS-1780-P), I do not see "custom" compression stockings for the leg included in the "example payment rate" list. I must wear custom stockings and not off-the-shelf. These are what are clinically prescribed. Off the shelf don't have the compression I need. I currently pay $350-$400 per stocking out of pocket. I hope you will include "custom" compression stockings for the legs in your payment rate schedule. Also - I wear a custom night garment by Jobst. . I hope you will include the "custom" night garment for the legs in your payment rate schedule as well. I currently pay about $1000 for the custom night garment and it is effective for about 3 years (no more than 5 years). Thank you for consideration. I do not purchase the compression stockings as often as I should because of the out of pocket cost. I work very hard keeping the swelling under control. This is a painful and uncomfortable disease. Your approval of custom made garments under this act would make life a lot better for me and thousands of other sufferers.
CMS-2023-0113-0099	CMS-2023-0113	ll7-ecis-ab8u	2023-08-22T04:00Z	**Phyllis**	**Monahan**	GA				I was diagnosed with lymphedema four years ago after uterine cancer surgery. I have paid out of pocket over $20,000 in made to order compression garments as prescribed by my physician at MD Anderson Cancer Center in Houston, Texas. Pertaining to the Lymphedema Treatment Act (CMS-1780-P), I do not see "custom" compression stockings for the leg included in the "example payment rate" list. I must wear custom stockings and not off-the-shelf. These are what are clinically prescribed. Off the shelf don't have the compression I need. I currently pay $350-$400 per stocking out of pocket. I hope you will include "custom" compression stockings for the legs in your payment rate schedule. Also - I wear a custom night garment by Jobst. . I hope you will include the "custom" night garment for the legs in your payment rate schedule as well. I currently pay about $1000 for the custom night garment and it is effective for about 3 years (no more than 5 years). Thank you for consideration. I do not purchase the compression stockings as often as I should because of the out of pocket cost. I work very hard keeping the swelling under control. This is a painful and uncomfortable disease. Your approval of custom made garments under this act would make life a lot better for me and thousands of other sufferers.
CMS-2023-0113-0595	CMS-2023-0113	llv-ab6m-4eaz	2023-09-14T04:00Z	**Miriam**	**Mondlin**	NY		Individual		I am writing concerning "Section VII.B.- Scope of the Benefit and Payment for Lymphedema Compression Treatment Items." I live on my Social Security and Pension, after having worked steadily for over 50 years. I will be 92 in December, and have Primary Lymphedema in both legs since I was a child. It has been an uphill battle to get any kind of help for lymphedema for all these years. I have not been able to find knowledgeable medical people to take care of me! I'm grateful Medicare is going to help after all this time, to pay for the necessary compression garments, but of course, that is not enough. In 2013, after trying and trying, I finally found a lymphedema physical therapist who was trained to lessen the swelling. I had to buy and pay for all the special bandages, special tape, day garments, night garments, and Jobst Made to Order knee high-open toe compression stockings. It costs a fortune, and I don't have a fortune. I couldn't get a lymphedema specialist at any of the big hospitals I live near, in NYC. They only attend to Secondary Lymphedema—from cancer. There is no difference in how you need to treat Primary or Secondary Lymphedema. There needs to be LPT massage available to lymphedema patients. Medicare needs to pay Lymphedema PT's to do this special massage. It makes no sense for Medicare not to pay for it. Recently, when I saw the Lymphedema Physical Therapist, she told me to stop using my old made to order stockings from Jobst—which I have been wearing daily since 2013. They are different sizes—some tight, some loose. Since seeing her, I've been having my legs bandaged every day by my aide. I can't do it myself. Some aides do it better than others, but I'm grateful because it helps. I have had to buy the special lymphedema bandages in different widths and the tape that closes them on my leg, and pay for it out of my own pocket. They are washed every day, and need time to dry—so I need to replace them and get the special tape every couple of months. I should have day garments and night garments. My old ones don't fit anymore. I need Compression wraps. To maintain health, it's necessary to have timely replacements every 3 months. The night time garments are also hand washed, so we should be able to get two sets at a time. There is cotton gauze, socks, and other items necessary to keep down the swelling. I don't know that I've included all the items needed, but I do know that these items and care are necessary. I'm grateful there will be some help come 2024! Thank you.

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CMS-2023-0113-0669	CMS-2023-0113	llv-zb0j-fpuj	2023-09-14T04:00Z	**Tammy**	**Mondry**	CA		Health Care Professional/Association - Physical Therapist	https://downloads.regulations.gov/CMS-2023-0113-0669/attachment_1.pdf	Comments on 2024 Home Health Prospective Payment System Proposed Rules - Lymphedema Treatment Act (LTA) I am a physical therapist with 34 years of experience, and a board-certified lymphedema therapist through the Lymphology Association of North America with 26 years of experience treating both primary and secondary lymphedema patients. My comments are in reference to Section VII.B. – Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. • Proposal to use a competitive bidding process o I strongly disagree with the use of a competitive bidding process o Competitive bidding would be detrimental to therapists that are provider / suppliers. To use a competitive bidding process and only allow a few suppliers to provide items to the patients would allow large suppliers the advantage and would essentially shut out individual therapists that are provider / suppliers trying to provide patients with exactly what they need, when they need it. There would be significant wait times if all patients had to go out to a few suppliers. During those wait times, the patient would have to continue with treatment and continue with bandaging until the garments or supplies arrive. With an unnecessary delay, this will cost the therapist, patient, and Medicare time and money trying to accommodate to a few suppliers who have been awarded the contract during competitive bidding. The therapist treating the patient would be the most efficient and effective at getting the patient the lymphedema garments or supplies that are medically necessary and appropriate without having to unnecessarily prolong treatment and wait times. • Payment based on Medicaid fee schedules, VHA, Tricare and Internet Pricing o I am extremely concerned about the use of Medicaid, VHA, Tricare and Internet Pricing. The internet retail pricing would be lower than what the provider would be able to obtain wholesale because the internet retail company would be buying in large bulk. If the rate is 100% of the internet retail pricing, the provider / supplier may not even break even with the wholesale price that was paid for the treatment item. Basing pricing on large company prices would be an unfair disadvantage for individual provider / supplier practitioners. This also would not allow for payment of time spent measuring and fitting the patient with the treatment item. o Recommend the pricing be 20-30% above the manufacturer minimal allowable price (MAP) for the lymphedema compression garments. • Payment for the time associated with measurements and fitting services o A considerable amount of time is involved in the measurement and fitting process, especially with custom garments. Medicare should have a timed CPT code that will be assigned for this purpose. The complexity of the patient's comorbidities will vary depending on the patient, so a timed code would allow for any variation between patients. • Proposal to cover and make payment for two garments or wraps with adjustable straps for daytime use (one to wash and one to wear) to be replaced every six months, as well as one nighttime compression garment to be replaced once a year o Recommend four sets of compression garments or wraps with adjustable straps for daytime use to be replaced every six months, with additional sets based on medical need; Recommend two nighttime compression garments to be replaced every six months, with additional sets based on medical need o The recommendation for a greater number of sets is based on the need to launder daily. The patient would need access to a washer and dryer daily, or possibly a laundromat. This could also cause problems for the beneficiary due to the costs associated with daily laundering of the garments. With direct contact of the skin, dirty garments have the potential of creating an environment that would make the patient much more susceptible to developing an infection of the involved limb or area. The garments also require cleaning to restore the compression qualities of the garment. If the patient is unable to launder daily, the patient will not be receiving the appropriate compression, or containment that is required to manage and or maintain the patient's condition of lymphedema. • Prescribing provider for gradient compression garments or wraps with adjustable straps o Recommend that the prescribing practitioner for compression garments or wraps with adjustable straps not only include the physician, physician assistant, nurse practitioner, and clinical nurse specialist, but should also include the treating therapist (physical or occupational therapist). The treating therapist will be able to determine exactly what garments are medically necessary, but also the quantity. If a referral has already been made for treatment, then the therapist should be included on the list of providers that are approved to prescribe compression garments or wraps with adjustable straps

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CMS-2023-0113-0438	CMS-2023-0113	llp-yp1j-iv1m	2023-09-12T04:00Z	**Holly**	**Monserret**	NV		Health Care Professional/Association - Physical Therapist		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0868	CMS-2023-0113	llw-wwtu-8ek7	2023-09-14T04:00Z	**Harold**	**Moore**	GA		Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0868/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0061	CMS-2023-0113	ll3-pdur-bsue	2023-08-10T04:00Z	**Julie**	**Moore**	MN				I am grateful that the Lymphedema Treatment Act was passed during the 117th Congress as part of the Consolidated Appropriation Act of 2023. As a certified lymphedema therapist working with clients who live with primary and secondary lymphedema everyday, I so pleased that the financial burden limiting best pracitce care for some of the Medicare beneficieries with whom I work will soon be eased. I so much appreciate the consideration of garments by the set for each limb effected as patient's may experience lymphedema in just one area but other can experience in multiple limbs or limb and trunk. Allotting 2 sets for day time every 6 months and 1 night garment per year will satisfy the minimum for most patients but I do appreciate the exception process as each case is different and infection, hospitalization, and injury are complications that can cause need for garments sooner than expected. This being said, well fitting garments that are replaced regularly do prevent infection with home managment and hospitalization, as well as managing mobility challenges relating to lymphedem to decrease falls and increase activity and mobility which is a very important part of management. I appreciate the inclusion of banaging supplies but would like to see these covered at all times, not just during intensive phase of therapy as they are an important part of the maintenance program for many of my patients. Gradient compression banaging is the gold standard. I have patients who bandage nightly because their lymphedema is so severe that even proper fitting night garment cannot contain the swelling as well, others who use bandages in combination with a night garments most nights and those who do a full bandages 1 time per week just to keep the volume of their extremities stable. The specialized bandages and foams can be reused and we education thoroughly on best care care for garments and bandages but they do lose elasticity over time and need to be replaced at least annually but more often if used regularly for home management. When I think about this act, I think about my patients who don't qualify for any medical assistance but truly cannot afford garments. I have a patient who unforntunately has adenocarcinoma of his colon with liver metastasis. His he is living with cancer but the surgery and immunotherapy side effects are much less bothersome than the lymphedema he has experienced from the disease and surgery. Before he was able to have lymphedema treatment he experienced terrible lower leg wounds and weeping, his clothing and shoes don't fit so he has to wear slippers and the financial burden of cancer has left him little to pay for even daily expenses. He has set aside funds over a 15mo period to pay for garments once we were done with therapy, had to delay therapy making the swelling and chronic tissue change worse, but soon after the intensive phase was started he was hit with a medical bill for another cancer procedure that he had expected to be covered and he was unable to get the garments. He now uses bandages, albeit not as effectively as we can do in therapy and is not able to hire help for this due to the financial constraint. This fellow is a great example of someone doing everything they can to manage their condition but they just do not have the resources (family/friends) or finances to help. He is doing his best until January but may need an additional few weeks of intensive therapy to prepare for compression garments. I work with another lady who has secondary lymphedema related to breast cancer treatment. She continues to work as a highschool paraprofessional at age 71y/o for her healthcare coverage specifically related to her lymphedema supply needs. She has experienced about 6 episodes of cellulitis infections over 11 years, often related to compression garment fit or just not being replaced often enough, we have recommended layering of garments which may require her to get more that the alloted 4 sets per year (2 per 6mo). Additionally she uses a foam pad in her glove due to hand swelling which makes a huge difference in the use of her hand. The inclusion of these specialized pads increase the effectiveness of the bandages. Finally I have a little guy, 7 years old with both leg and right arm swelling as well as gential swelling. He is active, things get dirty, have torn with regular 7y/o use. He and his parents are very understading of care for garments but also don't want to limit his childhood. Though not a Medicare beneficiary, he would require these exceptions to the rule to be in place without undue delay to prevent exacerbations in this growing boy. Thank again for passing this bill and allowing input from the public. I was so very pleased with the original proposal with the request of allowing bandages to be covered as needed outside of the intensive therapy phase. Sincerely, Julie Moore, PT,CLT-LANA
CMS-2023-0113-0662	CMS-2023-0113	llv-sy29-519k	2023-09-14T04:00Z	**Cindy**	**Moore**	PA		Home Health Facility - HPA25		Thank you for accepting comments on the 2024 Home Health Proposed Rule. I am a physical therapist who has worked in home health for over 35 years. Pages 43725-6 of this proposed rule highlight research showing ways home health services improve function, mobility and quality of life and reduce hospitalizations. Yet, despite increased costs of delivering home health services, this proposed rule directs a net 2.2% payment reduction. This will exacerbate current care access problems. Many patients needing home health are unable to access it in a timely manner. Those who are admitted to home health care are often receiving suboptimal amounts of care, in part due to payment models that incentivize providing few visits once a case rate threshold is achieved. I hope CMS will make course corrections to support beneficiaries' access to needed home health services. Regarding CMS' request for comments regarding ensuring beneficiary access to home health aide services, aide service dropped precipitously with PPS' financial disincentives to providing visits, and aides were let go or per diems were offered less work. Current aide recruitment and retention seems hampered by a limited supply of aides and more lucrative options in other employment sectors. As a caregiver for a parent who has dementia, I can appreciate how an aide's assistance can make a difference in a caregiver's ability to keep their loved one at home and avoid or at least delay institutionalization.

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CMS-2023-0113-0672	CMS-2023-0113	llw-6dmz-493x	2023-09-14T04:00Z	**Carrie**	**Morris**	IN				As a lymphedema therapist, I wholeheartedly support the Lymphedema Treatment Act. This vital legislation would ensure that individuals with lymphedema have access to necessary medical supplies and treatments, improving their quality of life and overall health. Lymphedema is a chronic condition that often arises after cancer treatments, surgeries, or other medical procedures. It can also arise due to a malformation of the lymphatic system without prior procedures. It can lead to painful swelling and discomfort, affecting mobility and daily activities. The Lymphedema Treatment Act recognizes the urgent need for improved insurance coverage of compression garments, bandages, and therapies that are essential for managing lymphedema. Without proper coverage, many patients are forced to bear the financial burden of these treatments, which can be prohibitively expensive. This Act addresses this issue by amending Medicare coverage to include compression supplies and garments, providing relief to countless patients who are struggling to afford the care they require. Furthermore, the Act's support is backed by a plethora of evidence demonstrating its necessity. Multiple studies have highlighted the effectiveness of compression therapy in reducing lymphedema-related complications and improving patient's overall well-being. By passing this legislation, we can ensure that individuals battling lymphedema can access the treatments they need to lead healthier, more comfortable lives. In conclusion, the Lymphedema Treatment Act is a crucial step towards providing essential medical coverage for those suffering from lymphedema. By supporting this Act, we are advocating for the well being of countless patients, enabling them to manage their condition effectively and maintain a higher quality of life. Some additional practical considerations for the act include: a self reimbursement process for garments ordered online from approved brands. Will there be a way for patients to submit for reimbursement through insurance? There are a couple of trusted brands for light containment that are more affordable than traditional compression garments including Wear Ease and Bioflect. There will be others emerging, but with the opportunity for fraud how will these brands be vetted and coverage be determined? I do not think it unreasonable to require a $20-50 co-pay per garment (pricing depending on the garment) for custom garments to ensure that the patient's being provided with the more expensive garments help to cover the cost and have some ownership in the custom garment. Thank you for your time and dedication to coverage in this act. Many lives with be effected in a positive way due to the coverage this legislation provides.
CMS-2023-0113-0575	CMS-2023-0113	llv-54fu-awfx	2023-09-14T04:00Z	**Arthur**	**Morton**	MD		Individual	https://downloads.regulations.gov/CMS-2023-0113-0575/attachment_1.pdf	SEE ATTACH FILE
CMS-2023-0113-0496	CMS-2023-0113	llr-8318-s6eg	2023-09-12T04:00Z	**Marisa**	**Moses**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0370	CMS-2023-0113	lln-fmnf-tlxm	2023-09-11T04:00Z	**Mary**	**Mowell**	MD		Individual	https://downloads.regulations.gov/CMS-2023-0113-0370/attachment_1.pdf	CMS-2023-0113-0002 I was diagnosed a couple years ago with hereditary lymphedema. I had gone through many years not being diagnosed. While the compression garments have been a life saver to me they are expensive ranging from $30,00 to as high as $900.00 and over. Because some of us with this condition are unable to work it becomes very difficult to pay for needed garments and supplies. Having coverage for my compression and supplies will really help me manage my condition and not end up in the hospital with infections.
CMS-2023-0113-0671	CMS-2023-0113	llw-5cl8-m8w2	2023-09-14T04:00Z	**Linda**	**Muckway**	IN		Individual		What do you think: Rough draft for LTA public comment I have cerebral palsy,and was diagnosed with secondary Lymphedema, 15 years ago. My insurance is Medicare only. I am very happy that Medicare is going to be providing a level of coverage for my custom garments in the near future. I'm very glad that quantity limits are going to be based on sets rather than pieces of garments. I currently have more than one custom garment on each leg. I am concerned that toe caps are not included in the proposed rule for coverage; I didn't see them listed anywhere. With the recent frequent swelling in my toes. I am certain we will have to go to toe caps the next time that I am reduced and fitted for my garments. I am also pleased, and It's important to have a minimum of two sets of garments so that they are clean and maintain their elasticity to remain therapeutically effective. it is necessary to rotate the sets of garments to have a clean and proper shape pair to wear each day. Thank you.

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CMS-2023-0113-0658	CMS-2023-0113	llv-rmal-0zq0	2023-09-14T04:00Z	**Naydza**	**Muhammad**	MS				I My name is Naydza Muhammad. I am an Occupational Therapist, a Certified Lymphedema Therapist and a lymphedema patient. I have secondary lower extremity lymphedema. I am a proud Board Member of the Lymphedema Advocacy Group. I had the amazing opportunity to take part in the CMS Listening Session with AOTA. I am grateful for the hard work and tenacity of Heather Ferguson and her Lymphedema Advocacy Group in getting the Lymphedema Treatment Act passed. Page 268 asks for comments regarding a bandaging benefit category. My comment is yes, a bandaging category is necessary to capture the skill needed to correctly bandage a patient. The addition of a new category will recognize the importance of this service. I would like to see codes like the ones I use when fabricating custom splints/orthotics. The DMEPOS/CLT should have the ability to bill for their measuring/fitting services. It is imperative for the CLT to be one of the professionals with the ability to measure/fit the patient for garments custom and non-custom. The CLT routinely assesses the patient for skin integrity, changes and irregularities, pressure sensitivities and patient tolerance. The CLT is aware of changes in each patient, subtle and otherwise that have a direct and significant impact on the successful management of lymphedema. Page 271 asks for comment regarding coverage of accessories needed for effective use of pressure gradient items. My comment is this coverage of accessories should be expansive, varied and inclusive. It should open and allow for new products and innovations on a regular basis. This coverage should include but not be limited to toe caps, skin adhesive, liners, skin protectants and low pH lotion etc. All of these products play a part in the successful management of lymphedema. Page 273 asks for comment on the existing HCPCS codes for compression treatment items. My opinion is that the existing codes are comprehensive and appear to be adequate. The existing codes are further clarified by the addition of the 3 new HCPCS codes which include venous ulcers. The ask for comment regarding whether to maintain pressure level differentiations described, in my opinion the gradient levels, while they do not encompass all levels of pressure used in garments, are appropriate and should remain. This portion should also include language that acknowledges that these descriptors are not inclusive of all gradient levels covered. The ask for comments on the use of descriptors such as "thigh-high, below knee" etc., in my opinion as an OT and a CLT these terms are familiar, and accurate descriptors of the items they represent. They have become industry standards and are widely used and understood. Page 274 asks for comment regarding if a "mastectomy sleeve" should be included under the same codes used for other arm sleeves. There is no such item as a "mastectomy sleeve" in actuality a compression sleeve is simply a compression sleeve. Regardless of whether the patient's lymphedema developed as the result of a mastectomy or other condition. Speaking as a CLT, some of my patients with breast cancer and lymphedema have never had a mastectomy. Their lymphedema is due to a lumpectomy, lymph node dissection and possibly subsequent radiation related scarring and tissue changes. We need to be very careful and refrain from using descriptors that are not inclusive and that divide and classify items inappropriately and unnecessarily. The goal here should be uniformity and clear language. Page 275 asks for comment on the need for adding pressure level descriptors for the upper body. It is my opinion that these gradient levels, while not inclusive of all levels of pressure used in garments, should be added. This makes for increased specificity, continuity and consistency with the lower body garment descriptors. This portion should also include language that acknowledges that these descriptors are not inclusive of all gradient levels covered. Page 288 asks for comment on the need for 2 nighttime/night garments a year. I am a lymphedema patient and I have to wear my nighttime garment without fail due to my difficulty with fluid refill at night. Since this is a garment that is very dense it makes it difficult to dry when washed which should be done regularly. I personally need at least 2 nighttime garments so that I may have a garment ready to wear when one is being laundered or drying. If not, my compression garment wear containment gained through the course of the day will be lost. This can put me at risk of worsening my condition, increase the girth of my limb and cause discomfort and pain. I propose that at the very least 2 nighttime garments be issued each year to decrease the above outlined negative outcomes. In closing, I hope that patients who need more than the covered number of compression garments a year due to damage, body changes etc. will receive the garments timely so we don't have patients losing limbs and lives waiting on a garment.
CMS-2023-0113-0372	CMS-2023-0113	lln-ouqn-zuxh	2023-09-11T04:00Z	**Joseph**	**Muniak**	PA		Health Care Professional/Association - Occupational Therapis		Hello, I would like to express my concerns around this proposed regulation. I feel as though this is a CMS potential threat to patients accessing the appropriate amount of OT services. All individuals are unique in how diagnosis and disability impact them. A global prescriptive amount of therapy based on diagnosis would be a disservice to those that benefit and require additional therapy to remain safe and meet functional goals. Need should be based on the clinical judgement of the medical professional, in conjunction with the needs and presentation of the patients being served. This need should also be based on the evaluation of OT, and not the recommendation of a PT or nurse. Physician orders asking for OT should be honored and not modified. I am OT in the home health care field, and I would like to continue to meet the needs of this patient population. Thank you for your time and consideration of my opinion. Best regards.

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CMS-2023-0113-0839	CMS-2023-0113	llw-sqd0-ldgr	2023-09-14T04:00Z	**Christy**	**Musick**	TX		Individual		RE: FILE CODE CMS-1780-P 5. Procedures for Making Benefit Category Determinations and Payment Determinations for New Lymphedema Compression Treatment Items Title VII. (B)(5) Pg. 277/392 COMMENTS: • We are against lymphedema compression treatment items being included in Competitive Bidding. It has been extremely difficult for lymphedema patients to gain access to the products they require, as you can see from the myriad of individual comments to this Proposed Rule. Adding CBP will create additional burdens on Medicare beneficiaries to find providers who understand the idiosyncrasy's lymphedema and the challenges of providing lymphedema products. • While we might recommend CBP for A6545AW Compression Wraps and A6531-A6532AW OTC compression hose in the Surgical Dressings category be included in CPT, we are against these codes for lymphedema be considered for CBP. • We must voice our concern that any "item" or garment prescribed for a patient with lymphedema should not be included in a bid process such as the CBP. • All compression garments for lymphedema require specialized measuring and fitting, especially when custom garments are needed. It is just not appropriate for this new Part B benefit category to be included in the competitive bidding process. Perhaps this is for this reason that the word "items" is used to describe these complex garments. Lymphedema garments are not items. They are medically correct and often custom-measured and custom-made to fit abnormal limbs and body parts. To describe these as "items" just so they will fit the definition of "items" for competitive bidding without public comment seems extremely unfair. Therefore, we propose all lymphedema compression treatment items be eliminated from the competitive bidding program.
CMS-2023-0113-0879	CMS-2023-0113	llx-0et2-71rc	2023-09-14T04:00Z	**Said**	**Nafai**	MA		Health Care Professional/Association - Occupational Therapis		The passage of the Lymphedema Treatment Act is a great initiative to address the care needs that people with lymphedema need. However, people with lymphedema need continuous and adequate care for lymphedema including access to compression and lymphedema therapy even when they are in inpatient hospitals or receiving home care services. Medicare need to do more to ensure that people with lymphedema are receiving proper treatment and compression to manage and control their symptoms and live life fully like the rest of us.
CMS-2023-0113-0010	CMS-2023-0113	lk7-4bbt-u3xz	2023-08-10T04:00Z	**Jenny**	**Nelson**	UT		Health Care Professional/Association - Physical Therapist		PLEASE STOP CUTTING HOME HEALTH! This is the most cost-effective provision of services in the healthcare continuum. Cuts are preventing us from recruiting and retaining quality clinicians to provide care. Home health is a labor of love but can not be sustained without fair and competitive wages. Also, CMS expects more documentation and data collection while denying more claims. This increased burden of documentation further strains the ability to maintain staff. This attempt to reduce the number of agencies and "trim fat" is certain to destroy an industry at a time when it is needed most.
CMS-2023-0113-0084	CMS-2023-0113	ll5-f6dv-j9cp	2023-08-22T04:00Z	**Megan**	**Nelson**	IA		Individual		My comment is in reference to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items. I am a certified lymphedema therapist. I currently am using circaid reduction kits for a lot of my patients. It is more user friendly than bandaging for a lot of the Medicare age group. Many patients are limited or unable to bend over, especially for long periods of time. Bandaging requires a patient to bend and lift the leg for longer periods of time and it is impossible for some patients to complete on their own. The Reduction kits are velcro straps that can be placed a strap at a time, allowing for breaks between placing straps if necessary. The Reduction kits allow for increased independence with care for many of my patients. It is my request that reduction kits be allowed coverage under this act to maintain independence for many of my patients.

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CMS-2023-0113-0632	CMS-2023-0113	llv-gpey-9g56	2023-09-14T04:00Z	**Amanda**	**Newman**	IL				Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within "Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update" 88 Fed. Reg. 43654 (July 10, 2023). Western Illinois Home Health Care provides home health services in Illinois Specifically, we serve ten, largely rural, counties within West Central Illinois. We have been a Medicare participating home health agency since 1981 and are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. As a result, we have instituted already or a facing in the near-term the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals with care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing.
CMS-2023-0113-0426	CMS-2023-0113	llp-ql27-64rv	2023-09-11T04:00Z	**Shelly**	**Nielsen**					I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0549	CMS-2023-0113	llu-y8yi-hkf8	2023-09-14T04:00Z	**Hailey**	**Nielson**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0207	CMS-2023-0113	llj-ug27-f5xa	2023-08-29T04:00Z	**Natalie**	**Niewoehner**	MD		Individual		I am writing regarding “Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” I have had suffered with Lymphedema of the right leg since 2011, caused by overly aggressive treatment for cancer in 2003. I have endured 5 surgeries to reduce the leg volume, and improve skin texture. Conservative treatment was ineffective, as was off-the-shelf compression. I am in compression 24/7 for the rest of my life. I swell in the 10-15 minutes it takes to shower. Custom garments have been required to control the swelling (both day time stockings and night time garments). I swell in off-the-shelf garments, and when the swelling continues, new rounds of surgery have been required to maintain mobility. My insurance provider covered those garments UNTIL the passage of the Lymphedema Treatment Act, after which coverage shrank to trivial reimbursement. The regulations need provision for at least two custom day-time garments, and one night garment per year at market rates for those patients for whom off-the-shelf are ineffective. The garments last approximately one year, and must be washed every day. Thus, a patient must have multiple garments on hand because of the length of time required to dry.

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CMS-2023-0113-0640	CMS-2023-0113	llv-i7jb-z4dp	2023-09-14T04:00Z	**Maggie**	**O'Hara**	ID		Health Care Provider/Association - Home Health Facility		Dear CMS, I am writing today as a nurse from a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. An almost 5% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which are to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. I urge you to do right by the residents of this state and this country, and to truly evaluate the moral and ethical implications of cuts to these programs. These cuts are absolutely shameful, and these patients and the clinicians and staff caring for them are deserving of much more respect and value. Thank you for your time and consideration. Sincerely, Maggie O'Hara Home Health Clinician
CMS-2023-0113-0760	CMS-2023-0113	llw-ns4f-5ijc	2023-09-14T04:00Z	**Jessica**	**O'Gorman**					it is imperative that the rates for home care do not go down. We are working harder than ever, seeing very sick patients . Reimbursement should be going up, not down. Patients are getting discharged from hospitals early to home care. Please reconsider this .
CMS-2023-0113-0870	CMS-2023-0113	llw-xfgv-x36k	2023-09-14T04:00Z	**Mercy**	**Obeime**	IN		Health Care Provider/Association - Hospice	https://downloads.regulations.gov/CMS-2023-0113-0870/attachment_1.pdf	Please see uploaded document requesting modification of criteria for large organizations serving minorities and underserved.
CMS-2023-0113-0642	CMS-2023-0113	llv-io43-0f7u	2023-09-14T04:00Z	**Blake**	**Ollivier**	ID		Home Health Facility - HPA25		Home health is already a financial struggle. Lowering the rate of reimbursement would only result in reduction of quality of care for patients. Everything costs drastically more than it did a few years ago, and cutting crucial funding would have negative implications on the health needs of all patients.

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CMS-2023-0113-0773	CMS-2023-0113	llw-owby-cvjy	2023-09-14T04:00Z	**Jason**	**Olsen**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0064	CMS-2023-0113	ll3-ycfq-v1em	2023-08-10T04:00Z	**Ron**	**Ordona**	CA		Health Care Professional/Association - Nurse Practitioner		If we can lower the threshold for the qualifier especially affecting those who serve the underserved and rural areas which may be impacted by volume.
CMS-2023-0113-0656	CMS-2023-0113	llv-q7dq-lfp2	2023-09-14T04:00Z	**Javette C**	**Orgain MD MPH**	IL		Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0656/attachment_1.pdf	See attached file(s) Attention: CMS–1780–P
CMS-2023-0113-0587	CMS-2023-0113	llv-7qst-rnwj	2023-09-14T04:00Z	**Joey**	**Ortega**	CO				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0358	CMS-2023-0113	llm-qyr0-re03	2023-09-11T04:00Z	**Melvin**	**Osburn**	IL				It is my understanding that Lymphedema patients will be reimbursed for their Compression garments. Is this correct? If it is I feel like it is not really going to help people that can't afford them now. And I myself along with many others aren't any better off. How long would it take to get reimbursed? Most people can't afford to pay for them and wait to get reimbursed. Also what about shoes? Are custom made shoes covered for people that have it in their feet such as myself
CMS-2023-0113-0150	CMS-2023-0113	lle-7z17-fc3w	2023-08-22T04:00Z	**L**	**P**	NC		Government - Federal		These comments are related to the lymphedema section of the proposed rule. Thank you for your consideration. 1. Measurements should be allowed to be made by either the therapist or a vendor. 2. Wrapping bandages for fluid reduction (for arms, legs, toes, etc.)should be covered for either fluid reduction therapy or maintenance as some people need them to manage their condition (such as cellulite). 3. Overnight compression garments and skin protection are not on the code list: 1. Ideally overnight compression garment should be allowed one per limb/affected area/ year. 2. A skin barrier stocking for under the overnight garment should be included ideally 2 per limb/affected area per year to allow for washing. 3. A cover for over the overnight compression garment (if needed) should also be included. 4. For legs these garments may be one set for the whole leg or 2 sets split by a set for the lower leg and one for the thigh area. This split (upper and lower leg) allows for better movement at night for some patients. A code for a foot garment should also be added to the list. 4. Miscellaneous items are also not on the code list such as those below. 1. Donning devices, which are sometimes needed for patients who cannot don the stockings without assistance. 2. Swell spot foam pads, often needed for targeted swelling areas. Two per year, per affected area may be sufficient for most patients. 5. A code should be included for the fitting of any garments. 6. There are no codes for compression garments such as compression underwear, boy shorts, and thigh length shorts. These are needed to control swelling in the midsection and upper legs if there is a swelling issue there. These ideally would be 2 per limb/ per 6 mos. 7. I understand that compression amounts go above 50mmhg. All the levels should be in the code chart for patients who need those levels. 8. I see that the rule allows for 2 compression garments per affected area per 6 mos. I would suggest that the amount be 3 garments per affected area per 6 mos to allow for washing and drying before wearing again as most people air dry these garments.
CMS-2023-0113-0387	CMS-2023-0113	llo-3nbt-2147	2023-09-11T04:00Z	**Melissa**	**Pace**	MO		Other - OT001		This proposed rule would be detrimental to the Home Health and Hospice field. Home Health Care has become a indispensable segment in providing much-needed care for the residents within our community. A loss for the provider only results in a loss for the community.
CMS-2023-0113-0892	CMS-2023-0113	llx-47q0-2dg2	2023-09-14T04:00Z	**Elizabeth**	**Packer**	NY		Hospice - HPA30		Please accept this comment as concerns implementation of Special Focus Program in 2024 based on HQRP data from 2023. We ask CMS to consider the effects of the PHE on the HQRP data from 2023. Because the PHE continued through May 11, 2023, the HQRP data from the first two quarters of 2023 is impacted by PHE circumstances and regulatory leniencies. Requirements for hospice assessment of patients are found at 42 CFR § 418.54 requiring update to comprehensive assessment at least every 15 days, which was expanded during the PHE to a 21-day time frame in consideration of the logistic and staffing challenges caused by the PHE. Hospice Care Index indicators are impacted by lower frequency of nursing visits for purpose of update to comprehensive assessment, including indicators of nursing minutes provided and gaps in nursing visits greater than 7 days. As a hospice in an area deeply impacted by COVID, we experienced severe nursing shortage during the PHE and so did at times rely on the expanded window for updates to comprehensive assessment. As a result, we notice in Q1 2023 and Q2 2023 lower number of nursing minutes provided and more occurrences in gaps in nursing visits, as compared to Q3 2023 data to date. We propose for consideration that (1) the Special Focus Program be based on data from Q3 2023 and forward and that (2) Q1 2023 and Q2 2023 be data be omitted from consideration by the Special Focus Program. Thank you for your consideration of this request.
CMS-2023-0113-0714	CMS-2023-0113	llw-hl7n-3gsw	2023-09-14T04:00Z	**Joanna**	**Palmer**	OR		Health Care Industry - PI015		I am a MSW working for a Home Health agency. I have work for about 9 years for Home Health. I see patients daily who have benefitted from having Home Health nurses and PT and OT and MSW and bath aids come to their home. We see people who are unable to drive to see a dr or get their wound cares met. The impact we have on people's lives is huge, we can see their home environments and truly make a difference. I know the Home Health I work for is at a loss every month. We work so hard to be effective and still work within the reimbursement model. I do not know how to be more effective with less dollars. Please do not cut any more funds from Home Health. Our service are so important. We cannot do it on less money. Please do not take this service from the small towns and people who need us. This is for code CMS–1780–P. Thank you, Joanna Palmer, MSW

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CMS-2023-0113-0027	CMS-2023-0113	lkl-ldjj-aky6	2023-08-10T04:00Z	**Debra**	**parduhn**	WI				Lymphedema treatments follow-up, recommending that once OT MLD treatment ends whether in-home or in-office, there could be allowed extra follow-up care or a maintenance appointments would be allowed (comparable to chiropractic maintenance) every couple on months to makes sure patient is adhering to self-care. Being cutoff cold turkey is difficult, and manual massage by a occupational therapist is way more effective than any machine or by patient who is living and monitoring the condition day by day.
CMS-2023-0113-0576	CMS-2023-0113	llv-5kz6-lyfk	2023-09-14T04:00Z	**Howard**	**Parks**	MD				I am a sixty-four year old male with primary lymphedema. I was diagnosed with Milroy's Syndrome at age 15. It took me many years to find adequate ways to manage my condition; after several bouts of cellulitis, including hospitalizations, I was led to manual lymph drainage (MLD), reduction therapies, and custom compression garments. While the irony is not lost on me that coverage for compression garments is being approved under Medicare just three months before my 65th birthday, I am very grateful that these rules are being put in place. I do have a couple of concerns with the proposed rules. I agree with some of the other comments that two sets of nighttime garments should be allowable under the rules, because the care and maintenance of these garments require regular washing. Also, "nighttime" and "daytime" describe the ordinary functioning of these garments, but there may be times when I may wear "nighttime" garments during the day, if I am actively trying to reduce swelling and may not be as concerned with mobility. I've had the nighttime garments I am using now for three or four years, and they desperately need to be replaced. The rules currently call for one set of nighttime garments every 12 months. At least two sets annually would be preferable; if that can only be allowed every 24 months, so be it. But two sets of garments should be the minimum. As I get older, I am finding it more difficult to doff compression garments, and this is only going to continue. I am sure I am not familiar with all the aids available to assist with this daily task, but I would like to see language that would ensure that such tools are included in the consideration of what is medically necessary and therefore covered by Medicare. Thank you!
CMS-2023-0113-0507	CMS-2023-0113	lls-5zg7-514d	2023-09-12T04:00Z	**Tamara**	**Patton**	OR		Health Care Provider/Association - Home Health Facility		To Whom it May Concern, My name is Tamara Patton, MS, OTR/L I have been an Occupational Therapist for 28 years. I have worked in hospitals, home health agencies, skilled nursing, and school districts. I live in a small community on the Oregon Coast. I really do not understand why there are so many cuts in home health for occupational therapy (OTs). OTs are the best for home health, because we look at how patients take care of themselves in their home. We make recommendations for adaptive equipment, how to dress, toilet, and cook for themselves independently. I left my full time home health job two years ago, because of the cuts to OT. Nursing and PT were determining what was best for the patient and not following doctor's orders to have OT in place. I currently work in a hospital. OT is valued in the hospital, because we help get patients strong to go home or to a higher level of care. I usually recommend home health OT, but I don't know if they always get it because of the cuts CMS is proposing and have implemented in the past. From AOTA and past studies, Occupational Therapy is the only spending category that has been shown to reduce hospital readmissions (Rogers, Bai, Lavin, & Anderson, 2016), through facilitating early mobilization, restoring function, preventing further decline, and coordinating care, including transition and discharge planning. I still work in home health on an on-call basis. I left home health 2 years ago and my company has not been able to replace me. They have OT travelers that are getting paid more than me. No OTs want to work in home health due to not being valued, even though we provide great value to preventing readmissions to hospitals. Please stop cutting home health occupational therapy services. With hospitals discharging patients earlier and earlier, home health is the last resource to keep patients at home. Home Health is way cheaper than a hospital admission. Please reconsider and encourage having OT as an important part of home health services. Thank you for your time and reading my letter. Tamara Patton, MS, OTR/L PO Box 2059 Gearhart, OR 97138.
CMS-2023-0113-0511	CMS-2023-0113	lls-gbiq-rnzs	2023-09-12T04:00Z	**Tina**	**Pecht**	VA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0511/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0861	CMS-2023-0113	llw-w4f5-69qv	2023-09-14T04:00Z	**Kim**	**Pettman**	MN		Government - Federal		Hi. My comment is about CMS-1780-P and specifically about compression garments for lymphedema treatment and related (such as high quality lymphedema pneumatic pumps) and other equipment that may be covered in this document. I have a disability so please excuse me that I haven't been able to read the entire document. Please excuse any mistakes I make. Doing the best I can etc I am a person who deals with Stage 4 Lipoedema which also causes Lymphedema It causes a medical disability and I am currently severely obese. Please make it easier for people to receive fittings by qualified people (preferably LANA certified PTs and OTs) and coverage to be available easily in all settings I am unable to go to a clinic as I am living in a med-surgical hospital. This is due to very little availability for bigger size (severely obese) capacity in care facilities . I need the compression garments. (CGs) I am wearing old and worn out CGs on my arms. It has been very difficult to find a fitter. There is a fitter shortage. Even in a big Metro area. Please help with this. Reimbursement rates etc. Please work with hospitals and HHS and HHS Depts in States so there is better coordination so that this can happen. Please figure something out re this Most hospitals I have encountered have policies that they won't let the nursing staff wash the CGs. I am bedbound. How am I supposed to do this? Please work on getting PCAs into hospitals in all States. I live in MN. We still don't have PCAs in hospitals past the ER. (Once admitted no PCAs) so this is a bigger topic. Please help with that too. I have had cellulitis 2x. On leg and upper thigh. Unable to use CGs on lower body due to advanced Lipoedema Please allow for more pairs when rips and tears. Please include people stuck in hospitals and other settings in your efforts to figure out solutions. Because things that work in community settings don't always work when people unable to do things the "regular" way. Please make it easier to have exceptions when necessary and please don't make people wait a long time. I am very very glad the the Lymphedema Treatment Act is finally passed and very happy you are working on it. I am very thankful that the Lymphedema Advocacy Group and others worked hard on this. It sure took a long time and now it's real. So thank you HHS for working on this. Please remember all patients wherever they are. Please help there be better coordination in HHS and CMS especially for when people don't fit inside "boxes". Because a lot of people have and are falling through the cracks. I still appreciate your work Thank you very much

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CMS-2023-0113-0515	CMS-2023-0113	llt-od3q-t70c	2023-09-12T04:00Z	**Nick**	**Pew**	ID		Home Health Facility - HPA25		Dear CMS, I am writing today as an administrator for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 4.69% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with that of other home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Nick Pew, RN Administrator Horizon Home Health and Hospice Meridian, ID 83646

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CMS-2023-0113-0189	CMS-2023-0113	llh-5hgr-eu6f	2023-08-29T04:00Z	**Elizabeth**	**Phelan**	MD				The direction said to include this number for the comment: S–1780–P. I am writing in support of providing CUSTOM COMPRESSION GARMENTS as well as NIGHT TIME WRAPS for lymphedema patients. Some background: I was diagnosed with lymphedema in both legs 11 years ago. My legs were like tree trunks. I couldn't see my feet and literally had fluid running down the outside of my legs. The GBMC lymphedema clinic had me come in 5 days a week for 5 weeks for several hours a day. Each day they would tightly wrap from every toe all the way up to my thighs. I would go home, come back the next day, get unwrapped, shower there, and get re-wrapped. At the end of 5 weeks, they had pumped 20 lbs. of fluid out of my legs! My legs looked normal! I was told to wear daily custom compression stockings, nightly wraps, and pump with a Lympha-press machine twice a day, an hour each time. I have followed that schedule to-the-letter for the last 11 years. At my last visit with the doctor who treated me, he said I was a "poster child" and called in others to see the success that could be maintained by following the after-therapy process as prescribed. I am sure that that was a very costly initial rehab treatment for my insurance company - 3-4 hours a day for 25 days plus materials. If I didn't keep up the regime, I'd be back to where I started and have to go through it all again. It was much more cost effective to maintain my legs through appropriate garments than start the process all over again. Prior to turning 65, the garments were covered by my insurance - 4 pairs of custom compression stockings & 2 pair of good nighttime wraps per year. However, once I turned 65 Medicare does not pay for them, and the cost is very expensive out of pocket - unaffordable for someone who relies on Social Security and Medicare. A person not following the proper regime would eventually have Medicare incur the major expense of starting that long rehab process over. That would be penny-wise and pound-foolish. A word about the nighttime wraps: I have been wearing these for 11 years and have had lots of experience. These are wraps with Velcro straps that you tighten according to prescribed need. They are only warranted by their manufacturers for 6 MONTHS. That said, there are two types. One type has a Velcro strap and a piece of Velcro that the strap adheres to (e.g. Circaid Juxtafit premium), and the other has a Velcro strap, but no receiving Velcro piece - just the material of the wrap itself (e.g. Redi-wraps or Circaid Juxtafit). Those do not last more than 3-4 months. Since the placement of the Velcro is essentially in the same place every time because of the required compression, over time the wrap material begins to "shred" in that spot and the Velcro no longer adheres to it. The Medicare benefit should allow for 2 pairs of night time wraps per year (because of the six-month warrantee) and should allow the type WITH VELCRO ATTACHING TO VELCRO, rather than to just the wrap material. OR it should allow for additional pairs of the of the night time wraps if the Velcro no longer adheres. making the night time wrap useless. Thank you for your thoughtful consideration.
CMS-2023-0113-0411	CMS-2023-0113	llp-6sen-kyjy	2023-09-11T04:00Z	**Ashley**	**Phelps**	IA		Health Care Professional/Association - Physical Therapist		Medicare cutting costs for PDGM reimbursement for our patients will limit the number of visits provided to our patients, as well as, cause clinicians to leave the field. Without quality Therapist, patient care will deteriorate and lead to increase hospitalizations. Prevention care has been proven to cost millions less compared to cost of care following fall or disease progression. Our country is aging and we need to provide proper care of our seniors for quality of life.
CMS-2023-0113-0732	CMS-2023-0113	llw-k43q-oylb	2023-09-14T04:00Z	**lanie**	**pineda-lu**	CA		Health Care Provider/Association - Home Health Facility		Home health has always played a vital role in caring for our frail elderly patients. We as a home health agency has been doing everything to assure that patients that are being discharged from the hospital and/or SNF (and most of the time prematurely being discharged with high acuity and a lot of medical care needs) will not be re-admitted back the facility. With the lack of resources in the field and high cost of living, the rate of the nurses/and other ancillary have gone up so much that it is hard for the agency to financially keep up with the overhead just to be able to maintain a high quality of care. I believe another cutdown will make it too difficulty for home health and hospice agencies to provide care we want to give to our community.
CMS-2023-0113-0205	CMS-2023-0113	llj-o8r9-wrrv	2023-08-29T04:00Z	**Robyn**	**Pipkin**	MO		Individual		I am commenting on the new Medicare coverage of lymphedema garments specified in CMS–1780–P. I have had lymphedema for 15 years. Compression stockings have kept my legs useful and free of skin conditions caused by uncontrolled swelling. Covering compression garments is more than practical because it saves hospitalizations from complications from lymphedema, such as cellulitis, ulcers, and thickening skin. Using compression garments is expensive. I wear knee-high stockings, 40-50 compression. I wear out about 8- 9 stockings every year. I wear these every day from 6 am to 11 am. Each pair of stockings is over $70. Your regulation should take into account the price of these stockings. Thank you.

LTA Proposed Rule Public Comments

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CMS-2023-0113-0756	CMS-2023-0113	llw-n88z-2zbj	2023-09-14T04:00Z	**Vincenza**	**Pittman**	TX				As the manager of Women's Health Boutique, a DMEPOS supplier with multiple locations, I sincerely applaud CMS for the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. Thank you for the Public Comment Phase allowing professionals, organizations, DME suppliers, manufacturers, and beneficiaries the opportunity to be an integral part of this process as the future of Medicare coverage of these items for beneficiaries with lymphedema is shaped. Although I could comment on every section of this act, I included only the following two comments about gradient compression wraps with adjustable straps. Title VII. (B)(3) Pg. 271/392 "as well as comments on whether there are additional items other than the gradient compression garments, gradient compression wraps with adjustable straps, and compression bandaging supplies that could potentially fall under the new benefit category for lymphedema compression treatment items." COMMENTS: Gradient compression garments that need to be included in this new benefit category include: • Compression Chest/Torso Garment, typically referred to as a Compression Bra. However, we recommend a code being established for a "second stage" post-surgical garment. The existing code L8015 provides the "first stage" post-surgical needs including drain pouches and fiber-filled puffs appropriate for the first 2-8 weeks after surgery. The "second stage" code, possible L8016 would replace the need for a "Compression Bra" or Compression Chest/Torso Garment that is frequently necessitated and prescribed. This "second stage" post-surgical garment code can be ongoing and cover an indefinite period for residual swelling all over the torso. In specific cases, a myriad of products might be indicated for use, including foam chip pads or "swell spots" to effectively treat targeted areas of lymphedema, fibrosis, or scar tissue. These need to be covered and provided at a minimum of two initially for wear and wash and replaced at least every four months, as the medical need dictates, up to six in a year. This garment is not indicative or descriptive of a "bra" and should be indicated as a Level 2 Post Surgical Garment with the addition of swell spots or foam pads as medically indicated and medically necessary. • Compression Arm Sleeve with Shoulder Attachment • Compression Arm Sleeve with Gauntlet Attachment • Gradient compression garments also need to include: o Toe Caps o Thigh to Waist Lenth (Compression Biker Shorts) o Calf to Waist Lenth (Compression Capris) • Gradient Compression wraps with adjustable straps must include garments for the full leg. HCPCS codes are needed for: o Foot Wraps o Calf Wraps o Knee Wraps o Thigh Wraps o Hand Wraps o Arm Wraps Title VII. (B)(4) Pg. 275/392 "Solicit comments on whether additional codes or coding revisions are needed for the purpose of submitting claims for gradient compression wraps with adjustable straps." COMMENTS: • For lymphedema, in addition to A6545 currently used under surgical dressings and described as a Calf Wrap, additional HCPCS Codes need to be established for Foot Wrap, Knee Wrap, Thigh Wrap, Hand Wrap, and Arm Wrap. • Gradient Compression Wraps for the full leg are incredibly necessary and coverage is extremely lacking for these garments. Gradient compression wraps with adjustable straps must include: o Foot Wraps o Calf Wraps o Knee Wraps o Thigh Wraps o Hand Wraps o Arm Wraps

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CMS-2023-0113-0661	CMS-2023-0113	llv-sl63-tkpa	2023-09-14T04:00Z	**Kate**	**Poisson**	FL				Stop cutting funding. Let therapists use their clinical judgement. I am so tired of being sad I can't provide proper care because, despite what I think, clients are consistently only approved for 3 or 4 treatment sessions. Then they re-enter the hospital system sooner. My agencies also can't even afford to use me to provide treatments as an occupational therapist. They can only afford assistants for that, and I perform evaluations and discharges only.
CMS-2023-0113-0849	CMS-2023-0113	llw-ty5z-1ljq	2023-09-14T04:00Z	**Shandra**	**Powell**	UT				I am an experienced home health employee who is in strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have seen firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. These cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital or skilled nursing stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0720	CMS-2023-0113	llw-ia7m-jind	2023-09-14T04:00Z	**Phil**	**Prehn**	NY		Individual		Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items I am very pleased that CMS, DPC, and OMB have taken time to research this topic and hosted stakeholder listening sessions. The proposed part of the rule to implement the new Part B benefit for lymphedema compression treatment items largely reflects these patient-centered priorities. These are my opinions on the proposed rule: 1. I am writing this as a person that has lived with lymphedema for nearly 30 years. I am currently 63 years old and getting ready to be eligible for Medicare coverage. I currently pay roughly $1200-1500 per year out of pocket for my compression supplies—socks for both legs and compression wraps. My job recently went from full time to part time and I lost most of my benefits. This rule will directly benefit me. 2. Covered supplies will include standard and custom fitted gradient compression garments; gradient compression wraps with adjustable straps; compression bandaging systems; and other items determined to be lymphedema compression treatment items. I am glad of the agency's decision to cover a broad spectrum of compression supplies and accessories, to ensure that the individual needs of patients can be met. 3. I appreciate that CMS is seeking feedback surrounding reimbursement for the measuring of custom garments, however, measurements are also required for standard-fit compression garments, and I encourage CMS to include reimbursement for both types of garments in the final rule. 4. CMS proposes covering two daytime garments every 6 months, and one nighttime garment each year, per affected body part. From my experience, the limit of two daytime garments every six months is just barely enough—it is acceptable because day and nighttime garments can be replaced sooner if the item is lost, stolen, irreparably damaged, or if needed based on a change in the beneficiary's medical or physical condition. 5. As with any medical treatment, avoiding delays is imperative to ensure effective treatment. In both the decisions involving coverage of custom garments and the replacement of lost or damaged garments, I cannot emphasize enough how delays in the decision-making process need to be avoided and any gaps in treatment with needed garments is avoided. Document ID CMS-2023-0113-0002
CMS-2023-0113-0628	CMS-2023-0113	llv-fqsq-lowb	2023-09-14T04:00Z	**Leslie**	**Puentes**	ID		Health Care Professional/Association - Nurse		This change would impact the Home Health companies in a very detrimental way. Home Health agencies are able to care for patients in their homes and work towards keeping them from having to return to the hospital. Please do not tie the hands of those trying to take care of the patients in our communities!

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CMS-2023-0113-0434	CMS-2023-0113	llp-ss9k-rkok	2023-09-11T04:00Z	**Adri**	**Pyper**	UT				As you are well aware, Medicare plays a pivotal role in ensuring access to quality healthcare services for millions of individuals, including the elderly and those with disabilities. The proposed reimbursement cuts, if implemented, could have far-reaching implications that undermine the very essence of this crucial program. We would like to bring to your attention some of the key points that underscore our concerns: Quality of Care: Reduced reimbursements would likely lead to a decrease in the quality of care that can be provided. Healthcare providers might be forced to cut corners or limit the scope of services offered in order to cope with financial constraints. Access to Care: Medicare reimbursement directly affects the ability of healthcare providers to maintain their services and facilities. The proposed cuts could force some providers to reduce their participation in the Medicare program or, in extreme cases, discontinue offering services altogether. This would disproportionately impact vulnerable populations who heavily rely on Medicare for their healthcare needs. Innovation and Advancements: Adequate reimbursement is essential for fostering innovation and advancements in healthcare. It supports investments in technology, staff training, and research, all of which contribute to better patient outcomes and advancements in medical science. Provider Sustainability: Healthcare organizations, especially those serving rural or underserved areas, already operate on tight budgets. The proposed reimbursement cuts could push many providers to the brink of financial viability, jeopardizing their ability to continue serving their communities effectively. Economic Impact: The healthcare sector is a major contributor to local economies. Cuts in reimbursement could lead to layoffs, reduced economic activity, and potentially hinder recovery efforts in the wake of ongoing economic challenges. We respectfully request that you carefully reconsider the proposed Medicare reimbursement cuts and explore alternative measures that do not compromise the integrity of this vital program. We are more than willing to collaborate with you to identify solutions that address the budgetary concerns while safeguarding the health and well-being of our patients.
CMS-2023-0113-0471	CMS-2023-0113	llq-sseo-627z	2023-09-12T04:00Z	**mary**	**rabchuk**	WA		Consumer Group		As a person who has been living with lymphedema for more than 25 years, and having to purchase all my own (expensive!) supplies since my retirement 7 years ago -- I am very much hoping that medicare finally steps in to help with these necessary equipment and treatment options! I am so glad that this need is finally being addressed. I DO hope that measures get passed to help the millions of us dealing with a devastating reality of lymphedema!!! thanks
CMS-2023-0113-0862	CMS-2023-0113	llw-w8my-vkax	2023-09-14T04:00Z	**Richard**	**RAINS**	ID				Oppose CMS rate reduction

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CMS-2023-0113-0431	CMS-2023-0113	llp-rpxt-23p4	2023-09-11T04:00Z	**Jessika**	**Reber**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0477	CMS-2023-0113	llq-v4wd-cfvl	2023-09-12T04:00Z	**DeAnne**	**Redder**	CO		Health Care Professional/Association - Occupational Therapis		I am an Occupational Therapist and a Certified custom lymphedema fitter for a DME in Fort Collins, CO. I have been a fitter since 2008 and I fit custom garments for 45 Certified Lymphedema Therapists up and down the front range. I support the endorsement of the US Medical Compression Alliance in regards to changes we want to see in the proposed bill.

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CMS-2023-0113-0834	CMS-2023-0113	llw-sh23-sels	2023-09-14T04:00Z	**Meghan**	**Regalado**	TX		Individual		RE: FILE CODE CMS-1780-P I am the cosmetologist and mastectomy fitter for Women's Health Boutique in Longview, TX. I sincerely applaud CMS for the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. Thank you for the Public Comment Phase allowing me the opportunity to be an integral part of this process as the future of Medicare coverage of these items for beneficiaries with lymphedema is shaped. Here is my comment: VII. Proposed Changes Regarding Durable Medical Equipment, Prosthesis, Orthotics, and Supplies (DMEPOS) B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items Title VII. (B)(3) Pg. 271/392 COMMENT: Doffers and Donners – I hear the compression fitters in our boutique say, "no garment works in the drawer or closet!" We see how our customers cannot get the compression hose on without assistance. They live alone so they don't wear them. Their legs or arm get worse and worse and worse! The fitters here give a complimentary pair of donning gloves with every pair of hose or arm sleeve, to help our customers get them on and off. I believe allowing coverage for donning and doffing aids is vital for Medicare to include because it enables a positive outcome and truly will help keep compression worn daily as prescribed and as needed. Other Accessories that I believe also need to be covered include: Donning Gloves Chipped Foam Padding, such as swell spots in various sizes, S, M, L, XL Dorsal Hand Pad Silicone Padding (could be covered under existing HCPCS code A6425) Liner with light (10 mmHg) compression, upper extremity arm Liner with light (10mmHg) lower extremity, Liners for upper or lower extremities with no compression or elastic (could be covered under existing HCPCS code A6457, cotton stockinette) Hybrid socks Thank you for working with Congress to get lymphedema garments covered by Medicare. This has been much needed and I am proud to see it come to fruition. Submitted by Meghan Regaldo, Fitter, Women's Health Boutique

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CMS-2023-0113-0652	CMS-2023-0113	llv-mwx8-hrc8	2023-09-14T04:00Z	**Merricki**	**Reynolds**	FL		Individual		As a person affected by primary lymphedema of both of my legs and lower body for the past 41 years, compression garments have been an essential component of my care. To manage the lymphedema successfully, custom compression garments are required as part of the treatment of this disease. For myself, I wear both a class 3 as well as a class 2 thigh compression garment on each leg, toe cap garment on each foot, as well as a compression bike short to help secure the thigh high garments and compress my hips, buttocks and torso which are also impacted by chronic lymphedema. Because the compression is required 23.5 hours out of 24 hours to optimize the therapeutic effect and reduce the risk of complications, 2 sets of 7 garments in total are needed so that sets may be rotated and laundered every other day. Additional compression straps and wraps are needed often to layer over the compression garments to further reduce swelling. In regards to Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items, my input is as follows. Since the draft rule does not mention how coverage will be addressed when it is necessary to layer, I implore this to be included as many patients with lymphedema, myself as one of them, must wear double layered compression to properly treat lymphedema swelling. Compression garments, including various compression garments and compression assistance products is important to promote the best outcome for individuals impacted by lymphedema as each may have unique needs. Having two sets of garments at one time is important to allow for washing one set while wearing the other set without any gap of time wearing the medically necessary compression. Coverage should include two sets each replacement cycle. Per compression manufacturers, such as Jobst and Mediven, the recommendation is that compression garments be replaced every 4-5 months to ensure proper compression is maintained. Therefore the proposal of replacing garments every 6 months should be adjusted to replacement every 4 months . Two sets of night time garments each replacement cycle should also be covered so that garments may be alternatively worn and washed. Certainly if a garment is lost , stolen or damaged beyond repair, it should be replaced sooner than the usual time frame. Reimbursement rates should be adjusted each year in accordance to average online prices calculated from various manufacturers of custom measured compression garments. As proper application of short stretch compression bandages is difficult to achieve when done by the patient, reimbursement for the bandaging supplies as well professional application would also be beneficial. Accurate measurements for compression garments is also of utmost importance for the compression garments to function. A patient's therapist should be reimbursed for this important skill and time of measurements for each garment replacement cycle. Without my knowledgeable lymphedema therapist, my garments would not fit properly and would be ineffective. Thank you for your time and consideration my input to develop rules for coverage and reimbursement of compression garments, supplies, therapy and measurements.
CMS-2023-0113-0700	CMS-2023-0113	llw-fod1-rrr4	2023-09-14T04:00Z	**Kara**	**Rich**			Health Care Professional/Association - Physical Therapist		I feel strongly that this proposal is poorly timed and focused only on the benefits at the federal level versus the quality of care and services to be provided to the individuals receiving and paying into this program. There has been a recent and successful push at the hospital level for patients to go home instead of skilled nursing facilities putting more pressure and labor expectations on the home health division. To cut the reimbursement in a setting that is being heavily referred to by a an overwhelmed hospital system will directly affect the health and recovery of all at a national level. Additionally, there have already been a significant and recent changes of PDGM and Oasis E just within the last 5 years which agencies have successfully pushed through to the benefit of the patients. To cut reimbursement after making all of these changes is unfair, untimely and immoral at an individual, agency and corporate level. Please reconsider this proposal.

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CMS-2023-0113-0193	CMS-2023-0113	lli-7lsz-ztbd	2023-08-29T04:00Z	**Deborah**	**Richardt**	CO		Consumer Group		I have been living with lymphedema for over 5 years. If it weren't for management therapy I could be in the hospital. I wear compression stockings everyday. Pump with a machine for an hour everyday. Wear a night compression garment every night. I do lymphedema drainage therapy every other week as I cannot afford to do every month as recommended. I also try to see my lymphedema therapist once a month to make sure all is good. All of these items are paid for our if pocket and not by Medicare. If I didn't do these things then cost in hospital would be much higher. My quality of life is so much better doing these things and to stay out of the hospital is my goal!
CMS-2023-0113-0146	CMS-2023-0113	llc-pwuk-lbox	2023-08-22T04:00Z	**Becky**	**Richens**	UT				I am an operator who lives in rural area in Utah. We have had rising costs with inflation and finding good people to take care of our community home health patients. This proposed rule will greatly impact our little community as we will have to make cuts to the care we are able to provide our patients. I see this increasing hospital stays and costs by cutting home care. We provide vital services to home health patients that will be impacted negatively with this proposed rule.
CMS-2023-0113-0366	CMS-2023-0113	llm-ygx3-cxcp	2023-09-11T04:00Z	**Robin**	**Richmond**	FL		Occupational Therapist - HC050		To whom it may concern, I am an OT working in home health, I am greatly concerned about the impact of the proposed payment cut on the utilization of OT services and patient access to medically necessary OT services. Since the adoption of PDGM, i have personally experienced the negative impact this has had on myself and more importantly my clients. Agencies are applying pressure to reduce the number of OT visits to clients. Agencies are using predictive analytic tools that use algorithms to determine how many therapy visits (if any) should be provided based on diagnosis. Agencies are instructing staff to delay OT to later in the HH episode, or patients are told they can wait to get therapy after discharge when they are outpatient. Physician orders for OT are ignored, revised, or deleted. Nursing and Physical Therapy are determining when and if OT services are needed. Agencies are shifting OT visits to PT or nursing colleagues. OTs are having to do more, with less support. Therapists' clinical judgment is overridden or ignored. I believe additional payment cuts could further decrease therapy utilization. I urge CMS to adopt safeguards to protect patient access to medically necessary OT services. Agencies must rely on the therapist's clinical judgment to determine the type and amount of therapy services an individual patient needs. To that end, I oppose the removal of item M2200 Therapy Needs from the OASIS because I believe it is an important item to help track the need for therapy, and removing the item could contribute to a further decrease in the provision of therapy services. Thank you in advance, for your time, Robin Richmond OT/L Florida OT Lic # 10517
CMS-2023-0113-0550	CMS-2023-0113	llu-yhh3-edfd	2023-09-14T04:00Z	**Kathleen**	**Richter**	NY		Individual		I am writing to support the proposed rule covering lymphedema compression garments. My husband is diagnosed with lymphedema as a result of radiation treatment for tongue cancer. The lymphedema in his neck significantly effects his everyday life including breathing and swallowing. The use of compression garments on a daily basis is required to maintain quality of life. We support the prosed rule to cover both standard and custom fitted compression garments. These garments, in our case cost between $350 and $950 per garment. Each garment is comprised of several pieces and should be treated as a single garment. Medicare should cover these. Proposed rules would cover 2 garments every 6 months. This would be most welcome. Those of us on a fixed income need the support. We cannot afford to replace the garments on our own. Lymphedema is not curable, but is manageable. The coverage of the compression garments is an integral part of the treatment. Thank you, Kathleen Richter

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CMS-2023-0113-0516	CMS-2023-0113	llt-odrt-3xe8	2023-09-12T04:00Z	**Neo**	**Riddick**	FL		Individual		As someone who suffers from lymphedema on a daily basis as a result of cancer surgery, I would like to offer my sincerest thanks to Congress for passing the Lymphedema Treatment Act which in turn, gives me the opportunity to comment on the proposed rules from Medicare. I spent 3 days in August, 2020 on capital hill lobbying that congress pass this Act and appreciate all the efforts put forth in these proposed new Medicare rules. After reading through the proposals several times, I am humbled and at times overwhelmed by the verbiage used to describe the new rules for Medicare. Although I am an end user of these DMEs, and not a care provider dealing with the specifics of billing, procuring or treatment for beneficiaries, I can only make limited scope comments. The first of which concerns the phrase "appropriate payment basis for Lymphedema Treatment Items under Medicare". 7. Payment basis and frequency Section 1834 (z)(1) and (3) of the act. "Where medicaid payment amounts are not available for an item, we propose to set payment amounts at 100% of the average of internet retail prices." I read through this section several times and realize pricing for these garments can be tricky. The efforts to establish prices and coverage are satisfactory based on industry availability and standard patient usages. However, I disagree with "average internet prices". As an end user, internet pricing for custom garments seems ludicrous. I am unable to determine any pricing via the internet without a prescription or medical provider number. For a Medicare provider to determine any cost schedules would be to go consult the suppliers directly as opposed to relying on questionable "internet pricing". After my initial diagnosis of Lymphedema, I was faced with finding a provider of any kind or quality in my home state of Florida. After a year of fighting with Medicare about billing and doctors that did not understand the disease, I was fortunate enough to get private insurance and an excellent provider/CFCS in Texas. I realize not everyone is as fortunate and urge CMS to recognize that care providers like Women's Health Boutique fill a vital role in dealing with this disease where so few exist due to inadequate training, experience or concern. End users like myself are truly blessed to have providers like WHB and sincerely appreciate the CMS for making all the effort to preserve and advance the care provided for people suffering from this awful disease.
CMS-2023-0113-0534	CMS-2023-0113	llu-in1k-unn9	2023-09-12T04:00Z	**John**	**Rider**	NV		Health Care Professional/Association - Occupational Therapis		Hello, As a home health OT, since the implementation of PDGM, I have seen a significant change in how the companies I work for handle referrals from physicians and frequency/duration of occupational therapy (OT) visits. OT referrals are being ignored, office staff and administrators are deciding therapy frequency based on the optimal reimbursement for the company, not the patient needs, and OT visits are being determined by other disciplines, such as physical therapy, and they are canceling OT visits to get more visits for themselves, since they are in a similar position. Overall, patient care has been poorer, and home health agencies are telling patients to wait until outpatient therapy to get therapy services, which is delaying therapeutic needs and contributing to poorer functional outcomes.
CMS-2023-0113-0775	CMS-2023-0113	llw-ozvc-neb8	2023-09-14T04:00Z	**Stefanie**	**Rider**	WA		Health Care Provider/Association - Home Health Facility		I am an OASIS Certified Quality Reviewer and Home Health Physical Therapist. I have worked for a hospital-based home health agency since 2012. I now function primarily as a quality reviewer for our agency and an educator. I see all that we are doing for our patients and the significant time we spend with patients to perform all the CMS required assessments as part of the OASIS assessment. I also see the invaluable work we do with our patients in educating them in disease process and providing skilled care to help them regain independence, decrease risk of falling/injury and helping to keep them home safely and OUT OF THE HOSPITAL. Home health agencies across the country are already struggling to remain solvent in our current health care system with reimbursement as it stands now. If you decrease reimbursement for home health agencies, you will ultimately cause agencies to close, skilled clinicians to lose their jobs and patients to have less access to quality care which will result in higher costs with increased use of Emergency Departments and increased hospitalizations. Stefanie Rider, PT, DPT, COS-C
CMS-2023-0113-0200	CMS-2023-0113	lli-e60y-gym2	2023-08-29T04:00Z	**Sharon**	**Roberson**	NC		Health Plan or Association		Please vote to have lymphedema treatment paid by insurance. It's a necessity and very expensive.
CMS-2023-0113-0557	CMS-2023-0113	llv-0u1k-o1an	2023-09-14T04:00Z	**Michael**	**Robertson**	OH		Home Health Facility - HPA25		Home Health is THE most efficient, cost-effective form of health care. The home health industry, in fact, proved itself during COVID pandemic by reaching patients needing care in their homes. Shouldn't we be funding such health care instead of cutting funding? Budget cuts are needed for sure. But cutting essential, cost-saving services runs contrary to what is logical. We should NOT reduce funding for home health care.

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CMS-2023-0113-0057	CMS-2023-0113	ll2-wrmq-sbq6	2023-08-10T04:00Z	**Susanq**	**Romanello**	FL		Health Care Professional/Association - Physical Therapist		I am very happy to see that we are finally getting some recognition and help for our chronic lymphedema; I have had it for 8 years now, after a double mastectomy. I use compression sleeves on both arms daily, ($70 a sleeve from Jobst) and I see a Lymphedema Therapist who massages my arms and trunk to get the fluid moving, and then tapes me up with compression tape. I am a retired lady on a fixed income and knowing that the sleeves have to be replaced every 6 months because of the stretch in the actual sleeve, but am unable to purchase them. I have had my sleeves for almost 2 years and they don't help the way they use to. It will be great to be able to get new sleeves and have my lymphedema under more control. Thank you for deciding this and helping us with our expense.
CMS-2023-0113-0119	CMS-2023-0113	lla-0eph-01wa	2023-08-22T04:00Z	**Frances**	**Rosenfeld**	CO				I am an 85 year old woman with Lymphedema in both legs. I live on a low fixed income. My comment regards the quantity of garments to be covered for the 6 month periods. I would personally find it difficult to keep only 2 sets of garments clean. 3 sets would ease the amount of times they need to be washed. I haven't started using night time garments, but my fitter is of the opinion that they would help me. Only 1 set of night time garments will be covered. Again, keeping them clean will be a chore that would be lessened if there were 2 sets allowed. I would also like comment on accessories. I have to use a donning device to get my compression stockings on my legs. I could not put them on without it. The device I have is plastic and rather expensive, in the range of $150 to $200. I worry about breaking it. It is my opinion that these devices need to be covered by this act as well as the garments. Thank you for your consideration.
CMS-2023-0113-0096	CMS-2023-0113	ll7-cyxn-9fi2	2023-08-22T04:00Z	**Carol**	**Rosskam**	MA				The Lymphadema Treatment Act must include coverage for compression pantyhose, stockings and other garments, starting at 20-30 mm hg Compression. It's critical thst this lower level compression also be included. Additionally, full inclusionary coverage for physical therapy, OT, manual lymphatic drainage massage, and bandages, is critical- especially to cover more than just a couple treatments because a "flare up" may take time to treat and bring back to an acceptable baseline. Our lives depend on this.
CMS-2023-0113-0616	CMS-2023-0113	llv-dk7t-7bur	2023-09-14T04:00Z	**Sara**	**Salles, DO**	KY		Physician - HC005	https://downloads.regulations.gov/CMS-2023-0113-0616/attachment_1.pdf	See attached comment letter.
CMS-2023-0113-0519	CMS-2023-0113	llt-sxdv-jnd7	2023-09-12T04:00Z	**Maureen**	**Salmon**	ID		Health Care Professional/Association - Occupational Therapis		CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year.

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CMS-2023-0113-0401	CMS-2023-0113	llo-a9q1-bqui	2023-09-11T04:00Z	**Emilee**	**Sanders**			Health Care Professional/Association - Occupational Therapis		Hello, . I would like to address the payment cuts to Home Health prospective payment system rate update. I believe that occupational therapists in home health should not receive the 2.2% pay cut. I am a doctoral level occupational therapy student at Northern Arizona University. I understand that health care costs are high, and that policymakers are doing their best to serve the people while containing costs. Occupational therapy services can help address these costs and provide effective patient care. Research shows that occupational therapy is the only profession that lowers hospital readmission rates (link to article: https://journals.sagepub.com/doi/10.1177/1077558716666981). The money spent in occupational therapy visits actually reduces the amount spent in hospitalizations. A hospital visit may average to be $6,000, and a readmission averages about $6,000 as well. Occupational therapy visits cost less money than this and is spread out over weeks rather than acute days. Moreover, as a student, I have learned that diagnoses have a wide range of ways they present between person to person. My healthcare education indicates that therapists need to treat individuals according to their specific needs, rather than solely by diagnosis. It is a holistic model that better treats and heals individuals. Our payment model should also reflect this viewpoint. . . Thank you for your time, . . Sincerely, . . Emilee Sanders, OTS
CMS-2023-0113-0531	CMS-2023-0113	llu-bnlo-f3y2	2023-09-12T04:00Z	**Shelby**	**Satko**	WA		Individual		I'm writing in support of the following related to the implementation of the Lymphedema Treatment Act - The supplies to effectively continue suppose phase one treatment should be covered while additional steps are determined for long term compression solutions to be identified. The allowance in the Lymphedema Treatment Act for the purchase of 2 custom flat knit garments for daily wear every 6 months and 1 nighttime garment per year is critical. I'm required to wear the custom day garments 365 days/year for approximately 13-15 hours/day. After each time I wear the day garment, you are required to wash it and let it air dry overnight. Putting them in the dryer significantly reduces their life. Even with meticulous garment care, their elasticity starts to loosen after about 4 months (that's 2 months short of the insurance limits to pay for additional garments). Once the garments begin to lose the level of compression my pain increases significantly, pain/swelling management becomes significantly more challenging resulting in significant limits my ability to exercise and fully participate in my daily responsibilities (i.e., work, family care, driving, etc.). In addition, there is a significant risk of developing severe skin infections. In the last two weeks, I experienced this firsthand. My current compression garments are about a year old, and I developed a very severe case of dermatitis that required extensive medical consultation, medications, and major impairment to life activities. In addition, the type of custom flat knit garments I require is referred to as an open toe with toe cap. These two pieces should be effectively determined as one set when the two pieces work together, one piece provides custom compression to my foot, ankle, and shin. The second piece, toe cap, provides customer compression for each of my toes. Using only one piece at a time would not be effective. The nighttime garment called "Tribute Night" that provides compression therapy while I sleep. Ideally, this category of garment would be replaced on an annual basis. There also needs to be exceptions for earlier replacement of flat knit custom compression garments. For instance, if the garment is lost, stolen, or irreparably damaged. In addition, a change may be determined due to the status of my medical condition. I find it completely unacceptable I should have to continually prove my need for the flat knit custom compression garments when I have provided clear letters of medical necessity and lymphedema is a condition I will live with for the rest of my life. Please remove requirements to have to re-prove my medical necessity for Lymphedema treatment garments and accessories on an ongoing basis. This is an undue burden when there is no cure for this rare disease.

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CMS-2023-0113-0341	CMS-2023-0113	llm-hno7-cxvp	2023-09-11T04:00Z	**Rick**	**Saxe**	NY				Home health care in my area and where my spinal injured friends are is in a shambles. Simply put … People I know and love are in their beds unable to start their day because there is not enough skilled people to get them out of bed. And along with that wheelchair companies who repair wheelchairs…. Have set low standards on how long it takes to repair wheelchairs to get people out of their beds and off their skin which makes them susceptible to deadly pressure sores and long stays In expensive long care facilities. What's wrong with this picture? EVERYTHING! Would someone please look at the process and save everyone valuable time and money and maybe reduce some waste?
CMS-2023-0113-0891	CMS-2023-0113	llx-4478-hcrf	2023-09-14T04:00Z	**Judith**	**Schaad**	PA		Individual		My comment is in reference to "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items" I appreciate the opportunity to comment on the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. I have been a physical therapist since 1979, a board-certified wound specialist since 1999, a board-certified lymphedema therapist since 2002, and a board-certified specialist in oncologic physical therapy since 2020. Over the years, I have treated many patients with lymphedema and chronic wounds (primarily venous and diabetic foot ulcers), with obesity-related lymphedema, with lipo-lymphedema, and with cancer-related lymphedema (primarily breast cancer or head and neck cancers). Unfortunately for these patients, lymphedema is a chronic, progressive, irreversible condition. Without proper treatment, they face a lifetime of decreased quality of life and a risk for recurrent cellulitis (a potentially dangerous infection). All these patients needed appropriate compression treatment items to accomplish effective treatment and to maintain the beneficial effects long-term. In my experience, patients without insurance coverage for essential items were difficult or impossible to treat effectively. Even if these patients could pay out-of-pocket for limited treatment supplies, they often could not afford proper maintenance devices or garments to prevent negative results of ineffective long-term lymphedema management. They were also at high risk for recurrence of their swelling, compounded by frustration after all their efforts. I am extremely happy to see that CMS has decided to cover these essential items going forward. This access will benefit many patients. The decisions that I think will especially benefit patients with lymphedema are: • Covering compression supplies for patients with lymphedema affecting all body parts where swelling may occur, including the trunk, genital, and head & neck regions, as well as the extremities. • Covering 2 sets of day garments every 6 months and one nighttime garment every year during the maintenance phase. Replacing garments may occur sooner if stolen, lost, damaged, or if the beneficiary's condition changes. • Covering various types of bandaging systems, zippers, foams, padding, and wraps with adjustable straps, as well as off-the-shelf and custom compression garments. These are all needed to properly treat patients with a wide variety of etiologies and affected body parts. I strongly support all these critically-important decisions. However, I have 2 concerns: 1. That compression supplies (ie bandages or gradient wraps with adjustable straps) may occasionally be needed during the maintenance phase of treatment. We always bring patients back in (to the PT clinic) to assess the effectiveness of their maintenance garments. I have seen patients whose swelling is not fully contained (controlled) and they may need additional bandaging on top of the daytime or nighttime garment. I have also seen patients who found that bandaging is more effective in controlling their swelling than a day or night garment and they need to bandage on a temporary or a long-term basis. So, sometimes phase 1 (treatment) supplies can be needed by some patients during phase 2 (maintenance). 2. That the reimbursement rates for these supplies and garments are sufficient for vendors to continue to provide these garments. If the reimbursement is set lower than vendors' costs (plus overhead and reasonable profit), they may decide they cannot continue to provide these items. If that occurs, we will again be unable to obtain these essentials items for our patients. Thank you for this opportunity to provide my comments on this Proposed Rule.
CMS-2023-0113-0044	CMS-2023-0113	lkx-753z-pgix	2023-08-10T04:00Z	**Amy**	**Schler**	NV			https://downloads.regulations.gov/CMS-2023-0113-0044/attachment_1.pdf	Please see attached document for comments

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CMS-2023-0113-0133	CMS-2023-0113	llb-o9df-3vcb	2023-08-22T04:00Z	**Kathy**	**Schuler**	MD		Individual	https://downloads.regulations.gov/CMS-2023-0113-0133/attachment_1.jpg	Regarding Lymphedema garments included in CMS-1780-P: I am an 80-year-old with lymphedema in both my lower legs and feet. I have been wearing garments measured by my therapist for just over two years. My first daytime garments first came with toe caps that irritated my toes. These garments are made in Germany and are called flat wraps. They have done a great job of keeping my ankles and calves reduced. I have had to buy Jobst toe caps (20-30 MMhG) every three months. In the rules, it is stated that daytime garments would be paid every six months. I would need these toe caps paid for every three months or two sets ordered every six months. I have had two different kinds of nighttime garments. Both of which last for one year. Because I would have to hand wash these garments, it would be preferable to have two sets of garments because they take a long time to dry. I would like to get a different leg garment which would require a cover for the velcro flaps. These garments would be easier to put on and take off than my current ones. I have not been able to buy daytime garments this year, except for the toe caps. My nighttime garments are good until November 2023, but I will continue to wear them as I can't afford new ones. I have also been wearing daytime garments that are past their expiration dates. Therefore, my lower limbs have increased a minor amount as of July of this year. I don't know if they will stay that way until next year. I will be attaching a page showing the toe caps that I have been buying. That page shows the price for one foot.
CMS-2023-0113-0008	CMS-2023-0113	lk6-x10r-l2tu	2023-08-10T04:00Z	**Franci**	**Schwab**	OH			https://downloads.regulations.gov/CMS-2023-0113-0008/attachment_1.pdf	As a 15 year breast cancer survivor with subsequent lymphedema and leader of a lymphedema support group, I applaud the decision to add Medicare Part B coverage for lymphedema compression garments and supplies. I do have some concerns about the proposed rule, however, which are outlined in my attached document.
CMS-2023-0113-0210	CMS-2023-0113	lll-0y1l-kt0u	2023-08-29T04:00Z	**Pamela**	**Scofield**	NY		Individual		This comment is in reference to "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items" I have had secondary lymphedema in my right leg from the waist down for 30 years, due to treatment for cervical cancer. Over that time, the regimen for handling my condition has expanded and shifted, due to both the progression of the condition and improved systems for containing it. I have had to increase the compression from a standard thigh high compression garment on one leg to a custom panty hose with 2 legs of differing lengths and compression levels. This garment costs upwards of $700.00 and has to be replaced every 6 months at least. I am concerned that there be a code for such a garment. I also use a toe cap, to facilitate donning the garment by avoiding overly manipulating and tugging on it and thus also extending its life. It is important that the toe cap has a code. Having 2 viable garments in my possession at all times is essential to be able to do the necessary daily laundering. Air-drying extends the life of the garment, so overnight laundering is not always feasible because the garment could still be damp when it is time to put it on. Additionally, I do not use a nighttime garment as I have never been able to sleep while wearing one. Therefore, I bandage my leg at night. This requires the same system of bandages, paddings and liner as that used during decongestive therapy. I hope that these bandages, etc, will also be covered for use by patients not in a clinical setting. Two sets of bandages are also required to be in use at all times due to laundering requirements. The use of donning aids becomes more necessary as time goes by, especially as a progressive condition requires that the compression level increases, at the same time that muscle strength and flexibility are inevitably decreasing. I hope that these items will also be covered. Lymphedema is a condition whose treatment requires an enormous amount of time - personal responsibility and self-care - as to hygiene and exercise as well as the necessity of wearing often cumbersome and uncomfortable garments at all times. The added burden of having to pay out-of-pocket for all the items necessary to avoid frequently dangerous complications has been difficult. I am grateful for the relief this legislation could afford.
CMS-2023-0113-0593	CMS-2023-0113	llv-9wiu-jy9b	2023-09-14T04:00Z	**Cynthia**	**Scott**	OH		Health Care Professional/Association - Nurse		The proposed rule for home care will be devistating to homecare agencies. The cuts that are proposed do not follow the current approved methodology. It does not take into consideration the current expenses of the home health agencies for wages, supplies and cost of living. It is very difficult for homecare to find staff. They are competing with hospitals that are paying exhorbitant salaries to nurses. When you live in the rural areas, it is even more difficult to compete. When given the choice, patients want to be care for in their own home. These budget cuts and difficulty finding staff will make it more difficult for hospitals to find agencies that are able to quickly take referrals. Patient will either remain in the hospital longer or leave without assistance or delayed assistance. Every agency is striving to provide high quality care while maintaining cost. However, there is a limit on how low agencies can cut while maintaining adequate staffing.
CMS-2023-0113-0104	CMS-2023-0113	ll7-v1pc-v9ww	2023-08-22T04:00Z	**cheryl**	**seaver**	CT		Health Care Provider/Association - HPA01		This comment is for section VII.B scope of the benefit and payment of lymphedema treatment items . Please include specific language to cover custom made flat knit compression toe caps for the toes and foot. Many lymphedema patients have toe Swelling and need the option to have a separate toe cap that is not part of the stocking. My insurance , Aetna in Ct. will not cover compressive Toe caps. I have to pay 200.00 for a custom toe cap garment that needs to be replaced every 6 months. Thank you.

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CMS-2023-0113-0020	CMS-2023-0113	lkf-x9gk-spuw	2023-08-10T04:00Z	**Edna**	**Sellars**	FL				Please consider passing the Lymphedema Treatment Act. We desperately need the supplies DAILY and cannot survive without them. They are extremely expensive. Too expensive. Lymphedema is not something we did to,ourselves, but usually the result of surgery or diseases. We did not ask for this to happen to our bodies so please help by lessening the burden of expenses. We need the supplies to manage Lymphedema. If we do not take care of our body properly now, we will only need to seek therapists and specialists which will cost insurance companies. This will cost more in the long run. PLEASE help.
CMS-2023-0113-0894	CMS-2023-0113	llx-4khh-mmbk	2023-09-14T04:00Z	**Janice**	**Sepcoski**	PA		Occupational Therapist - HC050		As an occupational therapist, I respectfully ask that caution be used when attempting to further decrease funding for home health occupational therapy. While working full time in home health from 2019 to 2022, the cuts to Medicare payments starting in 1/2020 resulted in a decrease in patient care, progress and satisfaction. Patients, families and home health teams became very frustrated. As an OT, my plan of care was dictated by limited visits, if OT was even allowed to enter a case! I was an OT for 32 years in home health, in-patient rehab hospitals and out-patient clinics, before I moved to full time home health. I was appalled at the limitations that Medicare and agencies placed on OT. Since I was frequently given 1-2 visits per case, my visits were long, which would have been more productive for the patient if there were multiple visits. Humans need repetition to learn and smashing all my OT education in 1-2 visits was not beneficial. So much documentation was required, that I spent hours after my shift, finishing my notes until midnight. This frustration led to burnout for me and many other home health professionals. I, like many others, have left the medical profession, at least temporarily, due to these changes. Please listen to AOTA and bring patient care back to the focus of home health.
CMS-2023-0113-0021	CMS-2023-0113	lkg-7bvz-q305	2023-08-10T04:00Z	**Linda**	**Serfass**	MA		Individual		I am in favor of implementation of Medicare Part B coverage for lymphedema compression treatment items. I have primary lymphedema. I support reimbursement for the measuring of custom and standard-fit compression garments, as measurements can change over time. I support covering two daytime garments every 6 months, and one nighttime garment each year, per affected body part. (Two daytime garments are necessary because after wearing one, that one is washed and cannot be put in the drier, so a second garment is needed to wear.) I support replacement of garments sooner if a garment is needed for any reason.
CMS-2023-0113-0041	CMS-2023-0113	lkw-pqo1-ly4i	2023-08-10T04:00Z	**Gira**	**Shah**	WA		Home Health Facility - HPA25		Home Health is a valuable service to our patient population. Reimbursement cuts have a negative impact on the operations of an agency in a heavily regulated area. During the recent cuts, it was seen that agencies had a hard time recruiting new staff, investing in innovative programs and ultimately in quality care. VBP was to be negative impact for an agency, which we saw was not the case. Urging to reconsider any further cuts, so that agencies can continue to provide this valuable care to the patients in the community.
CMS-2023-0113-0361	CMS-2023-0113	llm-rv75-nm0n	2023-09-11T04:00Z	**Rebecca**	**Sharp**	TN				I am commenting on the section of the Proposed Home Health Rule that addresses the Lymphedema Treatment Act B. Scope of the Benefit and Payment for Lymphedema Compression Treatment Items, Pages 260-289 I am a breast cancer survivor which resulted in secondary lymphedema in my right arm, trunk, and breast. I also have lymphedema in my legs and feet secondary to lipedema. I am commenting on the areas of need for me in terms of compression: NIGHTTIME GARMENTS: I propose that a person receive two nighttime garments minimally every two years but preferably every year. One can be worn while the other is being washed and dried. COVERAGE FOR LAYERING: My specific need is for toe caps layered under the leg stocking instead of one piece. Also to layer capri compression over leg stockings. This controls my swelling more effectively than one piece. COVERAGE RULES AND REIMBURSEMENT FOR THE MEASURING OF COMPRESSION: My Certified Lymphedema Therapist measures me for my custom garments. She knows my body and needs better than a fitter who does not know me. I propose that therapists also be allowed to measure.
CMS-2023-0113-0690	CMS-2023-0113	llw-cyos-gute	2023-09-14T04:00Z	**Patricia**	**Sheehan**	IL		Health Care Professional/Association - Other Health Care Professional		As a Certified Mastectomy Fitter I have attended several webinars regarding the LTA and none sufficiently informed regarding the potential coverage for compression bras for breast cancer patients. Compression bras are critical in providing proper lymphedema treatment for women who have had partial or complete mastectomies, or who have had lymph node biopsies and/or dissections without mastectomy. These bras do not fit the standard mmHg compression guidelines in their manufacturing so they do not fit within the categories defined to-date. They need their own HCPCS/CPT code as a stand-alone product.
CMS-2023-0113-0116	CMS-2023-0113	ll9-i0ow-jfg7	2023-08-22T04:00Z	**Anne**	**Shelton**	NC		Individual - I0001		While coverage for fittings for custom garments is appreciated, there is a need for measurement by certified fitters for "off-the-shelf" garments as well. This is often needed if a survivor gains or loses weight. Basing reimbursement on average retail pricing via the Internet will likely be quite low through retailers such as Amazon. This is likely to put an undue burden on patients.

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CMS-2023-0113-0035	CMS-2023-0113	lks-v2j5-bngb	2023-08-10T04:00Z	**Kelli**	**Silcox**	IN		Occupational Therapist - HC050		Inclusion of bandaging supplies is vital to the success of the patient. Inclusion of not only standard garments as well as custom and adjustable wraps is also necessary to facilitate successful outcomes for these patients. Inclusion of bandage liners and night garments is also beneficial since not all patients can tolerate day compression garments.
CMS-2023-0113-0046	CMS-2023-0113	lkz-2jh4-ked9	2023-08-10T04:00Z	**Helene**	**Simmons**	NE		Device Industry - PI005		Having to wear a compression garmet daily, I can attest that only covering 2 every 3 months is not enough. You have to wash them daily and they are usually stretched out by 3 months. Would you only want 2 pairs if underwear to have every 3 months?
CMS-2023-0113-0696	CMS-2023-0113	llw-efr8-gyh1	2023-09-14T04:00Z	**Ranee**	**Simon**	ID		Health Care Professional/Association - Other Health Care Professional	https://downloads.regulations.gov/CMS-2023-0113-0696/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0866	CMS-2023-0113	llw-wzlq-o7pk	2023-09-14T04:00Z	**Rebecca**	**Sims**	PA		Other - OT001		I am writing to express my concern for inadequate benefits under medicare for Lymphedema therapy. I am a Registered Nurse, currently working and have had 30 years of Secondary lymphedema. I was at the point with the extreme edema and fibrosis that I was losing my circulation and possibly my ability to work . I had cancer in 1993 that changed my life forever. I could not find lymphedema care and subsequently was treated with the wrong compression garments. The need to understand how time and life consuming lymphedema is very important to me . Three stockings every 6 months does not even begin to be adequate. The strength and compression retention is needed to be maintained at the highest levels possible . Six months is too long between new garments and slows sooner progression of the lymphedema . please consider the best plan for those that suffer from this life changing disease! Rebecca Sims
CMS-2023-0113-0058	CMS-2023-0113	ll2-x5rx-en4m	2023-08-10T04:00Z	**Joan**	**Singler**	WA		Association - Device		I am writing to let you know how important “Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” is to me. I have been living wiht lymphedema for 7 years. I know there is no cure. I exercise, diet, do self massage and wear compression garments. I am retired and almost 89 years old and trying to take good care of myself. Using my arthritic hands to get into the compression garments is a big challenge and painful. The cost is an every bigger challenge. Right now I need a little help. Financial support is needed and coverage for custom garments would make living with this condition tolerable. Please support this bill and help 1000s of others like me who are dealing with lymphedema every day for the rest of our lives. Thank you
CMS-2023-0113-0735	CMS-2023-0113	llw-kcz6-ecyk	2023-09-14T04:00Z	**Meg**	**Skipper**	OR		Health Care Provider/Association - Home Health Facility		I am a home health physical therapist in the state of Oregon. I have been working in home health for the past 7 years. Home Health is the most complex and rewarding setting that I have ever worked in. As a caregiver for my community, it is critical that we are being reimbursed sufficiently to be able to provide the level of care that our community deserves. Our communities have been tormented by the aftermath from the COVID pandemic. What this has led to from a home health perspective is, our patients are requiring a level of critical and interdisciplinary care that is unprecedented. Patients are presenting with far more complex disease processes in the home environment. Pre pandemic these patients would more often than not be sent to a skilled nursing facility or inpatient rehabilitation, however post pandemic, these patients are getting discharged to home rather than rehab due to caregiver shortage across the various healthcare systems. With the increase demand for home health, ensuring that our patients receive access to skilled clinicians with experience and expertise in this specialty is critical. Reimbursement should directly reflect the patients that we are serving. If reimbursement for home health decreases, then the system will be forced to decrease pay to it clinicians, thereby decreasing the quality of clinicians that will be treating patients in this very vulnerable time. Personally, the last 3 years have been the most challenging in my home health career. The needs of my patients are extensive and require great skill and interdisciplinary coordination in order to best serve them and to prevent them from returning back to the hospital. Home Health has a unique opportunity to keep the patients in their homes and out of the hospital, if reimbursement is decreased, I anticipate that the number of patients returning to the hospital after being discharged to home would greatly increase, thereby increasing health insurance costs and further burdening an already fragile healthcare system.
CMS-2023-0113-0681	CMS-2023-0113	llw-b1qk-92mm	2023-09-14T04:00Z	**LD**	**Skoutelas**	DE		Health Care Professional/Association - Physical Therapist		I am fully in support of the Lymphedema Treatment Act and as a Lymphedema Therapist am looking forward to taking better care of my many patients who can not afford compression bandages and/or garments. I feel I have been short changing them due to financial restrictions. My concerns are that 1- measurement time for custom as well as standard garments be included as both are time consuming for therapists and vendors. 2- reimbursement for vendors will be adequate so that they continue to provide service for lymphedema products. 3- that bandaging be covered in addition to garments as that is nearly always the first "medicine" we provide to patients - our "gold standard". When they are reduced, we move on to other garments. Some patients continue with bandaging lifelong as well. Thank you.

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CMS-2023-0113-0654	CMS-2023-0113	llv-oewe-xthl	2023-09-14T04:00Z	**Carol**	**Sloman**	WA				I would like to comment on 5 aspects of CMS-1730-P 1. Daytime Quantities: I recommend that either the number of medically necessary (as determined by the treating professional) or 3 pairs of daytime garments be allowed every 6 months. This would allow for the proper care and laundering of the garments. It is important that clean garments be worn each day both to protect the patient from skin infection and to preserve the life of the garments. Gradient compression garments are made of different fibers and in different thicknesses. They can not be heat dried. Climatic conditions (temperature, humidity) will affect drying time. Allowing at least 3 sets of garments would ensure that clean garments would be available to wear each day. 2. Coverage for Accessories: Garment accessories such as liners, over-sleeves, zippers, donning and doffing aids should be covered to insure that both daytime and nighttime garments are worn properly. 3. Items Covered: Toe caps appear to be missing from the list of overed garments. Toe caps are the lower extremity equivalent of upper extremity gloves to control swelling of the toes. Toe caps are essential for some lymphedema patients and should be covered. 4. Prescribing Practitioners: Certified Lymphedema Therapists should be able to prescribe the medically necessary and appropriate garments and supplies for the patient being treated. It should not be necessary to have to go back to the referring professional for the prescription. To do so adds unnecessary time and expense to the process. 5. Terminology: In several places in the document the phrase “garments or wraps with adjustable straps” appears when referring to daytime garments. This could be confusing. It is not clear if “with adjustable straps” refers to both garments and wraps. This could be remedied by eliminating “with adjustable straps.” The result would be to allow coverage for wraps that are adjustable by straps or by other means and would not imply that garments must have straps.
CMS-2023-0113-0514	CMS-2023-0113	lls-y142-zm7h	2023-09-12T04:00Z	**Pamela**	**Smith**	TX				I have had stage 3 lymphedema since 1996. I continue to use short stretch bandages night and day. This includes: stockinette, foam, toe bandages and tape. I use a left waist compression stocking 40-50 compression stocking. I only use it for exercise, then I wrap my leg again. Medicare has not covered any of my lymphedema management supplies since I was forced into Medicare 6 years ago. I am concerned about the proposed rule saying bandage supply kits will be covered for the initial reduction phase of treatment, but does not mention the maintenance phase of treatment. I am so beyond that point. The newer compression garments don’t work for me because I have no left hip or the top of my femur. I am so pleased that this progress is being made. However, I am concerned that my bandages won’t be covered since they are part of maintaining my condition. I have been buying them directly for over 20 years. The reimbursement needs to be more or good suppliers will not part of this. Glad to know the pumps are covered. My husband bought his 2 years ago and it wasn’t covered. Thank you.
CMS-2023-0113-0540	CMS-2023-0113	llu-us32-ezcp	2023-09-14T04:00Z	**Tammie**	**Smith**	WV		Academic - OT005		I've had lymphedema since 1988. It's been a hard long struggle and financially exhausting. I need full l3g garments. They must be custom made. The cost is unreal, yet understanding. To have insurance help would help with the financial burden on me. I get disability and that just doesn't work. I'm in need of garments now, but due to the high cost, I must go without and suffer swelling and pain.

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CMS-2023-0113-0655	CMS-2023-0113	llv-p0w8-pqoh	2023-09-14T04:00Z	**Corrina**	**Smith**	MD				I am a lymphedema patient- leg lymphedema for over 10 years. I have to wear a compression garment daily or risk severe leg swelling and pain that will negatively affect my ability to work and daily movements. I can attest that only covering 2 every 3 months is a start but not nearly enough. Patients with severe lymphedema should at a minimum have 5 custom day garments to rotate and wear for every day of the week. I myself must wear double compression during the day. You have to wash them daily and hang them to dry. They become stretched and worn out after about 3 months and the fit of your garments make a difference in how well you can maintain your lymphedema limb. A patient may only need 2 or 3 nighttime garments per year, again one garment per year is not enough. They have to be washed every day; this is very important to prevent infections. I would love for those who are making these decisions to walk in my shoes for one day to see what it's like living with this disease (lymphedema) and then to have to constantly fight for coverage of the basic necessities (garments, therapy, lymphedema supplies) required to maintain it so you can decent quality of life and stay out of the hospital with cellulitis. It's mentally exhausting and physically changing disease. Why make it so hard to maintain? I haven't been able to get new garments in over a year because of insurance issues. Thank you for your consideration, understanding, and compassion.
CMS-2023-0113-0633	CMS-2023-0113	llv-h5pj-3was	2023-09-14T04:00Z	**Lavar**	**Snyder**	ID		Health Care Professional/Association - Occupational Therapis		1 / 2 Dear CMS, I am writing today as an administrator for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A -4.6% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Lavar Snyder OTR/L Home Health Clinician
CMS-2023-0113-0553	CMS-2023-0113	llv-01v3-3xu0	2023-09-14T04:00Z	**Michael**	**Sokolowski**	OH				I write to ask Congress to support the LTA. As a lymphedema patient for a number of years now, my compression garments that are not covered by insurance are a vital part of my care and provides me the support to wear normal clothing outside of the home. I currently have purchase 2 sets of flat knit custom knee high garments with flat knit custom thigh segments. These 6 pieces cost me $200 each for a total of $1,200. My conditions demands the garments to be worn 23 hours a day, with a one hour break in which to shower and dress again. Since I only purchased one set of thigh bands given the cost, it's a race to the washing machine for my wife who is also my care provider to have them cleaned and ready to go in a hurry. For mental peace of mind, it would make sense to have at least three complete sets of knee highs and thigh bands. For me, the one full leg compression garment is too difficult for me to put on. The two piece knee high and thigh band is not only more comfortable, but manageable/easier for me to put on and also easier for a care provider to handle. The team of doctors, therapist, and I have worked hard to get me to the position where I can wear compression garments to get me as close as possible to a healthier, normal life. Please support the Lymphedema Treatment Act for not only myself, but for the many that face this unfortunate health concern. Thank you.
CMS-2023-0113-0120	CMS-2023-0113	lla-2zl6-cfsb	2023-08-22T04:00Z	**Cynthia**	**Somers**	WA		Other Health Care Professional - HC075		As a breast cancer survivor of 20 years, I cannot say it is over due to the lymphedema in my arm, an aftermath of surgery and radiation treatment. Infections are my biggest worry and without adequate compression for my involved arm, they put me at substantial risk. On a modest retirement, Medicare doesn't fund compression garments and they are an expensive out of pocket yet essential requirement to avoid sepsis. Please fund this necessary medical treatment.

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CMS-2023-0113-0625	CMS-2023-0113	llv-f15q-adxs	2023-09-14T04:00Z	**Beau**	**Sorensen**	UT		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0625/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0680	CMS-2023-0113	llw-anjo-g8vi	2023-09-14T04:00Z	**Heidi**	**Sovacool**	WI		Individual		I am commenting on the proposed changes for the Lymphedema Treatment Act. I am an OT who had been diagnosed with a condition that required a hysterectomy and as a result of the long term pressure my pelvis endured from the condition, my lymphatics of my abdomen and pelvis were squished to the point that even affected my ureters were forced closed and I could not urinate. The result of the long term damage to my lymphatics started the swelling (edema) in my abdomen and legs. After visiting numerous doctors and not getting a diagnoisis, I took the lymphedema certificaion course so that I could take care of my self. during this process I was given numerous resources, of which, I could find a doctor who would later verify my condition due to the extreme pressure my pelvis had withstood prior to my hysterectomy. This was the start of my own wellness--and the wellness of others. Since that time, I have (for my own personal gain) sought out and learned as much as I could (and continue to do so) to treat my lymphedema, and as an OT, I also see client's in my practice for lymphedema and lipedema. With a personal understanding of all the complexities, and with a personal understanding of how much I have to pay out of pocket, I deeply understand the frustration that plagues both clients therapists and PCPs regarding the coverage for compression garments. I have had way too many clients come through my practice and simply not accept the treatment as they can not afford the maintenance garments necessary for after-treatment. My journey began in 2018. Many people have been on this journey for way longer. I would also like to acknowledge that the coverage for garments is essential, but the necessity is to have multiple garments--in order to maintain laundering and wearing schedule. Most garments have washing instructions (to maintain a longer lifespan) of machine washing and line dry. In a warm climate- this is nearly impossible to "line dry" and have the garment available for the next day. Can you imagine having only 2 pairs of stockings to rotate between? Or only 2 pairs of underwear? Due to the nature and closeness of these being worn "on the skin" the necessity of washing is mandatory (even healthy skin needs to have daily sock and underwear changes--but for those with lymphedema or lipedema, these conditions have greater sloughing, oozing, and tendency for skin malformations due to the very nature of the disease (or underlying condition prompting the edema), and if I brought you a garment freshly removed from a lymphatic leg, arm, chest, genitals, or face, nobody would volunteer to wear it again against their skin. Thus, three garments, for any location, are not simply wanted--they are a mandatory necessity! Second, I must share with you that there are many different kinds of presentations of edema and lipedema. Some are easier to treat and some are very complex. This is why there are different kinds of lymphatic products (circular knit, flat knit, inelastic wraps, Velcro products, etc.). For example, a contractor or gardener in Wisconsin would not build the same kind of house, plant the same flowers, or drive the same type of well in Arizona. The temperature, the geological makeup, the humidity, the precipitation conditions--are all different. There are different types of window styles for those who live in the bitter winter cold versus the dry heat. There are different types of plants that can withstand the extreme temperatures in Arizona but can't survive a winter in Wisconsin. Thus, different body applications require different types of lymphedema garments. I know this not only from my personal experience but from my clients as well. The garments are priced differently, sized differently and even have different compression levels based on they type of knit. These are really important thoughts to consider. For example, have you ever purchased a pair of shoes that felt great at the store but when you brought them home you just couldn't tolerate them--or they just didn't feel right? I bet you returned them, or never wore them again. The shoes were perhaps not ?made for you" not made for your foot length, width, arch height, and flexibility and type of movement you do each day. Lymphedema garments need to be particular and need to feel "right". I can imagine that not one person would like to wear a pair of underwear that is two sizes too small -- this is ridiculous! Lymphedema garments are made to fit, and without this customization, the patient would be miserable! Thus, I am requesting that the committee that is listening (and reading) recommended comments, please consider if you yourself needed to wear them, how many pairs could you survive with? Also, please take a look at the greater public who is actually purchasing these garments and what the costs are. Please be practical in your decision. You can call on me to answer your questions.
CMS-2023-0113-0570	CMS-2023-0113	llv-4bjt-npma	2023-09-14T04:00Z	**Mary**	**Spechko**	SC				I am looking forward to my knee length support being covered by Medic
CMS-2023-0113-0856	CMS-2023-0113	llw-uicy-zpc7	2023-09-14T04:00Z	**Ann**	**Spungen**			Physician - HC005	https://downloads.regulations.gov/CMS-2023-0113-0856/attachment_1.pdf	See attached file.

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CMS-2023-0113-0349	CMS-2023-0113	llm-jvon-yiya	2023-09-11T04:00Z	**Missi**	**Spurgeon**			Health Care Industry - PI015		Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Iowa Home Care provides home health services in Iowa. Specifically, we serve West Des Moines, Ottumwa, Boone, Webster City and surrounding areas. We have been a Medicare participating home health agency since 2023 and currently have a patient census of 705. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare, therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state's citizens. Sincerely, Melissa Spurgeon Pediatric Care Coordinator Iowa Home Care West Des Moines, Iowa 50266

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CMS-2023-0113-0536	CMS-2023-0113	llu-tbu4-acic	2023-09-12T04:00Z	**Monica**	**Stalter**	OH		Health Care Professional/Association - Occupational Therapis		I am a CLT and work F.T with lymphedema patients for the past 14 years. It is important to have a CLT identify specifically the make, model, and size of the recommended compression. Many patients get a RX from their PCP and take to pharmacy and are dispensed the wrong compression that does not provide the support needed. So many compression manufacturers are not providing adequate compression for the management of lymphedema. The mmHg is important. However, the containment is not always taken into consideration. Not taken into consideration by the PCP or the DME fitter. Just because the patient "fits" in an off the shelf size, does not mean that the sleeve/stocking will contain the heaviness of their extremity. Most lymphedema patients have heavy fibrosis and scarring that requires a higher containing (containment is NOT the mmHg, but the material/weave of the garment) sleeve/stocking. DME providers will provide the patient with what THEY feel is appropriate (they really don't know what they patient needs) and some will provide with what they will make the most money on.... which is the $25 stocking which does not provide the patient with containment needed. CLT's who knows they patient should work with the PCP to ensure the correct sleeve/stocking is fit for the patient. Preventative sleeves/stockings are being billed to pt's and insurance companies... Stage 1-4 lymphedema patients are not in a preventative state. Only stage "0" is preventative. Lymphedema patients benefit from having the ability to obtain stockings/garments that they can apply and remove. Most do not have assist to do so. Layering garments makes it easier for the patient to do so. Applying 2 lighter containing garments is much easier than applying 1 heavier containing garment. Lower extremity lymphedema patients can also benefit from have 2 pieces - knee high plus a knee to groin segment. For some this is easier to apply vs. the full thigh high garment. Patients can be more compliant wearing the knee high... thigh high's can be uncomfortable and it is the first thing they stop using. The 2 pieces can give the patient a "break" from the full length. Some lymphedema patients have phlebo-lymphedema and benefit from the ulcer care stockings, which are venous related stockings. But can provide the lymphedema patient very good compliance and containment, when layered. Toe compression has been difficult to obtain. Some manufacturers do not see the benefit for the patients. We see folks on the daily with extensive toe lymphedema swelling- lobules/infections/wounds, that is NOT managed without toe compression/caps. At times, is best as a separate piece that is worn under the leg garment/stocking. Depending on the patients quality of skin integrity- flat knit vs trim to fit. Back to the fitter.... due to the expertise needed to properly measure and the time it takes to measure initially, it would benefit to be able to charge for this and then it is required to follow up to assess fit and return garments if needed, or re-order. Which should also be a separate charge as this also takes a significant amount of time to do. So many patients come back with ill fitting garments because they DID not return to the fitter for follow up.
CMS-2023-0113-0090	CMS-2023-0113	ll6-zyr4-13qp	2023-08-22T04:00Z	**Jilllian**	**Stanley**	CA		Congressional		RE: Lymphedema Treatment Act proposed: “We are specifically soliciting comments on the topic of coverage of accessories necessary” This would include the gloves for donning compression stockings. Only certain gloves can be used; they can be ordered online, but are not found in stores. Therapists usually have these gloves. “the suppliers of the garments are responsible for fitting the garments they furnish.” and “the supplier receiving payment for the garment would be responsible for paying the therapist for the fitting component” This sounds confusing. Is the “supplier” the manufacturer? My compression stockings are manufactured in Germany and ordered by a therapist; the therapist of a qualified fitter measures my leg. . However, I assume that lymphedema therapists will comment on this matter. Will any qualified therapist be able to fit and order supplies for a patient? At one time when I had private insurance, it was decreed that the garments had to be ordered by certain other businesses, not the therapist at the lymphedema treatment center that I used. This was a great problem, as one business was unable to measure properly and the other was far away. In the description of codes, would “Gradient compression garment, genital region” include compression shorts? These provide compression to the genital region but also the trunk area. “We are soliciting comments on whether two nighttime garments should be allowed.” Yes, they need to be allowed, as nighttime garments must be washed and dried; therefore, a patient usually needs to have two, one to use while the other is drying (as machine drying may not be available or advisable).
CMS-2023-0113-0684	CMS-2023-0113	llw-bwfh-0tg5	2023-09-14T04:00Z	**Joyce**	**Stathem**	MD		Individual		Regarding proposed rule Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items, I would like to voice my support for Medicare coverage of the compression garments and supplies. My compressions socks cost $400 to $500 a pair and I do not buy them as often as i should due to the cost. Two pair every six months would be helpful, as would two nighttime garments per year. This wouldalso help with laundering. Coverage of lymphedema treatment is very important to help individuals effected by it and also to help avoid worsening symptoms and hospitalizations.

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CMS-2023-0113-0365	CMS-2023-0113	llm-tsbc-xz62	2023-09-11T04:00Z	**Marlene**	**Steele**	CA		Occupational Therapist - HC050		As a Certified Occupational Therapy Assistant (COTA) with 35 years experience and the Value Based Improvement Coordinator for a home health company I would like to explain why I feel the cuts to OT in home health should not happen. The goal for patients to stay at home is the number on priority for occupational therapy. Home Health is the only place in which a patient learns how to be independent in their own environment. Every other level of care has to simulate the pts home. With the new changes in VBP and the focus is on improvement on function in the patients lives from start of care to discharge. This can't happen if occupational therapy is not part of the team in home health. The OT teaches the pt to manage safely in the home from everything from all the steps for toileting or preparing a meal or doing basic housekeeping when the pt has had a medical change in their lives. The OT looks at not just the physical changes but the psychological changes that happens when a pt becomes ill. Most pts cannot afford hiring an aide to come into the home to assist with these things because they are on a fixed income so that is why the pt needs to learn to be independent to stay safe in their homes. Nursing and Physical therapy don't have the training to break down a task or to adapt how a task can be done so the pt can progress functionally. Part of the OTs training is to do activity analysis and find out where the deficits are and make the changes. This is why I feel occupational therapy cuts should not happen.
CMS-2023-0113-0542	CMS-2023-0113	llu-vp3q-6wmd	2023-09-14T04:00Z	**JoRae**	**Stewart**	OR		Health Care Provider/Association - Home Health Facility		Dear CMS, I am writing today as an RN Supervisor for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 4.69% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, JoRae Stewart, RN Case Management Supervisor

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CMS-2023-0113-0706	CMS-2023-0113	llw-gmgd-8k77	2023-09-14T04:00Z	**Candace**	**Stock**	IN				I am a certified lymphedema physical therapist, and I would like to comment on the lymphedema garment coverage proposal. I feel the 2 garments per body part per 6 months proposal is good, but consideration should be given to those patients who need to layer garments for ease of donning or for additional containment of their lymphedema. Perhaps a process where a physician or therapist could request to increase the numbers of garments per body part in certain circumstances where a case could be made that more were medically necessary. I also would support a process where loss, damage, theft, change in patient's weight, or change in medical status, would be considered for an exception to have more garments if needed in those circumstances. For night garments, I would suggest one per body part for one year, vs two per body part every two years. I feel two years is too long to wait to be re-measured for a new garment. Their measurements might change and the night garment would no longer be a good fit. I would recommend a way to allow the patients to choose to be measured for compression garments by a lymphedema physical or occupational therapist if they so choose, with appropriate reimbursement and CPT codes. Many of these patients are followed by therapists who know their needs and individual situations better than a one-time fitter would. The knowledge and skills of a therapist would be beneficial in these situations to help them choose the appropriate garment to fit their unique needs. I am in support of the recognition of other body parts in need of compression, such as head/neck, breast, trunk, genital, etc. Obtaining compression for any areas outside of the extremities has been a great challenge due to expense and lack of reimbursement. Compression tank tops, shirts, bras, shorts, leggings, masks, etc are all essential garments for these areas when lymphedema is present, and can greatly improve these patients' quality of life and preserve and improve function. Accessories such as donning aids are also essential for assisting patients to be able to don the compression garments. Reimbursement for these times would also be very helpful for this patient population. Many patients are also dealing with arthritis, debilitation, decreased strength, and decreased range of movement, and donning aids can allow them to have more independence in donning their garments, as well as improve compliance with daily compression wear.

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CMS-2023-0113-0023	CMS-2023-0113	lki-nx9e-6pyl	2023-08-10T04:00Z	**Zabelle**	**Stodola**	MN		Individual		To the Centers for Medicare and Medicaid Services (CMS) Comments on The Lymphedema Treatment Act in the Draft of Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items I am pleased that compression garments will finally be covered under the Lymphedema Treatment Act, which is part of broader coverage for Home Health. I also commend the CMS for soliciting comments on the draft proposal. In 2015, I developed Secondary Lymphedema in my right leg following surgery for ovarian cancer. The diagnosis of lymphedema was confirmed at the Mayo Clinic in Rochester, Minnesota, and I was prescribed compression garments. However, although my insurance—United Healthcare Group Medicare Advantage—is supposed to partially cover the cost of the prescribed garments, bandages, and wraps, the reimbursement system was so cumbersome, user-unfriendly, and deliberately obstructive, that I did not try to submit reimbursement claims for many years. I bore the cost myself, which ran into thousands of dollars. When I did begin the process recently to submit a claim for several really expensive items, I discovered just how unlikely the insurer was to reimburse me for hundreds of dollars I expended during a severe lymphedema episode. As CMS knows, consistent access to compression garments is a cost-saver in the long run because it helps to prevent lymphedema from progressing to a serious stage requiring more extensive intervention. ACCESS TO CUSTOM-MADE SUPPLIES AND COMPRESSION GARMENTS Therefore, I am particularly happy to see CMS's decision to cover a broad range of compression supplies and accessories. I urge CMS to ensure that the criteria for coverage are clear and can be promptly approved so patients like me do not experience needless delays in receiving products that will help to mitigate problems during the phase called REDUCTION, when garments, wraps, and bandages, will help to reduce swelling and pain, and also during the subsequent MAINTENANCE phase, when other supplies are needed to continue with progress made. ALLOWABLE QUANTITIES The draft currently specifies two garments every six months for daytime use. This would certainly be adequate for the needs of someone with my level of lymphedema. The draft currently suggests one garment every year for nighttime use; I would prefer to see that increased to two garments annually. The final version of the rule must also recognize the complicated meaning of "garment." For example, for nighttime use, a patient like me will require a wrap or wraps that will be used on my foot, lower leg, knee, and thigh. This might come in the form on an all-in-one wrap that will extend from foot to upper thigh, or I might be recommended to purchase the wraps separately for the foot, lower leg, knee, and thigh. CMS must ensure that the term "garment" would include buying four separate items for the affected limb. VENDORS AND REIMBURSEMENT RATES Since I am a patient, not a vendor, I can speak only briefly to this issue. CMS must ensure that vendors will be reimbursed enough that plenty of vendors will be willing to take part in the program. However, I hope that with additional competition among companies as well as the huge increase in business for these vendors, costs to Medicare/Medicaid (and to the general public) will decrease. Right now, the cost of these compression supplies seems unaccountably high to me. Patients often feel that medical supply companies are taking advantage of sick and vulnerable people.
CMS-2023-0113-0197	CMS-2023-0113	lli-ag79-374x	2023-08-29T04:00Z	**Larry**	**Struck**	MN		Individual		Pertaining to the Lymphedema Treatment Act, it is important for a member of my family that costs of compression garments and any related professional services be covered. This should include all kinds of compression garments including custom garments, day and nighttime garments and accessories such as liners for as often as necessary to control the lymphedema condition and maintain our patient's health. The expense of these garments is too much for my family to afford otherwise. Garments that wear out or are lost should be replaceable at no cost. The continued use of these garments has been and will continue to be essential in preventing more serious medical complications that require expensive treatment or hospitalization.
CMS-2023-0113-0097	CMS-2023-0113	ll7-dchj-7p08	2023-08-22T04:00Z	**Carol**	**Super**	FL		Consumer Group		Lymphedema is a chronic disease that causes pain to millions of Americans. As a chronic disease it must be managed. Presently there are two major ways that go hand-in-hand to treat lymphedema: physical therapy, and the wearing of both daytime and 19 compression sleeves. Many of your constituents are unable to afford the cost of replenishing these sleeves they only have a limited. Time of use Consequently, having gone through the ordeal of surviving cancer myself, I implore you to pass this bill for those who have survived, and unfortunately have lymphedema.

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CMS-2023-0113-0467	CMS-2023-0113	llq-r49a-5rvm	2023-09-12T04:00Z	**Chad**	**Swank**			Health Care Professional/Association - Physical Therapist	https://downloads.regulations.gov/CMS-2023-0113-0467/attachment_1.pdf	See attached file.
CMS-2023-0113-0346	CMS-2023-0113	llm-jd5h-7lyn	2023-09-11T04:00Z	**Christine**	**Swanson**	IA		Health Care Provider/Association - Home Health Facility		Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS–1780–P P.O. Box 8013 Baltimore, MD 21244–8013 Re: CMS–1780–P; RIN 0938–AV03 To whom it may concern: Thank you for the opportunity to comment on the proposed rules within the “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). I work for Iowa Home Care which provides home health services in Iowa. Specifically, we serve Ottumwa, Fort Dodge, Webster City, Boone, Knoxville, Marshalltown, Des Moines and all of the outlying communities to the referenced cities. We have been a Medicare participating home health agency since 2004 and currently have a patient census of 700-800. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to serve individuals in our community who need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the Patient-Driven Groupings Model (PDGM). We respectfully request that CMS refrain from implementing any proposed rate cuts in 2024, as such action would exacerbate the already diminished care access within our community. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases, particularly in staff wages and benefits, without a corresponding payment rate increase. Consequently, we face the looming possibility of curtailing our service area, imposing limitations on patient admissions, discontinuing vital community programs, and encountering obstacles to engaging in progressive home health care initiatives. These initiatives encompass assuming shared financial responsibilities with payers and embracing novel technologies that demand substantial financial commitment. If the proposed pay rates are implemented, patients who can be cared for at home with high quality and cost-effective care will end up with costly extended stays in hospitals and nursing homes. Our services are critical to the well-being of the patients we serve. The reduction and loss in care access due to increasing financial pressures has extended hospital stays, pushed patients to institutional care, and left individuals without care. This also has negative consequences for Medicare; therefore, we ask that you not institute the proposed rate cuts and work with us on meaningful solutions to protect access to home health care for our state’s citizens. Sincerely, Christine Swanson Payroll Accountant Iowa Home Care West Des Moines, Iowa
CMS-2023-0113-0042	CMS-2023-0113	lkw-z1hf-xebz	2023-08-10T04:00Z	**P**	**T**	TX		Health Care Provider/Association - Home Health Facility		We are already struggling with retaining clinical and office employees with higher pay requirements along with increasing medical supply, vendor, and operational costs. Please reconsider the negative effects of this rule as agencies like ours are struggling for the past few years although our care level has been maintained and we’ve eaten the high costs due to inflation, supply, and labor shortages.

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CMS-2023-0113-0050	CMS-2023-0113	ll1-bbfd-8dw1	2023-08-10T04:00Z	**Paul**	**Tabungar**	CT		Physical Therapist - HC045		Paul Tabungar PT/ CLT Lymphedema Therapist in Southington Care Center, Connecticut Comments for CMS on LTA 1. Reimbursement for specific pieces a. Currently there is one code used for compression wraps with adjustable straps, A6545 which describes non elastic compression wrap below knee. b. There are body parts that require separate pieces of adjustable strap garments: foot, calf, knee, thigh, arm, hand c. Using one code for all of these body parts limits appropriate coverage of the edematous limb, as the patient is limited to sets. If a patient requires a foot and calf unit, they would not qualify for the 2 different units due to the same code being used for both pieces. d. This has created problems in wound centers when the A6545 code is used to bill for an adjustable strap garment as a surgical dressings, section 1861(s)(5) of the Act for the treatment of an open venous stasis ulcer. The patient is issued an adjustable strap garment for the calf (ankle to below knee coverage), but not for the foot, as they cannot be reimbursed for both units using the same A6545 code. The patient develops increased foot edema, often resulting in progressed disease, infections, difficulty with shoe fit leading to imbalance and safety issues. e. Separate codes should be created for adjustable strap garments for the lower leg, foot, knee, thigh, arm and hand. 2. Reimbursement Codes for compression bandages and supplies a. Using DME codes for the bandaging supplies needed for phase 1 treatment will block clinicians from receiving reimbursement for these products they provide as hospital based clinics that are not considered DMEs. b. Hospitals purchase foams and bandaging supplies for patients as a part of providing therapy and should be reimbursed through medical codes in the clinic setting. 3. Coverage Rules and Reimbursement for Measuring of Compression Garments a. DME fitters are often not available, requiring the therapist to measure and fit the compression garments. b. Time and additional lymphedema therapy appointments are saved by having the therapist measure and fit the patient with compression garments, as the patient does not have to coordinate measuring and fitting with an outside 3rd party. This provides a more efficient discharge and reduces overall visits during the active phase of treatment. c. Therapy clinics do not usually have DME status, and would not be able to bill for measuring and fitting using DME codes. d. Currently therapists use medical CPT codes to bill for their time and expertise in measuring and fitting the patient with compression garments. Codes such as 97530, 97535 are often utilized by therapists to bill for these services. e. Requiring a DME to provide measuring and fitting may limit patients from receiving compression garments when a DME is not available.
CMS-2023-0113-0758	CMS-2023-0113	llw-nfzl-zcbt	2023-09-14T04:00Z	**Peppi**	**Talley**	AL		Association - Device		After lymphedema in left leg from cancer surgery 11 years ago, it would be nice to be able to get a pump and garments without a Continuous fight with UHC insurance. I pray we get this all passed so we can get garments,bandages,therapy etc that we desperately need for this terrible condition.
CMS-2023-0113-0425	CMS-2023-0113	llp-okgw-stdj	2023-09-11T04:00Z	**Keith**	**Tansey**			Physician - HC005	https://downloads.regulations.gov/CMS-2023-0113-0425/attachment_1.pdf	See attached file.
CMS-2023-0113-0710	CMS-2023-0113	llw-gtnb-zp8g	2023-09-14T04:00Z	**Mary Ellen**	**Taylor**	DE		Health Care Industry - PI015		After living with Lymphedema and its condition for 5 years, I would plead that the cost of buying compression stockings and wraps for my legs be covered by Medicare and private insurance. Currently, I make the stockings last more than the six months recommended because the cost is prohibitive. Thank you!
CMS-2023-0113-0102	CMS-2023-0113	ll7-jb5q-tmzs	2023-08-22T04:00Z	**Pamela**	**Thacker**	MD		Health Plan or Association		For those of us that have been dealt lymphedema and or lipedema ii is a cruel disease it's painful it causes mobility issues and it's expensive. None of us should have to do without or make do with what helps us manage daily life as best we can. None of us should be expected to manage with a single pair of stockings or wraps because our insurance won't help or we can't afford them. Just like undergarments we should be able to change them regularly as they to must be washed and they take time to dry so more than one pair is required. Stockings do not last longer than 4 to 6 months and if we wear them longer they are not helping us from swelling and pain and maintaining our condition. Some of us need custom made stockings because off the shelf don't fit us properly and if they don't fit us they can roll and cut into our skin and cause pain and possible injury, injury is very dangerous for us as we may heal very slowly. I personally have lymphedema and lipedema and I hurt I can swell from stress and heat I wear knee highs and thigh highs that have silicone and they cost $170.00 and $220.00 each piece I need both legs so 2@$170.00 and 2@$220.00 in addition I have to wear leg Velcro wraps @$258.00 each, the stockings I need to buy at the longest every six months the Velcro wrap will hold up one year. As you can see they are expensive. In addition some of us may need more help like a leg pump which can be thousands of dollars. I would not wish my disease on anyone what I do wish for is help for medical supplies to help me fight another day.
CMS-2023-0113-0060	CMS-2023-0113	ll3-2t0q-ujq5	2023-08-10T04:00Z	**Nathan P.**	**Thomas,Sr.**	MD				Lymphedema is a difficult side effect of many illnesses and it can be difficult to treat.

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CMS-2023-0113-0196	CMS-2023-0113	lli-938s-dqrd	2023-08-29T04:00Z	**Nathan P.**	**Thomas,Sr.**	MD				I agree with the report on the 2024 Home Health Prospective Payment System Rate Update - patients with lymphedema, need all the help they can get. Bad enough to suffer from lymphedema, but many patients are suffering from other illnesses.
CMS-2023-0113-0527	CMS-2023-0113	llu-7i71-xvro	2023-09-12T04:00Z	**Janell**	**Thome**	MO		Health Care Professional/Association - Occupational Therapis		Thank you for the time and effort you put into these draft rules. I have been a certified lymphedema therapist practicing for seven years and present the comments below keeping in mind the different needs of each patient, including their ability to tolerate and to don/doff various garments for day and night wear. Compression bandaging (VII.B.3): 1. Please consider also covering bandaging for the maintenance phase. Some patients prefer bandaging overnight rather than wearing the nighttime garments. 2. I support being able to charge a code for OT or PT therapy services for applying compression bandaging to patients. 3. I' m not sure what is meant by "padding." It should include foam sheets, foam rolls, cotton or synthetic padding, and chip pads. Swell Spots or similar quilted items to be used under clothing or bandaging for various body parts are also necessary in some cases. 4. (VII.B.7) It should be up to the therapist to determine how many and what type of bandaging items are needed, as it varies greatly between individuals depending on the nature and severity of their swelling. Custom gradient compression garment measuring, fitting, education (VII.B.3): 1. It is important to allow the therapist to participate in this part of the custom process. Some therapists are highly skilled in measuring and fitting, and some DME providers are not able to offer this service due to distance. There may be times when a patient is not comfortable having a stranger measure them in sensitive areas. 2. The therapist is ultimately responsible for the direction of the patient's lymphedema therapy process. There are times when decisions are made regarding measurements and compression choices based upon a larger picture which the DME provider does not have (sensitive skin, inability to don tight garments independently). It is not advisable to put the DME in the corner of being responsible for the fit to the extent that they feel they need to disregard the therapist's measurements and/or recommendations. 3. I do not feel comfortable relying on the DME to educate the patient in donning, as some patients require the critical skills of a therapist to problem solve issues with reach or balance which the DME is likely not trained to do. 4. A code similar to orthotics initial/fabrication could be used to capture the therapist's time measuring and fitting a patient. Two Velcro wraps allowed per affected extremity every 6 months may not be sufficient in certain cases in which the swelling is so severe that two wraps are necessary to cover one part (such as the thigh when swelling overhangs in the inside of the knee) (VII.B.7). Two sets should be broad enough to cover whatever the therapist thinks is necessary to adequately address that extremity. Codes for garments (VII.B.4): 1. Along with the other items listed for new codes, please be sure the final list is able to cover toe caps, compression capris/shorts/leggings and compression bras. Mastectomy bras are not the same thing as a compression bra, and many women who have lumpectomies need a compression bra to address lymphedema of the breast following surgery and radiation. 2. I assume mastectomy sleeves are compression sleeves for patients post-mastectomy, so those can be included in compression sleeves which are also necessary for patients post-lumpectomy or axillary lymph node dissection. Reimbursement rates (VII.B.7). I work in a state which does not have Medicaid coverage for compression items. Medicaid typically reimburses at low rates for any services and goods, and I caution that cut-rate reimbursement rates end up pushing providers out of the market. That leaves patients with fewer opportunities to get the care they need. Thank you for your time and consideration.
CMS-2023-0113-0128	CMS-2023-0113	llb-71pf-8ddg	2023-08-22T04:00Z	**Crystal**	**Tipton**	TX		Individual		I am in favor of implementation of Medicare Part B coverage for gradient compression garments to treat Lymphedema. Garments are integral to the treatment of both primary and secondary Lymphedema. I support reimbursement for the measuring of custom and standard-fit compression garments, as measurements can change over time. I support covering at least two daytime garments per affected extremity every 6 months, and one nighttime garment each year, per affected body part. No less than two daytime garments are necessary because after wearing one, that one is washed and cannot be put in the drier, so a second garment is needed to wear. However, imagine only having 2 pairs of socks to wear! I support replacement of garments sooner if a new or different garment is needed for any reason. Lymphatic swelling can fluctuate greatly from day to day so it is important that people have access to garments that fit them properly in order to manage and maintain gains from Complete Decongestive Therapy (exercise, elevation, compression and MLD).

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CMS-2023-0113-0451	CMS-2023-0113	llq-njl3-65bd	2023-09-12T04:00Z	**Theodore**	**Tom**	CO		Health Care Provider/Association - Home Health Facility		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0473	CMS-2023-0113	llq-td40-jslp	2023-09-12T04:00Z	**Brooke**	**Torres**	ID		Health Care Provider/Association - Home Health Facility		the proposed rule will be detrimental to Home Health agencies. It feels as if decisions are being made before scientific evidence that the previous changes have even had time to have been evaluated and determined in a positive or negative light. With the continuation of escalating costs to the agencies in both the cost of clinical wages, supplies and to run an agency in general, to be compounded by the approved decrease in reimbursement for 2023 - only to then be proposed to decrease again in 2024 - will see many agencies suffering to provide the life changing service that is the most cost effective and beneficial to both patients and goverment funding in the health care industry. I suspect if approved, this will be a significant hardship on many agencies and result in fewer HHA being able to sustain buisness and offer the community the benefits of Home Health. If this is to proceed, it will not only be the HHA's that suffer - we will see higher rehospitalizations, increased costs of health care as more and more patients will not be able to be set up for success in DCing successfully from the hospitals, getting the care needed from any agency that might still be available, and rising costs of health care in the governments division of what they will be needing to pay out for the increased ER and re-hospitalizations. Please reconsider this proposed ruling and allow sufficient time for the recent changes in 2023 to be properly evaluated and studied before more proposals of reimbursement change will be submitted.
CMS-2023-0113-0597	CMS-2023-0113	llv-ajae-ew5k	2023-09-14T04:00Z	**Clarisse**	**Torres**	ID		Health Care Provider/Association - Home Health Facility		CMS's proposed rate reduction does not consider the high costs of inflation, staffing shortages, turnover, and labor stresses that home health providers are facing. Combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. The Proposed Rule ignores the ongoing Covid-19 pandemic and the significant impacts it has on providing home health care, including increased costs of infection control, labor, and medical supplies. Other health care providers have not seen such significant rate cuts, despite home health care providing higher costs savings. The most vulnerable populations rely on our high-quality care and these cuts will restrict their access to care, particularly in rural and underserved areas. CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures, and now CMS is pulling the rug out from under us mid-year. Please reconsider this proposed rule.
CMS-2023-0113-0121	CMS-2023-0113	lla-9dna-aqd3	2023-08-22T04:00Z	**Sam**	**Traffas**	SC		Health Care Professional/Association - Occupational Therapis		As a home health therapist and lymphedema therapist, I see first hand the challenges patient's face. So many of my patients are underpriveledged and cannot afford to purchase the necessary compression that is required for a daily maintenance of their diagnosis. Too often, they would have to return to the hospital, thereby causing an even greater strain on Medicare, instead of a much smaller fee up front.

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CMS-2023-0113-0476	CMS-2023-0113	llq-tk9r-c5wg	2023-09-12T04:00Z	**Janelle**	**Trippany**	WA		Health Care Professional/Association - Physical Therapist		* Currently the proposal only specifies the ability to bill for bandages in the in the acute/decongestive phase, but does not specify maintenance phase. Many patients need to bandage long term and bandages only last for about several months. Therapists may also start treatment years later when they're not technically in the decongestive phase anymore, but bandages are still required for their treatment. *in the proposal, there is a code for fitting/measuring for compression garments that is tied into the garment fee. Many therapists measure for the garment and then send those measurements to the company for production. As the proposal is written, it would not be possible for the therapist/clinic to be reimbursed for the measuring. I would suggest two separate codes – 1 for measuring and 1 for fitting. *There is no garment code specifically for toe caps, which are critical to this population. *There is no currently no indicator of how many liners someone could get with a Velcro garment. I would suggest that at least 2 liners are included so patients can wash them. Hygiene is a very important aspect of lymphedema treatment to prevent infections and skin breakdown. *Thank you so much for increasing coverage for people living with lymphedema. It was desperately needed and so appreciated!
CMS-2023-0113-0192	CMS-2023-0113	lli-5h1x-y8uz	2023-08-29T04:00Z	**Martha**	**Trout**	PA		Other - OT001		I just went on Medicare and was shocked to discover that my custom gradient compression stockings are not a covered benefit. These custom garments would cost me $2600 a year, if not covered, as they need to be replaced every 6 months. These garments are essential to my health and allow me to have a fairly normal lifestyle and have always been covered under other insurance plans. Adequate coverage of custom gradient support compression garments, such as what is proposed in the lymphedema treatment act, should be covered by Medicare and available to the many people who depend on them to live their lives.
CMS-2023-0113-0144	CMS-2023-0113	llc-oy1a-ak9t	2023-08-22T04:00Z	**Patrick**	**Utley**	TX		Health Care Professional/Association - Other Health Care Professional		The proposed rule, which would reduce home health reimbursement significantly, seems shortsighted and irresponsible. On average, Medicare spends less than $100 per patient per day for healthcare in the Home Health setting. One of the primary purposes has always been to reduce hospitalization and to allow our seniors to heal in their own homes, in the environment of their choosing. Home health, when used effectively, can also significantly reduce overall Medicare costs of hospitalization and skilled nursing and rehab. If anything, Medicare should be increasing Medicare reimbursement and utilization. There is no way our hospitals can keep up with the need of the aging population's healthcare needs.
CMS-2023-0113-0047	CMS-2023-0113	ll0-zemi-hwli	2023-08-10T04:00Z	**Lindsey**	**Valentine**	MD		Health Care Provider/Association - Home Health Facility		As both a occupational therapist in the field and clinical manager in the office I urge you to reconsider the proposed cut to Medicare reimbursement in home health care. Patients are coming home from the hospital with increased needs we have not seen in past years requiring more extensive services to be provided in the home in order for them to remain home. As a company working ethically to provide needed and appropriate care to the patients we have been able to adjust to the recent payment structure changes, PDGM, that came out in 2020 with minimal impact. However the cost of everything recent has gone up and so has our overhead and this cut would substantially impact our ability to compensate our staff and provide enough support staff to provide the most effective care for patients. At a time when costs are rising and patients needs are rising we urge you not to cut payments that would only negatively effect patient care in the short term and likely result in an increase in hospitalizations costing Medicare much more in the long term.

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CMS-2023-0113-0481	CMS-2023-0113	llq-x7wm-9509	2023-09-12T04:00Z	**Chanda**	**Vaniman**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0398	CMS-2023-0113	llo-6c45-orm7	2023-09-11T04:00Z	**Rebecca**	**Vardiman**	TX		Individual		I've lived with long-term lymphedema tarda in my left leg for about 45 years. So my condition is old and I couldn't find informed care for about the first 20 years. Because of that I need to wear three layers of support -- light support knee-highs to help the next layer, a custom made Jobst socking, last as long as possible (they're terribly expensive). Then I wear a thigh high support stocking over that. This arrangement of three layers prolongs the life of the Jobst garment and gives the high pressure I need to maintain my leg in the condition it's in. Also, at night I wear a toe cap to bring down the extreme swelling in my toes along with an older Jobst stocking, so I have to buy the custom toe caps (also very expensive), as well. I've paid for all these items myself for over 20 years and am very grateful that they might finally be covered by Medicare. Thank you so much for this help!
CMS-2023-0113-0569	CMS-2023-0113	llv-3gr6-pi7d	2023-09-14T04:00Z	**Brittany**	**Vasquez**				https://downloads.regulations.gov/CMS-2023-0113-0569/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0504	CMS-2023-0113	llr-ja1a-q7r1	2023-09-12T04:00Z	**Katherine**	**Vaughn**	CA		Individual		Thank you for providing an opportunity to comment on Section VII.B Scope of the Benefit and Payment for Lymphedema Compression Treatment Items and for your consideration of the input of persons like myself living with lymphedema. I am a 34/year cancer survivor including a stage 4 diagnosis 22 years ago. I have been living with secondary lymphedema for 22 years as well as a primary mild lymphedema in both legs. I wear left-arm compression 23 hours/day, out of my sleeve and gauntlet only for showers or aqua exercise. My ongoing treatment includes daily MLD, 1-hour on a pneumatic pump, a padded night garment with power sleeve or bandages applied on top. I need to bandage for greater compression after travel, time at high elevation or high heat, and during recovery from cellulites outbreaks. I have had cellulitis 4 times this year alone. I see a physical therapist for MLD 1-2 times per month and every six months for intensive 5-10 day treatments. Recovery from cellulitis also requires additional physical therapy sessions once antibiotics have reduced the infection. I appreciate the provisions you have already included for (a) garments both off-the-shelf and custom (mine require custom fitting); (b) 2 SETS of garments per year (as noted I wear both arm sleeves and gauntlets); (c) at least 1 night garment per year; (d) a process for the consideration of exceptions to replacement frequency. My suggestions in response to the areas you have requested comment include (a) provide easy approval based on medical necessity as established by doctor or physical therapist trained to treat lymphedema; (b) establish codes to allow measurement for garments by a trained physical therapist or DME provider; (c) at least 1 night garment per year, 2 if measurements have changed or the garment has stretched out; (d) coverage for bandaging supplies during the maintenance phase as well as intensives. Believe me, we do not bandage unless our condition requires the greater compression to overcome our increased swelling. Again, you have my deepest gratitude for your careful implementation of the Lymphedema Treatment Act. You are helping millions of us who live with this incurable condition.
CMS-2023-0113-0561	CMS-2023-0113	llv-1fql-gve5	2023-09-14T04:00Z	**YULIYA**	**VEEN**			Health Care Provider/Association - Hospice		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.

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CMS-2023-0113-0888	CMS-2023-0113	llx-3mk0-do2e	2023-09-14T04:00Z	**Judith**	**Vilbrandt**	CA				I have suffered from Lymphedema in both upper extremities since complications occurred following breast cancer reconstruction surgery in 2011. Bilateral upper extremity swelling and discomfort will be a chronic issue the rest of my life, but hopefully will remain in the mild category due to diligent wearing of my compression sleeves and gloves while working full time as a nurse and when exercising and flying and whenever my arms are painful. My private insurance covered 2 garments/2 gloves per extremity every 6 months and this is absolutely the minimum I need in order to keep my condition under control and to have clean garments to continue the day to day activities that keep me employed and mentally and physically fit. I will be 65 soon and will be converting to Medicare coverage so I will need to continue to have this requirement and pray that I will never need nighttime compression(as long as I maintain and keep my daytime compression fitting properly) but this requirement for those that do need it is absolutely imperative. Within the past 6 months, I discovered that my supplier no longer takes my insurance (contract ended) and I ended up paying privately in order to have my sleeves fitted. This is disappointing as I had gone to the same supplier for 12 years and paid cash this time, but will have to look elsewhere SO please also consider how important it is to reimburse the suppliers for the time it takes to measure properly to ensure the properly fitted compression is provided. I worry we will lose our seasoned fitters/suppliers should the price for the compression fitting not be factored in and this will not be a good for the suffering lymphedema patients as a whole. I know I can now order from Mediven or Juzo online but only will do so knowing that I was first measured properly by my professional home care supplier who has measured Lymphedema patients for 25 years. I usually get measured around once per year but sometimes can go longer if my arms are stable. Thank you.
CMS-2023-0113-0003	CMS-2023-0113	ljz-w04q-qxaf	2023-08-10T04:00Z	**stan**	**vinet**	CA				I believe the behavioral adjustment is not in line with the factors and considerations that we are having to consider and manage at the Agency and Branch level. The fact that staffing shortage and wages increase demands are continuing to be extreme is preventing capacity ability and financial stability. Additional cuts using data from Pandemic years to make assumptions is not valid methodology.
CMS-2023-0113-0063	CMS-2023-0113	ll3-vo4e-lvjs	2023-08-10T04:00Z	**Nicole**	**Walton**	TN		Health Care Provider/Association - Home Health Facility		The cuts proposed in Home Health will impact our professional ability to help more patients gain access to the care they need to live longer, fuller lives.
CMS-2023-0113-0403	CMS-2023-0113	llo-c15t-tbh9	2023-09-11T04:00Z	**FAYOLA**	**WARD**	NC		Home Health Facility - HPA25		The proposed rule having to do with support for lymphedema garments is much needed. After surgery for a melanoma on my ankle and removal of lymph nodes, my right leg swells within minutes if not covered with compression stockings. I wear two 20-30 weight, thigh-high stockings on that leg constantly (I need the additional, second-stocking's compression) except for bath time. A stronger compression stocking would be too difficult to get on. At bedtime, I remove one of the stockings. The stockings cost $69 at Lymphedemaproducts.com. At times I can get a discount and pay closer to $60/pair. I have bought 13 pairs in the 3 years since my surgery. I wear one of the older stockings on my other leg during the day; it swells if I don't wear a compression stocking on it. I am 83 years old and control my lymphedema with this regimen--but the stockings are essential!!! I need Medicare support in order to continue this care of my condition.
CMS-2023-0113-0108	CMS-2023-0113	ll8-bt9d-atel	2023-08-22T04:00Z	**Lisbeth**	**Warren**	NJ		Individual		I write today regarding “Section VII.B.- Scope of the Benefit and Payment for Lymphedema Compression Treatment Items.” I was diagnosed with lymphedema in my left arm 3 years after having surgery for breast cancer. My arm and axilla area are painful, tender and swollen and it negatively impacts my quality of life. Unfortunately, there is no effective cure and only limited treatment modalities. In addition to physical therapy, management of lymphedema with compression garments is currently the standard of care and presently the only way to manage the swelling, minimize the pain and reduce the risk of progression of this condition. I wear custom compression garments 24/7. I have done so at my own expense since these medically prescribed therapeutic garments are not currently covered by Medicare. A set of custom daytime garments (arm garment and hand gauntlet) for me costs approximately $320. Because they lose compression over time, the garments are recommended to be replaced every six months. A nighttime custom garment should be replaced at least every year. It costs approximately $1,000. I need two sets of the daytime and nighttime garments so I can wash them and let them dry overnight. I also can alternate with the two sets to extend the life of each garment. The consequences of not aggressively managing lymphedema is not only discomfort and pain but also an escalation to even more expensive therapeutic measures which would cost even more. There are a couple of surgical procedures (for example, lymph node bypass and transplant) but they are not standard of care, are considered experimental, do not have a proven track record and are only performed by a handful of experienced surgeons. In my view, they are to be avoided unless desperation sets in. I would also like to see breast compression bras included in this bill. They are another tool in the toolbox for managing painful lymphedema which occurs after breast and axilla surgery on a frequent basis.
CMS-2023-0113-0009	CMS-2023-0113	lk7-3230-qrsa	2023-08-10T04:00Z	**Ann Marie**	**Webb**	FL		Home Health Facility - HPA25		This proposed rule would be detrimental to the Home Health and Hospice field. Home Health Care has become a vital role in caring for our community with excellent outcomes.

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CMS-2023-0113-0393	CMS-2023-0113	llo-4bgz-x8xg	2023-09-11T04:00Z	**Jacob**	**Webb**	UT		Home Health Facility - HPA25		I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0766	CMS-2023-0113	llw-o4n3-1mbp	2023-09-14T04:00Z	**Katherine**	**Wedemeyer**	OR		Health Care Provider/Association - Home Health Facility		Please consider the impacts to patients with the proposed reimbursement cuts for home health. I work for a not-for-profit home health agency. It is extremely challenging to meet the needs of our patients while still breaking even financially. I would ask for consideration as well of how Medicare HMOs are regulated, as they frequently deny payment with little to no justification and they reimburse at rates much lower than the Medicare rate. As a mission-driven organization, we accept all insurances, however this places a huge financial burden on us. We do all we can to use resources responsibly. Please reconsider making further cuts, as this would likely result in a reduction in quality outcomes for patients, who are needing home-based services more than ever.
CMS-2023-0113-0201	CMS-2023-0113	llj-2yvl-jwcx	2023-08-29T04:00Z	**Robert**	**Weiss**	CA		Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0201/attachment_1.pdf	Please consider my comments to Proposed Rule Code CMS-1780-P Calendar Year (CY) 2024 Home Health Prospective Payment System Rate Update; …; Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; … My comments apply to Section VII B. Proposed Changes Regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Scope of the Benefit and Payment for Lymphedema Compression Treatment Items.

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CMS-2023-0113-0436	CMS-2023-0113	llp-wtfc-8hrb	2023-09-11T04:00Z	**George**	**Wertz**	AZ				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0083	CMS-2023-0113	ll5-9iye-51x4	2023-08-22T04:00Z	**Janyce**	**Westerman**	TN		Association - Device		Overall, I am pleased with rules concerning allotment of garments. Two night garments at one time would allow for air drying, which protects garments and increases wear time.
CMS-2023-0113-0480	CMS-2023-0113	llq-vyzt-wn96	2023-09-12T04:00Z	**Sonya**	**Weston**	UT				I am writing today as a home health employee to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I am a seasoned home health employee, and I see firsthand the impact that these cuts will have on the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of 5%, which will be compounded by an estimated almost 3% inflation rate, resulting in higher operating costs. A 5% cut may not seem like a lot, but it would have a significant impact on the bottom line of home health agencies, agencies like mine who are already operating on tight margins. These cuts would make it even more difficult for HHAs to stay afloat and provide care to millions of Americans. This would have a devastating impact on the patients who rely on home health care. Many of these patients are frail and elderly, and they need the support of home health to stay in their homes and avoid costly hospital stays. The cuts would make it more difficult for these patients to get the care they need and could lead to unnecessary costly hospitalizations and even death. In addition, these proposed cuts seem highly irrational. Home health is already the lowest-cost setting of healthcare. A 2022 study by the Medicare Payment Advisory Commission found that home health care costs an average of $13,471 per year, compared to $24,513 per year for hospital care, which is already an average of $11,000 less per patient per year. The cuts would not save money in the long run. In fact, they would likely lead to higher costs overall, as patients who are unable to get the care they need in their homes would end up in the hospital or other more costly settings of care. I urge you to reconsider the proposed budget cuts to home health reimbursement. These cuts would have a devastating impact on the patients who rely on home health care, and they are irrational from a financial standpoint. Thank you for your time and consideration.
CMS-2023-0113-0407	CMS-2023-0113	llo-l2r5-lxud	2023-09-11T04:00Z	**Malorie**	**Wheeler**			Health Care Professional/Association - Physical Therapist		Home health care providers deserve better wages for the wrk they are doing. My mom received home health care when she was recovering from a torn Achilles tendon, and she would not have been able to recover if it wasn't for the physical therapists that visited her at home. I know more and more people around me will eventually need in home health care, and they deserve to have people who are paid well and not overworked. I feel that cutting the budget is unsustainable and will affect so many lives negatively. Please take care of our home health care workers so they can take care of those in need.

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CMS-2023-0113-0772	CMS-2023-0113	llw-orhu-gwaq	2023-09-14T04:00Z	**Michael**	**Wheelwright**	UT		Health Care Provider/Association - Home Health Facility		As a Home Health and Hospice Administrator the rate cuts proposed are not taking into account the high costs of inflation requiring us to pay higher wages to retain staff. In recent years we have also been faced with an increased shortage of licensed clinical staff including nurses, physical therapists, and CNA's. There has also been an increase in overall staff turnover, decreased retention, and increased labor stresses that home health providers are facing. My fear that country wide by combining those challenges with significant cuts to funding would reduce our patients' access to life-changing care. The proposed permanent rate reduction of 5.653% vs the cost inflation of 2.7% (which does not come close to actual cost inflation) will result in an overall reduction in reimbursement for all Medicare patients. It was not long ago that our clinicians and healthcare providers were heralded as heroes for going to the front lines to provide life changing care during the COVID-19 pandemic. The effects of this pandemic are ongoing still, with increased costs of infection control, labor, and medical supplies. These additional costs are what is required and needed to keep our patients safe, and have added to the cost of providing patient care. This reduction in reimbursement is significantly more than other health care providers. Home health has proven its effectiveness in reducing costs by effectively caring for patients outside of a skilled nursing/hospital setting. There are also parameters set in place for lower-performing companies to receive reduced reimbursement based on their annual outcomes. As an agency that serves a large geographical area, with may patients residing in rural and underserved areas, reducing reimbursement will inhibit us from providing care to some patients in outlying areas. The reimbursement for these patients already does not cover the expenses, but as a healthcare provider we have found ways to provide the best care possible under the current rate structure. The Proposed Rule unfairly intends to change quality measures without industry feedback. It also proposes to change the baseline year for certain measures to 2023. These proposed changes devalue the great progress and focus we have made and does not allow providers to prepare for the new measures eight months into the baseline year. We have worked hard to focus on the current measures that have been laid out. These measures have been highly scrutinized, and have required many hours of focus and training to ensure we are meeting all expectations set for us. Now 8 months into the year CMS is changing the rules and regulations mid-year, which puts all participating providers at a severe disadvantage. CMS relies on flawed data and methodology regarding the behavioral adjustments and those flaws should not form the basis for the rate cuts. If the goal is to provide better care for patients there are many more ways to do this over a rate reduction. After surviving the pandemic and keeping patients safe in their homes a significant rate reduction will impede our ability to provide this care to patients in the future.

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CMS-2023-0113-0807	CMS-2023-0113	llw-qz0y-ohw3	2023-09-14T04:00Z	**VALARIE**	**WHITE**	TX				RE: FILE CODE CMS-1780-P I have been employed by Women's Health Boutique, a DMEPOS supplier with multiple locations as a corporate assistant for the past two years and have been amazed at the discrepancies of Medicare's non-coverage of lymphedema products for women who have had mastectomy surgeries. Post-Mastectomy Lymphedema is something so outwardly visible that women must deal with for the rest of their lives. I sincerely applaud CMS for the Medicare Proposed Rule to Implement Part B Coverage for Lymphedema Compression Treatment Items. Thank you for the Public Comment Phase allowing me the opportunity to be an integral part of this process as the future of Medicare coverage of these items for beneficiaries with lymphedema is shaped. My comment is specifically for the inclusion of compression bras. In addition to coverage for lymphedema arm sleeves, Medicare needs to include compression garments for lymphedema of the chest, torso, breast, axilla, and back as well. Title VII. (B)(3) Pg. 271/392 "as well as comments on whether there are additional items other than the gradient compression garments, gradient compression wraps with adjustable straps, and compression bandaging supplies that could potentially fall under the new benefit category for lymphedema compression treatment items." COMMENTS: I propose the following gradient compression garments be included in this new benefit category: ~ Chest/Torso Compression Garment, typically referred to as a "compression bra", but is not a bra. It generally covers the entire torso with compression on the chest wall, torso, back and underarm, sometimes extending to the waist and even to one or both arms. I recommend staging of the post-surgical garment. Existing HCPCS code L8015, post-surgical camisole, provides the "first stage" post-surgical needs including drain pouches and fiber-filled puffs appropriate for the first 2-8 weeks after surgery. The "second stage" could be a post-surgical compression garment, possibly HCPCS code L8016 and could be described as "second stage" post-surgical compression garment for post-surgical use, or for ongoing use as necessitated, covered for an indefinite period for residual lymphedema over the torso, chest, axilla, underarm, and back. This would most probably be chest length and could be described as: ~ Post-surgical compression garment, chest length, without arms, L8016 ~ Depending on compression levels and length of garment, differentiating chest length from torso length, HCPCS codes could also include: ~ Chest/Torso length compression garment, without arms, L8017 ~ Chest/Torso length compression garment, with one arm, L8018 ~ Chest/Torso length compression garment, with bilateral arms, L8019 ~ Chest compression vest, without arms ~ Torso compression vest, without arms ~ Compression bodysuit with arms ~ Compression bodysuit with arms and legs I also propose these chest/torso compression garments have an allowed minimum of two garments initially, one to wear and one to wash, and with replacement at least every three months, as medical need dictates, up to eight per a year. In specific cases, the addition of swell spots, foam pads, or silicone pads as medically necessary might be indicated for use to effectively treat targeted areas of lymphedema, fibrosis, or scar tissue on the torso, chest wall, surgical site, breast, or back. I also propose these additional gradient compression garments be added under this new benefit, including: ~ Compression Arm Sleeve with Shoulder Attachment ~ Compression Arm Sleeve with Gauntlet Attachment Thank you for considering the inclusion of all the above compression garments and accessories in this Proposed Rule. Respectfully submitted, Valarie White

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CMS-2023-0113-0493	CMS-2023-0113	llr-638e-upgp	2023-09-12T04:00Z	**Ciera**	**Whitmore**	OK		Health Care Professional/Association - Occupational Therapis		As an occupational therapist that has worked in home health for the past 9 years, the past 3 have been a devastating hit on therapy provision in the home. The implementation of PDGM has resulted in many agencies to inappropriately cut therapy visits and staff. Even for agencies that have not limited therapy visits for medicare beneficiaries, the funds provided for CMS for clients for post-CVA are not adequate to pay for the needed services these patients require especially when PT/OT/ST are all required in order to return the patient to an safe and adequate level to maintain safely at home while preventing medical fragility. The proposed 2.2% cut would only further limit patients access to therapy services. The further change of utilizing the M1800 scores for HHVBP payment to GG scores makes sense, but would be better managed and reduced confusion and improper scoring at the clinician level if the M1800 scores were removed from the OASIS in favor of GG scores only as has occurred in the SNF and IRF settings.
CMS-2023-0113-0194	CMS-2023-0113	lli-8q0g-hj4o	2023-08-29T04:00Z	**Mary**	**Wiley**	IL				Daytime Quantities • My only comment is that daily compression garments should be changed two for every six months, they're worn daily(7 days a week for level three conditions. Nighttime sleeping compression garments could be changed once a year. At level three maybe two per year. Custom nighttime comfortable compression garment. sets.) Nighttime Quantities • The rule proposes covering one nighttime garment every year per affected body part. (One set.) FROM CMS: We are soliciting comments on whether two nighttime garments should be allowed, with both garments being replaced once every 2 years, to allow for more than 1 day for washing and drying of the garment(s).
CMS-2023-0113-0406	CMS-2023-0113	llo-jau7-wi5c	2023-09-11T04:00Z	**Elizabeth**	**Wilke**			Occupational Therapist - HC050		I am deeply concerned about the impact of the proposed payment cut on the utilization of occupational therapy (OT) services in the home health setting/patients' access to these services. Per the American Occupational Therapy Association (AOTA), since the rollout of the Patient Driven Groupings Model (PDGM), the Assocation has heard from OTs and OT Assistants about the model's negative impact on their ability to treat patients in the home health setting. These reports include: Agencies are applying pressure to reduce the number of OT visits to clients. Agencies are using predictive analytic tools that use algorithms to determine how many therapy visits (if any) should be provided based on diagnosis. Agencies are instructing staff to delay OT to later in the HH episode, or patients are told they can wait to get therapy after discharge when they are outpatient. Physician orders for OT are ignored, revised, or deleted. Nursing and Physical Therapy are determining when and if OT services are needed. Agencies are shifting OT visits to PT or nursing colleagues. OTs are having to do more, with less support. Therapists' clinical judgment is overridden or ignored. I believe additional payment cuts will further decrease OT utilization within the home health setting, and ultimately, negative impact long-term patient functional outcomes.
CMS-2023-0113-0038	CMS-2023-0113	lkv-9pzs-okur	2023-08-10T04:00Z	**Cindy**	**Williams**	PA		Other - OT001		I am a 63 year old woman ans Medicare due to a disability. I was diagnosed with lymphedema over 15 years ago, I tried over the counter compression socks, but they did not prove to be effective/helpful. since then, I have used custom made garments. They have proven to help immensely in my treatment regimen. Each pair costs me $350. I have to have at least 2 pair, making it extremely cost prohibitive, especially because I am on a fixed income. The Lymphedema Treatment Act would be extremely beneficial to so many patients with similar challenges.
CMS-2023-0113-0052	CMS-2023-0113	ll1-o5hi-uc7o	2023-08-10T04:00Z	**Sarah**	**Willner**	MD		Health Care Professional/Association - Occupational Therapis		As a clinician in healthcare for many years I will share that cutting costs and corners NEVER benefits the patient. If a patient does not feel they are getting adequate treatment in the home the first place they run is to the ER. They do not want to go to urgent cares. I find that it is imperative to ensure that corners are not cut in the world of home health care because it will flood our ERs. I have been on the other side of this with family members and I identify this to be a disaster. Patient know when they are not receiving top quality care and it trickles down and will hurt us all in the long term. thank you for reading and I truly suggest finding a way to cut corners somewhere else in the world but not healthcare. Just wait - we will all need these services for ourselves or our loved ones - I promise you do not want to feel like you are not receiving top quality in time of need.
CMS-2023-0113-0846	CMS-2023-0113	llw-t44r-94ad	2023-09-14T04:00Z	**Sharon**	**Wilson**	TX			https://downloads.regulations.gov/CMS-2023-0113-0846/attachment_1.pdf	See attached file(s)Number of Nighttime garments allowed per year. Should not be based on a set quantity but on the change of medical need for the product.

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CMS-2023-0113-0686	CMS-2023-0113	llw-c9gl-g7ri	2023-09-14T04:00Z	**Shamea**	**Wilson**	NY				home health aides' usage is declining even though there's still strong need for the service is because aides are not as reliable and aren't filling the need, so clients give up on home care because the aides discontent. Medicare clients who have multiple or more severe impairments having more difficulty accessing home health aide service because cl are often told that they are not covered through Medicare to receive long term assistance and home care is remedial. HHAs recruitment isn't the problem it's that cost of living that someone would have to make off of the pay given to aides. The benefits aren't there for employes and then retention of home health aides becomes an issue.
CMS-2023-0113-0212	CMS-2023-0113	lll-80hf-58zo	2023-08-29T04:00Z	**Derrick**	**Winegardner**	PA		Health Care Provider/Association - Home Health Facility		I had to pay over $5,000 for in home antibiotic IV's since I had no transportation to hospital every day for 30 days. Medicare would pay if I could of went to hospital to get IV every day.Medicare should pay higher wages for in home care because it is less costly than in rehab and hospitals.
CMS-2023-0113-0217	CMS-2023-0113	lll-drdx-zp4m	2023-08-29T04:00Z	**Jacey**	**Witmer**	PA		Health Care Professional/Association - Nurse		Re: "Section VII.B. - Scope of the Benefit and Payment for Lymphedema Compression Treatment Items", I would like to say, thank you for helping our Lymphedema patients get better coverage for their medically necessary garments, critical for preventing open areas, cellulitis, sepsis and even death. We see this repeatedly in our Wound Healing Center and as the Nurse Manager and Certified Wound Care Nurse, am so pleased to see this come to fruition. The only concern I have regarding the proposed rule is the potential reimbursement rate, based on Medicaid reimbursement which is historically low and pennies on the dollar which will deter suppliers from offering the product to patients if they will not get reimbursed at a high enough rate to break even on them. Our patient population that needs this coverage most, is our Medicare and Medicaid patients. The patients that have other insurance or can pay out of pocket for them are not the target population to benefit from this important proposed rule. Please consider the rate of reimbursement to make sure that suppliers will continue carrying them. Again, thank you for proposing this life and limb saving ruling!
CMS-2023-0113-0376	CMS-2023-0113	lln-ut1g-0gni	2023-09-11T04:00Z	**Lana**	**Wolf**	NE				I was blessed with Lymphedema following surgery for breast cancer 6 years ago. I live in a rural area, so it is not so easy to obtain medical help for this illness. I wear compression garments and use a pump. My nighttime compression garment is over $300. I cannot afford to replace it as often as it should be. We need help with the cost of these garments and pumps. Wouldn't wish this on anyone as it is often painful if not taken care of daily.
CMS-2023-0113-0195	CMS-2023-0113	lli-90cl-c5i8	2023-08-29T04:00Z	**Patricia**	**Wolkow**	MD		Individual		I was devastated when I learned I had lymphedema in my right leg and hip, months after recovering from heartbreaking news of needing a hysterectomy because of cancer. I was not going to let this next diagnosis rob me of my now cancer free status. I pursued therapy and followed my medical instructions exactly as prescribed! When I learned the lack of insurance coverage for my garments, I just couldn't comprehend the rational for it. My future dreams of a full life with my new grand child and family began to blur. Not just the financial burden of my care but the thought that without my garments doing there job, I would end up in pain and misery dealing with the ramifications of wounds, trauma, and doctor and hospital visits. I researched alternatives, such as transplants of other lymph nodes to the affected area and worried that such a procedure might weaken another area of my body without those nodes there doing their job. It makes no sense to me that insurance companies would rather pay for continued medical care to doctors, hospitals, and pharmacies instead of paying for preventatives! An additional concern that I think needs to be addressed is the entire process from taking measurements for customized garments to manufacturers, to patient. There needs to be technicians and perhaps technology for taking accurate measurements for garments. In my short time of wearing garments, I have had to have three different professionals complete measurements. Also the garments each turned out differently and not fitting the same each time. Consequently I have to live with the imperfection because it is too costly to have them remade, and often nobody is still in the line of communication between the therapist and the manufacturer that understands or can handle the concern. I'm happy that we are moving in the right direction for having garments covered by insurance for lymphedema. I pray that there is measurable relief for all patients, regardless of financial means. I believe that further medical cost will be reduced for patients with this condition, and others who have been undiagnosed and misdiagnosed for lymphedema. (Yes, I get many wrinkled brows from doctors when I tell them I have be diagnosed with lymphedema.) Thank you for taking time to read my comment.)

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CMS-2023-0113-0094	CMS-2023-0113	ll7-8gjw-3dbf	2023-08-22T04:00Z	**Emm**	**woodyrich**				https://downloads.regulations.gov/CMS-2023-0113-0094/attachment_1.pdf	Home Health System is Broken My comments apply to both Home Health & Hospice Agencies. The current Medicare home healthy services is a broken system. Fix what is broken. HH Agencies nationwide (including Hospice agencies) are riddled with epic failures of policy/process/procedural execution. This has been true since at least 2007, but certainly before. Agencies should not be drafting/writing Plan of Care if that is a responsibility of physician. Agencies are biased and write based on their own business plan & ROI. Agencies consistently lie to beneficiaries stating Medicare does not pay for/cover home health aides even when Ch7 Home Health Manual is referenced by the beneficiary. "The law requires the 30-day period to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 30-day period payment rate includes costs for the six home health disciplines and the costs for routine and nonroutine medical supplies. The six home health disciplines included in the 30-day period payment rate are: 1. Skilled nursing services; 2. Home health aide services; 3. Physical therapy; 4. Speech-language pathology services; 5. Occupational therapy services; and 6. Medical social services." Where a patient is eligible for coverage of home health services, Medicare covers either part-time or intermittent home health aide services or skilled nursing services subject to the limits below. The law at $1861(m) of the Act clarified: "the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week). Agencies do not make nurses available for Feeding Tube services including feedings. 40.1.2.5 - Tube Feedings (Rev. 1, 10-01-03) A3-3118.1.B.5, HHA-205.1.B.5 Nasogastric tube, and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization. and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services. Additional examples and commentary is included in detailed attached PDF There's so much more to address on the home health failed system for beneficiaries.
CMS-2023-0113-0014	CMS-2023-0113	lke-fl7s-vcad	2023-08-10T04:00Z	**Ellen**	**Wright**	MD				I need for insurance to pay for Lymphedema bandaging supplies which I need to use every day. Also to pay for compression garments and all medical supplies for the management and Treatment of Lymphedema
CMS-2023-0113-0015	CMS-2023-0113	lke-fl7u-2loz	2023-08-10T04:00Z	**Ellen**	**Wright**	MD				I need for insurance to pay for Lymphedema bandaging supplies which I need to use every day. Also to pay for compression garments and all medical supplies for the management and Treatment of Lymphedema
CMS-2023-0113-0016	CMS-2023-0113	lke-fl7v-mscs	2023-08-10T04:00Z	**Ellen**	**Wright**	MD				I need for insurance to pay for Lymphedema bandaging supplies which I need to use every day. Also to pay for compression garments and all medical supplies for the management and Treatment of Lymphedema
CMS-2023-0113-0017	CMS-2023-0113	lke-fxdb-43qz	2023-08-10T04:00Z	**Ellen**	**Wright**	MD		Government - Federal		I need for insurance to pay for Lymphedema bandaging supplies, garments, and all medical supplies for Lymphedema care
CMS-2023-0113-0123	CMS-2023-0113	lla-v1po-6y28	2023-08-22T04:00Z	**Rosalind**	**Wright**	NC		Individual		I use the leg garments and they are very expensive from time to time. They last for a year if you don't stretch them out of shape. My left leg swells more than the right leg its be very difficult to put the liner on my left leg. They need to make a change in lowering the price on these garments.

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CMS-2023-0113-0103	CMS-2023-0113	ll7-rdxg-fb7h	2023-08-22T04:00Z	**MICHAEL**	**WYSOCKI**	FL		Individual		Hello I have the primary lymphedema from my chest to my toes since I was a baby. That's over 50 percent of my body. I've been to a million doctors. So the coverage will help me manage it better by covering compression garments, foam padding night time garments etc. I'm on ssdi and have Medicare. It will be good knowing one has their medical condition covered for garments because I gave up going to doctors. It's very expensive for me otherwise because I have the swelling everywhere. I have to buy new garments all the time. I'm 45 now. It would be nice to get a few garments every 6.months. The lymphedema pump I have is helpful.and that was covered. I think the machine is better than going to those lymphedema clinics because they really don't know how to measure properly. The medical supply store found company mobiderm. All I did was give the rep hundreds of medical papers to get it approved.
CMS-2023-0113-0812	CMS-2023-0113	llw-rbzf-5o40	2023-09-14T04:00Z	**Cristina**	**Yeron**	ID				Dear CMS, I am writing today as a Physical Therapy Assistant for a home health agency to express my strong opposition to the proposed CY 2024 budget cuts to home health reimbursement. I have significant experience in the home health industry, and it is from that experience that I am able to foresee the disastrous impact these cuts will have on patients accessing home health care as well as the ability of home health agencies to provide quality care to their patients. The proposed cuts would reduce reimbursement by an average of –2.2%, nationally. However, when considering all pertinent elements (wage index, comorbidity, functional impairment, case mix and the rate cut), many of our affiliates are projected to see a much larger impact, in particular, at our rural and isolated home health environments—places where there are already significant barriers to accessing home health services. A 4.44% cut is anticipated with internal data for my agency, which may not seem noteworthy, but a negative reimbursement adjustment of that nature will have a tremendously negative impact on our operating costs, as we already operate on tight cash flows. Given the increased costs of care and the already lower reimbursement rates under which home health agencies across the country are operating, these cuts would make it even more difficult for these agencies to stay afloat and produce enough cash flow to provide crucial home health care to the millions of vulnerable Americans that need it. This in turn is likely to produce poor quality outcomes, which will affect the outcomes of numerous other providers (e.g., long-term care facilities, hospitals, hospices). The cuts to home health do not help to accomplish CMS's stated goals, which is to provide the right care at the right time for the right cost to produce the best outcomes for the individual and for US healthcare. In fact, they run contrary to those goals. Proceeding with these cuts would make it more difficult for our patients to get the care they need and push patients to more costly services like unnecessary hospitalizations rather than value-added, low-cost care in the home. How would this save money in the long run? I urge you to reconsider the proposed budget cuts to home health reimbursement. We are committed to providing life-changing home health service and these cuts would have a devastating impact on our ability to do so, along with the ability of home health agencies across the nation to do so as well. This, in turn, will risk indirectly harming patients who rely on that care. In addition, if CMS seeks to help provide proper access to home health services through the Medicare benefit, the reduced funding set out in the proposed rule will stand as a significant barrier to that access. Thank you for your time and consideration. Sincerely, Cristina Yerón PTA Home Health Clinician
CMS-2023-0113-0355	CMS-2023-0113	llm-lwpy-ouh3	2023-09-11T04:00Z	**Lea**	**Yost**	OR		Physical Therapist - HC045		In the 30 plus years practicing as a Physical Therapist in the Home Health setting, I have never been more appalled as I am now by this proposed decrease in reimbursement from CMS to the EXTREMELY HARD WORKING home health agencies and clinicians that provide life changing health care services to our home health patients. Every year, we have patients that are discharged from the acute setting with higher levels of acuity and far more complex co-morbidities as well as far greater levels of intervention required for safe and effective care due to the significant impact that social determinants of health are having on our patients due to the poor economy, The fact that doctors offices and clinics are understaffed and patients cannot get in to see them timely, and devastation still being felt from the Covid pandemic. Our number one job is to keep people out of the hospital, and working for an agency, as a clinical director that helps to maintain a rehospitalization rate of 9-11% I feel we are doing an outstanding job already of REDUCING THE COST TO MEDICARE. We are doing this with less staff because our highly educated professional clinicians are being asked to provide more care, without equitable reimbursement because once again, CMS is CUTTING our reimbursement. THIS IS NOT based on data! This is NOT what CMS originally informed providers what would happen. PLEASE utilize appropriate DATA and do the right thing here and do not follow through with this as the final rule.

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CMS-2023-0113-0697	CMS-2023-0113	llw-f77x-3n4x	2023-09-14T04:00Z	**Brandi**	**Young**	IL		Home Health Facility - HPA25		As a small rural community Home Health and Hospice agency who is currently operating in the red due to the ever-increasing operational costs a decrease in our payment may surely seal our fate of closure. We are a small agency operating thru our local health department and have serving our community since 1967. We haven't had surplus revenue in our program for many years and with the salary costs continuing to rise among other increased expenses we don't have any room for cuts to our revenue. As a matter of fact, we have already experienced great cuts to our revenue from the implementation of managed Medicare programs. With our Illinois Managed Medicaid programs becoming primary over dual eligible, once traditional Medicare clients, changing our pay from episodic to per visit at a very low rate, we suffered significant reductions to our revenue. In addition, Advantage Medicare plans are also taking the place of traditional Medicare and paying per visit rates that are much lower than our costs to provide the services. Logistically it could be said that all we need to do is cut our costs and the largest impact to reducing costs would be to reduce our nursing staff. However, over the last 30 years that I have been involved in Home Health care the demands on nursing staff for increased paperwork continues to increase which takes time away from patient care. That time is spent trying to substantiate why we should be paid for doing the care. And with RCD, we have to prove we deserve payment before we can bill for services we have already provided. In addition, we must depend on documentation from a physician who has no incentive to provided quality documentation because his payment isn't at risk as ours is. So frankly after all of this and much much more that is put on home care I believe a pay cut is completely unwarranted and if anything for all the expectations CMS keeps handing out an increase is much more deserved for most of us providing care to some of your most vulnerable populations. If there is fraud in the system, take the time to investigate those on an individual basis and stop trying to use blanket polices that fit the few to punish the mass.
CMS-2023-0113-0664	CMS-2023-0113	llv-v24m-ql3c	2023-09-14T04:00Z	**Sherry**	**Youtz**	PA		Individual		My comment is in reference to “Section VII.B.- Scope of the Benefit and Payment for Lymphedema Compression Treatment Items” I am a primary lymphedema patient suffering my first swelling 50 years ago. Coverage for Layering Garments - Layering of garments was necessary in my situation in order to reduce the swelling in my legs. There was a cloth that covered my leg, then a cotton layer. After that there was a foam wrap layer and finally several layers of compression wraps. All of these items are needed for initial reduction as well as from time to time during the maintenance phase. There should be some coverage for maintenance as initial wrapping procedures are sometimes needed in maintenance. Reimbursement Codes for Specific Pieces • Toe caps are an important part of my lymphedema regiment. Please add toe caps to the list of proposed new reimbursement codes. Calculation of Reimbursement Rates • 2024 reimbursement rates need to be determined based on average online retail pricing or some method that ensures vendors will be willing to provide needed compression items. I spent many months trying to figure out that a vendor would not supply my night-time garment because the reimbursement by my employer's insurance company was not enough to make it worth the vendors time and effort. Coverage Rules and Reimbursement for the Measuring of Compression Garments • In my experience over the last several years, my PT is the one who does the measuring and fitting. My vendor only supplies the garments. It should be made easy for a therapist to provide the measuring and fitting services. Could this be a separate code so that either the vendor or the therapist could bill for measuring and fitting? I do not know about CIP codes. Daytime Quantities • I believe the proposed rule covering two daytime garments every 6 months per affected body part (two sets) is sufficient. That timing of replacement garments has been recommended by my PT fitter. Nighttime Quantities • The nighttime proposed rule covering one nighttime garment every year per affected body part (one set) should be changed in my experience. Receiving two nighttime garments per body part, with both garments being replaced once every 2 years, would allow for more than 1 day for washing and drying of the garment(s). The nighttime garments are very thick and it is hard to get them to dry in one day even using a clothes dryer.

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CMS-2023-0113-0819	CMS-2023-0113	llw-r5we-n1zo	2023-09-14T04:00Z	**Jan**	**Zarick**	PA		Individual	https://downloads.regulations.gov/CMS-2023-0113-0819/attachment_4.png https://downloads.regulations.gov/CMS-2023-0113-0819/attachment_2.png https://downloads.regulations.gov/CMS-2023-0113-0819/attachment_5.png https://downloads.regulations.gov/CMS-2023-0113-0819/attachment_3.png https://downloads.regulations.gov/CMS-2023-0113-0819/attachment_1.png	The suggested reimbursement rates for over-the-counter compression garments differ significantly between lower legs (50%) and arms (75%). Can the leg reimbursement match the arm reimbursement for similar products? EXAMPLE: Juzo Dynamic, knee-high 20-30mmHG, over-the-counter compression hose online retail cost is $75.85 per pair. Your proposed reimbursement is $37.95 [assumed] per pair - half (50%) the cost. A Juzo Dynamic over-the-counter arm sleeve and glove retail online for $124.20. The proposed reimbursement is $95.55 - 75% of the cost.
CMS-2023-0113-0847	CMS-2023-0113	llw-tgmt-1py1	2023-09-14T04:00Z	**Hannah**	**Ziersch**	ID		Nurse - HC065		I am a Home Health RN Case Manager. The proposed financial cuts to home health agencies would affect agencies greatly. We rely on Medicare and other insurance reimbursement in order to see our patients in a timely manner and in order to promote their overall health. Many patients require supplies and as needed nursing visits, especially when we must provide intervention timely and efficiently to prevent rehospitalization. A financial cut would be putting patients more at risk to go back to the hospital.
CMS-2023-0113-0789	CMS-2023-0113	llw-pomy-4z2j	2023-09-14T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0789/attachment_1.pdf	Please consider the accompanying letter addressing the ramifications the proposed payment rate cuts would have on home health agencies throughout the country, but especially on small home health agencies in rural states. For many small, rural counties there is only one home health agency providing care to the senior citizens and disabled person and any cuts to our reimbursement would be detrimental to our ability to provide care.
CMS-2023-0113-0771	CMS-2023-0113	llw-o9ke-vngp	2023-09-14T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0771/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0703	CMS-2023-0113	llw-fttd-yox1	2023-09-14T04:00Z					Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0703/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0683	CMS-2023-0113	llw-b26h-k799	2023-09-14T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0683/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0415	CMS-2023-0113	llp-8q95-vp6b	2023-09-11T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0415/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0359	CMS-2023-0113	llm-qq14-4ctf	2023-09-11T04:00Z					Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0359/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0396	CMS-2023-0113	llo-4ibu-n637	2023-09-11T04:00Z					Home Health Facility - HPA25	https://downloads.regulations.gov/CMS-2023-0113-0396/attachment_1.pdf	See file
CMS-2023-0113-0397	CMS-2023-0113	llo-591n-lpli	2023-09-11T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0397/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0216	CMS-2023-0113	lll-czp1-kj1u	2023-08-29T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0216/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0222	CMS-2023-0113	llm-cy1u-3190	2023-08-29T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0222/attachment_1.pdf	See attached file(s) CMS–1780–P; RIN 0938–AV03
CMS-2023-0113-0381	CMS-2023-0113	lln-yivf-5x6x	2023-09-11T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0381/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0380	CMS-2023-0113	lln-yb0i-dcli	2023-09-11T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0380/attachment_1.pdf	See attached file(s)

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CMS-2023-0113-0488	CMS-2023-0113	llr-25sh-2qqc	2023-09-12T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0488/attachment_1.pdf	On behalf of the Texas Association for Home Care & Hospice (TAHC&H) thank you for the opportunity to comment on the proposed rule.
CMS-2023-0113-0646	CMS-2023-0113	llv-jgqt-6fxi	2023-09-14T04:00Z					Hospice - HPA30	https://downloads.regulations.gov/CMS-2023-0113-0646/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0854	CMS-2023-0113	llw-u9qq-4f4h	2023-09-14T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0854/attachment_1.pdf	Comment is attached as a file.
CMS-2023-0113-0864	CMS-2023-0113	llw-w3ul-4ycx	2023-09-14T04:00Z					Health Care Provider/Association - Home Health Facility	https://downloads.regulations.gov/CMS-2023-0113-0864/attachment_1.pdf	See attached file(s)
CMS-2023-0113-0901	CMS-2023-0113	llz-gpza-q4m0	2023-09-14T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0901/attachment_1.pdf	See Attached
CMS-2023-0113-0902	CMS-2023-0113	lm0-t2mu-d2dr	2023-09-14T04:00Z						https://downloads.regulations.gov/CMS-2023-0113-0902/attachment_1.pdf	See Attached
CMS-2023-0113-0138	CMS-2023-0113	llc-cos4-9tok	2023-08-22T04:00Z					Health Care Provider/Association - Long-term Care		• Why is the use of home health aides declining even though there's still strong need for those services? - Lack of available aides, cost, high turn-over, poor quality/reliability of aides • To what extent are people eligible for Medicare who have multiple or more severe impairments having more difficulty accessing home health care services, specifically home health aide services? - Many are not eligible for Medicaid to cover personal care assistance, but are still struggling to afford privately paying for services • What are the consequences of beneficiary difficulty in accessing home health aide services? Beneficiaries are typically unaware of what they need to do to get services and what is/isn't available to them
CMS-2023-0113-0151	CMS-2023-0113	lle-8z17-r2b2	2023-08-22T04:00Z							Lowering payments to Home Health agencies would be very detrimental to health outcomes of patients. The people that work in this industry are already underpaid for the services that they provide. For several years I worked for a Center for Independent Living where I moved people out of nursing homes back to their own homes within the community. Without the support of these agencies these moves would not be possible. The problem within the industry is a high turnover rate and lack of people willing to work for the low wages to do this demanding job. If the goal is to save money than more money should be given to the agencies so they can retain quality workers. It costs far more to care for someone in a nursing home that it does to meet their needs at home. It is also a matter of dignity for someone to be in charge of their own life while living at home.

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CMS-2023-0113-0404	CMS-2023-0113	llo-c4xy-pxzm	2023-09-11T04:00Z					Health Care Provider/Association - Home Health Facility		Access to home health services is getting progressively more difficult to provide. The current payment model is flawed as it does not include the documentation time, travel time, mileage, administrative costs, education, and supplies that are required to care of patients. The numbers portrayed on the home health cost reports are not correct, and it is hurting the most vulnerable patients and home health agencies that are trying to do what is right for their patients. One example of this is the decline in home health aides each year. Even if the patient really needs the aides assist, the agency has to decide to either pay for skilled services or the aide services. The patients are on home health due to having a real need for nursing or therapy, so spending the money on aide services takes away from the skilled services. There is usually not enough payment to cover skilled and non-skilled services at the same time. It puts the patients and the agencies in a very difficult situation. Further cuts to the home health benefit could mean the end of home health services as we do not want to accept a patient if we are not sure we can provide the best possible care for them. It is extremely difficult. Patients are usually discharged from the hospital's much sooner that they use to be due to hospital regulations. Due to this, patients that would usually be cared for in the hospital setting end up on home health services. Home health cannot be at the patients home 24/7 as the hospital setting provides. Patients that are seen in the home are much sicker and more fragile. This causes all kinds of difficulties, which include re-hospitalizations and ER visits that would not have been required if the patient received the proper care in the hospital. If a patient is severely ill, agencies worry about having enough reimbursement to cover the cost of their care and supplies. Therefore, some patients cannot find home health services willing to care for them. The health care environment is absolutely limiting access to care, and it will continue to get worse if reimbursement continues to decline. Staffing is difficult for home health agencies for many reasons. The home setting can be unpleasant due to smells, filthy environment, animals, difficult patients and/or family members, and can be seen as unsafe. Schedules are also a barrier to keeping aides employed with home health agencies. In an in-patient setting, aides can often work (3) 12 hours shifts, but home health aides usually need to work 4-5 days per week. This can be difficult more many. The coordination between Medicare and Medicaid would be very helpful in providing care to patients. When a patient is on skilled Medicare services, the aide services are included in the lump sum payment the agency receives. If a patient needs an aide 2 or 3 days a week for several weeks, the funds for the whole episode is well diminished by the aide services. Many times, the patients do not receive aide services, or the amount is decreased. When a patient has Medicaid, I think they should be able to receive their usual aide services through Medicaid. This would allow the payment to cover more skilled services so the patient receives what they need. There are many consequences of patient's not receiving the home health services they need. For one, the patients will often return to the hospital, ER or SNF, which will cost much more than a full 60 day certification that home health agencies can provide. Home health services are a bargain for Medicare and Medicaid when you compare it to in-patient facilities. Healthcare costs will increase exponentially if home health cannot care for the patients that need it. Patients will be negatively impacted physically due to falls and injuries. They will also miss out on the emotional support and knowledge that nurses, therapies, and aides can provide during their visits. Patients love their time with the home health staff as they are often the main company they have all day. The lack of home health services will also hurt the patients, agencies, and the entire country financially due to the rising healthcare costs. Something needs to be done or there will be dire consequences.

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CMS-2023-0113-0412	CMS-2023-0113	llp-6ulo-ktms	2023-09-11T04:00Z							Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1780–P, P.O. Box 8013, Baltimore, MD 21244–8013. Re: CMS–1780–P; RIN 0938–AV03 Thank you for the opportunity to provide comment on the proposed rules within “Medicare Program; Calendar Year (CY)2024 Home Health (HH) Prospective Payment System Rate Update” 88 Fed. Reg. 43654 (July 10, 2023). Benton County Health Department provides home health services in a Rural County in Missouri. Specifically, we also have majority seniors and persons on limited income. We also do not have a hospital available in our County and a minimum of 30 miles to reach a Rural Hospital which causes transportation issues.. We have been a Medicare participating home health agency since the 1980’s. Being rural has presented may disparities in our community. The economy plus the funding cuts we have received and managed care insurance companies not paying even Medicaid rates has been devastating. We are very concerned about the likely impact of the proposed payment rate cuts on our ability to continue to serve individuals in our community that need home health services. As such, we hope the following information will be useful as CMS takes steps to finalize the 2024 Medicare home health services payment rates. We understand that CMS has the authority to determine the time and manner of applying any rate adjustments under the payment model, PDGM. We respectfully ask that CMS withhold the imposition of any of the proposed rate cuts in 2024 as doing so will further reduce care access in our community beyond the already reduced access. Since 2019, we have experienced a significant reduction in our ability to serve home health patients. The proposed rate cuts will only increase the likelihood that home health services access in our community will further diminish. We have experienced unprecedented cost increases particularly in staff wages and benefits without a corresponding payment rate increase. I do not anticipate any other agency to be able to afford to provide services in our county. As a result, we have instituted already the reduction of our service area, restrictions on patient admissions, the elimination of important community programs, and barriers to our participation in innovative programs that include taking on a shared financial risk with payers and the adoption of new technologies that require significant financial investment overreaching what our county taxes provide. The end result has been and will continue to be that patients who can be cared for at home with high quality and cost effective care will end up with costly extended stays in hospitals and nursing homes. As I stated before we do not have any hospitals and our nursing homes are often full. Our services are very valuable to the patients we serve. The reduction and loss in care access has extended hospital stays, pushed patients to institutional care, and left individuals without care. That also has negative consequences for Medicare, we ask that you not institute the proposed rate cuts and work with us to solve the problems in access that are only increasing. Thank you for your attention as it is vital. Katherine Poppen Occupational Therapist
CMS-2023-0113-0468	CMS-2023-0113	llq-s4ev-tiho	2023-09-12T04:00Z					Health Care Professional/Association - Other Health Care Professional		I support the endorsement of the US Medical Compression Alliance in regards to changes we want to see in the proposed bill.
CMS-2023-0113-0552	CMS-2023-0113	llu-zwy2-t7qx	2023-09-14T04:00Z					Health Care Professional/Association - Nurse		Home Health is a critical part of community health nursing and patients ability to have care outside of outpatient clinics. If you continue to deduct money from agencies you are going to bankrupt home health agencies depriving patients from much needed services that allow them to have care in their home that does not require them to be re-hospitalized. Home health would should be one of the highest paid disciplines as they are the ones preventing patients from returning to the hospital which decrease Medicare cost.