Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

August 27, 2021

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

Re: **CMS-1747-P: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements**

Dear Administrator Brooks-LaSure,

The Partnership for Quality Home Healthcare ("PQHH" or the "Partnership") appreciates the opportunity to submit comments on the CY 2022 Home Health Prospective Payment System (HH PPS) Proposed Rule published at 86 *Federal Register* 35874 on July 7, 2021 (the "Proposed Rule").[1] We submit the following comments to offer constructive feedback and recommendations that we believe will help avoid disruptions in patient care so that Medicare beneficiaries will continue to have access to skilled home health services. In addition, we offer comments regarding the impact that COVID-19 had in 2020, and continues to have, on patient care in the home.

As a national coalition of skilled home healthcare providers, we appreciate the fact that the Centers for Medicare & Medicaid Services (CMS) has consistently recognized the value and quality that the Medicare home health benefit provides to patients, as well as the value it creates for the Medicare program as a lower-cost setting for patients to receive high quality skilled care.

We are commenting on several important provisions in this Proposed Rule, including continued concerns relating to CMS' implementation of the Patient Driven Groupings Model (PDGM) as well as concerns that the annual payment rate update does not reflect rising costs, including labor costs. We urge CMS to review and incorporate these important considerations before finalizing the rule and in considering future rulemaking.

The Partnership commends CMS' proposal to expand the Home Health Value-Based Purchasing (HHVBP) Model and offers recommendations based on experience with the original model. We are also responding to CMS' request for input regarding improvement to quality reporting and opportunities to advance health equity.

[1] 86 Fed. Reg. 35874 (July 7, 2021), *available at* https://www.govinfo.gov/content/pkg/FR-2021-07-07/pdf/2021-13763.pdf.

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Attachments

I. Home Health Prospective Payment System

a. Overview

The Partnership believes that Medicare payments should be accurate, predictable, and support access to high quality home healthcare. We are concerned that certain payment proposals and policies outlined in the CY 2022 home health PPS proposed rule work against that goal by applying unwarranted payment reductions. In the interest of ensuring a viable home health benefit for Medicare beneficiaries, we urge CMS not to finalize these proposals.

In CY 2019, CMS implemented PDGM, which shifts the focus of payments away from the volume of services provided toward patients' clinical characteristics. The new payment system requires that Medicare expenditures for home health be budget neutral, taking into account updated rates and growth in anticipated utilization. In the CY 2022 home health PPS proposed rule, CMS proposes to (1) maintain its -4.36 behavioral adjustment in the CY 2022 rates; (2) establish a methodology aimed at ensuring budget neutrality that is projected to produce a further rate reduction; and (3) recalibrate the case mix weights using 2020 data that may be unreliable.

In each case, these policies would result in payment reductions for home health providers in CY 2022 and potentially in future years and are based on flawed assumptions, data, and methodologies. In addition, they are contraindicated by the data and inconsistent with the approach taken by CMS for other Medicare payment systems. More importantly, these policies result in financial harm for providers and undercut patient care and quality at a time when in-home care is an essential option for many patients and the costs of providing that care are increasing faster than Medicare's payments.

According to our analysis, Medicare payments are already 5.76 percent lower than they should be based on the budget neutrality requirement. In the absence of any corrective action, we estimate that CMS' -4.36 behavioral adjustments alone could lead to a reduction of approximately $2.43 billion in payments to home health providers between CY 2020 and CY 2022. Given the cost pressures and the importance of maintaining a viable home health benefit for Medicare beneficiaries, now is not the time to implement further payment reductions. The Partnership urges CMS to rescind the -4.36 behavioral adjustment for CY 2022, accept our recommendations for a more accurate assessment of budget neutrality in the PPS for future years, and follow CMS' approach in other payment systems where case mix weights are not being recalibrated using 2020 Data.

We have included detailed analysis and findings on these issues for CMS' consideration below and in the attached report from Dobson|DaVanzo & Associates in support of our recommendations on these critical issues. We also include other comments and recommendations related to the payment system.

b. Annual Payment Rate Update for CY 2022 / Increases to Staffing and other Costs of Care

The Partnership supports the application of the annual update to the home health payment rates for CY 2022. However, we are concerned that annual increases to the home health payment rates have not kept pace with recent increases in the cost of labor and other resources necessary to deliver care. The significant increase in such costs adds to financial pressure on providers already facing numerous challenges and impacts access to care for patients.

The law[2] requires that the home health prospective payment rates be increased annually by an update factor equal to the applicable home health market basket update adjusted by changes in economy-wide productivity. The law also defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) estimated for the 10-year period ending with the year the Medicare annual rate update applies.

The CY 2022 proposed rule provides for an overall increase to home health payments of 1.7 percent, or an addition $310 million for CY 2022 compared to CY 2021 expenditures. This increase reflects the effects of the 1.8 percent home health payment update factor which is based on a market basket increase of 2.4 percent minus a .6 percent productivity adjustment. There is also an estimated 0.1 percent decrease in aggregate payments due to the phase out of the rural add-on policy mandated by the Bipartisan Budget Act of 2018.

We are concerned that the market basket and annual update factors in recent years do not align with recent increases in home health providers' staffing and other costs. Specifically, our analysis of recent price growth for staffing shows that the home health market basket may not be reflective of actual price trends experienced by providers.

The COVID-19 pandemic has impacted the supply of and demand for certain inputs, including health care labor, leading to a general increase in labor prices. However, the CMS home health market basket update factor has recently declined from 3.0 in CY 2019 to 2.4 in CY 2022. This is likely because the market basket price indices do not reflect the pandemic-driven inflation. This may be in large part because the market basket composite index is determined on a four-quarter rolling average basis and reflects general cost changes within the healthcare industry. It therefore fails to account for home health specific price changes on a real-time and industry specific basis. More detailed analysis of the market basket is included in the attached report from Dobson|DaVanzo & Associates.

Like other sectors of the health system, home health providers have experienced significantly higher labor and other costs over the past several years. These include higher salaries and wages, but also increased costs in hiring, retention, fringe benefits and other staffing related areas. The cost of services and supplies necessary to provide care has also increased (e.g., technology to provide remote care, personal protective equipment, administrative services). To better understand the nature and magnitude of these cost trends, the Partnership commissioned Dobson|DaVanzo & Associates to survey its members regarding staffing and other costs incurred in delivering care. The survey provides more real-time data from Partnership member companies about the increase in expenses from 2019 through 2021. As detailed in the report, responses were

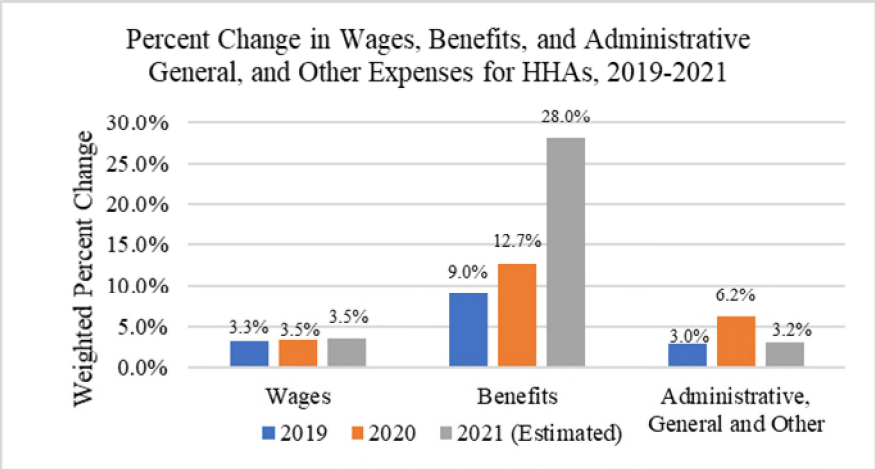
[2] Section 1895(b)(3)(B) of the Social Security Act.

weighted by market share and percent of patient population in rural and urban areas to derive the aggregate percent increases by cost category for each year.

These data show that home health labor (wages and benefits) costs, as well as costs associated with administrative, general, and other services, increased at a higher rate in 2020 than they did in 2019. HHA wages increased at a rate that was 0.2 percentage points higher in 2020 compared to 2019, benefits costs increased at a rate that was 3.7 percentage points higher in 2020 compared to 2019, while administrative, general, and other costs increased at a rate that was 3.2 percentage points higher in 2020 compared to 2021.

Although benefits costs are anticipated to increase at a higher rate in 2021 than in 2020, costs for wages and administrative, general, and other areas are anticipated to grow at the same rate or at a slower rate in 2021. Specifically, HHA wages are anticipated to grow at the same rate in 2021 as they did in 2020, benefits costs are expected to grow at a rate that is 15.3 percentage points higher in 2021 than in 2020, while administrative, general, and other costs are expected to grow at a rate that is 3.0 percentage points lower in 2021 than in 2020. These results are shown in Figure 1 below.

Figure 1: Percent Change in Wages, Benefits, and Administrative and General Expenses for HHAs reported in the 2021 PQHH HH Labor Market Survey



Source: Dobson|DaVanzo Analysis of CY 2021 PQHH Labor Cost Survey Data

The data and analysis show that wages, benefits, and other costs of care increased significantly between 2019 and 2021, yet these increases aren't adequately accounted for in current market basket updates. As noted above, the home health market basket update factors actually declined during this period as actual provider costs were increasing. These results suggest that the current proxies for price inflation and methodology that CMS uses do not accurately reflect trends in the home health industry. As suggested in the attached report, this may be because they measure inflation across the broader healthcare industry.

The Partnership is very concerned that updates to the home health payment rates have not kept pace with recent price trends. We urge CMS to consider the attached report which details the survey and analyses conducted by Dobson|DaVanzo & Associates and presents additional findings and analyses not discussed above. Further, the Partnership believes that the results of this survey strongly suggest that CMS should comprehensively assess all aspects of the market basket to ensure that it reasonably forecasts annual price increases and that the proxies accurately reflect trends in the home health industry. It is critical that Medicare home health payments keep pace with evolving trends in the price of labor, goods, and services to ensure delivery of high quality care.

c. CY 2022 - Patient Driven Groupings Model/Behavioral Assumptions/Budget Neutrality

For CY 2022, CMS proposes to continue to apply the -4.36 behavioral adjustment to the home health payment rates, which was originally intended to maintain budget neutrality of the payment system. As in CYs 2020 and 2021, the rate reduction is based on specific "behavioral assumptions" made by CMS related to certain aspects of PDGM, including the case-mix component of payment. However, based on an analysis of a full 12 months of Medicare 2020 claims data, where over 9.1 million 30-day PDGM episodes were evaluated, it is clear that the two most significant of these assumptions are not accurate.

Over the past several rulemaking cycles, the Partnership has provided comments, detailed data analysis, and recommendations addressing our significant concerns regarding the behavioral adjustments that CMS has applied in establishing payments under the payment system. We continue to have concerns about CMS' behavioral assumptions, and we question the need for continued application of rate reductions based on these assumptions when actual data from the implementation of the PDGM demonstrates that they are not accurate or necessary to ensure budget neutral payments, particularly at a time when home health providers continue to face challenges associated with the COVID-19 pandemic, higher labor costs, and other challenges in providing high quality care to their patients.

In establishing new payment rates under the home health PPS for CY 2020, CMS made three behavioral assumptions in predicting how home health providers would respond to the new PDGM framework. In our comments to last year's CY 2021 proposed home health PPS rule, we presented analysis and findings from the first half of 2020 that cast significant doubt regarding the accuracy of these behavioral assumptions and thus the need for the associated rate reductions to achieve budget neutrality.

In the final CY 2021 rule[3], CMS stated that it would continue to monitor patient outcomes and Medicare expenditures but believed it would be premature to release any information related to the behavioral assumptions based on the amount of data currently available and in light of the COVID–19 public health emergency (PHE). CMS further indicated that it planned to determine whether any changes need to be made to the national, standardized 30-day period payment rate

[3] 85 Fed. Reg. 70298 (Nov. 4, 2020).

based on the analysis of the actual versus assumed behavior change and address this in future rulemaking.

Given home health providers' significant concerns with this negative adjustment, the Partnership commissioned Dobson|DaVanzo & Associates to examine 2020 Medicare claims data for the full 12 months of 2020. The analysis and findings from this analysis, like the analysis submitted with our comments to the CY 2021 rule, continue to demonstrate that these behavioral adjustments do not comport with actual provider behavior under PDGM and are therefore inaccurate, as discussed in detail below and in the attached report.

The Partnership believes that these empirical findings provide ample justification for CMS to discard its theoretical prediction of behavior and remove the -4.36 percent behavioral adjustment for CY 2022. CMS may have questions concerning the data in light of the COVID-19 pandemic and public health emergency, as it indicated in the CY 2021 final rule. However, more than 18 months after PDGM was implemented, and with a year or more of data from the new system available to inform policy direction, it is not reasonable to maintain speculative reductions in the payment rate that were conceived in 2018. Providers' actual experience in 2020 defied all predictions and cannot be ignored.

i. CMS' Application of Behavioral Assumptions is Not Justified

The CY 2022 proposed rule outlines various statutory requirements with respect to establishment of home health payments under the PPS.[4] The statute requires the Secretary to calculate a standard prospective payment amount (or amounts) for the 12-month period beginning January 1, 2020, in a budget neutral manner. The statute also requires that, in calculating these amounts, the Secretary must make assumptions about behavior changes that could occur as a result of the 30-day unit of payment and case-mix adjustment factors associated with the new payment system.[5] Finally, the Secretary must annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures under the HH PPS with respect to years beginning with 2020 and ending with 2026.[6]

In the CY 2020 final rule, CMS identified three behavioral assumptions that could occur as a result of the implementation of PDGM: (1) clinical group coding – home health providers will change their documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code; (2) comorbidity coding – home health providers will further adjust payments based on patients' secondary diagnoses; and (3) low-utilization payment adjustment ("LUPA") threshold – home health providers will provide additional visits in order to meet the LUPA threshold and obtain a full episode payment. Applying these behavioral assumptions, CMS proposed a behavioral adjustment of -8.01 percent for CY 2020 payments. However, in the final rule for CY 2020, CMS applied a lower adjustment of -4.36 percent. This negative adjustment was maintained in CY 2021 under the final rule for that year and is proposed for CY 2022.

[4] Section 1895(b)(3)(A) of the Social Security Act.
[5] Section 1895(b)(4)(B) of the Social Security Act.
[6] Section 1895(b)(3)(D)(i) of the Social Security Act.

On clinical group coding, CMS had previously asserted in the CY 2020 proposed rule that home health providers would likely change their documentation and coding practices in 100 percent of the cases where opportunities are present and indicate the highest paying diagnosis code as the principal diagnosis code on the claim in order to have a 30-day period be placed into a higher-paying clinical group.[7] CMS assumed that when there are available secondary diagnoses that would produce a higher reimbursement if placed in the primary diagnosis field under the PDGM, home health providers would choose the higher-paying code 100 percent of the time—an assumption we strongly disagreed with and have commented on previously. As the Partnership has noted in past comments, CMS still has not provided any evidence nor the actuarial data to support this coding behavior in the context of PDGM, and has said that in some instances, it is appropriate to bill the secondary coding as primary. In addition, this practice runs counter to clinical coding guidelines and common practice of coding, which are to ensure that the documentation contained in the patient's record supports the coding. While not transparent, CMS appears to have somewhat modified this assumption in the CY 2020 final rule;[8] however, it continues to have a significant and unjustified downward impact on payments as the largest component of the -4.36 behavioral adjustment.

On the behavioral assumption related to LUPAs, CMS assumes that in one-third of instances when a case is one or two visits away from the LUPA threshold, home health providers will provide an additional extra visit(s) solely in order to receive a full 30-day episode payment. CMS has not provided support for this assumption with any solid data or evidence. LUPAs are not a new feature of the payment system under PDGM. Prior to CY 2020, the home health PPS had a single LUPA threshold for all cases. However, under the PDGM, the LUPA threshold ranges from 2–6 visits depending on the case-mix group assignment for a particular period of care, and the LUPA thresholds correspond to the 432 case-mix groups under the PDGM. It remains unclear why CMS still believes provider behavior with respect to LUPAs should be so different under PDGM, particularly after examining providers' actual experience in 2020 under the new model.

It also appears from the 2020 data for both acute care hospital and home health claims that the third area (comorbidity coding), while more consistent with CMS' assumptions, does not relate to coding behavior but rather higher actual patient case-mix and acuity during 2020, a period when many patients delayed or avoided elective surgeries (and subsequent home health episodes for these typically lower-acuity patients did not occur). Our comments below and the attached report explore this further.

As explained above, CMS' behavioral adjustments are based on "assumed" provider behavior under PDGM without any empirical or actuarial information to support them. Now that twelve months of actual data exists for CY 2020 under PDGM, those assumptions must be evaluated against that data. We note that, while our comments outline concerns with CMS' use of the 2020 data to effectuate changes in other areas of the payment system, we believe that, given the current behavioral adjustments are based on no data at all and the results of the Partnership's analysis are so unambiguous with respect to their lack of accuracy in two cases, it is appropriate

[7] 84 Fed. Reg. 34598 at 34614 (July 18, 2019).
[8] 84 Fed. Reg. 60478 (Nov. 8, 2019).

to rely on that data here. The attached analysis conducted by Dobson|DaVanzo provides critical information on the operation of PDGM and calls into question key assumptions made by CMS.

ii. Analysis of Behavioral Assumptions under PDGM

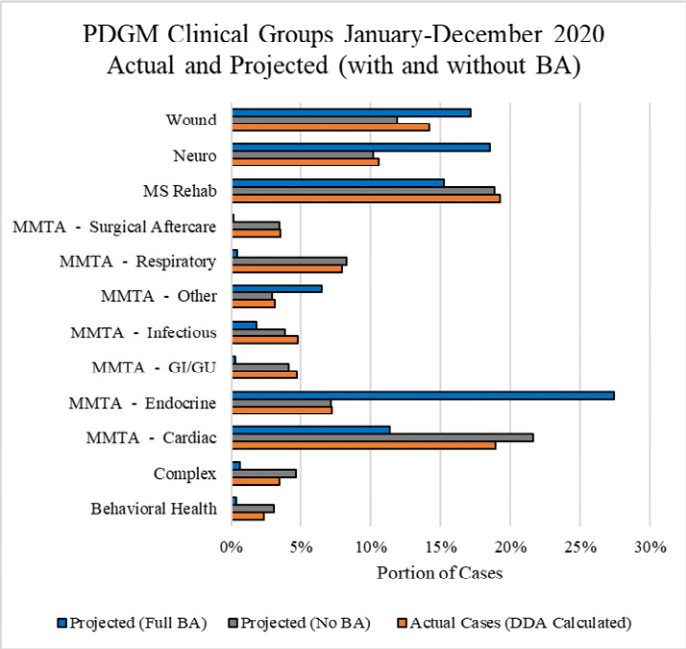
In order to understand whether the behavioral assumptions made by CMS were substantiated by CY 2020 data, Dobson|DaVanzo compared outputs from CY 2020 claims and the rate setting files issued by CMS with the CY 2020 HH PPS final rule. The CY 2020 data presented in this analysis cover January 1 through December 31 of 2020. The data comprise over 9.1 million 30-day PDGM eposides and thus represents the universe of claims for that year subject to any additional claims run-out occurring later in 2021. The CMS rulemaking files used 2018 claims and OASIS data and included both unadjusted and 'behaviorally adjusted' estimates for case-mix groups, payments, and LUPAs.

Based on our analysis of the full year of CY 2020 Medicare claims data, home health providers' actual behaviors are inconsistent with two of the three behavioral assumptions described by CMS in the CY 2020 HH PPS final rule.[9] These were used by CMS as the justification for the prospective reductions to home health payments to ensure budget neutrality in CYs 2020, 2021, and as proposed for CY 2022. These two assumptions, related to clinical group coding and LUPAs, provide the basis for most of the of the -4.36 percent reduction applied by CMS in the rates and are not accurate. Based on the analysis of CY 2020 data, it also appears that the third area (comorbidity coding), while more consistent with CMS' assumptions, does not relate to coding behavior but rather actual patient case-mix and acuity, as noted above. Highlights of this analysis are summarized below, and, as noted above, a complete report detailing the analysis from Dobson|DaVanzo & Associates is attached to our comment letter.

As shown in Figure 2 below, case-mix groupings reflect historical trends of primary diagnoses from prior to the implementation of PDGM and not payment-optimized groupings as CMS had assumed in making downward adjustments to home health payments. This behavioral assumption resulted in the largest portion of the base reduction applied to home health payments by far.

[9] *Id.* at 60512.

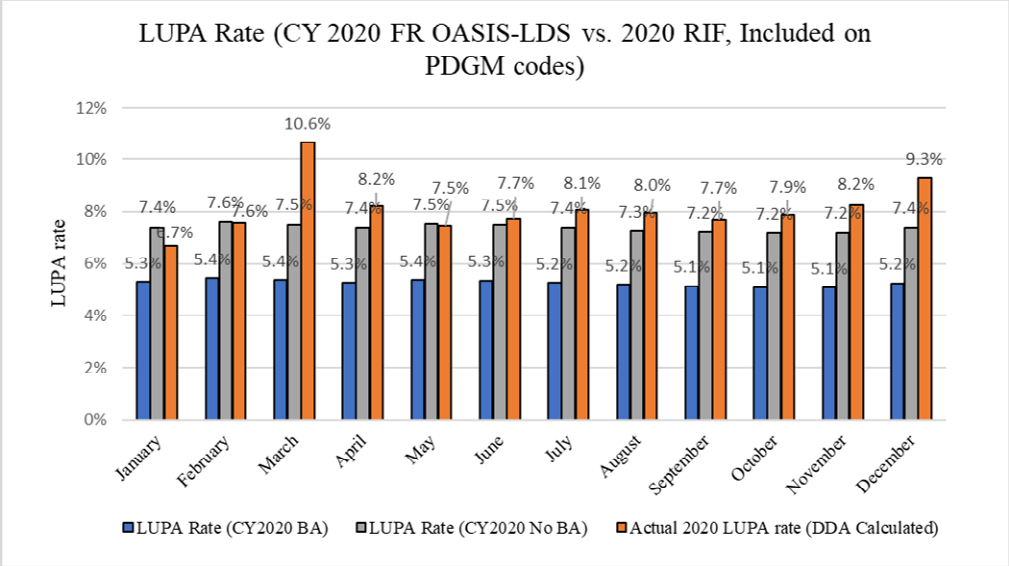
Figure 2: Observed Clinical Groups January-December 2020 Compared to Projected Clinical Groups (with and without Behavioral Adjustments)



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

In addition, as shown in Figure 3 below, between January and December 2020, analysis of the data shows an 8.17 percent LUPA rate compared to CMS' predicted 5.3 percent level (with behavioral assumptions) or 7.5 percent (historical trend without behavioral assumptions). In addition, it is important to note that LUPA rates were higher than CMS projected in January and February of 2020 after the implementation of PDGM and prior to the widespread effects of COVID-19 on the health system. This assumption represented the second most significant reduction to HH payments.

Figure 3: Actual CY 2020 LUPA Rate vs. Projected LUPA Rate (with and without Behavioral Assumptions)

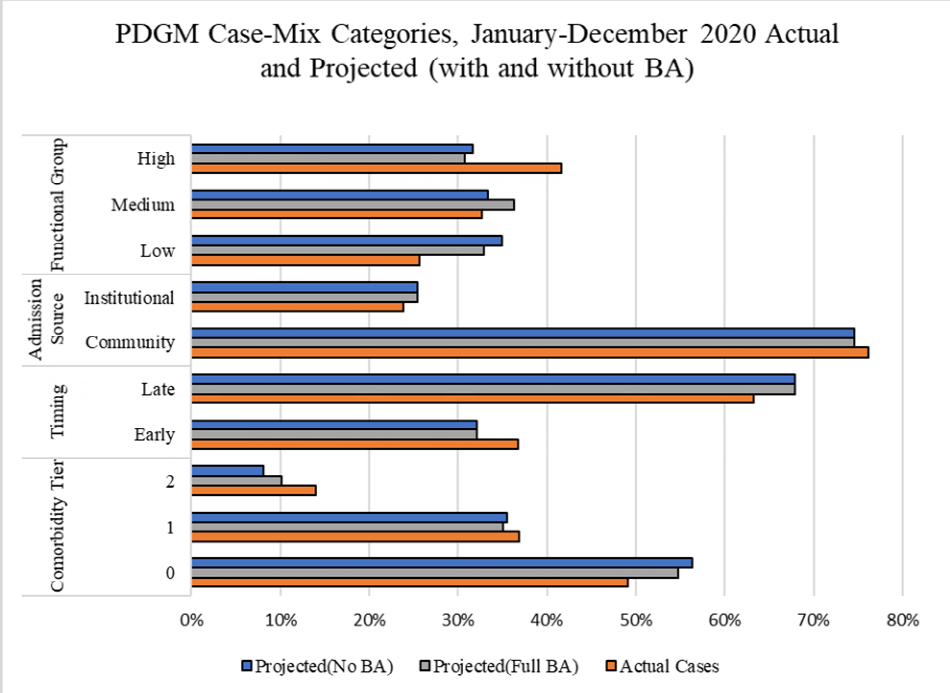


Source: Dobson|DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

While by far the smallest of the three behavioral adjustments in terms of effect on HH payments, comorbidity and functional group scores are somewhat higher than anticipated, as shown in Figure 4 below. This may, in part, relate to CMS assumptions regarding improved coding under PDGM, but the apparent increase in case-mix severity shown in the data could also relate to the overall reduction in volume of home health services that accompanied the onset of the COVID-19 pandemic and such trends as the increasing substitution of home health for skilled nursing facility care. It is also likely that some beneficiaries were unable to have elective surgeries or simply decided not to receive care in the home in order to self-isolate and thus did not receive home health care, however, more severe cases could not avoid such care.

An analysis of short-term acute care hospital discharges to home health for 2020 shows a similar increase in severity and DRG weight compared to past years, a finding that supports this view of higher acuity in home health in 2020. This analysis is detailed in the attached report from Dobson|DaVanzo and strongly suggests that the increase in comorbidity and functional scores does not relate solely to provider coding behavior but rather real increases in acuity. The analysis in Figure 4 below shows the proportion of cases by functional score and comorbidity tier. As noted above, the increases in scores may reflect the relative increase in case-mix severity due the ongoing coronavirus pandemic and increasing substitution of home health for SNF care.

Figure 4: PDGM Case-Mix Categories January-December 2020, Actual and Projected (with and without BA)



Source: Dobson|DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

While CMS has not applied behavioral assumptions based on other areas of PDGM, CMS details its analysis of several in the preamble discussion of monitoring PDGM in 2020. We note that while functional status and comorbidity level are potentially sensitive to coding, admission source and episode timing are not, as these aspects of case-mix are obtained from the home health claim rather than agency reporting. These changes likely represent changing referral patterns related to COVID-19 or post-acute care generally or other operational and care practice changes by post-acute providers as they adopt to various policy and payment changes by Medicare in this area of the program.

iii. Impact of Continued Behavioral Adjustment Cuts on Providers and Patients

The proposed -4.36 behavioral adjustment to HH payments for CY 2022 is not justified. Two of the three behavioral assumptions made by CMS are contraindicated by the data from 2020, and the third appears related to real changes in acuity and not provider behavior. We recognize that, regardless of the validity of the specific assumptions CMS made, CMS nonetheless has an obligation to assess the effects of actual behavior changes on estimated aggregate expenditures (as discussed below), now that full CY 2020 data is available.[10] Even if CMS has concerns about the

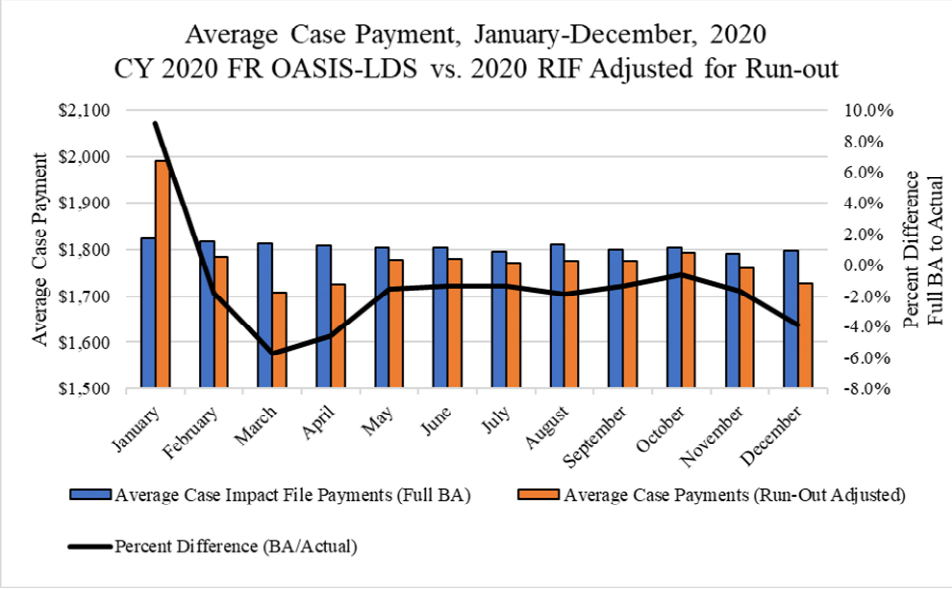
[10] Section 1895(b)(3)(D)(i) of the Social Security Act.

2020 data in assessing its assumptions, the actual experience of 2020 should still be the basis for analyzing overall budget neutrality. Our analysis of the actual 2020 data indicate that CMS is not justified in carrying forward the -4.36 behavioral adjustment, not only because the assumptions themselves were not realized, but also because actual average case payments were below budget neutrality.

	Actual CY 2020 Payments	CMS projected Payments (BA)
Average Payments	$1,780.71	$1,805.41

Analysis conducted by Dobson|DaVanzo & Associates shows that actual average case payments for CY 2020 are 1.4 percent below what CMS projected in its CY 2020 final rule on PDGM based on CMS' CY 2018 impact data file released with that rule (See Figure 5 below). Accordingly, payments in CY 2020 were approximately 5.76 percent below the non-behaviorally adjusted payment rates where the assumptions used to justify 4.36 percent of that reduction on the basis of providers' behavioral response to PDGM are clearly not accurate. Finally, as explained later in this comment letter, CMS' methodology and related assertion that CY 2020 payments are 6 percent higher than they should be are faulty.

Figure 5: Actual CY 2020 Claims Average Case Payments vs. Projected Case Payments with Behavioral Adjustments



Source: Dobson|DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

Home health providers continue to face enormous challenges in delivering care to patients as the significant financial and clinical impact of the COVID-19 pandemic continues to affect the nation

and health system. In addition, as detailed above and in the attached survey by the Partnership, staffing and other costs related to delivering home health care have increased substantially, creating new financial pressure on providers. These effects threaten both delivery of care in the short term, particularly in rural and inner-city areas, and the long-term sustainability of the home health benefit.

The Partnership and all home health providers and associated state and national organizations know that this reduction will continue to cause harm to Medicare beneficiaries and promote instability in the home health delivery system. Most importantly, these behavioral assumptions and associated reductions in payment deprive providers of the resources needed to furnish high quality care and serve to limit the provision of home health care at a time when patients have a critical need for in-home services and the Medicare program should be supporting expanded use.

iv. Summary and Recommendation on Behavioral Adjustments

The Partnership continues to be concerned that CMS has failed to provide any data or evidence to support these behavioral assumptions and has chosen not to consider the available data for the entire 2020 calendar year in proposing to continue related cuts for 2022. As demonstrated above and in the attached report, CMS' assumptions were not accurate. CMS has indicated in past rulemakings, including last year's CY 2021 final rule, that it "planned to determine whether any changes need to be made to the national, standardized 30-day period payment rate based on the analysis of the actual versus assumed behavior change and address this in future rulemaking". However, the agency has failed to do so both in the CY 2021 final rule and in the CY 2022 Proposed Rule, choosing instead to rely on theoretical assumptions about provider behavior that are clearly refuted by actual data.

In the Proposed Rule, CMS has offered no real explanation for not evaluating the data and setting aside these assumptions. CMS provides a detailed accounting of its monitoring efforts related to the CY 2020 data, yet fails to address the specific issues with the assumptions it originally used to justify the -4.36 percent adjustment. The Agency may continue to have unspecified concerns – as it stated in the CY 2021 final rule, "in light of the current public health emergency resulting from the COVID–19 pandemic" – or may be seeking to rely on its yet-to-be codified methodology and analysis of budget neutrality and behavioral effects (for which it is soliciting comments) that asserts that home health payments are 6 percent higher than they should be. As discussed later in this comment letter, the Partnership believes that methodology to be flawed.

CMS has an obligation to examine the data it has available and authority to eliminate the behavioral adjustments for CY 2022, even if it is not prepared to justify new adjustments. The current 4.36 percent reduction harms providers, adversely impacts patient care, and does not support a budget neutral implementation of PDGM based on our analysis of CY 2020 data. While the Partnership acknowledges CMS' responsibility under the law to evaluate budget neutrality, the law does not require continuing to apply a 4.36 percent reduction that is based on theoretical assumptions when data exists that refutes them.

The Partnership encourages CMS to remove the -4.36 percent adjustment to the payment rates for CY 2022. Nothing in law or regulation prevents CMS from setting aside speculative adjustments conceived in 2018 that are no longer supportable based on the available data. In addition, CMS' authority to make and adjust for assumptions about provider behavior does not include using this mechanism to generate program savings, which appears to be the effect of the proposed rule.

Partnership Recommendation: Based on the data and analysis discussed above and more fully in the attached report, the Partnership recommends that CMS establish CY 2022 payment rates in the final rule that do not include the -4.36 percent behavioral adjustment.

d. Comment Solicitation on the Annual Determination of the Impact of Differences Between Assumed and Actual Behavior Changes on Estimated Aggregate Expenditures

In the CY 2022 proposed rule, CMS solicits comments on a potential methodology for annually determining the difference between assumed for versus actual behavior and its impact on aggregate expenditures. The results of this determination would be used by CMS to propose adjustments to the home health payment rates in a given year. The Partnership appreciates that CMS has provided stakeholders with the opportunity to provide input in the development of this process. We also appreciate the agency's acknowledgement in the proposed rule that there may be alternative approaches to analyze the data to determine budget neutrality and the difference between assumed versus actual behavior change on estimated aggregate expenditures.

We have examined the methodology carefully and find significant flaws with the approach CMS has outlined in the proposed rule. Our concerns relate to a number of critical methodological issues with how CMS combines the CY 2020 30-day periods under PDGM to simulate 60-day periods under the former 153 group payment model, elimination of data from the analysis, and the impact of the COVID-19 pandemic and incentives inherent with the transition to PDGM on care delivery, including visit volumes. These flaws result in an apples-to-oranges comparison of aggregate expenditures under each model and significant estimation error and bias in CMS' results. We also find that, even at the conceptual level, CMS' approach is not one that is aimed at assessing behavior, as the rule states. These concerns are discussed below and further detailed in the attached report prepared by Dobson|DaVanzo & Associates. We also include discussion of an alternate approach that more accurately addresses CMS' intended purpose.

i. Budget Neutrality in the Home Health PPS

The law[11] requires CMS to annually determine the impact of the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures beginning with 2020 and ending with 2026. The statute provides no further detail on the process for how this should be done. However, in the CY 2020 final rule[12], CMS stated that the agency interprets actual behavior changes to encompass both behavior changes that were previously outlined, as

[11] Section 1895(b)(3)(D)(i) of the Social Security Act
[12] 84 Fed. Reg. 60478 at 60513 (Nov. 8, 2019), *available at* https://www.federalregister.gov/d/2019-24026/p-222.

assumed by CMS, and other behavior changes not identified at the time that the budget neutral 30-day payment for CY 2020 was determined. The law[13] also requires the Secretary to, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide for one or more permanent or temporary increases or decreases to the standard prospective payment amount (or amounts) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures.

Using CY 2020 data, CMS indicates that it analyzed the impact of the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures to determine whether a temporary and/or a permanent increase or decrease is needed to the national, standardized 30-day period payment in CY 2022. CMS' approach was to analyze the data to determine if the CY 2020 30-day payment amount resulted in the same estimated aggregate expenditures that would have been paid if the PDGM and change in the unit of payment had not been implemented.

To evaluate whether the 30-day budget neutral payment amount for CY 2020 maintained budget neutrality given the change to a 30-day unit of payment and the implementation of a new case-mix adjustment methodology (PDGM) was accurate, CMS used actual CY 2020 30-day period claims data to simulate 60-day episodes and estimated what CY 2020 payments would have been under the 153-group case-mix system and 60-day unit of payment. CMS describes its methodology for simulating payments under the 153-group case-mix system and 60-day periods in detail in the proposed rule.

As discussed in the CY 2022 proposed rule, CMS indicated that, based on its analysis, aggregate payments to home health providers were higher in CY 2020 under PDGM and the 30-day unit of payment compared to what they would have been paid had PDGM and the 30-day unit of payment not been implemented. CMS calculated a percent change between the average payment amounts and determined that the CY 2020 30-day base payment rate was approximately 6 percent higher than it should have been relative to budget neutral payments (we assume CMS means compared to the current behaviorally adjusted payment rate).

The Partnership believes that this methodology is fundamentally flawed. The premise that claims billed under one case-mix system, with different incentives, coding and billing rules, and unit of payment can be retrofitted to another accurately and without a high level of estimation error is not reasonable. CMS clearly recognized this challenge in the Skilled Nursing Facility (SNF) PPS Final Rule, where it used 2019 data to address similar issues to avoid what the agency termed an "overcorrection" and ensure a "more accurate calculation."[14] We address specific areas of concern below and in the attached report from Dobson|DaVanzo & Associates.

ii. Specific Concerns with CMS' Methodology

Congress specified that the standard prospective amount for the new payment system (PDGM) had to be calculated in a manner such that the estimated aggregate expenditures under the new

[13] Section 1895(b)(3)(D)(ii)-(iii) of the Social Security Act.
[14] 86 Fed. Reg. 42424 at 42468 (Aug. 4, 2021).

30-day unit of payment system would be equal to the estimated aggregate expenditures that otherwise would have been made under the HH PPS during CY 2020 "in the absence of the change to a 30-day unit of payment".[15] Given that the 2020 data very much reflects billing, coding, and care delivery under PDGM and a 30 day unit of payment, it can hardly be used for a baseline comparison to an earlier year, prior to the implementation of these changes. In addition, specific aspects of PDGM and the 2020 data result in bias in the results using CMS' approach. We outline these concerns further below and in the attached report.

1. CY 2020 Shifts in Therapy Utilization

There are major differences between PDGM and the home health payment system in effect before 2020. One key area is that payments under the 60-day system were driven by therapy utilization. As a result, any shifts in therapy utilization in the CY 2020 data will have a significant impact on case-mix and aggregate payments repriced under the 60-day system, thereby undermining attempts to determine what CY 2020 payments would have been under the 60-day payment system. We note that the elimination of therapy thresholds under PDGM and the impact of COVID-19 in CY 2020 significantly impacted therapy utilization in CY 2020, resulting in CMS' observed lower case-mix and lower aggregate payments under the 60-day unit of payment. We note that, according to Medicare claims data, between 2019 and 2020, therapy utilization declined by 29.7 percent. Importantly, we also note that CY 2021 data may also present the same limitations to CMS' methodology.

In the CY 2022 SNF PPS proposed rule, CMS solicits comments on a very similar methodology to determine an appropriate adjustment factor to achieve budget neutrality in the SNF PPS by comparing aggregate payments under both the current system (Patient Directed Payment Model, or PDPM) and the prior system (RUG-IV) by using claims and assessment data for a given year. In the case of SNF PPS, CMS acknowledges that the COVID-19 PHE and significant differences in both patient assessment requirements and payment incentives related to therapy utilization under RUG-IV compared to PDPM significantly impacted FY 2020 SNF utilization data in the first year of PDPM. As a result, CMS concludes that the methodology they used in the past to calculate a budget neutrality may be inappropriate and "could lead to a potentially inaccurate recalibration". It is unclear why CMS acknowledges and corrects for these methodological concerns in one 2022 payment rule (SNF PPS) yet does not do so in another (home health PPS) when addressing a very similar set of issues and magnitude related to therapy utilization.

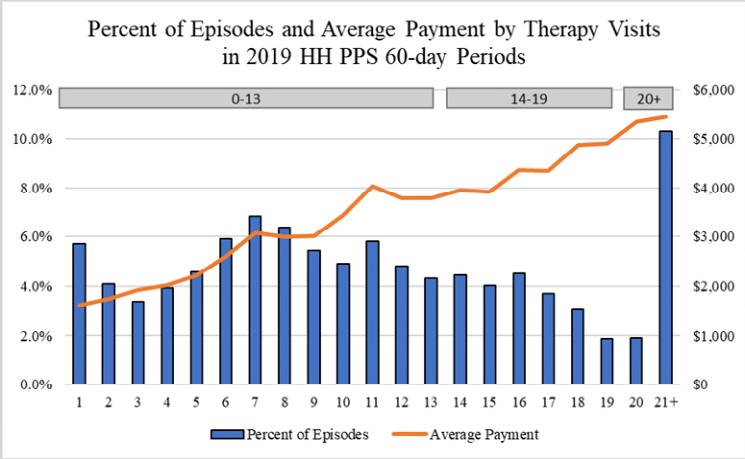
The focus of CMS' methodology outlined in the CY 2022 proposed rule is estimating the CY 2020 home health payments that would have been made in the absence of the change to a 30-day unit of service and new case-mix system (PDGM). However, similar to the SNF PPS example, PDGM resulted in significant differences in payment incentives that dramatically altered CY 2020 home health utilization and therefore CMS' ability to estimate payments under the form system accurately.

While shifting the home health PPS away from therapy utilization was a deliberate policy goal of CMS, it makes aggregate payments made under PDGM not comparable to simulated payments

[15] Section 5001(a)(2)(A) of the Bipartisan Budget Act of 2018.

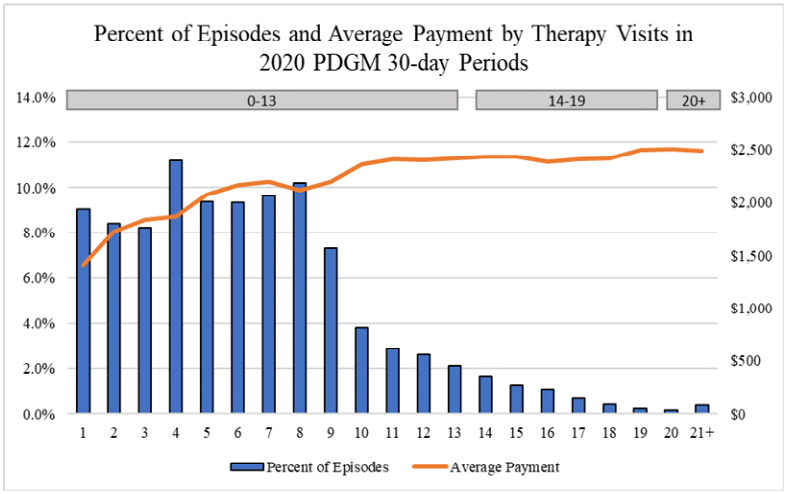
that would have been made under the 60-day system in absence of the payment system change. These are simply not the payments that would have been made**.** Figures 6 and 7 below illustrate this change as clusters around therapy thresholds that are visible in CY 2019 under the 153-group case-mix model are no longer visible in CY 2020 under PDGM.

Figure 6: Percent of Episodes and Average Payments by Therapy Visits under 2019 HH PPS 60-day Unit of Payment



Source: Dobson|DaVanzo Analysis of HH Claims in DUAs LDS 57157 and RIF 54757

Figure 7: Percent of Episodes and Average Payments by Therapy Visits under 2020 PDGM 30-day Periods



Source: Dobson|DaVanzo Analysis of HH Claims in DUAs LDS 57157 and RIF 54757

The COVID-19 PHE in 2020 also disrupted therapy and other home health services, leading to a drop in the number of visits. There were nationwide cancellations of elective or "non-essential" surgeries—the largest referral source for home health therapy. This led to a significant drop in

visits. In addition, home health patients were more likely to decline services or only accept telehealth visits, which currently are not reimbursable by Medicare and not captured in the claims data. Finally, since some states failed to designate therapists as essential workers, therapy visits could not be conducted in assisted living and other facilities as under normal circumstances, leading to further reductions in visits.

It is clear that the lower CY 2020 aggregate home health payments under the 60-day payment system relative to 30-day payments under the PDGM, as determined by CMS, are largely driven by the reduction in therapy visits in CY 2020 as payments under the 60-day payment system are largely driven by therapy utilization. This renders the CMS methodology critically flawed because the 2020 data is significantly affected by the shift to PDGM and away from therapy utilization.

The Partnership recognizes that CMS intended to remove incentives to "over-provide" therapy services and shift the focus toward a system based on patient clinical characteristics. However, the resulting changes in utilization in CY 2020 data lead to an inaccurate assessment of budget neutrality using CMS' methodology, as the payments that would have been made under the 60-day system cannot be accurately modeled using CY 2020 data or data from future years.

2. Different Case Mix Systems are Fundamentally not Comparable

In general, case-mix systems are used to categorize patients based on clinical characteristics and/or resource utilization in order to account for the complexity of cases. Case-mix systems are unique to each payment system as they are dependent on the underlying variables used to describe clinical characteristics or resource use. The 153-group case-mix model under the home health PPS prior to CY 2020 and PDGM are very different. They are each driven by different factors measuring different aspects of resource use and patient characteristics. Fundamentally, this means that a case mix of 1.0 is not the same across the two systems as they do not use the same variables or underlying regression analyses to determine resource utilization.

CMS asserts that the CY 2020 30-day base payment rate was approximately 6 percent higher than it should have been, explaining that this difference is primarily determined by the shift in case mix from 0.96 under the 60-day payment system to 1.03 under PDGM's 30-day payment system. This comparison is flawed because these two case-mix measures are not comparable. Critically, the CMS cited case-mix of 0.96 does not (nor can it given the gaps in the data) appropriately measure what the case-mix would have been without the implementation of a 30-day unit of payment under PDGM. As a result, CY 2020 30-day PDGM payments repriced under the 153 group 60-day system cannot be used to accurately determine the degree to which payments under PDGM were overpaid or deemed not to be budget neutral.

3. CMS' Methodology Results in Analytic Bias

In addition to the concerns discussed above, there are other methodological issues with how CMS combines the CY 2020 30-day PDGM claims to simulate a 60-day period under the former 153 group model that may have led to bias in the agency's case-mix and aggregate payment comparisons resulting in inaccurate conclusions. We note the following areas, which are further detailed in the attached report.

iii. Clinical Grouping Concerns

Under PDGM, roughly 40 percent of the diagnoses previously allowed for under the 60-day payment system are not accepted as primary diagnoses.[16] This systematic change likely impacted the coding behavior of providers under the new system, ultimately leading to an inaccurate simulation of the clinical domain under the 60-day payment system using CY 2020 data. In addition, for two 30-day periods with different principal diagnoses, CMS had to make assumptions on the ultimate clinical domain under the 60-day system, potentially resulting in inaccurate assignments.

1. PDGM Early/Late Designation

Under PDGM, the first 30-day period of care in a sequence is assigned early timing while the second or any other subsequent 30-day periods are assigned late timing. In contrast, under the 60-day payment system, the first two 60-day episodes in a sequence of adjacent-covered episodes were assigned early timing, while the third and any other subsequent episodes were assigned late timing.

Given the difference in timing assignments under PDGM compared to the 60-day payment system, and the shortened episodes of care under PDGM, it is likely that timing assignments from the CMS simulation using CY 2020 data overrepresent early visits in a 60-day system, possibly leading to CMS estimating lower aggregate payments under the 60-day payment system.

2. Impact of COVID-19 PHE on CY 2020 Utilization Patterns

In addition to the issues discussed earlier in this section, the COVID-19 pandemic may have also had an impact on the observed patterns of utilization. Pandemic-related CMS waivers permitting the use of telehealth during CY 2020 may have led to the appearance of a shortening of 30-day periods and decreased visits given the large volume of therapy and other services provided remotely that, while appropriate under Medicare rules, are not reflected in the claims data.

3. Excluded Cases

CMS also notes that as the agency converted CY 2020 30-day periods to 60-day episodes, they excluded 724,206 (or almost nine percent of) cases for several reasons including OASIS assessment dates occurring on or before October 31 or no OASIS data at all—potentially introducing bias.

iv. Recommended Alternative Methodology for Assessment of Budget Neutrality

Given the limitations and concerns described with the methodology outlined in the proposed rule and CMS' recognition that there may be other approaches to assess budget neutrality, the Partnership offers an alternative methodology below which we believe results in a more accurate assessment.

[16] PDGM Clinical Groups and Diagnosis Codes, *available at* http://kb.barnestorm.biz/KnowledgebaseArticle51498.aspx.

Because CMS cannot accurately use CY 2020 data to determine case-mix weights and aggregate payments under the prior 60-day payment system to determine payments that would have been made in the absence of PDGM, we propose that a more accurate and less biased approach would be to use the projected payments used by CMS to set CY 2020 payment rates based on data from CY 2018 60-day episodes converted to 30-day episodes. The use of 2018 60-day episode data converted to 30-day episodes eliminates the need to model other changes that occurred due to the implementation of PDGM and avoids the impact of the COVID-19 PHE on therapy utilization.

Following this approach, the Partnership compared actual CY 2020 30-day episode payments to projected CY 2020 30-day episode payments used by CMS to set CY 2020 payment rates (based on data from CY 2018 60-day episodes converted to 30-day episodes). This methodology is more similar to the approach used by CMS for the SNF PPS proposed rule. In addition, we examined the actual changes in provider coding behavior under PDGM in comparison to CMS projections using data from CY 2020 claims files and the CY 2020 CMS OASIS-LDS PDGM rate-setting file (containing historical projections of PDGM using 2018 data).

The methodology and conclusions are detailed in the attached report by Dobson|DaVanzo & Associates. Based on this approach, PDGM does not appear to be budget neutral at its currently implemented payment levels, indicating higher base payments may be required to achieve budget neutrality. In CY 2020, average case payments were 1.4 percent lower than predicted average payments with behavioral assumptions. (Actual payments were $1,780.71 in CY 2020 compared to $1,805.41 projected payments with behavioral adjustments). Figure 5, presented earlier in this section, shows this comparison between the 2018 rate-setting file outputs with CMS behavioral adjustments (full BA) compared to observed payments from 2020 claims.

Again, the Partnership appreciates the opportunity to provide input on the development of a process for making annual determinations of budget neutrality. Based on our review of the methodology outlined in the proposed rule, we have significant concerns that CMS' approach will result in a significantly inaccurate assessment of budget neutrality that will harm providers and have adverse consequences for patient care. We note that CMS has the discretion to consider and apply different approaches for different years. Finally, we can find no legal or programmatic reason why CMS should maintain the current 4.36 behavioral adjustment reduction in the absence of data to support it, while it considers how to establish a methodology for future annual determinations of budget neutrality.

Partnership Recommendation: We recommend that CMS adopt the Partnership's alternative approach, as outlined above and in the attached report, which provides for a more accurate methodology for annually determining budget neutrality.

iv. Recalibration of the Case Mix Weights

Under normal circumstances, the Partnership supports annual recalibration of the case-mix weights to ensure payments reflect current trends in care delivery and are as accurate as possible. However, we believe that CY 2020 was not a normal year. Our comments in Section C above have already documented a number of concerns with data from this period and how utilization and services were impacted. These are the same concerns associated with the COVID-19 pandemic

and its impact on the health system that caused CMS to not use 2020 data to update relative weights for acute care hospitals for FY 2022. We believe that this data should not be used and that CMS should forgo recalibration of the home health case-mix weights for CY 2022.

1. CMS Proposal to Recalibrate Case-Mix Weights

The PDGM case-mix methodology results in 432 unique case-mix groups each with a corresponding case mix weight. In general, CMS regulations call for annually recalibrating the PDGM case-mix weights using the most recent and complete utilization data available at the time of annual rulemaking. Annual recalibration of the PDGM case-mix weights is intended by CMS to ensure that the case-mix weights reflect, as accurately as possible, current home health resource use and changes in utilization patterns. However, since CY 2020 was the first year of PDGM, CMS did not propose to recalibrate the PDGM case-mix weights since data under PDGM was not yet available.

In the CY 2022 proposed rule, CMS used CY 2020 home health claims data with linked OASIS data to generate recalibrated CY 2022 case-mix weights. CMS notes that these data are the most current and complete data available at this time. The agency also states its belief that recalibrating the case-mix weights using data from CY 2020 would be more reflective of PDGM utilization and patient resource use than case-mix weights that were set using older pre-PDGM data from claims with 60-day episodes. CMS notes that using data from CY 2020 would begin to shift case-mix weights derived from data with 60-day episodes grouped under the old system to data from actual 30-day periods under the PDGM.

CMS estimated that total CY 2022 payments using the recalibrated case-mix weights would be 3.44 percent lower than total payments using the CY 2021 PDGM case-mix weights. Therefore, as part of recalibration of the weights, CMS also proposes to apply a case-mix budget neutrality factor in order to account for the change between the previous year's PDGM case-mix weights and the new recalibrated PDGM case-mix weights. For CY 2022, this factor is proposed as an upward adjustment to the payment rates of 1.0390 percent. While this factor is intended to ensure overall budget neutrality of the recalibrated weights, if the weights themselves are not accurately determined due to the reliability of the data, it could cause significant distortions in payment negatively impacting providers and patient access.

CY 2022 National, Standardized Payment Amount

CY 2021 National Standardized 30-Day Period Payment	Case-Mix Weights Recalibration Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update	CY 2022 National, Standardized 30-Day Period Payment
$1,901.2	1.0390	1.0013	1.018	$2,013.4

Source: CY 2022 HH PPS Proposed Rule (86 Fed. Reg. 35874)

2. Partnership Concerns with use of 2020 Data for Recalibration

CMS believes that the COVID-19 pandemic would have impacted utilization within all case-mix groups similarly. Therefore, the impact of any reduction in resource use caused by the pandemic on the calculation of the case-mix weights would be minimized since the impact would be accounted for evenly across the various case-mix groups. Given what we know about the COVID-19 pandemic and its impact on utilization and care delivery, this does not seem plausible.

This comment letter and the attached report from Dobson|DaVanzo & Associates highlight a number of trends that point to significant shifts in home health utilization occurring in 2020 as a result of the pandemic and the introduction of PDGM. These include increases in intensity and types of cases seen by home health providers, changes in referral patterns by hospitals and physicians, a general reduction in average visits, and a higher volume of patients discharged by hospitals to home health compared to SNF. CMS should therefore exercise caution as they use CY 2020 for any purposes such as rate-setting or case-mix recalibration.

While annual recalibration is an appropriate mechanism to ensure that that case-mix weights reflect recent trends in utilization and resource use under normal circumstances, it is clear that the COVID-19 pandemic has had significant effects on home health utilization and overall case-mix severity in CY 2020. Given these atypical trends, the use of CY 2020 data for rate-setting or case-mix recalibration may be inaccurate and cause distortions in payment as CY 2020 data may not be representative of utilization in CY 2022. This is especially important at the provider level where case-mix recalibration will have re-distributional effects on total payments. For example, CMS impact analyses indicate that providers in the Pacific region will experience payment reductions of 0.6 percent due to the case-mix recalibration, while providers in the Mid-Atlantic region will experience 0.8 increases in payment.[17]

CMS does not use CY 2020 data to recalibrate LUPA thresholds in the CY 2022 proposed rule indicating that "visit patterns and some of the decrease in overall visits in CY 2020 may not be representative of visit patterns in CY 2022."[18] Using the same logic, it should follow that the atypical visit patterns and decrease in overall visits in the CY 2020 data present similar limitations for case-mix recalibration. We also note that CMS acknowledges the impact of the COVID-19 PHE on CY 2020 data in the FY 2022 Inpatient Acute Hospital PPS proposed rule[19] and forgoes use of CY 2020 data in favor of 2019 data for FY 2022 rate setting, recalibration of relative weights, and numerous measurements of value-based purchasing, readmissions, and hospital acquired conditions.

Partnership Recommendation: Given the atypical trends reflected in the 2020 data, we caution CMS against the use of CY 2020 data for case-mix recalibration as this data may not be representative of utilization in CY 2022 and lead to distortions in payment. The Partnership

[17] Table 38 of Proposed Rule, 86 Fed. Reg. 35874 at 35992 (July 7, 2021).
[18] Proposed Rule, 86 Fed. Reg. 35874 at 36001.
[19] *See generally* CY 2022 IPPS Proposed Rule, 86 Fed. Reg. 25070 (May 10, 2021), *available at* https://www.govinfo.gov/content/pkg/FR-2021-07-07/pdf/2021-13763.pdf.

recommends that CMS maintain the current set of case-mix weights for CY 2022 and reevaluate more recent data in future rulemaking.

v. Wage Index Transition to New OMB Geographic Delineations

In the CY 2021 HH PPS final rule[20], CMS finalized a proposal to adopt revised Office of Management and Budget (OMB) geographic delineations. Due to concerns regarding the significant financial impact of this change on home health providers in certain areas due to steep declines in wage index values that resulted, CMS also finalized a one-year 5 percent cap on wage index decreases to mitigate the substantial financial impact of this change on home health providers that were significantly affected. The proposed rule would continue this policy and end the transition in CY 2022.

The Partnership is very concerned that the one-year transition period established in last year's rule is too short and the change to the new wage index still results in a large financial "cliff" in CY 2022 that will devastate many providers and certainly impact patient care and access. We note that providers in some areas are facing decreases of close to 20 percent in their wage index values amounting to tens of millions in losses in Medicare payments as a result of the change. In addition, these changes create a major disadvantage in hiring and retaining nurses and other clinical staff, particularly when adjacent counties have maintained significantly higher wage indexes. Providers are already facing significant challenges in hiring and retaining staff due to the COVID-19 pandemic.

Given the challenges home health providers are already facing, now is not the time to compound problems in staffing and resources needed for patient care. We urge CMS to address this concern in the final rule, as it did for inpatient acute care hospitals in the recent FY 2022 IPPS final rule.[21] In that rule, CMS noted "the unprecedented nature of the ongoing COVID–19 public health emergency (PHE)" as reason for continuing to apply a transition policy for FY 2022.[22] The Partnership notes that home health providers also face many of the same challenges that hospitals and other healthcare providers are contending with as a result of the COVID-19 pandemic. Above in this comment letter, we discuss the higher costs of staffing and other challenges in maintaining a labor force, increased costs for PPE and other supplies, higher costs due to enhanced infection control, and other challenges.

To address these concerns for hospitals, CMS considered several options for continuing to apply a transition to the FY 2022 wage index for hospitals negatively impacted by adoption of the updates to the new OMB geographic delineations. While CMS considered a hold harmless on the current (FY 2021) wage index values for hospitals benefiting from the 5 percent cap, ultimately, the agency decided to continue the transition for FY 2022 for hospitals that received a transition adjustment in their wage index in FY 2021 by applying a 5 percent cap on any decrease in the hospital's wage index compared to its wage index for FY 2021. CMS also noted that by more gradually continuing the transition in this way, there is a more limited impact of the budget

[20] 85 Fed. Reg. 70298 (Nov. 4, 2020).
[21] 86 Fed. Reg. 44774 (Aug. 13, 2021).
[22] *Id.* at 45532.

neutrality factor applied to the standardized payment amount while continuing to mitigate significant decreases in the wage index for FY 2022.

Partnership Recommendation: The Partnership appreciates CMS' thoughtful consideration of this issue in the FY 2022 IPPS rule. We urge CMS to apply this same consideration to home health providers in the HH PPS final rule given the numerous challenges they too are facing. We recommend that CMS apply a transition in CY 2022 following the same approach used for hospitals in the FY 2022 IPPS final rule by applying a 5 percent cap on any decrease in a home health provider's wage index for CY 2022 compared to its wage for CY 2021. Consistent with the IPPS final rule, the policy would apply to home health providers that benefited from the transition in CY 2021 and be budget neutral. Finally, we also recommend that CMS reevaluate the need for further extending this transition in next year's (CY 2023) rulemaking.

vi. Rural Add-on

The Bipartisan Budget Act of 2018 mandated a phase-out of the rural add-on policy for home health providers. For CY 2022, there will be a 1 percent rural add-on for low population density rural areas only. This is a significant step back from prior laws which applied a 3 percent add-on to all rural areas and served to support improved access for rural patients.

Medicare beneficiaries living in rural areas present distinct and unique challenges to home health agencies that serve them. The delivery of home health services in rural areas is substantially more challenging and costly than serving urban or suburban beneficiaries due to the additional travel times required to cover long distances between visits, higher transportation costs and still other factors that make rural service delivery distinctly different and more difficult than home health care delivered in metropolitan centers.

Historically, Congress has recognized these difficulties and additional costs associated with rural service delivery, and, over several decades, authorized CMS to make additional or "add-on" payments to the standard episode rate that have ranged from a high of ten percent in 2000 to one percent in 2021. While PQHH understands CMS is constrained by the current authorizing statute, the Bipartisan Budget Act of 2018, and supports the current proposed Rural Add-On Payment for CY 2022, we encourage the agency to continue to work with the Partnership and with Congress on longer-term solutions that address the cost and population health differences in rural America that create challenges for the provision of high quality home health care.

The Partnership strongly views itself, its member organizations and their diversity of nurses, therapists and skilled clinicians as critical to reversing this trend, and to improving the overall health status of rural Americans through in-person and telemedicine encounters in the beneficiary's home. We welcome the opportunity to engage with Congress, CMS, and the White House on initiatives to improve rural health through an expanded deployment of home health agency personnel specifically trained in chronic disease management and in treating conditions like cancer, heart disease, and chronic lower respiratory disease – all from the safety and security of a beneficiary's home.

II. Home Health Value-Based Purchasing (HHVBP) Model

a. Expansion of the HHVBP Model

CMS proposes to implement a nationwide Home Health Value-Based Purchasing (HHVBP) Model and to end the original Centers for Medicare & Medicaid Innovation (CMMI) HHVBP Model a year early.[23] The national model would start in CY 2022, with payment adjustments of up to ± 5 percent beginning in CY 2024 based on performance in the first year.

b. Baseline Year

Due to the potentially destabilizing effects of the COVID-19 public health emergency (PHE) on quality measure data in CY 2020, CMS proposes CY 2019 as the baseline year for the CY 2022 performance year/CY 2024 payment year and subsequent years. The Partnership appreciates CMS' mindfulness of the impact of the PHE on home health agencies (HHAs) and potential distortions related to quality measures. Given the effects of the pandemic, we support CMS' proposal to avoid heavily relying on CY 2020 data for VBP. Despite this, relying on CY 2019 data as a baseline for HHA performance into the future would result in comparing pre-COVID and pre-PDGM performance to performance in a new era. This could create advantages and disadvantages for HHAs that may not be the optimal basis for HHVBP.

The Partnership suggests that CMS consider options to account for outlier performance years and to incorporate actual experience, which will incentivize all HHAs to strive for overall performance improvement. Further, the Proposed Rule does not provide details on how CMS plans to update the baseline year for years beyond 2022. If the same baseline data will be used for years beyond 2022, incorporating more recent data and not relying exclusively on 2019 may be even more important.

Given the challenges posed by both 2019 and 2020 as potential baseline years, CMS should also consider 2023 as the initial year for an expanded model, such that 2021 data could be used as a baseline that better reflects HHA performance under the PDGM and with the influence of COVID-19 on both patient care and on providers themselves.

As CMS considers final timing for the model, we also note the significant investment of time many HHAs will need to make in order to prepare for HHVBP, particularly those located in states not included in the original model. Indeed, the administrative burden of setting up internal systems to participate in the HHVBP Model should not be underestimated. This could significantly impact patients and providers in states that were not part of the original HHVBP Model and potentially unfairly advantage HHAs in original participating states. Given that this model is being implemented nationwide, such asymmetry could have a significant impact on nationwide comparative performance.

[23] For a discussion of the implementation of the original HHVBP Model, *see* 80 Fed. Reg. 68623 at 68656 (Nov. 5, 2015), *available at* https://www.federalregister.gov/d/2015-27931/p-366.

Partnership Recommendation: For these reasons, in order to smooth the implementation of the nationwide HHVBP Model, we urge CMS to consider a one-year delay in implementing the nationwide HHVBP Model.

c. Measures

CMS proposes that the initial applicable measure set for the expanded HHVBP Model for the CY 2022 performance year focus on: 1) patient outcome and functional status; 2) utilization; and 3) patient experience.[24] The proposed expanded Model measures are mostly but not completely aligned with those under the Home Health Quality Reporting Program (HH QRP). CMS intends to consider new measures in future rulemaking. Unlike the HH QRP, the proposed measure set includes two composite measures: Total Normalized Composite (TNC) Self-Care and TNC Mobility, which were included in the original Model in CY 2019. Additionally, in contrast to the HH QRP, CMS proposes to include the Acute Care Hospitalization During the First 60 Days of Home Health (ACH) measure and Emergency Department Use Without Hospitalization During the First 60 days of Home Health (ED Use); CMS proposes to exclude these two measures from the HH QRP.

We appreciate CMS' interest in stakeholder input on the proposed measure set and offer comments on the measure set, on specific measures, and on the proposed process for updating the measure set.

i. The measure set should be more closely aligned with other HHS quality measurement programs

In general, we note that differences in the measure sets used for HHVBP, for star ratings, and for HH QRP may create confusion for beneficiaries seeking to access HHA quality and for HHAs striving to improve overall performance. The Partnership urges CMS to consider alignment across various quality programs. CMS should consider ways to align the HH VBP Model and Star Ratings programs in terms of measures and reporting. Specifically, with respect to the HH QRP which we discuss further below, CMS proposes to replace two claims based measures, the Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171) and the Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (NQF #0173) and replace them with the Home Health Within Stay Potentially Preventable (PPH) Measure, beginning in 2023. We support this change for the HH QRP but note that, in the spirit of measure harmonization and in an effort to streamline metrics and reduce confusion, the NQF #0171 and NQF #0173 measures should be removed from the HH VBP in 2023 as well, replaced by the PPH.

ii. Equity considerations and comments on specific measures

In evaluating specific measures for inclusion in HHVBP, we believe CMS has an opportunity to support equity in access by ensuring that the program does not rely on measures for which performance varies based on the socioeconomic status or other social determinants of health of populations HHAs serve. CMS should look to its experience making adjustments to Medicare Advantage measures in recent years to avoid underpaying for plans serving disadvantaged

[24] Table 26 of Proposed Rule, 86 Fed. Reg. 35874 at 35923 (July 7, 2021).

populations, and avoid establishing a new pay-for-performance program where certain measures may drive inequitable outcomes.

iii. CMS should clarify the circumstances under which measures will be updated without notice and comment rulemaking

CMS proposes to use a sub-regulatory process to make necessary updates to measure specifications that would not substantially change the nature of the measure. CMS would use notice and comment rulemaking to adopt changes that would substantially change the nature of the measure. In general, the Partnership supports CMS' proposed process to update the measure set but recommends that CMS provide greater clarity with respect to how CMS will differentiate between substantial and insubstantial changes. In general, stability in the measure set will allow HHAs to invest in improving performance as well as the quality of patient care.

CMS also indicates that it may propose new measures in the future that may not otherwise already be collected or submitted by HHAs. The Partnership supports alignment of any new measures with other quality measurement programs. We also suggest that CMS take a judicious approach to adding new reporting requirements, in order to allow HHAs to focus on patient care and outcomes.

d. Defining Cohorts for Benchmarking and Competition

CMS proposes to establish nationwide volume-based cohorts for the expanded HHVBP Model, such that HHAs nationwide would compete within either the larger-volume cohort or the smaller-volume cohort.

Under the original Model, HHAs were grouped into cohorts by State for setting benchmarks and achievement thresholds, and by both State and smaller- versus larger-volume HHAs when determining the cohorts used for competing for payment adjustments. As proposed, the expanded Model would use volume-based cohorts for benchmarks, achievement thresholds, and competing for payment adjustments. The expanded Model would use the same size delineation as the original Model (based on a threshold of 60 eligible unique HHCAHPS survey patients). Unlike the original Model, the proposed expanded Model would not use state-based delineations for benchmarks, achievement thresholds, and determination of payment adjustments. CMS notes that under the original Model, a cohort had to have at least 8 HHAs for competition comparison. CMS estimates that a minimum of 20 HHAs would be necessary in each cohort to ensure that attrition and variation in episode counts do not lead to insufficient counts at the end of the performance year. If CMS were to maintain state (and territory) delineations in the expanded Model, 11 states and territories would not meet the 20 HHA minimum, even when volume cohorts are combined.

The Partnership appreciates the need to ensure adequate competition in the HHVBP program and believes that larger cohorts are generally sound policy. We note, however, that a nationwide program will shift dollars not just within states but across the country. This may have the unintended consequence of shifting payments from low-performing areas to high-performing areas more dramatically than under a state-based approach. For example, we are concerned that

some states with historically higher rates of rehospitalization, such as West Virginia, could be at a disadvantage in a nationwide comparative payment system. Further, we are concerned that the nationwide cohorts would shift dollars across states and exacerbate regional differences in outcomes and access to care.

Given regional differences in social determinants of health, as well as differences in state investments in the health of communities, this could have negative consequences for communities that can least afford to see payment reductions. Given the importance of home health in such communities, we believe further analysis is warranted to avoid unintended consequences for equity in access to care across the country.

Partnership Recommendation: CMS notes that it is considering an alternative approach of applying state/territory-based cohorts only, without volume-based cohorts. We recommend that CMS consider whether this approach would lead to a more equitable distribution of payments for home health in various states.

e. Performance Scoring Methodology

CMS' proposed performance scoring methodology under the expanded HHVBP Model closely follows the original Model. CMS would assess each HHA's total performance score (TPS) based on all applicable quality measures in the expanded Model measure set in the applicable performance year. The performance scoring methodology would be used to determine an annual distribution of value-based payment adjustments among HHAs in a cohort so that HHAs achieving the highest performance scores would receive the largest upward payment adjustment. At a minimum, an HHA that does not meet the minimum threshold of cases (20) or completed HHCAHPS surveys (40), as applicable, on five or more measures (out of 12) would not receive a TPS or payment adjustment based on that performance year. The result of this process would be a TPS for each competing HHA that can be translated into a payment adjustment percentage using the Linear Exchange Function (LEF) applicable to each cohort. The Partnership commends CMS for simplifying the formulae to be used in the nationwide expansion of the HHVBP Model. We believe that the proposed performance scoring methodology is an improvement over the original HHVBP Model.

CMS proposes a payment adjustment percentage of no more than ± 5 percent for the applicable performance year and the payment adjustment would occur on the final claim payment amount for the applicable payment year. CMS invited comments on this proposal and on the proposed payment adjustment percentage. CMS indicated it may make changes to the payment adjustment through rulemaking in the future.

We have concerns that the proposed payment reduction of up to five percent could be harmful to implement while the home health industry is still working under the unprecedented crisis of the COVID-19 PHE. While we are hopeful that we are nearing the end of the pandemic, HHAs continue to face economic uncertainty. For example, HHAs are experiencing a nationwide staffing shortage, as discussed below. This uncertainty provides further support for CMS to consider delaying the nationwide expansion of the HHVBP.

f. Performance Feedback Reports

CMS proposes to use two types of reports that would provide information on performance and payment adjustments under the expanded HHVBP Model. The first is the IPR that would be *distributed to HHAs quarterly*. The second report, the Annual TPS and Payment Adjustment Report (Annual Report), would be made available to each of the competing HHAs in approximately *August of each year preceding the payment adjustment year*, expected beginning in August 2023. CMS would make the report available via a CMS data platform, such as the iQIES. It is unclear why reports cannot be provided prior to August.

The Partnership urges CMS to work towards more timely performance reporting. While we recognize that there may be practical obstacles to this, more frequent performance indicators would increase the ability of HHAs to respond quickly to any areas of underperformance and would ultimately increase overall patient care.

In order to drive quality improvement through value-based purchasing, it is essential for HHAs to understand their own baseline performance as well as how they are performing during the performance year as early as possible, such that they can invest in adjustments that may benefit their patients.

Partnership Recommendation: Data on the baseline year should be provided to HHAs as early as possible. CMS indicates that the achievement threshold and benchmarks for each cohort, and the improvement threshold for each HHA, calculated using baseline year performance scores, would be provided to the HHAs as soon as feasible, and restated on each HHA's Interim Performance Report (IPR). The Partnership urges CMS to complete these reports expeditiously.

g. Public Reporting

Under the expanded Model, CMS proposes to publicly report performance data, including applicable measure benchmarks and achievement thresholds for each small- and large-volume cohort and the following information for each HHA that qualified for a payment adjustment: Applicable measure results and improvement thresholds; TPS; TPS Percentile Ranking; and the HHA's payment adjustment for a given year.

The Partnership supports public availability of performance data. As noted above, we believe CMS should take steps to mitigate confusion among the public regarding various quality reporting information that will be available for HHAs in order to assist beneficiaries in selecting quality providers.

III. Home Health Quality Reporting Program (HH QRP) and Other Home Health Related Provisions

a. Vaccinations for Home Health Agency Health Care Personnel

The Partnership agrees with CMS that HHAs have the opportunity to and should educate and promote vaccination among their Health Care Personnel (HCP) as part of their efforts to assess and reduce the risk of transmission of COVID-19. CMS believes HCP COVID-19 vaccination among Home Health staff could similarly increase uptake among that patient population.

b. Home Health Quality Reporting Program (HH QRP)

The proposed rule would update the HH QRP by removing an OASIS-based measure, the Drug Education on All Medications Provided to Patient/Caregiver During All Episodes of Care measure, from the HH QRP under measure removal factor 1: Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made. CMS also proposes to replace the Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171) measure and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (NQF #0173) measure with the Home Health Within Stay Potentially Preventable measure and proposes to publicly report the Percent of Residents Experiencing One or More Major Falls with Injury measure and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) measure beginning in April 2022. Finally, CMS proposes revisions for certain HH QRP reporting requirements. This proposed rule would also revise similar compliance dates for certain IRF QRP and LTCH QRP requirements. In general, the Partnership supports these proposed measure adjustments and believes they sync with the spirit of the agency's Meaningful Measures 2.0. As noted above in comments related to CMS' proposed HHVBP measure set, the Partnership supports alignment in measures across home health quality measurement programs.

Finally, the Partnership notes that the proposed rule intends for home health providers to begin collecting additional data at transfer and implement six new categories of standardized patient assessment data elements (SPADES), effective January 1, 2023. In general, we support the inclusion of SPADES categories but are concerned about the extensive reporting obligation associated with an expanded OASIS-E, which already contains hundreds of reporting items and sums to 31 pages. Accordingly, the Partnership believes SPADES categories should ultimately be included, but only if CMS moves to remove other elements and diminish the burden faced by providers in managing the OASIS-E. As a general rule, the Partnership is not opposed to new reporting fields; however, we believe that as new elements are added, other items that may be less valid in a patient assessment should be retired to keep the OASIS-E process from expanding, unmanageably, without limitation.

c. Proposed Changes to the Home Health Conditions of Participation

CMS is proposing changes to the home health aide supervision requirements at § 484.80(h)(1) and § 484.80(h)(2) and conforming regulation text changes at § 484.55(a)(2) and (b)(3),

respectively, to allow occupational therapists to complete the initial and comprehensive assessments for patients in accordance with changes in the law.

i. CMS should clarify when remote supervision is permitted

CMS specifically proposes that HHAs be permitted to use interactive telecommunications systems for purposes of aide supervision, on occasion, not to exceed 2 virtual supervisory assessments per HHA in a 60-day period. CMS would revise the language at § 484.80(h)(1)(i) to require that if a patient is receiving skilled care (that is, skilled nursing, physical or occupational therapy, or speech language pathology services), the home health aide supervisor (RN or other appropriate skilled professional) must complete a supervisory assessment of the aide services being provided, either on-site (that is, an in-person visit) or by using interactive telecommunications systems to ensure aides are furnishing care in a safe and effective manner, no less frequently than every 14 days. We appreciate CMS' support for remote supervision and use of technology.

CMS is proposing to define interactive telecommunications systems as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. While CMS is proposing to allow this flexibility, CMS states that it expects that in most instances, the HHAs would plan to conduct the 14-day supervisory assessment during an on-site, in-person visit. The Partnership seeks clarification on whether CMS intends to limit use of telecommunications technology for supervision to circumstances where in-person supervision is impractical, or whether HHAs can incorporate this flexibility more broadly into regular practices.

ii. Flexibility in supervisory assessment requirement

CMS is also proposing revisions to the supervisory assessment requirements for "aides providing care to patients who are not receiving skilled care services." Given the eligibility requirements for home health care, we assume CMS is referring to such services provided to patients who also receive skilled care services during a home health episode. Whereas current rules require an RN to directly observe aides in person every 60 days, CMS proposes to remove this requirement based on feedback that the current requirement is overly burdensome for the patient and the HHA if multiple home health aides provide care to the same patient. CMS also proposes to add a new requirement to 42 CFR 484.80(h)(2) that would require the RN to make a semi-annual on-site visit to the location where a patient is receiving care in order to directly observe and assess each home health aide while he or she is performing care. This semi-annual in-person assessment would occur twice yearly for each aide, regardless of the number of patients cared for by that aide.

The Partnership appreciates the proposed changes to allow virtual supervisory assessments of home health aides.

iii. Provision of home health aide services

CMS notes that ensuring that aide services are meeting patient needs is a critical part in maintaining safe, quality care and seeks information about the adequacy of aide staffing, including the effect of the public health emergency on the ability of HHAs to employ home health aides or

arrange for the provision of home health aide services. As detailed in the attached Dobson|DaVanzo report, HHAs experienced increases in labor costs as well as higher costs associated with staffing and retention in 2020 than they did in 2019, and costs for 2021 are estimated to remain higher than 2019. Further, the average percent increase in administrative and general expenses doubled in 2020—2.6% in 2019 compared to 4.7% in 2020—coinciding with COVID-19-related increases. These forces in the labor market contribute to increased costs for HHAs as they ensure appropriate staffing to provide high quality care in accordance with a patient's plan of care.

IV. Requests for Information

a. Fast Healthcare Interoperability Resources (FHIR) in Support of Digital Quality Measurement in Post-Acute Care Quality Reporting Programs

In alignment with the Meaningful Measures 2.0, CMS seeks feedback on future plans to define digital quality measures for the HHS QRP, and on the potential use of Fast Healthcare Interoperable Resources (FHIR) for digital quality measures (dQMs) within the HH QRP, aligning where possible with other quality programs. The Partnership wholly supports the use of this open source framework that establishes a common language and process for all health information technology. The Proposed Rule solicits comments on specific system types employed by Partnership member companies, whether they participate in a health information exchange (HIE), and various information sharing practices, incentives and resources employed to reinforce the sharing of health information between care settings. It also seeks specific guidance on ways to incentivize or reward innovative uses of health information technology (HIT) that could reduce burden for post-acute settings. Without commenting on specific tools, strategies or preferences preferred by our member companies, we broadly support the transformation of CMS' quality measurement enterprise to be fully digital. We welcome the opportunity to continue working with CMS and other agencies and stakeholders to coordinate and inform CMS' transformation to dQMs leveraging HIT standards.

b. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs—Request for Information

The Partnership shares the Proposed Rule's conclusions that significant and persistent inequities in health outcomes exist in the United States and also shares the important goal of closing the equity gap. The Partnership supports the definition of equity established in the Executive Order 13985 as the "consistent and systematic fair, just and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment . . . and persons otherwise adversely affected by persistent poverty or inequality."[25]

The Partnership applauds the Proposed Rule's focus on addressing disparities in health outcomes by leveraging data, starting by identifying the unique needs of patients. Data and analytics can provide post-acute providers insight into the challenges and barriers some patients confront when accessing care. In turn, post-acute providers can help ameliorate less than ideal outcomes by deploying data to address gaps in access and quality of care.

As we have stated in other sections of this comment, we share CMS' goal of harmonizing quality measurement in the QRP and in other quality measurement programs and encourage CMS to aim for consistency and alignment across reporting regimes. The Partnership supports efforts to improve data collection that includes gender, race, and ethnicity as a first step in a larger process to monitor and improve disparities in health. As has been noted by other provider commenters, it must be absolutely clear that these factors themselves do not represent an individual's risk, but

[25] *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, E.O. 13985 (Jan. 20, 2021).

rather that such factors may be valuable proxies for social risk factors until it is feasible to quantify and capture the actual risk of bias and misallocation of resources that heighten inequities.

The Partnership believes it is essential that health equity is integrated and aligned across CMS programs. The Partnership and its member organizations are committed to correcting historic inequities and look forward to future opportunities to engage stakeholders on developing constructive solutions to the same.

Echoing concerns raised by other provider organizations, including hospitals, the Partnership finds it unconscionable that rates of COVID-19 infections and death among Black, Latino and other minority populations are disproportionately higher. Accordingly, these horrific outcomes only underscore the need for data collection and analysis by race, ethnicity and preferred and spoken language of patients. Data are crucial to understanding the unique challenges and disparities marginalized communities face.

The Partnership also joins other provider groups in supporting efforts to improve the collection of SDOH information to better understand how these demographic factors affect outcomes. The Partnership supports a consensus approach that brings stakeholders together to determine relevant social factors and how to control for them in a standardized, culturally sensitive way.

V. Conclusion

The Partnership appreciates the opportunity to submit comments on this important CY 2022 Proposed Rule. We commend CMS for bringing attention to opportunities to improve quality and enhance equity for Medicare beneficiaries. We urge CMS to address what we believe to be fundamental flaws in its assessment of budget neutrality for PDGM, in order to ensure that payments in 2022 and beyond will support Medicare beneficiaries' access to the skilled services they need in their homes. CMS should not finalize its proposal to maintain a -4.36 behavioral adjustment in the CY 2022 rates, as neither CMS' underlying assumptions nor its proposed methodology are supported by available data and analysis. We look forward to continuing to work with CMS in our efforts to provide quality health care services to Medicare beneficiaries.

Sincerely,

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Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

Attachments

Attachment 1 – Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2022 HH PPS Proposed Rule, Dobson|DaVanzo & Associates, August 27, 2021

Attachment 2 – Home Health Labor Cost Survey, Dobson|DaVanzo & Associates, August 26, 2021

Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2022 HH PPS Proposed Rule

Assessing the Impact of PDGM Implementation and the COVID-19 Pandemic on Home Health Agencies

Submitted to:
Partnership for Quality Home Healthcare (PQHH)

Submitted by:

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Friday, August 27, 2021

Introduction

Dobson DaVanzo & Associates (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to analyze available Medicare home health claims data reflecting the implementation of the Patient-Driven Groupings Model (PDGM) in support of PQHH development of comments for the CY 2022 Home Health Prospective Payment System (HH PPS) proposed rule. Dobson | DaVanzo previously supported PQHH in the review of PDGM as included in the Calendar Year (CY) 2018, CY 2019, CY 2020, and CY 2021 Home Health Prospective Payment System (HH PPS) proposed and final rules, as well as accompanying technical reports. To inform our analyses and conclusions, we draw on this prior work along with other responses to the prior comment periods, the Abt Technical Expert Panel report, as well as available claims data, published CY 2022 PDGM case-mix weights and LUPA threshold information, and a Dobson | DaVanzo-led survey of PQHH members on the state of Home Health labor costs.

Effective January 1, 2020, the PDGM overhauled the HH PPS episode and case-mix group definitions, payment weights, and base rate. PDGM is a revision of the Home Health Resource Group (HHRG) case-mix group definitions initially proposed in the CY 2018 HH PPS administrative rulemaking cycle that was refined and finalized in the CY 2019 and CY 2020 HH PPS rulemaking cycles. The CY 2021 HH PPS rule made limited changes to PDGM and in the CY 2022 HH PPS rule CMS' seeks comment on the method used to assess budget neutrality for CY 2020 while proposing additional changes.

When implementing PDGM in the CY2020 Final Rule (FR), CMS prospectively reduced the HH PPS base rate from the budget-neutral calculated level by 4.36%. The level of rate reduction was justified by CMS through analytic assumptions on how providers might change their behavior once PDGM was implemented. In the CY 2020 FR, CMS described three underlying assumptions to determine the behavioral adjustment:

- For one-third of LUPAs that are one to two visits away from the LUPA threshold, HHAs will provide one to two extra visits to receive a full 30-day payment.
- HHAs will change documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code (payment optimized clinical coding). This allows a 30-day period of care to be placed into a higher-paying clinical group.
- By considering additional ICD-10-CM diagnosis codes listed on the HHA claim (that exceed the six allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment than periods otherwise would have received if CMS had only used the OASIS diagnosis codes for payment.

We commend CMS for making extensive case data available and showing transparency to enable robust and productive commentary by the public. In the CY 2020 FR CMS OASIS-LDS PDGM rate-setting and impact files, CMS provided payment estimates which included case-level estimated behavioral responses, as well as data appropriate for reproducing PDGM payments without behavioral responses.

Executive Summary: Conclusion, Supportive Evidence, and Policy Recommendations

1. **CMS's conclusion that CY 2020 base payments were set 6% higher than they should have been is fundamentally flawed**

Supportive evidence: CMS' methodology that compares aggregate payments under both PDGM and the prior 60-day system using CY 2020 data is inherently flawed—under the 60-day system case-mix and payments are largely driven by therapy visits especially when a high number of therapy visits are present. In contrast, under PDGM case-mix and payments rely more heavily on patient clinical characteristics as therapy thresholds are eliminated. CY 2020 data are thereby distorted by the effects of PDGM implementation and the COVID-19 PHE, as the shift of payment incentives away from therapy visits and the COVID-19 PHE drove a 29.7% reduction in CY 2020 therapy visits. This likely explains the inaccurate conclusion by CMS that CY 2020 base payment rates were set 6% higher than they should have been.

Policy recommendation: Similar to CMS conclusions in the CY 2022 SNF PPS final rule, CMS should not consider any temporary or permanent decreases to PDGM 30-day payment amounts reflecting the proposed 6% increase in CY 2020 base payment rates stemming from an inaccurate budget neutrality assessment methodology. This issue can reasonably be addressed using CY 2021 data in the calculation of CY 2023 payment rates, although it is possible that CY 2021 data may also be distorted by recent developing trends related to the surge of COVID-19 delta variant cases.

2. **CMS requested alternative approaches to assess budget neutrality. One approach is to compare CY 2020 30-day period payments to projected 30-day payments obtained from CY 2018 60-episode data converted to 30-day episodes (provided by CMS in CY 2020 HH PPS proposed rulemaking impact files). Based on this approach, we find that the CY 2020 average payments were 1.4% below CMS projections with behavioral assumptions.**

Supportive evidence: In the CY 2022 HH PPS proposed rule, CMS requests alternative approaches to the assessment of budget neutrality. One approach would be to compare actual CY 2020 30-day period payments to projected CY 2020 payments based on data from CY 2018 60-day episodes converted to 30-day episodes provided by CMS in the CY 2020 HH PPS proposed rule impact files. This approach is less biased as CY 2018 data is not distorted by behavioral changes as a result of the implementation of PDGM or the COVID-19 PHE. In contrast to findings from the CMS approach, results from this approach show that CY 2020 average payments were -1.4% under CMS projected average payments with behavioral assumptions. These results mean that for every $10,000 in projected home health payments, CMS behavioral adjustments decrease payments by 4.36% to $9,565, and we find that on average home health payments are 1.4% ($9,431) below the projected budget neutral payments with behavioral adjustments. This suggests that the CY 2020 base payment rates were set approximately 5.76% below budget neutral levels. Ultimately, there appear to be many factors that are driving the reduction in home health payment amounts, of which the three behavioral assumptions are not the totality.

Policy recommendation: Instead of the potential proposed 6% reduction, CMS should consider taking corrective action to increase base payment rates by 5.76% so the HH PPS will be more likely to achieve budget neutrality for CY2022, as authorized by the Bipartisan Budget Act of 2018.

3. The observed -1.4% difference between average CY 2020 30-day episode payments and projected 30-day episode payments with behavioral assumptions are likely because two of three behavioral assumptions have not been met using CY 2020 claims data with run-out through July 2021.

Supportive evidence: To ensure that CY 2020 payments were budget neutral, CMS finalized three behavioral assumptions, after considering a phase in approach, which in aggregate resulted in a 4.36% reduction in base payment rates in CY 2020. Using CY 2020 data downloaded in July 2021, we find that two of the three anticipated behavioral changes that CMS used to justify prospective payment rate reductions have largely not occurred:

- The PDGM LUPA rate was higher than projected in 2020. Overall, we find an 8.17% LUPA rate under PDGM compared to the 5.3% average projected by CMS with behavioral assumptions.
- Case-mix groups continue to reflect historical trends of primary diagnoses rather than payment-optimized groupings.
- Comorbidity and functional group scores were higher than anticipated which may be some part behavioral adjustment but also due to the relative increase in case-mix severity as a result of the pandemic-related shifts in types of home health cases.

The combined effects of these behavioral changes impact case-mix in complex ways. Ultimately, an unexpectedly high LUPA rate and clinical grouping reflecting historical trends drive lower case-mix weights and payments than CMS projected with behavioral assumptions, but this is balanced by the increase in case-mix weight due to the increase in high comorbidity and functional group scores. In aggregate, these effects in CY 2020 result in an average payment that is 1.4% lower than projected budget neutral average payments with behavioral adjustments. In total, this means that CY 2020 payments were 5.36% lower than they would have been in absence of the change to the 30-day payment system (PDGM).

Policy recommendation: CMS should continue to track the behavioral assumptions using data for future years not impacted by the COVID-19 PHE to determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. We caution however, that given that CY 2021 data may also be distorted by recent developing trends related to the surge of the delta variant of COVID-19 cases, 2021 data may not be useful for such an endeavor.

4. In the absence of any corrective action, we estimate that CMS behavioral adjustments could lead to a reduction of approximately $2.43 billion in home health payments between CY 2020 and CY 2022.

Supportive evidence: Using CY 2020 home health payments[1] with behavioral adjustments (approximately $16.86 billion) as a baseline, we assumed payments with behavioral adjustment in CY 2021 and CY 2022 would increase by 5.6% and 5.3% respectively. We estimated the percent increase in payments for CY 2021

[1] Obtained from actual CY 2020 claims data.

and CY 2022 using data from the Congressional Budget Office's (CBO) baseline of March 2020.[2,3] We then estimated the aggregate payments without behavioral adjustments for CY 2020 through CY 2022 by increasing the total payments with behavioral adjustments by 4.36%. Finally, we determined the aggregate impact of the -4.36% behavioral assumptions reduction on home health payments from the difference in payments with and without behavioral adjustments for the respective years. Our results showed that payment reductions due to behavioral adjustments could lead to approximately $2.43 billion reduction in home health payments between CY 2020 and CY 2022.

Policy recommendation: As CMS recognizes and the data shows, any current or future reductions to account for provider behavioral shifts for payment optimization are not appropriate as this time.

5. HH PPS Market baskets may not be reflective of actual price trends in the HH industry.

Supportive evidence: The COVID-19 PHE in CY 2020 has in some part affected the supply of and demand for certain inputs, including home health labor leading to a general increase in labor and other input prices. The CMS HH PPS market basket update factor, however, has recently declined from 3.0 in CY 2019 to 2.4 in CY 2022. This is likely because the market basket price indices do not reflect the pandemic-driven inflation in large part because the market basket composite index is determined on a 4-quarter rolling average basis and reflect general cost changes across the healthcare industry—failing to account for home health specific price changes on a real-time and industry specific basis.

Based on our construction of an estimated market basket index using results from the 2021 PQHH Labor Cost Survey related to the three largest components of the index (wages and salaries, benefits, and administrative and general expenses), we determined that the home health specific market basket update factor should have increased by approximately 1.1 percentage points between CY 2019 and CY 2020 and by approximately 1.2 percentage points between CY 2020 and CY 2021. These results are in stark contrast to CMS HH PPS market basket update factors that decreased by 0.1 percentage points between CY 2019 and CY 2020, and further by 0.6 percentage points between CY 2020 to CY 2021.

Policy recommendation: CMS should comprehensively assess all aspects of the HH PPS market basket index derivation to ensure that it reasonably forecasts annual cost increases and that the price proxies accurately reflect trends in the home health industry.

6. Inadequate reimbursement for and reporting of telehealth utilization will affect future rate-setting as home health payments and claims do not reflect telehealth utilization and related costs that have risen during the pandemic.

Supportive evidence: Initially allowed under Section 1135 waivers and finalized in the CY 2021 HH PPS proposed rule, CMS has allowed HHAs to use telehealth and remote monitoring to provide services to patients. However, telehealth visits cannot be considered a home visit for the purposes of patient eligibility or payment, but HHAs can report the costs of telecommunication technology as allowable administrative

[2] Baseline budget projections as of March 6, 2020. Congressional Budget Office. (2020, March 19). https://www.cbo.gov/publication/56268.

[3] Note that these growth rates are reflective of both price and quantity. Additionally, as noted in the document the budget projections provided in the March 2020 update do not account for changes to the nation's economic outlook and the fiscal situation arising from the COVID-19 PHE. As such, projected payments in CY 2021 and CY 2022 may increase at a much higher rate due to deferred care during the PHE and the increased severity of cases for those diagnosed with COVID-19.

and general costs. While the allowance of telehealth visits for home health services will continue to be helpful in ensuring continuous beneficiary access during the COVID-19 pandemic, these visits are still not adequately reimbursed and do not count towards the LUPA threshold. Given there is no requirement to capture these services in the claims and telehealth costs are not well reported in Medicare Cost Reports, the service shift toward telehealth must be accounted for outside of the traditional rate setting and rebasing of payment models at the risk of decreasing the payment accuracy and adequacy of the HH PPS. We raise this issue because this factor can affect analyses and lead to an incorrect imputation that there is less home health care or that home health margins have risen; instead, it this reflects a new source of measurement error.

Policy recommendation: We urge CMS to institute an appropriate reimbursement methodology for home health telehealth services. This will ensure that telehealth services are well captured in home health claims and Medicare Cost Reports which will subsequently increase the accuracy of future rate-setting, case-mix recalibration, and home health reimbursement.

7. **While CMS' proposed case-mix recalibration and subsequent 1.039 case-mix budget neutral adjustments are in accordance with Section 1895(b)(3)(A)(i) of the Act, the redistributional effects of recalibrated case-mix weights based on CY 2020 data are likely inappropriate for CY 2022 payments. Given the impact of the COVID-19 PHE, CY 2020 utilization patterns may not be reflective of future CY 2022 utilization and should only be used for case-mix recalibration with an abundance of caution.**

Supportive evidence: Ultimately the COVID-19 PHE will affect future rate setting, rebasing, and payment system overhauls across all the HH PPS payment system. For instance, CMS uses CY 2020 data to set rates and recalibrate case-mix weights in the CY 2022 HH PPS proposed rule. The recalibrated case-mix weights appear to result in lower aggregate payments for CY 2022 compared to aggregate payments under the CY 2021 PDGM case-mix weights. Although CMS implements a budget neutrality factor of 1.039 to offset the aggregate reduction in payments due to the recalibrated case-mix weights, we believe the varying distributional effects on individual HHAs are unjustifiable.

Additionally, the CY 2020 data that CMS relies upon to set rates and recalibrate case-mix weights are likely not representative of utilization patterns in CY 2022. The COVID-19 PHE directly led to shifts in referral sources for HHAs—most significantly HHAs likely substituted for SNF care. Further, the cancellation of elective surgeries and patient avoidance of institutional settings to handle exacerbations of chronic illnesses resulted in a reduction in STACH referrals to HHAs and an increase in referrals from other sources. Among STACH referrals to HHAs, the severity of cases (as indicated by DRG weights) seemed to increase—suggesting that sicker patients were unable to defer care. Finally, the respiratory home health cases increased by 4.7% while infectious disease home health cases increased by 30.6% between CY 2019 and CY 2020 likely indicating that HHAs took on COVID-19 cases that differed in severity from cases in prior years.

Policy recommendation: We caution against the use of CY 2020 data for case-mix recalibration as indicated in the CY 2022 HH PPS proposed rule.

8. **In conclusion, as with the CY 2022 IPPS proposed rule, we recommend that CY 2020 data should not be used for CY 2022 rate-setting or case-mix recalibration.**

Detailed Findings

The Bipartisan Budget Act (BBA) of 2018[4] mandated CMS to develop a new payment model for the Medicare home health program with a number of requirements, namely that:1) HH PPS cases are shortened from 60 days to 30 days, 2) case payments no longer account for the volume of therapy services, and 3) changes are implemented in a budget neutral manner.

Budget Neutrality Definition

Section 51001(a)(2)(A) of the BBA of 2018 specified that the standard prospective amount for the new payment system (PDGM) had to be calculated in a manner such that the estimated aggregate expenditures under the new 30-day unit of payment system would be equal to the estimated aggregate expenditures that otherwise would have been made under the HH PPS during CY 2020 in the absence of the change to a 30-day unit of payment.[5]

To achieve budget neutrality, the BBA of 2018 mandated that CMS apply "behavioral adjustments" to account for changes in provider behavior given the change to a 30-day unit of payment. The law also required CMS "to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures beginning with 2020 and ending with 2026"[6] and to make temporary and permanent increases or decreases, as needed, to the 30-day payment amount to offset such increases or decreases.

While the BBA of 2018 did not specify the standards or the process of determining budget neutrality, in the CY 2022 proposed rule (86 FR 35874),[7] CMS provides preliminary analyses of the first year of the PDGM and a description of the methodology CMS used to estimate the difference between assumed and actual behavior changes.

CMS Methodology for Determining Budget Neutrality

"To assess whether the 30-day budget neutral payment amount for CY 2020 maintained budget neutrality given the change to a 30-day unit of payment and the implementation of a new case-mix adjustment methodology without therapy thresholds was accurate", CMS used CY 2020 30-day period claims data to simulate 60-day episodes and estimated what CY 2020 payments would have been under the 153-group case-mix system and 60-day unit of payment in absence of the change the 30-day unit of payment under PDGM. CMS applied exclusions and assumptions to group actual CY 2020 30-day periods under PDGM into 60-day periods of care. CMS then priced out the simulated 60-day episodes of care using the payment parameters under the 60-day payment system and compared the aggregate payments under the 60-day payment system to payments for the same cases under PDGM's 30-day unit of payment system.

[4] BBA of 2018, H.R.1892. Available at: https://www.congress.gov/bill/115th-congress/house-bill/1892.

[5] Underlined by Dobson | DaVanzo for emphasis.

[6] Section 51001(a)(2)(D)(i) of the BBA of 2018. Available at: https://www.congress.gov/bill/115th-congress/house-bill/1892.

[7] CY 2022 HH PPS Proposed Rule, 86 FR 35874. Available at: https://www.federalregister.gov/documents/2021/07/07/2021-13763/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home.

CMS' preliminary analyses indicated that aggregate payments to HHAs were higher in CY 2020 under the PDGM case-mix adjustment methodology and the 30-day unit of payment compared to what HHAs would have been paid had the PDGM and 30-day unit of payment not been implemented.

Additionally, CMS calculated what the CY 2020 30-day periods of care base payment rate and fixed-dollar loss ratio (FDL) should have been to achieve the estimated aggregate payments for the simulated 60-day episodes in CY 2020. CMS then calculated a percent change between the base payment rates and determined that the CY 2020 30-day base payment rate was approximately 6% higher than it should have been relative to budget neutral payments.

Why CMS Budget Neutrality Assessment Methodology is Fundamentally Flawed

While CMS does not finalize any specific method or behavior assumption payment adjustments in the CY 2022 HHPPS proposed rule, a few issues warrant examination with regard to the agency's proposed methodology for assessing budget neutrality.

CY 2020 SHIFTS IN THERAPY UTILIZATION

As case-mix weights and resulting payments under the 60-day system were driven by therapy utilization, any shifts in therapy utilization in CY 2020 data will have a significant impact on case-mix and aggregate payments repriced under the 60-day system, thereby undermining attempts to determine what CY 2020 payments would have been under the 60-day payment system. We note that the elimination of therapy thresholds under PDGM and the impact of the COVID-19 PHE in CY 2020 negatively impacted therapy utilization in CY 2020 resulting in CMS' observed lower case-mix and lower aggregate payments under the 60-day unit of payment. Importantly, we also note the CY 2021 data may also present the same limitations to CMS' methodology.

Additionally, we note that CMS acknowledges the impact of the COVID-19 PHE on CY 2020 data in the CY 2022 IPPS proposed rule (86 FR 25070)[8] and suppresses the use of CY 2020 data for FFY 2022 rate setting, and numerous measurements of value-based purchasing, readmissions, and hospital-acquired conditions. CMS indicates for example, that "the differences in utilization for certain types of services in FY 2020 as compared to what would have been expected in the absence of the PHE affects the calculation of CMI values for Rural Referral Centers."[9]

Similarly, in the CY 2022 SNF PPS final rule (86 FR 19954),[10] CMS acknowledges that the COVID-19 PHE and significant differences in both patient assessment requirements and payment incentives under RUG-IV compared to PDPM significantly impacted FY 2020 SNF utilization data in the first year of PDPM. As such, CMS concludes that the methodology they used in the past to calculate a PDPM adjustment factor for budget neutrality may be inappropriate and "could lead to a potentially inaccurate recalibration."[11] For reference, CMS' unfinalized proposed methodology to determine an appropriate adjustment factor to achieve budget neutrality in the SNF PPS compares aggregate payments under both the

[8] CY 2022 IPPS Proposed Rule, 86 FR 25070. Available at: https://www.federalregister.gov/documents/2021/05/10/2021-08888/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

[9] 86 FR 86 FR 25070, Page 25438 https://www.federalregister.gov/d/2021-08888/page-25438.

[10] CY 2022 SNF PPS Final Rule, 86 FR 19954. Available at: https://www.federalregister.gov/documents/2021/04/15/2021-07556/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.

[11] CY 2022 SNF PPS Final Rule, 86 FR 19954, Page 19986. Available at: https://www.federalregister.gov/d/2021-07556/p-283.

current system and the prior system using claims and assessment data for a given year—a methodology similar to CMS' proposed budget neutrality assessment for PDGM.

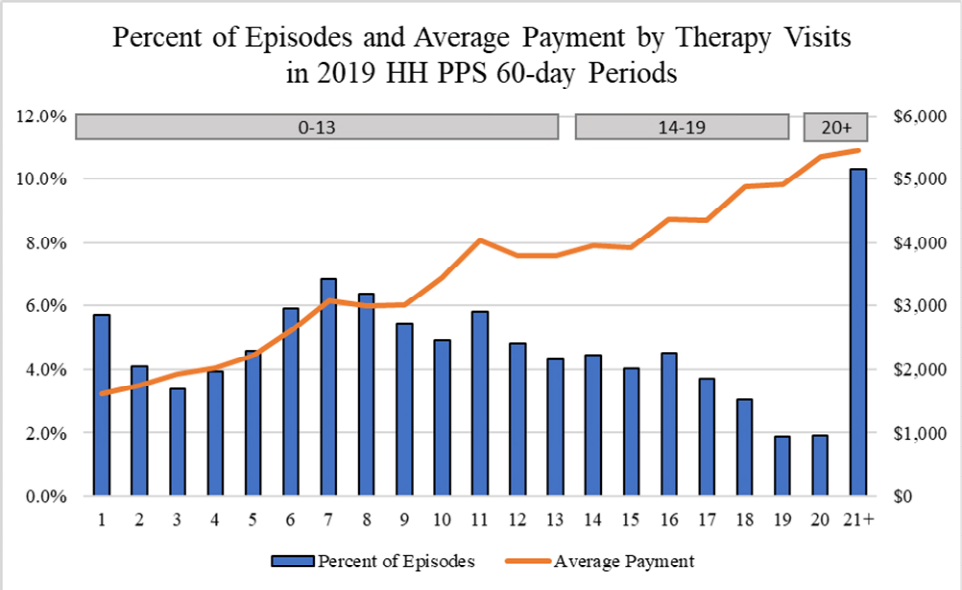
PAYMENT INCENTIVES-DRIVEN SHIFT IN THERAPY UTILIZATION

Fundamental to the definition of budget neutrality is the idea that the assessment must be conducted under the assumption that all else remains the same except the specific change in payment policy modeled. The desired counterfactual in this instance is CY 2020 home health payments that would have been made in the absence of the change to a 30-day unit of service. However, PDGM resulted in significant differences in payment incentives that dramatically altered CY 2020 home health utilization making aggregate payments made under PDGM incomparable to simulated payments that would have been made under the 60-day system in absence of the payment system change.

Prior to PDGM, under the 60-day payment system, case-mix weight and payments were driven in large part by the number of therapy visits as HHA providers could receive higher payments if certain therapy volume thresholds were met during the 60-day period. PDGM eliminated these therapy thresholds and CY 2020 data shows that therapy visits fell by 29.7% between CY 2019 and CY 2020. The data show a reduction from 41,395,470 total therapy visits under the 60-day payment system in CY 2019 to 29,110,582 total therapy visits under PDGM in CY 2020.

As shown in **Exhibit 1**, therapy visits under the 60-day payment system tended to cluster around the therapy thresholds (0-14, 15-19, 20+) used to adjust payments. As can be observed, 10.3% of 60-day episodes had 21 or more therapy visits, while more than half had at least 10 therapy visits.

Exhibit 1: Percent of Episodes and Average Payments by Therapy Visits Under 2019 HH PPS 60-day Unit of Payment

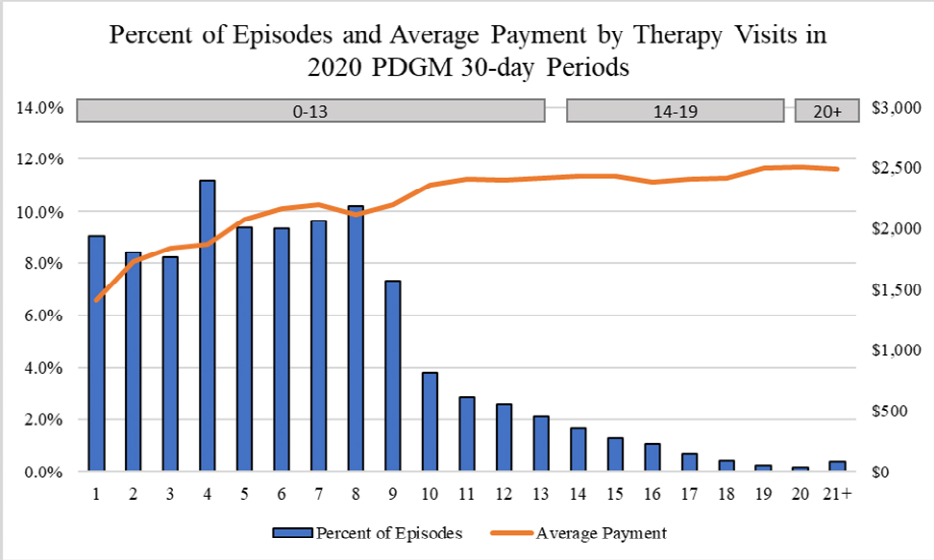


Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 57157 and RIF 54757

In contrast, under PDGM, previously observed clusters around therapy thresholds that are visible in CY 2019 are no longer visible in CY 2020 as shown in **Exhibit 2**. The exhibit shows that therapy visits are left-skewed

in CY 2020 with more than half of 30-day episodes having fewer than 6 visits. This is a marked departure from the therapy visit distributions observed in CY 2019 data.

Exhibit 2: Percent of Episodes and Average Payments by Therapy Visits Under 2020 PDGM 30-day Periods



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 57157 and RIF 54757

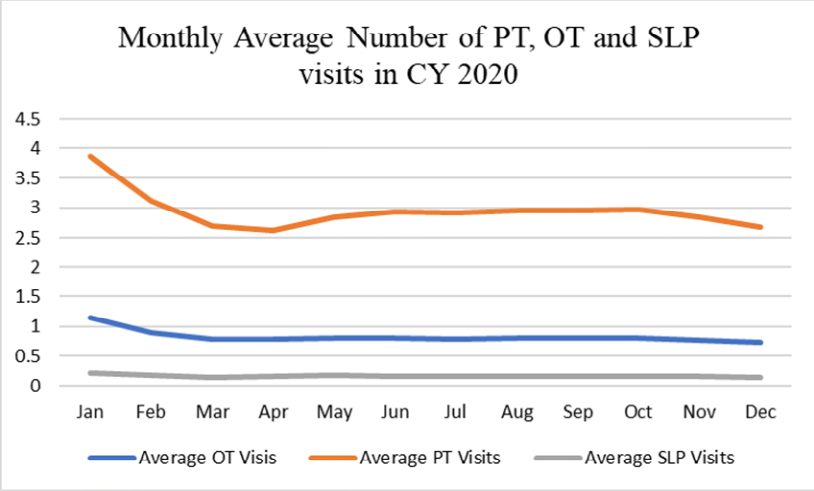
These data show that the change in payment systems from 60-day to 30-day and the elimination of therapy thresholds was accompanied by an overall reduction in volume of therapy visits and a marked change in the distribution of therapy visits delivered in CY 2020. Therefore, the current attempt to use CY 2020 data to estimate what CY 2020 case-mix and payments would have been without the implementation of PDGM is fundamentally flawed. The desired counterfactual is impossible to deduce using CY 2020 data as it exists, because of the introduction and contaminating effect of the 30-day unit of payment under PDGM that eliminated thresholds as a determinant of case-mix and payments.

IMPACT OF COVID-19 PHE ON THERAPY UTILIZATION

Further, the occurrence of the COVID-19 PHE in 2020 also disrupted therapy and other case-mix related service delivery. First, due to the pandemic, there were nationwide cancellations of elective surgeries—the largest referral source for home health therapy—leading to a programmatically significant drop in therapy visits. Additionally, due to fear of contracting the virus, many home health patients declined services or only accepted telehealth visits, which currently aren't reimbursable or otherwise well reported by HHAs. Finally, since some states failed to designate therapists as essential workers, therapy visits could not be conducted in assisted living and other facilities as they would have regularly been further leading to a reduction in the number of therapy visits that could be delivered amid the pandemic. All of these factors had a "dramatic" impact on home health therapy delivery, leading to large reductions and changes in the distribution of therapy visits in CY 2020, which as noted above reduced the case-mix and payments for repriced 30-day payments under the 60-day payment system. Importantly, as the COVID-19 pandemic recedes in future years, these impacts may become a lesser concern.

Exhibit 3 shows the average monthly home health therapy visits by discipline in CY 2020. As shown by the data in **Exhibit 3**, we observed a reduction in monthly Physical Therapy (PT) and Occupational Therapy (OT) visits starting in March 2020 during the initial PHE which appeared to recover during the summer months, and once again declined in November and December, perhaps coinciding with the second major wave of outbreaks. We also observed minimal but directionally consistent declines in Speech Language Therapy (SLP) visits starting in March 2020, although volumes appeared to recover throughout the rest of the year. Importantly, note that the reduction in therapy visits began before COVID-19 PHE started in March 2020—indicating that HHA providers were already experiencing significant declines in therapy visits as a result of PDGM, even before the onset of the pandemic.

Exhibit 3: Monthly Average Number of Home Health Therapy Visits in CY 2020



Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

Given the observed shifts in therapy utilization in CY 2020, it is inevitable that repricing of CY 2020 payments under the 60-day payment system using CY 2020 data resulted in a lower case-mix resulting in lower counterfactual aggregate payments. The lower aggregate payments to HHAs under the 60-day payment system relative to payments under the CY 2020 PDGM case as determined by CMS are largely driven by the reduction in therapy visits in CY 2020 as payments under the 60-day payment system are largely driven by therapy utilization. This renders the CMS methodology critically flawed because the CY 2020 data is "critically" affected by a behavioral process as a result of the payment-incentive shift away from therapy-driven payments and therapy visit reductions due to the COVID-19 PHE.

While we recognize that the intention of PDGM was to remove any financial incentives to "over-provide" therapy services and help shift the focus toward a payment system based on patient clinical characteristics, the resulting changes in utilization in CY 2020 data lead to a potentially inaccurate assessment of budget neutrality using CMS' methodology detailed in the CY 2022 HH PPS Proposed Rule. In summary, the counterfactual—payments that would have been made under the 60-day system—cannot be accurately modeled using CY 2020 data or data from future years.

CASE-MIX ACROSS CY 2019 HH PPS AND PDGM PAYMENT SYSTEMS INCOMPARABLE

Case-mix systems are intended to describe cases in terms of clinical characteristics and/or resource utilization so as to account for case complexity. Case-mix systems are therefore unique to each payment system as they are dependent on the underlying variables used to describe clinical characteristics or resource use. We note that case-mix under the 2019 HH PPS and PDGM are driven by different factors measuring different aspects of case-mix as described below:

- Under the CY 2019 HH PPS, case-mix adjustment for payments was made using one of the 153 possible HHRGs derived from three categories: Clinical Domains, Functional Domains, and Service Utilization computed from responses to selected data elements in the OASIS (Outcome and Assessment Information Set) assessment instrument and patient utilization of therapy visits. Case-mix weights for each of the different 2019 HH PPS payment groups were determined using each of the three categories. The 153 HHRGs were then split into 5 categories based on the amount of therapy provided and the episode's timing in a sequence of episodes—this means that HHAs could receive higher payments for later episodes in a sequence of consecutive episodes and higher payments as therapy visits increase.[12]
- In contrast, under the PDGM payment model, a case-mix adjusted payment for a 30-day period of care is made using one of 432 HHRGs and is based on the following five categories: Admission Source (Institutional or Community), Timing (early/late), Clinical Grouping (principal diagnosis on the claim), Functional Impairment Level (OASIS items), and Comorbidity Adjustment (secondary diagnoses on the claim). Case-mix weights for each of the different PDGM payment groups are determined by regressing resource use on each of the five categories.

Fundamentally, this means that a case mix of 1.0 is not the same across the two systems as they do not use the same variables or underlying regression analyses to determine resource utilization. As noted above, the case-mix weights assigned to each HHRG grouping under the 60-day unit of payment in the 2019 HH PPS are based on empirical findings from a model that includes the number of therapy visits as a variable. Given that the distribution and volume of the therapy visits are significantly different under PDGM compared to the 2019 HH PPS as shown previously in **Exhibit 2** and **Exhibit 3**, the case-mix weights derived using CY 2020 PDGM data repriced under the 60-day system are not a valid comparison to case-mix weights observed in CY 2020 under PDGM.

CMS asserts that the CY 2020 30-day base payment rate was approximately 6% higher than it should have been—claiming that this difference is primarily determined by the shift in case-mix from 0.96 under the 60-day payment system to 1.03 under PDGM's 30-day payment system. This comparison is flawed because these two case mixes are not comparable. Additionally, the cited case-mix of 0.96 does not (nor can it given the data) appropriately measure the desired counterfactual of what the case-mix could have been without the implementation of a 30-day unit of payment under PDGM. This indicates that the CY 2020 30-day base payments rate repriced under the 60-day system based on CY 2020 data has little bearing on the degree to which cases under PDGM were overpaid or deemed to not be budget neutral.

[12] MEDPAC Home Health Care Services Payment System, October 2016. Available at: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hha_final.pdf.

ANALYTIC BIAS

Additionally, there are methodological issues with how CMS combines the CY 2020 30-day periods to simulate a 60-day period that may have led to analytic bias in the agency's case-mix and aggregate payment comparisons.

CLINICAL GROUPING

Under PDGM, roughly 40% of the diagnoses previously allowed for under the 60-day payment system are not accepted as primary diagnoses.[13] This systematic change likely impacted the coding behavior of providers under the new system ultimately leading to an inaccurate simulation of the clinical domain under the 60-day payment system using CY 2020 data.

Further, for two 30-day periods with different principal diagnoses, CMS had to make assumptions in their assignment of one clinical domain in their simulation of the 60-day system, potentially resulting in inaccurate clinical domain assignments.

TIMING (EARLY/LATE DESIGNATION)

Under PDGM, the first 30-day period of care in a sequence is assigned early timing while the second or any other subsequent 30-day periods are assigned late timing. In contrast, under the prior 60-day payment system, the first two 60-day episodes in a sequence of adjacent-covered episodes were assigned early timing, while the third and any other subsequent episodes were assigned late timing.

Given the asymmetry of timing assignments under PDGM compared to the 60-day payment system, and the shortened lengths of stay under PDGM, it is likely that timing assignments from the CMS simulation using CY 2020 data overrepresent early visits in a 60-day system, possibly leading to lower aggregate payments for CY 2020 payments repriced under the 60-day system.

IMPACT OF COVID-19 PHE ON CY 2020 UTILIZATION PATTERNS

The COVID-19 PHE may have had an impact on the observed pattern of utilization. Pandemic-related CMS waivers granted the use of telehealth during CY 2020, and this may have led to the appearance of fewer visits per 30-day period as home health telehealth visits are not adequately reimbursable or accurately captured on home health claims. In the CY 2022 HH PPS proposed rule, CMS notes that the average number of visits in a 30-day period was 9.3 visits—a decrease of approximately 12% relative to 10.5 average visits estimated using CY 2017 simulated 30-day periods.[14]

EXCLUDED CASES

CMS notes that as they converted CY 2020 30-day periods to 60-day episodes, they excluded 724,206 cases for several reasons including OASIS assessment dates occurring on or before October 31 or no OASIS data at all—potentially introducing bias.[15] Exclusion of these 724,206 (8.9%) cases potentially introduces some

[13] Bryant, B. (2019, March 19). Primary diagnosis changes among pdgm's most overlooked aspects. Home Health Care News. https://home-healthcarenews.com/2019/03/primary-diagnosis-changes-among-pdgms-most-overlooked-aspects/.

[14] 86 FR 86 FR 25070, Page 35884. Available at: https://www.federalregister.gov/d/2021-13763/p-117.

[15] From 8,165,808 CY 2020 30-day periods, CMS' final dataset included 7,441,602 actual 30-day periods of care and 4,378,823 simulated 60-day episodes of care for CY 2020.

level of bias in the case-mix and subsequent repriced payment for the derived 60-day periods, which we cannot directionally assess.

Proposed Methodology for Budget Neutrality Assessment

As CMS cannot plausibly use CY 2020 data to determine case-mix weights and aggregate payments under the prior 60-day payment system to determine payments that would have been made in the absence of PDGM, we propose that a less biased approach would be to use the projected payments used by CMS to set CY 2020 payment rates based on data from CY 2018 60-day episodes converted to 30-day episodes. The use of CY 2018 60-day episode data converted to 30-day episodes eliminates the need to model other behavioral shifts that occurred due to the implementation of PDGM and avoids the impact of the COVID-19 PHE on therapy utilization.

To assess budget neutrality, we compare average CY 2020 30-day episode payments to projected average CY 2020 payments with behavioral assumptions used by CMS to set CY 2020 payment rates (based on data from CY 2018 60-day episodes converted to 30-day episodes). This methodology better aligns with the notion that budget neutrality analyses should be conducted under the assumption that all else remains the same except the specific policy modeled. Note that we discuss budget neutrality in terms of average payment which is not influenced by changes in case volume.

In addition, we examined the actual changes in provider coding behavior under PDGM in comparison to CMS projections using data from CY 2020 claims files and the CY 2020 CMS OASIS-LDS PDGM rate-setting file (containing historical projections of PDGM using 2018 data).

The data sets we used to determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures in CY 2020 are described below:

- Preliminary 2020 claims are available to Dobson | DaVanzo under CMS Research Identifiable File (RIF) Data Use Agreement (DUA) 54757. Data included in this report goes through July 2021, the most recent available month with sufficient claims run out as of writing. Should subsequent data updates be made available during the comment period, we will include these in a brief update.
- Historical projections of PDGM using 2018 data and including both a regrouping of HH PPS cases to PDGM as well as the behavioral assumptions are available in the CY2020 OASIS-LDS file, Data Use Agreement 53367.[16] This dataset was issued as a companion to the CY2020 Final Rule.

BUDGET NEUTRALITY ASSESSMENT

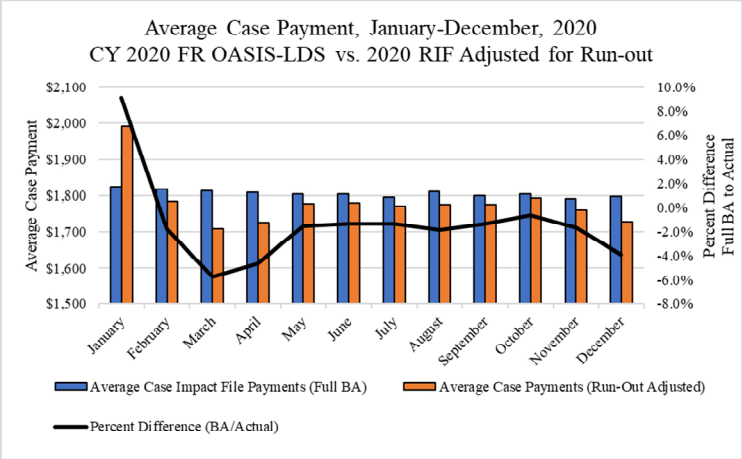
We find that PDGM does not appear to be budget neutral at its currently implemented payment levels, indicating higher base payments may be required to achieve budget neutrality. In CY 2020, average case payments were 1.4% lower than predicted average payments with behavioral assumptions. ($1,780.71 in CY 2020 compared to $1,805.41 projected payments with behavioral adjustments). In **Exhibit 4**, we show the

[16] Note that as CMS converted 60-day episodes to 30-day episodes, 9.5% of claims were excluded because they could not be linked to an OASIS assessment, or were RAPs without a final claim, or they were claims with zero payment amounts. After these and other exclusions, the resulting 2018 analytic file represented 5,471,454 60-day episodes and $16.6 billion in total expenditures.

rate-setting file outputs with CMS behavioral adjustments (full behavioral adjustment) compared to observed rates from preliminary 2020 RIF claims. Here, full behavioral adjustment (BA) represents projected impact file payments made at 2020 HH PPS rates (set 4.36% below budget neutrality but the difference presumably made up for by provider behavior change).

Average case payments were partially "inflated" in January due to the transition to PDGM (there were more higher paying "early admission timing" cases because "late admission timing" cases could not occur, increasing average payment) which declined in subsequent months. Per-case payment rates declined subsequently and have yet to recover fully but are trending closer to projected average payments with behavioral assumptions.

Exhibit 4: Actual CY 2020 Claims Average Case Payments vs. Projected Case Payments with Behavioral Adjustments



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

Average payments had major declines during the initial PHE and state lockdowns in March and April of CY 2020. Although payment levels appeared to recover during the summer months, they subsequently declined in November, and December, perhaps coinciding with the second major wave of outbreaks but also intersecting with traditional home health and other health system seasonality patterns, and pent-up demand.

Note that we adjusted observed CY 2020 payments and case counts to account for PDGM transition effects and claims run out. Transition effects are the 60-day cases in the historic payment system that were completed in 2020 (we make an adjustment to impute these into PDGM cases). We developed claims run-out factors by making repeated measures of static time periods as data matured and new data became available.[17]

Monitoring Behavioral Assumptions under PDGM

To achieve budget neutrality, the law required CMS to make assumptions about behavior changes that could occur because of the implementation of the 30-day unit of payment under PDGM. CMS finalized three

[17] Claims data here are from the July 2021 update and results are adjusted with completion factors. After comparing multiple files with varying run-out, we concluded that January through September 2020 is adequately complete for the purposes of this report. Completion factors were 0.53, 0.46, and 0.80 to adjust observed payments October, November, and December (respectively), based on investigation of claims run out. Completion factors were 1.53%, 1.63%, and 2.27% to adjust observed cases October- December (respectively), based on investigation of claims run-out.

behavioral assumptions (clinical group coding, comorbidity coding, and a low utilization payment amount (LUPA) threshold) resulting in a 4.36 percent reduction to the CY 2020 national, standardized 30-day payment rate. The three underlying behavioral assumptions are summarized below:

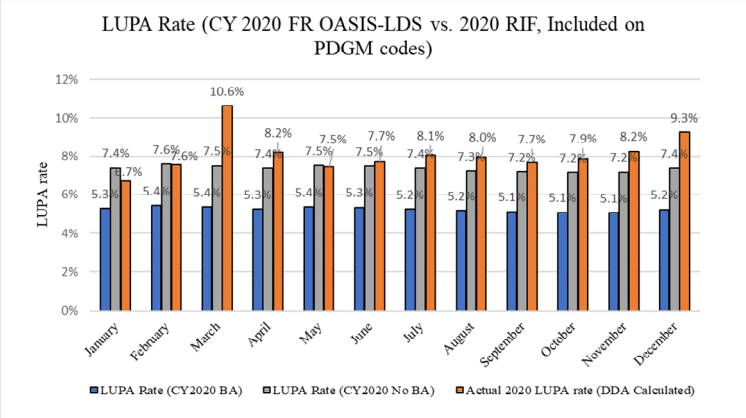
Combined, CMS indicated in the CY2020 HH PPS proposed rule that these three assumptions (which are interactive) would lead to 8.01% increase in payments, relative to "true" Budget Neutrality; but subsequently in the CY 2020 final rule, CMS reduced this to 4.36% on the assumption that only half of the behavioral assumptions could be immediately achieved. As described above, we find that the HH PPS is underpaying relative to projected payment levels with behavioral assumptions and below we address each behavioral assumption in greater detail. Ultimately, we find the behavioral assumptions have not entirely been met as summarized below:

- Observed LUPA rates remain higher than predicted rates.
- Payment optimization of primary diagnostic coding has largely not occurred (clinical case-mix groups represent historical rather than optimized groupings).
- High comorbidity and functional need groups are larger than expected, but this is tempered by increased relative case-mix in part influenced by the impact of the COVID-19 PHE.

LUPA RATES

During CY 2020, LUPA rates were much higher than historical levels or levels in the rate-setting file (with or without behavioral adjustment). LUPAs are cases that do not meet the full payment visit threshold and are paid on a per-visit basis; the large portion of LUPA cases serves to reduce average case payments. Between January and December 2020, we observed an 8.17% LUPA rate compared to the predicted 5.3% (with behavioral assumptions) or 7.5% (historical trend without behavioral assumptions). Observed PDGM LUPA rates were higher than CMS projected LUPA rates with behavioral assumptions in January and February, prior to widespread state responses to the COVID-19 PHE, as shown in **Exhibit 5**—suggesting that providers were struggling with the new PDGM LUPA rules even before the onset of the pandemic. LUPA rates further increased with the onset of the COVID-19 PHE in March, and while they began trending back down in April, they have remained consistently higher and almost twice the rate CMS predicted with behavioral assumptions.

Exhibit 5: Actual CY2020 LUPA Rate vs. Projected LUPA Rate (with and without Behavioral Assumptions)

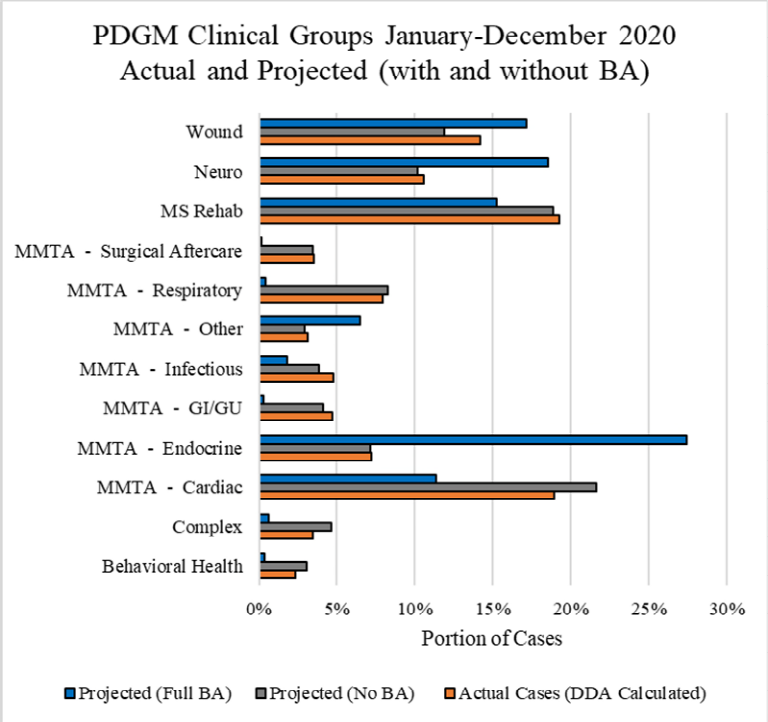


Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

CLINICAL GROUP CODING

We find that case-mix groups are more similar to historical trends of primary diagnoses rather than payment-optimized groupings as projected by CMS in the behavioral assumptions, as shown in **Exhibit 6**. The Agency assumed home health agencies would change their documentation and coding practices to assign the highest-paying diagnosis code as the principal code for the 30-day period of care, which has largely not occurred. Certain groups stand out for their departure in the behavioral assumption group from historical trend—especially clinical groups MMTA-Endocrine and Neuro groups—where actual 2020 case-mix results hewed close to historical levels. This behavioral assumption would require agencies to substantially disregard international agreed coding schemas, so it is unsurprising shifts did not occur to the extent predicted in the behavioral assumption.

Exhibit 6: Observed Clinical Groups January-December 2020 Compared to Projected Clinical Groups (with and without Behavioral Adjustments)

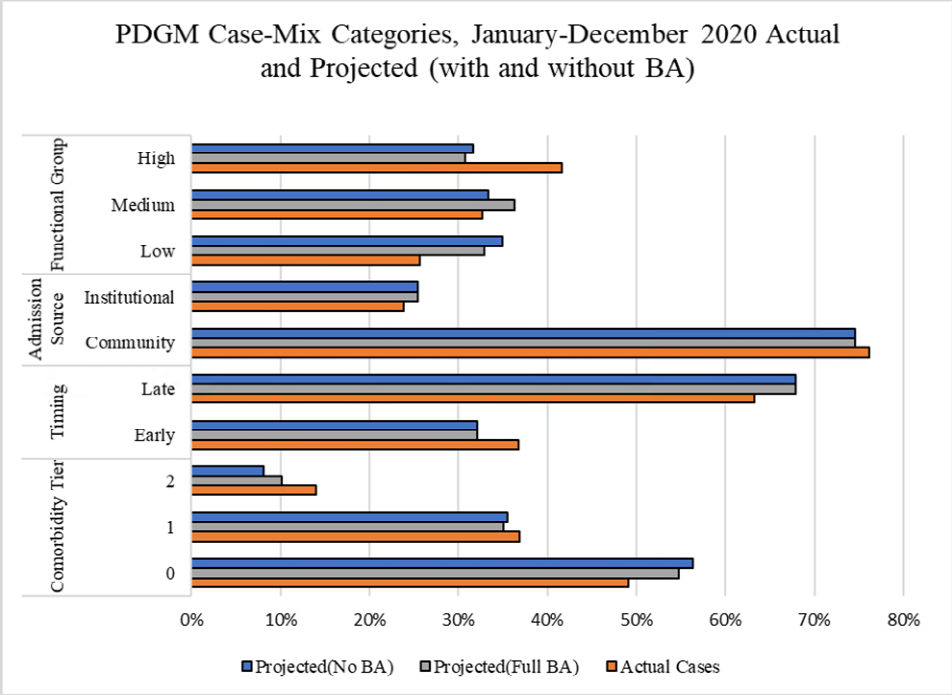


Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

IMPACT ON COMORBIDITY, FUNCTIONAL STATUS, ADMISSION SOURCE, AND TIMING

Home health agencies reported higher comorbidity and functional group scores in 2020, even much higher than scores projected from the rate-setting files with behavioral adjustment as shown in **Exhibit 7**. The increases in scores could be partially explained by the change in coding behavior as anticipated by CMS but also by the relative increase in case-mix severity due the ongoing coronavirus pandemic that has likely resulted in substitution of home health for SNF care and increasing severity of Short-Term Acute Care Hospital (STACH) referrals. CMS could consider examining changes in home health comorbidity and functional case-mix groupings within the context of changing SNF volume and case-mix to address how unanticipated leakage across systems may be impacting HHA case-mix groupings (comorbidity scores, functional scores, admission source, and timing).

Exhibit 7: PDGM Case-Mix Categories January-December 2020, Actual and Projected (with and without BA)



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 and RIF 54757

While functional status and comorbidity level are potentially sensitive to coding, admission source, and episode timing are not because these aspects of case-mix are obtained from the home health claim rather than agency reporting. Observed changes in admission source and timing inherently represent real changes in referral sources and new patient home health admissions.

We find a greater portion of cases were Early (+5 percentage points) while fewer cases were Institutional (-2 percentage points) compared to the behaviorally adjusted CMS impact file estimate. These changes are subtle but impactful and represent real changes in case-mix. These changes likely represent changing business models to adapt to PDGM and/or a changing mix of referral sources due to the COVID-19 PHE. While institutional cases are highly incentivized in PDGM, the pandemic-related cancellation of elective procedures, decreased utilization of institutional settings and exceedingly poor SNF pandemic performance likely led to a reduction in these case types.

Aggregate Impact of -4.36% Behavioral Adjustment Payment Reduction, 2020-2022

In aggregate, we estimate that the payment reductions due to behavioral assumptions could lead to an approximate reduction of $2.43 billion for home health-related payments from 2020 through 2022.

METHODOLOGY

The methodology we use to estimate the overall payment reductions is outlined below:

Step 1: Estimate projected HH payments with behavioral adjustments for CY 2021 and CY 2022

We determined from CY 2020 claims data that CY 2020 home health payments with behavioral adjustments were approximately $16.86 billion. Based on the Congressional Budget Office's (CBO) baseline of March 2020, home health payments are projected to increase by 5.6% in CY 2021 and 5.3% in CY 2020.[18,19]

We then calculated the projected home health payments with behavioral adjustments for CY 2021 and CY 2022 by applying CBO's projected percent increase in aggregate payments for CY 2021 and CY 2022 to the actual CY 2020 aggregate home health payments.

As shown in **Exhibit 8** below, we determined projected home health payments with behavioral adjustments of $17.80 billion in CY 2021 and $18.73 in CY 2022.

Exhibit 8: Actual Home Health Payments in CY 2020 and Projected Home Health Payments in CY 2021 and CY 2022 (with behavioral adjustments)

Year	Projected Percent Increase	Total HH Payments (with behavioral adjustments)
2020	ACTUAL	$16,859,300,947
2021	5.6%	$17,795,928,777
2022	5.3%	$18,732,556,608

Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

Step 2: Determine aggregate payments without behavioral adjustments for CY 2020 through CY 2022

We estimated the aggregate payments without behavioral adjustments for CY 2020 through CY 2022 by increasing the total payments with behavioral adjustments by 4.36%. Note that reverse percentage derivation of payments without behavioral adjustments requires further adjustments to the 4.36% increase. We further adjusted the payments without behavioral adjustments by 0.2% to account for this.

[18] Baseline budget projections as of March 6, 2020. Congressional Budget Office. (2020, March 19). https://www.cbo.gov/publication/56268.

[19] Note that these growth rates are reflective of both price and quantity. Additionally, as noted in the document the budget projections provided in the March 2020 update do not account for changes to the nation's economic outlook and fiscal situation arising from the COVID-19 PHE. As such, projected payments in CY 2021 and CY 2022 may increase at a much higher rate due to deferred care during the PHE and the increased severity of cases for those diagnosed with COVID-19.

We then estimated the aggregate impact of the -4.36% behavioral assumptions reduction on home health payments from the difference in payments with and without behavioral adjustments for the respective years. As shown in **Exhibit 9** below, we estimate that payment reductions due to behavioral adjustments could lead to approximately $2.43 billion reduction in home health payments between 2020 and 2022.[20]

Exhibit 9: Actual Home Health Payments in CY 2020 and Estimated Home Health Payments in CY 2021 and CY 2022 with and without Behavioral Adjustments

Year	Total HH Payments (with behavioral adjustments)	Total HH Payments (without behavioral adjustments)	Difference between total payments with and without behavioral adjustments
2020	$16,859,300,947	$17,628,085,070	($768,784,123)
2021	$17,795,928,777	$18,607,423,129	($811,494,352)
2022	$18,732,556,608	$19,586,761,189	($854,204,581)
Aggregate Impact of behavioral adjustments 2020-2022			($2,434,483,057)

Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

Overall Impact of the COVID-19 PHE on Home Health Case-Mix and Payments

As noted throughout the report, the COVID-19 PHE has had significant effects on home health utilization thereby influencing types of patients receiving home health services and payments for those services in CY 2020. In addition, HHAs experienced an increase in input prices that may not have been accounted by CMS as they update payment rates using the HH PPS market basket. Key areas of concern include:

- The market basket indices used to update payments for CY 2020 – CY 2022 do not capture observed price increases experienced by HHAs due to pandemic-related shifts in the supply and demand.
- Observed atypical home health utilization trends in CY 2020 indicate that CY 2020 data may not be representative of future utilization in CY 2022. As such, CY 2020 data should not be used for CY 2022 rate-setting or case-mix recalibration. Observed CY 2020 trends include:
    - While in CY 2019, SNFs typically took on more STACH discharges compared to HHAs, these trends reversed in CY 2020 amid the pandemic—HHAs appeared to take on more STACH discharges compared to SNFs. These trends have only begun to reverse in 2021. This indicates that HHAs likely substituted for SNF care during the pandemic in CY 2020.
    - HHAs experienced a reduction in STACH referrals, although patients referred to HHAs from STACHs appeared to be of higher and increasing severity compared to prior years.
    - Further, there was a general increase in respiratory and infectious cases while cardiac cases decreased—signifying that HHAs took on COVID-19 cases that differed in severity from cases in prior years.

[20] We conducted a series of sensitivity analyses and found comparable results.

- Finally, overall, there were significant in average visits across PT, OT, and SLP visits in addition to an overall decline in total number of visits across all disciplines and average visits per unique beneficiary. This suggests that HHAs likely experienced declines in beneficiaries seeking home health services as volumes from referral sources declined and patients avoided care in fear of contracting the virus. Further, the provision of services through telehealth visits that are not captured in-home health claims may have contributed to the observed reduction in visits.

Below we describe the key areas of concern in detail and provide data (where available) to describe the impact of COVID-19 PHE on home health utilization and payments with regard to PDGM and subsequent final and proposed rules for CY 2021 and CY 2022.

CMS' MARKET BASKET UPDATE FACTORS

Section 1895(b)(3)(B) of the Act[21] required that the standard prospective payment amounts for home health be increased by the applicable home health market basket update[22] for those HHAs that submit quality data as required by the Secretary.

The HH PPS market basket is a "Laspeyres fixed-weight index that is used to determine how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period."[23] As such, it measures "pure" price changes only and not changes in volume of services. The market basket is constructed in three steps outlined below:

i. First, total expenditures for identified spending categories during a selected base period expenditures are estimated (CMS determines total expenditures for the HH PPS market basket from Medicare Cost Report data). The proportion of total costs for each spending category is computed and these represent the cost weights. There are six cost weight categories for the HH PPS market basket: compensation (76.1%, of which 65.1% is associated with wages and salaries and 10.9% is associated with benefits), operations and maintenance (1.5%) professional liability insurance (0.3%), administrative and general and other expenses (17.4%), transportation (2.6%), capital-related costs (2.1%).24

ii. In the second step, CMS identifies a price proxy index that measures the changes in price for each of the cost categories. For example, CMS uses the CPI-U for transportation published by Bureau of Labor and Statistics as a price proxy for transportation cost increases.

iii. Finally, the price proxy index for each cost category is multiplied by the respective cost weights and summed to compute a composite index in the market basket in a given year. The market basket update factor is then derived from percent changes in the composite index level from quarter to quarter.

[21] https://www.ssa.gov/OP_Home/ssact/title18/1895.htm.

[22] The HH market basket is further adjusted by changes in economy-wide productivity and used to update the standard prospective payments.

[23] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf.

[24] In CY 2019, CMS rebased and revised the home health market basket weights using the 2016 Medicare cost. Weights reported are those determined in CY 2019.

Exhibit 10 below shows the HH PPS regulation market basket update factors from CY 2015 – CY 2022. Actual final regulation market basket update factors typically lag in comparison to the market basket index derivation year. For example, the proposed home health market basket update percentage for CY 2022 was based on IHS Global Inc.'s first-quarter 2021 forecast with historical data through fourth-quarter 2020. However, in the final rule, CMS may update this, if more recent data become available.[25]

Exhibit 10: Actual HH PPS Regulation Market Basket Update Factors, CY 2015 – CY 2022

Home Health Agency PPS[1,4]	CY 15	CY 16	CY 17	CY 18	CY 19	CY 20	CY 21	CY22
Market Basket Update	2.6	2.3	2.8	2.5	3.0	2.9	2.3	2.4
Productivity Adjustment	0.5	0.4	0.3	0.6	0.8	0.3	0.3	0.6
Market Basket Update less Productivity	2.1	1.9	2.5	1.9	2.2	2.6	2.0	1.8

Source: CMS Market Basket Data[26]

As shown in **Exhibit 10** above, it appears that the market basket update factor has recently declined from 3.0 in CY 2019 to 2.4 in CY 2022. Further analysis of the trends in the price proxies showed that labor costs (weighted at 76.1%) and administrative, general, and other expenses costs (weighted at 17.4%) do not seem to show an increased rate of growth from CY 2020 through CY 2022 possibly explaining the declines in the market basket update factors.

We note that the COVID-19 pandemic in CY 2020, along with the associated lockdowns, mobility, restrictions, and physical distancing rules, altered the spending patterns of consumers and affected the supply of and demand for certain home health inputs and, hence their prices. CMS market basket price indices, however, do not reflect the pandemic-related inflation, in large part because the market basket composite index is determined on a 4-quarter rolling average basis. Further, the price proxies used by CMS to determine price growth for the cost categories reflect general cost changes within the broader healthcare industry. This approach fails to account for home health specific cost trends that may differ from the general industry as a result of the pandemic.

For example, the pandemic intensified staffing shortages for HHAs as home health workers left their jobs due to fear of exposure to the virus. As such, HHAs had to raise wages to attract adequate staff. Additionally, the CMS HH PPS market basket price indexes and cost weight categories may not capture increased telehealth and personal protective equipment (PPE) costs that HHAs faced as a result of the pandemic. Data from a PQHH member HHA for example, suggests that in March and April of CY 2020, average pricing for masks and gowns approximately increased 8 and 6 times, respectively.[27]

We also note that in CY 2020, some portion of home health visits were shifted to telehealth during the COVID-19 PHE, however, this is not captured in the claims data, per CMS pandemic flexibilities guidance.[28] HHAs can report costs of telehealth on the HHA cost report, but incompletely. This implies that cost weights and price proxies in CY 2020 and future years fail to accurately account for telehealth use.

[25] While CMS' CY 2022 market update percentage is based on IHS Global Inc.'s first-quarter 2021 forecast with historical data through fourth-quarter 2020, CMS notes that in the final rule, "if more recent data becomes available after the publication of this proposed rule and before the publication of the final rule (for example, more recent estimates of the home health market basket update and productivity adjustment), they would use such data, if appropriate, to determine the home health payment update percentage for CY 2022 in the final rule."

[26] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

[27] Data obtained from PQHH member HHA.

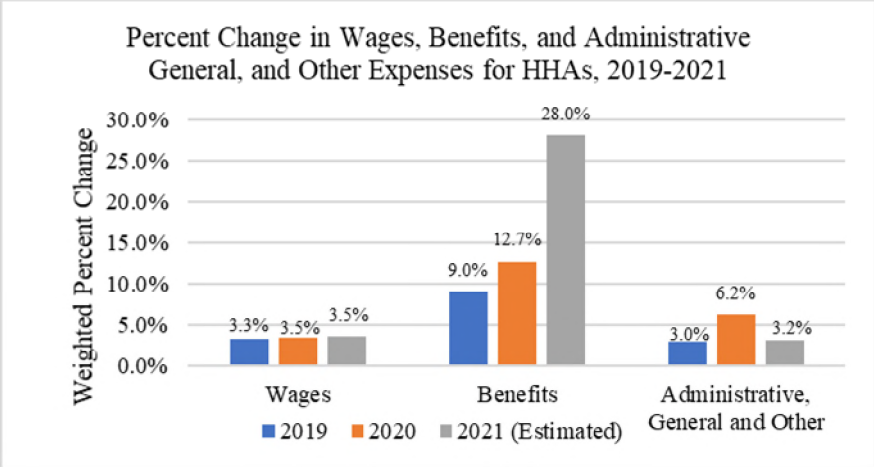
[28] https://www.cms.gov/files/document/covid-home-health-agencies.pdf.

To better understand the impact of the COVID-19 pandemic on home health labor (wages and benefits), administrative and general costs, PQHH commissioned a survey to provide more real-time and trending data from the PQHH membership about the increase in expenses from 2019 through 2021. Responses were weighted by market share and percent of patient population in rural and urban areas to derive the aggregate percent increases by cost category for each year.

Results from the 2021 PQHH Labor Cost Survey showed that home health labor (wages and benefits) costs as well as costs associated with administrative, general, and other services increased at a higher rate in 2020 than they did in 2019. HHA wages increased at a rate that was 0.2 percentage points higher in 2020 compared to 2019, benefits costs increased at rate that was 3.7 percentage points higher in 2020 compared to 2019, while administrative, general, and other costs increased at rate that was 3.2 percentage points higher in 2020 compared to 2021.

Although benefits costs are anticipated to increase at a higher rate in 2021 than in 2020, costs for wages and administrative, general, and other are anticipated to grow at the same rate or at a slower rate in 2021. Specifically, HHA wages are anticipated to grow at the same rate in 2021 as they did in 2020, benefits costs are expected to grow at a rate that is 15.3 percentage points higher in 2021 than in 2020, while administrative, general, and other costs are expected to grow at a rate that is 3.0 percentage points lower in 2021 than in 2020. These results are shown in **Exhibit 11** below.

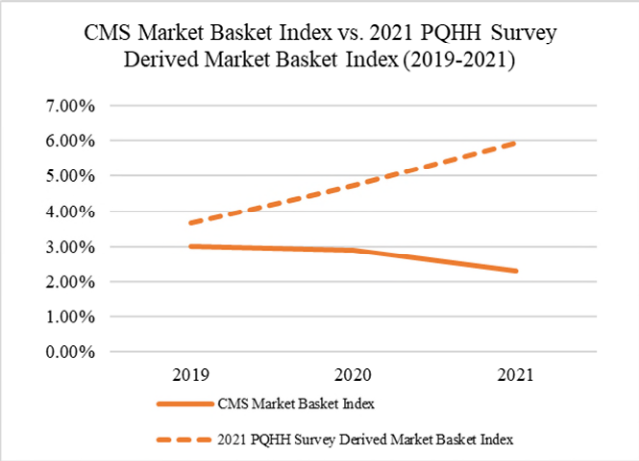
Exhibit 11: Percent Change in Wages, Benefits, and Administrative and General Expenses for HHAs reported in the 2021 PQHH HH Labor Market Survey



Source: Dobson | DaVanzo Analysis of CY 2021 PQHH Labor Cost Survey Data

Based on our construction of an estimated market basket index using results from the survey related to the three largest components of the index (wages and salaries, benefits, and administrative, general, and other expenses), the home health specific market basket update factor should have increased by approximately 1.1 percentage points between CY 2019 and CY 2020 and 1.2 percentage points between CY 2020 and CY 2021. In contrast, CMS HH PPS market basket update factors decreased by 0.1 percentage points between CY 2019 and CY 2020, and further decreased by 0.6 percentage points between CY 2020 to CY 2021. These results are shown in **Exhibit 12** below.

Exhibit 12: Actual Regulation Market Basket Update Factors Compared to Counterfactual Market Basket Update Factors Determined from the 2021 PQHH HH Labor Cost Survey



Source: Dobson | DaVanzo Analysis of CY 2021 PQHH Labor Market Survey Data

While results from the 2021 PQHH Labor Cost Survey provided us with the data to derive a counterfactual market basket based on only the three top cost categories (representing 93.4% of the market basket), the observed upward trends across cost categories, and the overall market basket indicate that the market basket should have remained flat or risen between CY 2019 to CY 2021 instead of the observed decline. As noted above, CMS' methodology for deriving the market basket update factors is unable to accurately take into account sudden upward shift in market prices as shown by the PQHH survey data where we observed spikes in wages, benefits, and administrative and general expenses between 2019 and 2021.

Note that CMS' indicated in the CY 2021 final rule that the lower update (2.3 percent) for CY 2021 was "primarily driven by slower anticipated compensation growth for both health-related and other occupations as labor markets were expected to be significantly impacted during the recession that started in February 2020 and throughout the anticipated recovery."[29] In contrast, our results show that HHA wages grew at a slightly higher rate between 2019 and 2021, although underlying data shows that therapy professions primarily those in urban areas experienced a decline in wage growth in 2020.[30] In addition, the significant increase in benefits costs and administrative, general, and other costs seem to influence a large part of the increase in the estimated market basket constructed from the survey data. These results reflect that the COVID-19 pandemic in 2020 likely resulted in price inflation for most HHA inputs as opposed to a recession and highlight the need for CMS to consider using price proxies that accurately reflect trends in the home health industry.

COVID-19 PHE-RELATED SHIFTS IN HOME HEALTH UTILIZATION

The utilization of home health care services underwent "dramatic" shifts as a result of the COVID-19 PHE. With fewer inpatient hospitalizations and much lower patient interest in SNFs, home health likely

[29] 85 FR 70298, Page 70312. Available at: https://www.federalregister.gov/d/2020-24146/p-89.

[30] The observed decline in wage growth for therapy professions in 2020 is likely due to PDGM implementation, as the new payment system eliminated therapy thresholds and resulted in a reduction in therapy utilization. Wage deceleration in this discipline has a downward impact on our wage growth estimates for the broader category of wages and salaries in our approximated market basket. For reference, therapy professions in urban areas experienced a 2% reduction in wages in 2020.

substituted for SNF care. CY 2020 data shows that the relative volume of STACH discharges to HHA remained higher than STACH discharges to SNF in 2020, and the STACH referrals to HHAs appeared to be of higher and increasing severity compared to prior years. In addition, HHAs experienced a reduction in STACH referrals as a total of HHA cases. Further, there was a general increase in respiratory and infectious cases while cardiac cases decreased—signifying that HHAs took on COVID-19 cases that differed in severity from cases in prior years. Finally, overall, there were significant reductions in average visits across PT, OT, and SLP visits in addition to an overall decline in total number of visits across all disciplines and average visits per unique beneficiary—indicating that HHAs likely experienced declines in beneficiaries seeking home health services as volumes from referral sources declined and patients avoided care in fear of contracting the virus.

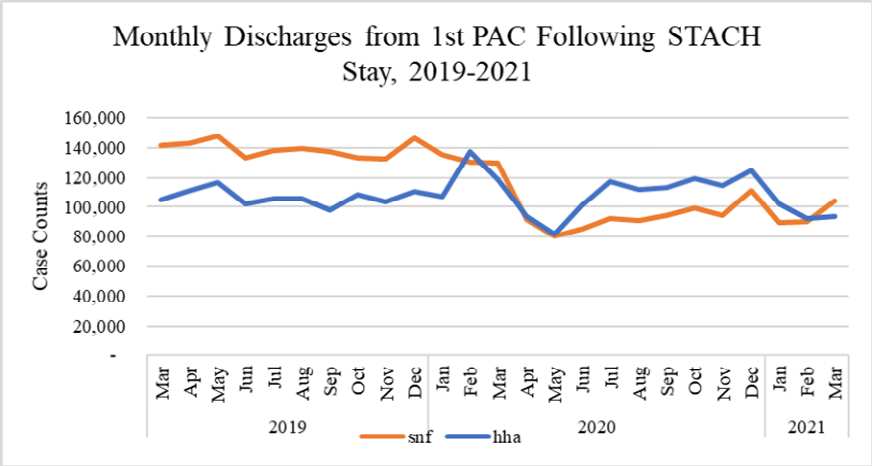
Overall, these trends indicate that the observed shifts in utilization observed in CY 2020 data are atypical and CY 2020 data should not be used, or very carefully used in CY 2022 rate setting or case-mix recalibration.

HIGHER RELATIVE VOLUME OF HOSPITAL DISCHARGES TO HHA COMPARED TO SNF

As shown in **Exhibit 13**, in the early months of the COVID-19 PHE starting in March 2020, both HHAs and SNFs experienced substantial declines in the volume of patients from STACH settings likely as a result of surgery cancellations and declining STACH volumes as patients deferred care.

However, beginning in July 2020, the volume of patients discharged to HHAs was much higher than the volume of patients discharged to SNF. These trends are likely a result of increased patient and provider preference for discharge to home health following a STACH stay, as institutional settings such as SNFs became a less desirable setting. This indicates that HHAs likely substituted for SNF care. These trends have only begun to reverse in early 2021, where a relatively higher volume of STACH discharges appear to go to SNF compared to HHAs—which appears to be more similar to the pre-pandemic trends in 2019.

Exhibit 13: Average Monthly DRG Weights of STACH Referrals to SNF and HHA, CY 2019 - CY 2021

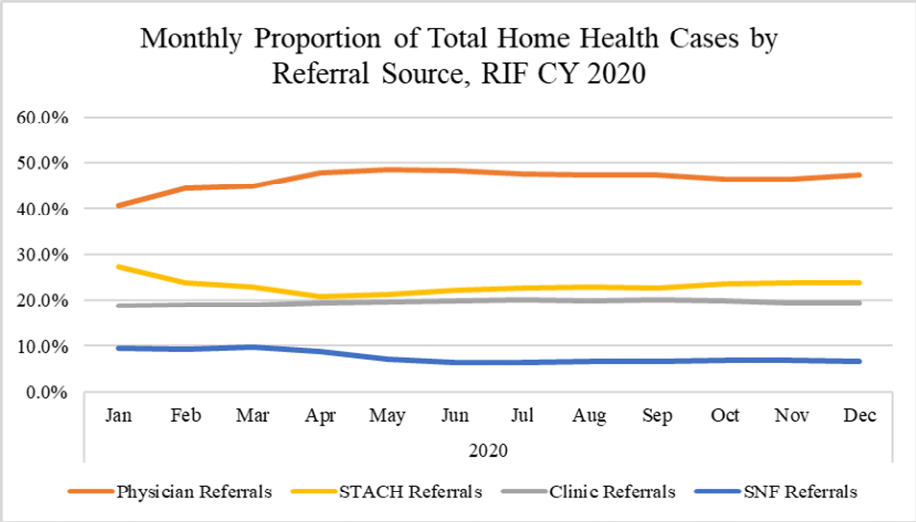


Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

DECLINES IN STACH REFERRALS TO HHAS COUPLED WITH INCREASES IN PHYSICIAN REFERRALS

Our analysis of CY 2020 claims data on reported referral sources showed that SNF and Short-Term Acute Care Hospital (STACH) referrals as a proportion of total HHA cases experienced reductions with the onset of the pandemic in March and April of 2020 while Physician referrals increased. Those proportions remained relatively stable throughout the rest of the year. Particularly, SNF and STACH referrals as a proportion of total cases have not returned to pre-pandemic levels. During the same time period, clinic referrals remained relatively stable. This data is shown in **Exhibit 14** below. These findings indicate that referral sources may have been impacted by the pandemic, especially due to the cancellation of elective surgeries and volume reduction in STACH settings—possibly driving the decrease in STACH referrals to HHAs.

Exhibit 14: Monthly Proportion of Patients by Referral Source, CY 2020[31]



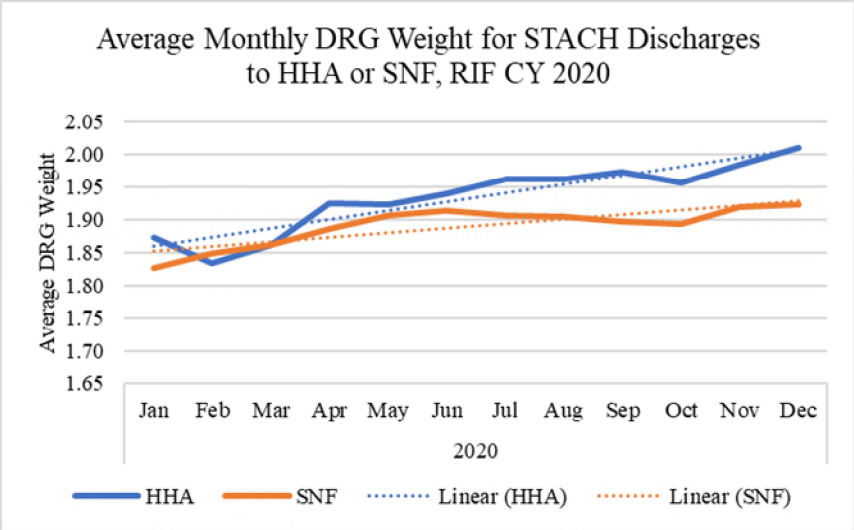
Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

INCREASE IN DRG WEIGHTS FOR STACH DISCHARGES TO HHA

As shown in **Exhibit 15**, we also observed that average DRG weights for STACH discharges to HHAs were higher and rose faster (see linear trend line in Exhibit 12) than DRG weights for STACH patients discharged to SNF during CY 2020. We note that in February and March 2020, DRG weights for STACH discharges to HHAs were comparable to STACH discharges to SNFs. However, starting in April of 2020, we observed an increase in DRG weights for STACH discharges to HHAs rising at a higher rate than DRG weights for STACH discharges to SNF. These findings likely represent the diversion to home health that occurred during the PHE where home health agencies took on patients discharged from STACH settings who might traditionally have gone to a SNF or other post-acute care (PAC) institutional setting, thereby redirecting them from institutional settings where COVID-19 infection rates were high. As a result, HHAs received higher severity patients from STACHs throughout 2020. This may explain the observed increases in comorbidity and functional scores observed in CY 2020 compared to projected cases with behavioral adjustments.

[31] Physician referrals indicate that the patient was admitted upon the recommendation of a personal physician, while clinic referrals indicate that the patient was admitted upon the recommendation of this facility's clinic physician.

Exhibit 15: Average Monthly DRG Weights of STACH Referrals to SNF and HHA, CY 2020



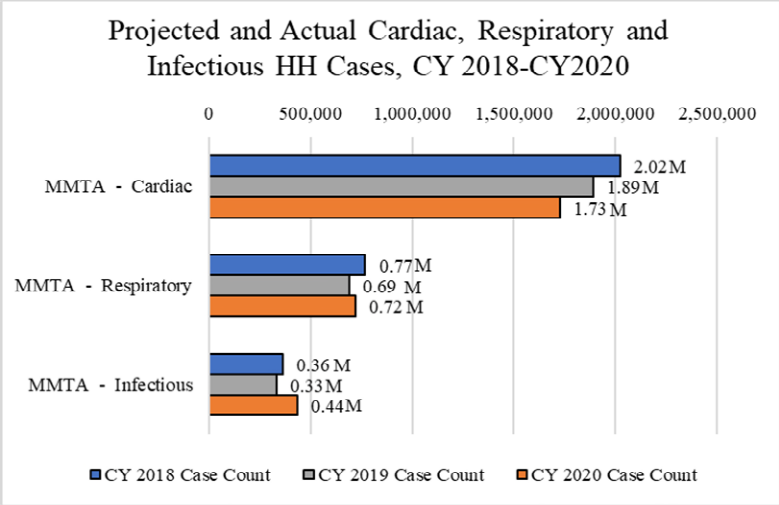
Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

INCREASE IN RESPIRATORY AND INFECTIOUS DISEASE CASES COUPLED WITH DECREASES IN CARDIAC CASES

We note that respiratory and infectious disease home health cases increased in CY 2020. As shown in **Exhibit 16**, respiratory cases declined from 0.77 million cases in CY 2018 to 0.69 million in CY 2019 and then increased to 0.72 million cases in 2020. This represents an increase of 4.7% in respiratory cases between CY 2019 and CY 2020. Similarly, infectious disease cases declined from 0.36 million cases in CY 2018 to 0.33 million in CY 2019 and then increased to 0.44 million cases in 2020. This represents an increase of 30.6% in infectious disease cases between CY 2019 and CY 2020. These findings likely indicate that home health agencies absorbed some of the PAC and STACH COVID-19 cases with the onset of the PHE in 2020—signifying that HHAs likely took on different types of cases in CY 2020 than they did in prior years possibly again influencing the observed increase in comorbidity and functional case-mix groupings.

Further **Exhibit 16** shows that in CY 2020, there were fewer cardiac home health cases—declining from 2.02 million cases in CY 2018 to 1.83 million in CY 2019 and further to 1.73 million cases in 2020. This represents a decline of 8.7% between CY 2019 and CY 2020. These findings corroborate several reports by hospitals that suggest that the pandemic may have had an indirect toll on patients with cardiovascular disease, potentially due to the avoidance of hospitals out of fear of exposure to the virus patients likely delayed receiving care resulting in delays in cardiovascular disease diagnosis and treatment.

Exhibit 16: Projected and Actual Cardiac, Respiratory and Infectious Disease Home Health Cases, CY 2018 - CY 2020



Source: Dobson | DaVanzo Analysis of HH Claims in DUAs LDS 53367 LDS 57157 RIF 54757

REDUCTION IN AVERAGE VISITS ACROSS DISCIPLINES AND PER UNIQUE BENEFICIARY

We also observed significant changes in home health utilization; for instance, we note a reduction in average home health visits per episode and a reduction in average visits across all disciplines. While these changes can in part be explained by the shift from 60-day to 30-day episodes of care, they are also in part due to the onset of the COVID-19 PHE.

As shown in **Exhibit 17**, the average number of home health visits for 30-day periods under PDGM was much lower than average visits for estimated 30-day periods using CY 2018 and CY 2019 data across all disciplines. Similar to monthly trends shown in **Exhibit 3**, Physical Therapy, Occupational Therapy, and Speech Therapy disciplines experienced significant declines in average visits per 30-day episode. Across all disciplines, the total number of visits, reduced by 12% relative from 9.86 visits in CY 2018 simulated 30-day periods to 8.59 visits in CY 2020.

Exhibit 17: Average Visits per 30-Day Episode by Home Health Discipline, CY 2018 - CY 2020

Discipline	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020
Skilled Nursing	4.53	4.49	4.35
Physical Therapy	3.30	3.33	2.71
Occupational Therapy	1.02	1.07	0.78
Speech Therapy	0.21	0.21	0.16
Home Health Aide	0.72	0.67	0.54
Social Worker	0.08	0.08	0.06
Total (all disciplines)	**9.86**	**9.85**	**8.59**

Source: CY 2022 HH PPS Proposed Rule (86 FR 35874)

It is also important to note that coupled with the decline in the average number of total visits per 30-day episode and across each discipline, we observed a decline in the total number of unique beneficiaries and a subsequent reduction in the average number of visits per unique HH beneficiary. This signifies that the observed reduction in average visits is likely because the pandemic resulted in an overall reduction in

beneficiaries seeking care. In addition, some home health providers conducted care through telehealth visits which are not captured in claims data—possibly explaining the reduction in the observed number of visits for CY 2020. These results are shown in **Exhibit 18**.

Exhibit 18: Overall Utilization of Home Health Services, CY 2018 - CY 2020

Discipline	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020
30-Day Periods of Care	9,336,898	8,744,171	8,165,402
Unique HHA Users	2,980,385	2,802,560	2,786,662
Average Number of 30-Day Periods of Care per Unique HHA User	3.13	3.12	2.93

Source: CY 2022 HH PPS Proposed Rule (86 FR 35874)

The above trends underscore the significant shifts in home health utilization that occurred as a result of the pandemic. CMS should therefore exercise caution as they use CY 2020 for any purposes such as rate-setting or case-mix recalibration.

Implications for Using CY 2020 Data to Recalibrate CY 2022 Case-Mix Weights

In accordance with Section 1895(b)(3)(A)(i) of the Act, in the CY 2022 HH PPS proposed rule, CMS proposes a recalibration of PDGM case-weights using CY 2020 data. For reference, the Act requires that the standard prospective payment rate and other applicable amounts be standardized in a budget-neutral manner. In the CY 2022 HH PPS proposed rule, CMS indicates that they believe that recalibrating the case-mix weights using data from CY 2020 would be more reflective of PDGM utilization and patient resource use than case-mix weights that were set using simulated claims data of 60-day episodes.

CMS conducted regression analyses of resource use on the 30-day period's clinical group, admission source category, episode timing category, functional impairment level, and comorbidity adjustment category using CY 2020 home health claims data linked OASIS data to generate the recalibrated case-mix weights for the 432 HHRG groups. From these analyses based on CY 2020 data, CMS determined that total payments using the recalibrated case-mix weights were 3.4% lower than total payments using the CY 2021 PDGM weights. CMS then calculated a case-mix budget neutrality factor of 1.039 used to update the CY 2022 payment rates. The CY 2022 national standardized payment amounts and inputs for case-mix weight budget neutrality are shown in **Exhibit 19**.

Exhibit 19: CY 2022 National, Standardized Payment Amount

CY 2021 National Standardized 30-Day Period Payment	Case-Mix Weights Recalibration Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update	CY 2022 National, Standardized 30-Day Period Payment
$1,901.20	1.0390	1.0013	1.018	$2,013.40

Source: CY 2022 HH PPS Proposed Rule (86 FR 35874)

While the annual recalibration of case-mix weights is statutorily sound and is meant to ensure that case-mix weights are reflective of recent trends in resource use, it is important to note that the COVID-19 PHE has had significant effects on home health utilization and overall case-mix severity in CY 2020. Given these atypical trends, the use of CY 2020 data for rate-setting or case-mix recalibration may be inaccurate as CY 2020 data may not be representative of utilization in CY 2022. This is especially important at the HH agency level where case-mix recalibration will have varying impacts on distributional effects of total payments even

though. For example, CMS impact analyses indicate that small HHAs with less than 1,000 cases and HHAs in the pacific region will experience significant payment reductions due to the case-mix recalibration.[32]

Further, we note that CMS does not use CY 2020 data to recalibrate LUPA thresholds in the CY 2022 HH PPS proposed rule and they indicate that "visit patterns and some of the decrease in overall visits in CY 2020 may not be representative of visit patterns in CY 2022."[33] Using the same logic, it should follow that the observed atypical visit patterns and decrease in overall visits in the CY 2020 data present similar limitations for case-mix recalibration.

Given these atypical trends, we caution against the use of CY 2020 data for rate-setting or case-mix recalibration as CY 2020 data may not be representative of utilization in CY 2021 or CY 2022.

Conclusions

Implemented in CY 2020, PDGM was designed to be budget-neutral, meaning that Medicare payments under PDGM cannot exceed or come below what the payments would have been in absence of the conversion to the new system of payment. PDGM changed the unit of payment from 60-day periods to 30-periods and relies more heavily on patient characteristics. Most importantly, PDGM eliminated therapy service thresholds that primarily drove case-mix and payments under the 60-day system, in part, leading to a decline in therapy services furnished in CY 2020. In addition, the COVID-19 PHE disrupted operations for home health agencies that had only just begun adapting to the new Patient-Driven Groupings Model (PDGM). As such, there were significant reductions in average therapy visits with the onset of the pandemic likely as a result of patients turning away care in fear of contracting the virus. Further, with fewer inpatient hospitalizations and much lower patient interest in SNFs, home health likely substituted for SNF care and HHAs experienced an influx of respiratory and infectious cases. Overall, the COVID-19 PHE likely influenced case-mix severity observed in CY 2020 in complex ways.

The impacts of PDGM and the COVID-19 PHE on home health utilization have complex but separate implications for the assessment of budget neutrality in CY 2020 and the use of CY 2020 data for future rate-setting and case-mix recalibration.

First, the congressional statute requires that budget neutrality be maintained under PDGM, as such, CMS must compare actual CY 2020 payments under the PDGM to payments that otherwise would have been made had PDGM not been implemented. This necessitates the accurate identification of data that represents case-mix and payments of a counterfactual 60-day system that would have existed in the absence of PDGM.

However, in the CY 2022 HH PPS proposed rule, CMS uses CY 2020 data to compare payments under both PDGM and the prior 60-day payment system—which we find inaccurate because PDGM eliminated therapy thresholds which by design drove case-mix and payments under the 60-day system. The combination of the shift in payment incentives away from therapy and the COVID-19 PHE led to an observed 29.7% reduction in therapy visits, this likely led to CMS' inaccurate conclusion that payments under PDGM were 6% higher than they should have been.

[32] Table 38 CY 2022 HH PPS, 86 FR 35874 Page 35992 https://www.federalregister.gov/d/2021-13763/p-1135
[33] CY 2022 HH PPS, 86 FR 35874 Page 36001, Available at https://www.federalregister.gov/d/2021-13763/p-1176.

Under an alternative approach that compares CY 2020 payments under PDGM to payments under a more accurate counterfactual based on CY 2018 payments for 60-day episodes converted to 30-day episodes, we find that CY 2020 payments were 1.4% below projected payments with behavioral adjustments. In addition, regardless of the root cause, two of the three anticipated behavioral changes that CMS used to justify prospective payment rate reductions of 4.36% have not occurred—LUPA rates remain higher than projected and clinical groupings continue to reflect historical trends without behavioral adjustments. The combination of unrealized behavioral changes under PDGM and the COVID-19 PHE likely impacted CY 2020 payments in complex ways leading to a total 5.76% shortfall in payments. In the near-term, CMS may consider taking corrective action to increase the base rate by 5.76% so the HH PPS will be more likely to achieve budget neutrality in CY2022.

Separately, the atypical utilization trends observed in CY 2020 data as a result of PDGM implementation and the COVID-19 pandemic will affect future HH PPS case-mix recalibration and rate-setting. Under PDGM, CMS finalized a rule that they would annually recalibrate case-mix using the most recently available claims data in a budget neutral manner, which for CY 2022 would be CY 2020 claims data. However, because the CY 2020 claims data includes services furnished during the COVID-19 public health emergency (PHE)—which altered utilization significantly—the redistributional effects of case-mix recalibration would be unjustifiable. Observed utilization trends in CY 2020 may not be representative of future utilization trends in CY 2022 and the effects of the pandemic on case-mix vary by market and provider. With the recalibrated case-mix weights, small HHAs with less than 1,000 cases annually and agencies in the pacific region could likely experience significant payment reductions.

Ultimately the COVID-19 PHE will affect future rate setting, rebasing, and payment system overhauls across all Medicare payment systems. The allowance of telehealth visits for home health services while reasonable, also impacts payment data accuracy because telehealth visits are currently not reimbursable or captured in claims data. The agency will therefore need to carefully consider how it addresses and corrects for these issues. The COVID-19 PHE is changing the shape of healthcare across the country—how CMS incorporates this into rate setting (future incentives) will help determine to what extent these changes are permanently ingrained in the payment systems.

Home Health Labor Cost Survey

Understanding the impact of the COVID-19 Public Health Emergency (PHE) on home health agency labor costs

Dobson | DaVanzo
HEALTH ECONOMICS CONSULTING

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Home Health Labor Cost Survey

Understanding the impact of the COVID-19 Public Health Emergency (PHE) on home health agency labor costs

Submitted to:
Partnership For Quality Home Healthcare (PQHH)

Submitted by:

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August 26, 2021

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Executive Summary

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to investigate the potential impact of the COVID-19 Public Health Emergency (PHE) on the Home Health Prospective Payment System (HH PPS) market basket used to update payments in the CY 2020 – CY 2022 HH PPS final and proposed rules. Below are several highlights from the results of an appropriately anonymized and aggregated survey of home health industry participants taken in August 2021.

- Home health agencies experienced increases in wage growth as well as increased growth in costs associated with staffing and retention (benefits) in 2020 than they did in 2019. All labor-related costs for 2021 are estimated to continue to grow at a higher rate than 2019.[1]
- Wages for home health staff in urban areas increased at a slightly lower rate in 2020 (an average percent increase of 3.1%) which coincides with the impact of COVID-19 on labor costs generally. In 2021, the average percent increase in wages is expected to rebound at 3.5% — an increase that is higher than the increase observed in 2019.
- In contrast to trends in wages for home health staff in urban areas, wages for home health staff in rural areas increased at a higher rate in 2020 than they did in 2019. Rural HHA wages are expected to continue to increase in 2021, although the rate of increase is estimated to be much lower than observed in 2020.
- Wages for home health staff are estimated to continue to increase in 2021 for all professions.
- Expenses on staff benefits increased by almost three times the rate in 2020 as compared to 2019. Benefits expenses are expected to continue to increase, on average, by 28.0% in 2021—more than twice the rate of increase in 2020.
- The average percent increase in administrative, general, and other expenses was 6.2% in 2020, twice the rate in 2019. This coincides with COVID-19-related increases observed in the literature. In 2021, administrative, general, and other expenses are expected to increase at a rate almost comparable but slightly higher than increases before the COVID-19 pandemic in 2019.

[1] The Labor Cost Survey was distributed to PQHH members in August 2021, thus data for January 2021-December 2021 are estimated by respondents based on year to date (YTD) information known at that time of data collection.

- The results of this survey indicate that wages and associated home health industry expenses rose significantly between 2019 and 2021, yet these increases aren't adequately accounted for in current market basket updates. Instead, the HH PPS market basket update factors declined from 2.9 in CY 2020 to 2.4 in CY 2022. These results suggest that the current proxies for price inflation that CMS uses do not reflect trends in the home health industry, perhaps because they measure inflation across the broader healthcare industry.

Introduction

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to investigate the potential impact of the COVID-19 Public Health Emergency (PHE) on the Home Health Prospective Payment System (HH PPS) market basket used to update payments in the CY 2020 – CY 2022 HH PPS final and proposed rules. The HH PPS market basket percentage is updated annually as required under section 3401(e) of the Affordable Care Act (ACA) and it reflects price inflation for several home health cost categories for each calendar year. Cost categories are derived from Medicare cost report (MCR) data and include wages, benefits, administrative and other expenses. To determine the market basket update factor, CMS calculates a weighted inflation factor based on price proxies for inflation obtained from the Bureau of Labor Statistics from each of the cost categories. However, the price proxies CMS uses are representative of the broader healthcare industry and not specific to the home health industry. CMS updated CY 2020 payments using a market basket update factor of 2.9 in CY 2020 and CY 2021 payments using an update factor of 2.3. The proposed CY 2022 HH PPS market basket update factor is 2.4 percent—a slight increase compared to CY 2021.

In March 2020, the United States healthcare system initiated its response to the coronavirus (COVID-19) pandemic. Federal and state governments issued a PHE which resulted in changes to the use and delivery of home healthcare services. During the early stages of the PHE, home health (HH) agencies saw a decrease in client volume due to fears of contracting the virus through contact with healthcare workers.[2] Federal and state governments began implementing policies during the pandemic that were intended to protect essential workers from the virus by increasing access to COVID-19 supplies and resources.[3] However, some healthcare workers were not designated as essential workers in all states, thus limiting agencies' ability to access PPE, cleaning supplies, and COVID-19 tests.[4]

Fear of contracting COVID-19 also strained HH agencies' labor force. Specifically, HH agency turnover rates and staff shortages increased significantly during the pandemic.[5] The unemployment rate in home healthcare services rose from 2.5% in March to 7.8% in April of 2020 (approximately 327,000 workers).[6] As unemployment rates increased there was also increased competition for minimum wage workers resulting in a tight labor environment.[7] In order to retain home healthcare workers, HH agencies began offering higher wages and retainer payments through federal disaster funding.[8] Hazard pay was distributed through the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act; however, the distribution of funds was determined on a state by state basis.[9] HH agencies who received funds stood a better chance of remaining competitive for healthcare labor. However, the end of hazard pay may create additional financial burden on HH agencies due to COVID-19 PHE altered labor costs.[10]

Federal and state governments set fixed Medicaid and Medicare reimbursement rates for recipients, thus serving as a strong influence on home healthcare workers' wages. Medicare is the largest public payer for home health services; therefore, agencies are limited in their abilities to offer competitive and comprehensive wages and benefits. Investing in funding reimbursement rates would better allow for HH agencies to retain workers at a high rate by providing more sustainable wages.[11] This would decrease the financial burden HH agencies are likely to face in a COVID-19 imposed labor market.

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[2] Porter, K., Hunter, M., Mulmule, N., & Tyler, D. (2021, May 31). *COVID-19 intensifies home Care WORKFORCE Challenges: Policy Perspectives ISSUE BRIEF*. ASPE: Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief.

[3] Ibid.

[4] Ibid.

[5] Galewitz, P. (2021, June 30). *With workers in short Supply, Seniors often wait months for home health care*. NPR. https://www.npr.org/sections/health-shots/2021/06/30/1010328071/with-workers-in-short-supply-seniors-often-wait-months-for-home-health-care.

[6] Bhandari, N., Batra, K., Upadhyay, S., & Cochran, C. (2021). Impact of COVID-19 on Healthcare Labor Market in the United States: Lower Paid Workers Experienced Higher Vulnerability and Slower Recovery. International journal of environmental research and public health, 18(8), 3894. https://doi.org/10.3390/ijerph18083894.

[7] Woods, B. (2019, April 9). America's $103 billion home health-care system is in crisis as worker Shortage worsens. CNBC. https://www.cnbc.com/2019/04/09/us-home-healthcare-system-is-in-crisis-as-worker-shortages-worsen.html.

[8] Porter, K., Hunter, M., Mulmule, N., & Tyler, D. (2021, May 31). *COVID-19 intensifies home Care WORKFORCE Challenges: Policy Perspectives ISSUE BRIEF*. ASPE: Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief.

[9] Ibid.

[10] Kinder, M., Stateler, L., & Du, J. (2021, March 17). The COVID-19 hazard continues, but the hazard pay does not: Why AMERICA'S essential workers need a raise. Brookings. https://www.brookings.edu/research/the-covid-19-hazard-continues-but-the-hazard-pay-does-not-why-americas-frontline-workers-need-a-raise/.

[11] Essential, Undervalued, and Underpaid: Home Health Care Workers in the United States during the COVID-19 Pandemic. (n.d.). https://global.lehigh.edu/sites/global.lehigh.edu/files/11%20Home%20Health%20Care%20Workers%20in%20the%20United%20States%20during%20the%20COVID-19%20Pandemic.pdf.

Introduction

To assess the impacts of the COVID-19 PHE on home health agencies' labor, Dobson | DaVanzo, in collaboration with PQHH board members, developed a Labor Cost Survey with the purpose of collecting data from PQHH members about factors that influence their labor costs which are otherwise not available. The goal of the survey was to collect real-time and trending data from the PQHH membership and use the aggregated data to highlight the increasing costs of labor in the home health industry and to document the unusual churn in the labor market that is affecting the operations of home health agencies, all of which can promote industry advocacy and public policy discussions about the accurate reflection of such costs in federal reimbursement rates.

Consistent with applicable federal antitrust compliance guidelines, all individual agency survey responses are confidential and accessible only to Dobson | DaVanzo as an independent third party. Only aggregated data are being reported, and only questions for which at least 5 agencies responded are included in the results. No individual provider's data represents more than 25 percent on a weighted basis of any statistic that is reported, as either this threshold was not exceeded and/or further weighting was done to take into account the size dispersions among all home health providers nationally. As such, all information is aggregated such that it would not permit recipients to identify the price charged, compensation paid by, or any expected trend projected by any particular agency.

All recipients of this report are also reminded that the information contained in this report should be used solely for its intended and appropriate purpose and in compliance with all applicable antitrust laws. Recipients should not discuss, suggest, or agree to any coordination of their individual business decisions or disclose or discuss any of their competitively sensitive non-public information outside their organizations. Recipients should consult their individual legal counsel with any questions about appropriate antitrust compliance.

Methodology

The survey tool was designed to assess the factors which impacted labor supply and demand in the home health industry based on a review of available literature as well as input from PQHH leadership and member agencies. The questions were developed in an iterative process with the feedback of PQHH representatives. In addition, PQHH provided input to ensure that survey recipients would find it as feasible as possible to report the requested data.

The survey tool was administered through Survey Monkey with a mix of questions aimed at gathering the nuances that can affect the market basket index. The questions were designed to obtain basic information about the PQHH member agencies, demographic information about their labor, recent changes in the mix of labor and their wages, and the factors affecting these changes (such as labor retention strategies, as well as administrative and benefits costs). Questions requested both data, selection from multiple options, and open-ended comments..

A confidential survey link was emailed on August 6, 2021 to thirteen PQHH member agencies with instructions not to share their individual links with any other respondent. Dobson | DaVanzo followed-up to obtain confirmation of receipt. Members were initially given four business days to complete the survey, but this deadline was extended by an additional four business days to allow agencies to provide the most accurate and complete data available. Technical assistance was provided by Dobson | DaVanzo via email and phone throughout this duration to ensure consistency in reporting and to support a higher response rate. Agencies which could not complete the survey in the given timeframe were also offered an abbreviated survey with 5 key questions, focusing on those that were directly used for determining market basket projections.

Survey data was downloaded by Dobson | DaVanzo in an Excel file from Survey Monkey and quality checks were performed. We also followed up with agencies with aberrant or missing data via phone and email to determine data completion and accuracy. All data analysis was conducted using Microsoft Excel.

Survey Results

Results Overview

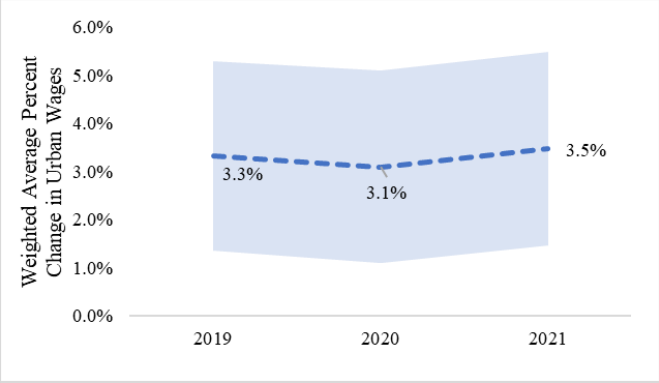
In total, ten PQHH members responded to the 2021 Labor Cost survey, although not all respondents answered each question. Responding members represented home health agencies in 44 of the 50 states.

Wages for Home Health Staff in Urban[12] Areas

Exhibit 1 shows the average weighted overall percent change in wages for field staff and clinical supervisors in urban areas from 2019 to 2021. Interestingly, wages for home health staff in urban areas increased at a slower rate in 2020 (an increase of 3.1% in 2020 as compared to 3.3% in 2019) which coincides with the impact of COVID-19 on the labor market generally. In 2021, the percent increase in wages is expected to rebound to 3.5%..

Exhibit 1:Average Percent Change in Urban Wages for Field Staff and Clinical Supervisors, 2019-2021

Light blue shading indicates the average lower and upper ranges for reported values

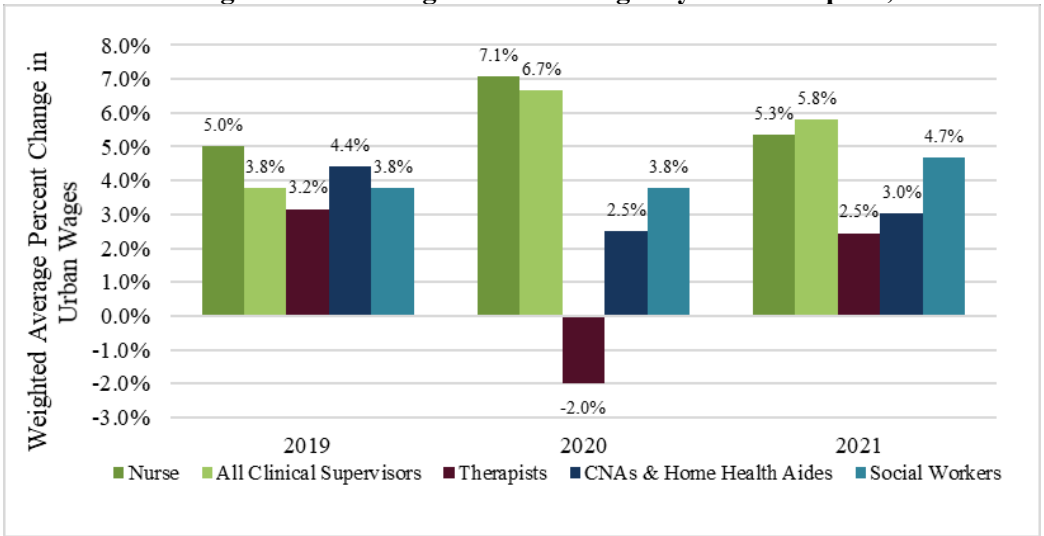


[12] Note that we defined urban areas as counties that are part of Metropolitan Statistical Areas (MSAs).

Wages for Home Health Staff in Urban Areas by Discipline

The observed reduction in the average weighted percent increase in wages for home health staff in urban areas in 2020 is likely primarily driven by the decline in wages for therapy professions (which declined by 2.0% from 2019 to 2020 as shown below). The observed decrease in wages for therapy professions in 2020 is likely a result of the change in payment system away from one which incentivized therapy utilization to one which does not. Wages for nurses and clinical supervisors increased at a higher rate in 2020 compared to 2019.Wages for social workers increased at the same rate in 2020 as in 2019, while wages for CNAs and home health aides increased at a lower rate in 2020 as compared to 2019. Wages for HHA staff in urban areas are estimated to increase in 2021 for all disciplines.

Exhibit 2: Average Percent Change in Urban Wages by Staff Discipline, 2019-2021



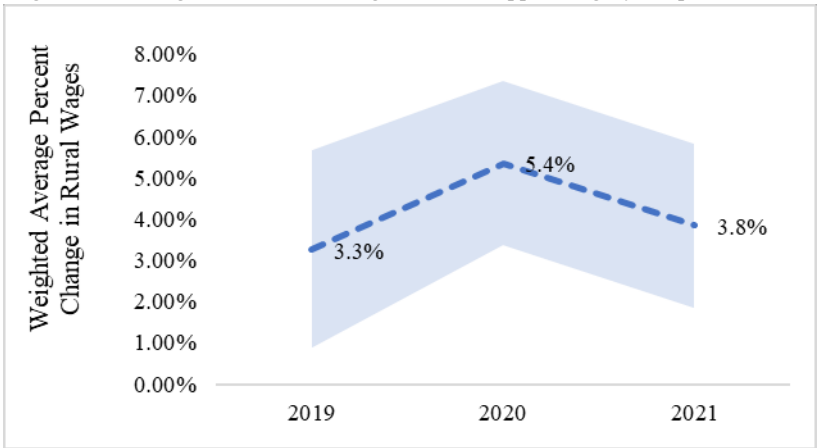
Wages for Home Health Staff in Rural[13] Areas

Exhibit 3 shows the average weighted overall percent change in wages for field staff and clinical supervisors in rural areas from 2019 to 2021.

In contrast to trends in wages for home health staff in urban areas, wages for home health staff in rural areas increased at a higher rate in 2020 than they did in 2019. Rural HHA wages are expected to continue to increase in 2021, although the rate of increase is estimated to be lower than observed in 2020. Wages for HHA staff in rural areas increased by 3.3% in 2019, 5.4% in 2020, and 3.8% in 2021, as shown below.

Exhibit 3: Average Percent Change in Rural Wages for Field Staff and Clinical Supervisors, 2019-2021

Light blue shading indicates the average lower and upper ranges for reported values

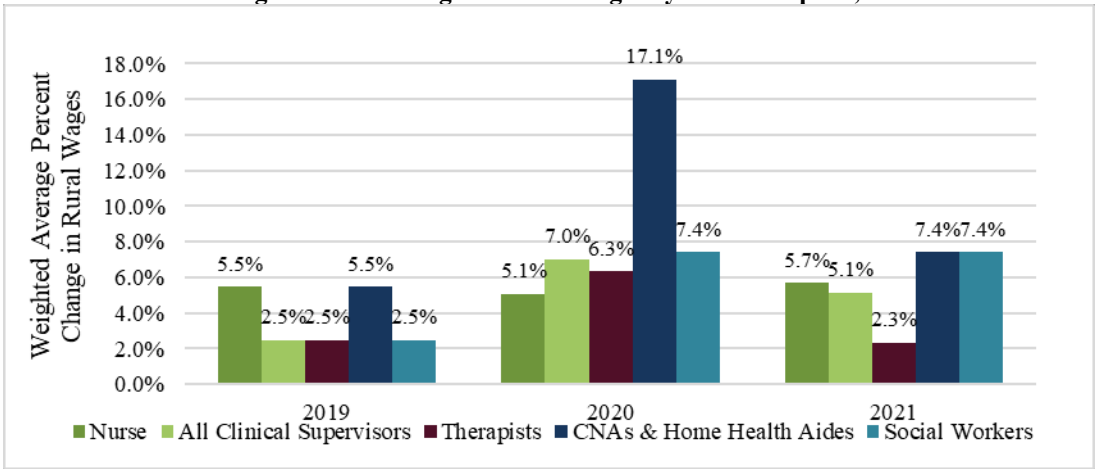


[13] Rural areas are defined as counties that are not part of a Metropolitan Statistical Area (MSA).

Wages for Home Health Staff in Rural Areas by Discipline

The observed increase in the average weighted percent change in wages for home health staff in rural areas in 2020 is likely primarily driven by the increase in wages of rural certified nursing assistants and home health aides which increased by 17.1% in 2020 as shown in **Exhibit 4**. Wages for all home health disciplines in rural areas increased at a higher rate in 2020 compared to 2019 except for nurses. Further, wages for all home health disciplines are estimated to continue to increase in 2021. Although, the estimated wage increases for therapists in 2021 are much lower than 2020.

Exhibit 4: Average Percent Change in Rural Wages by Staff Discipline, 2019-2021



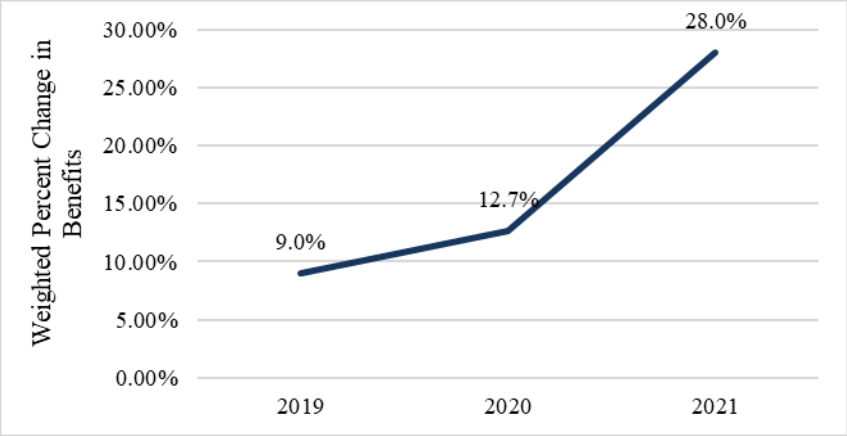
Additional responses by participating PQHH members indicated that wages for field staff and clinical supervisors are expected to increase at a faster rate in 2022 than they did in 2021. Responses indicated that increasing competition for clinical staff, particularly nurses, would be a driving force for wage increases, especially as hospitals are able to pay higher salaries for nurses than home health agencies and the ongoing national shortage of nurses continues.[14]

[14] https://pittsburgh.cbslocal.com/2021/08/23/local-hospitals-offer-big-sign-on-bonuses-amid-nursing-shortage/.

Benefits

Exhibit 5 shows the weighted average percent change in benefits expenses. As shown below, benefits costs increased in 2020 compared to 2019. Benefits expenses are expected to continue to increase by 28.0% in 2021—more than twice the rate of increase in 2020.

Exhibit 5: Average Percent Change in Benefits, 2020-2021

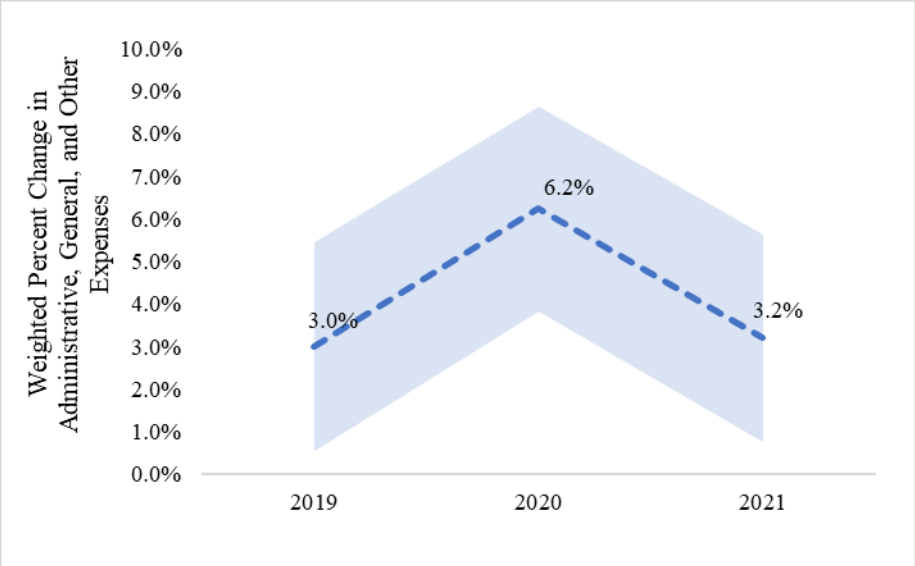


Administrative, General and Other Expenses

Exhibit 6 shows the average weighted percent change in administrative, general, and other expenses from 2019 to 2021 for PQHH members operating in both urban and rural areas. We defined administrative, general, and other expenses as expenses related to administrative support, financial services, medical supplies, rubber and plastics, telephone, professional fees, other products, and other services. As shown, the average percent increase in administrative, general and other expenses more than doubled in 2020—6.2% in 2020 compared to 3.0% in 2019—coinciding with COVID-19-related increases observed in the literature. In 2021, administrative, general, and other expenses are expected to increase at a rate almost comparable although slightly higher than increases before the COVID-19 pandemic in 2019.

Exhibit 6: Average Percent Change in Administrative, General, and Other Expenses, 2019-2021

Light blue shading indicates the average lower and upper ranges for reported values



PQHH agencies indicated that they face a number of pressures in the current environment for recruiting home health labor. Most significantly, losing potential candidates to higher paying healthcare jobs was cited as the most prevalent pressure reported by the agencies. Losing potential candidates to other healthcare sectors due to safety concerns was the second most frequently cited reason by home health agencies. Current literature supports these findings.[15]

[15] Porter, K., Hunter, M., Mulmule, N., & Tyler, D. (2021, May 31). *COVID-19 intensifies home Care WORKFORCE Challenges: Policy Perspectives ISSUE BRIEF*. ASPE: Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief; Bhandari, N., Batra, K., Upadhyay, S., & Cochran, C. (2021). Impact of

Limitations

- These responses reflect providers' best estimates and their interpretation of the questions. As such, accuracy and consistency of the responses may vary.
- Given the survey's quick turnaround, agencies may have been limited in the extent to which they could complete the survey.
- The sample size is limited as some providers could not participate.
- For these reasons, the results should be taken as correct in terms of direction and magnitude, but the actual numbers may be different in future analyses.
- The respondents who participated operate in different geographical areas and manners, thus any averaged or aggregated data may not necessarily be indicative of activities in all or particular areas within the United States.

COVID-19 on Healthcare Labor Market in the United States: Lower Paid Workers Experienced Higher Vulnerability and Slower Recovery. International journal of environmental research and public health, 18(8), 3894. https://doi.org/10.3390/ijerph18083894.

Conclusion

The results of this survey indicate that labor costs and other associated home health industry expenses rose significantly between 2019 and 2021, yet these increases aren't adequately accounted for in current market basket updates. Instead, the HH PPS market basket update factors declined from 2.9 in CY 2020 to 2.4 in CY 2022. These results suggest that the current proxies for price inflation that CMS uses do not reflect trends in the home health industry, perhaps because they measure inflation across the broader healthcare industry.

Further analyses showed that these cost increases from the survey data translate into a market basket update factor that should have increased by 1.1 percentage points between CY 2019 and CY 2020 and by 1.2 percentage points between CY 2020 and CY 2021. While results from this survey provide data to derive a counterfactual market basket based on only the three top cost categories, the observed upward trends in price increases across cost categories and the overall market basket indicate that the market basket should have remained flat or risen between CY 2019 to CY 2021 instead of the observed decline. For reference, the CMS HH PPS market basket update factors decreased by 0.1 percentage points between CY 2019 and CY 2020, and further decreased by 0.6 percentage points between CY 2020 to CY 2021

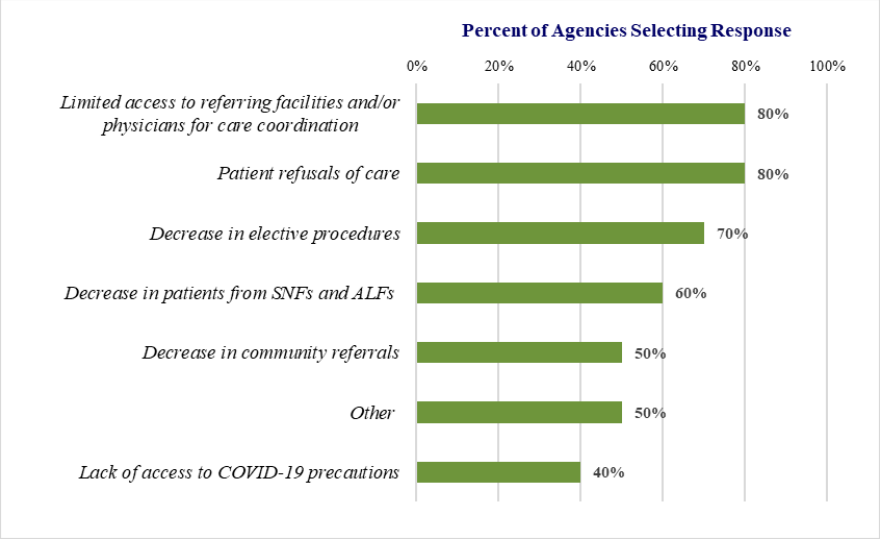
Overall, the results of this survey underscore the need for CMS to comprehensively assess all aspects of the HH PPS market basket derivation to ensure that it reasonably forecasts annual cost increases and that the price proxies accurately reflect trends in the home health industry.

Appendix

This appendix provides a summary of results from a selection of additional questions asked as part of the survey (for which we received a reportable number of responses).

Additionally, we asked questions pertaining to factors affecting geographic distribution of patient populations and percent of patients who experienced delayed starts of care due to shortage of staff, both of which resulted in fewer than five responses and are not tabulated in this report due to low sample reporting size.

Figure 1: Factors Affecting the Changes in the Number of 60-day Episodes or 30-day Periods Delivered by Home Health Agencies in CY 2020 as Compared to CY 2019



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 2: Average Percent of Patient Population by Geographical Distribution

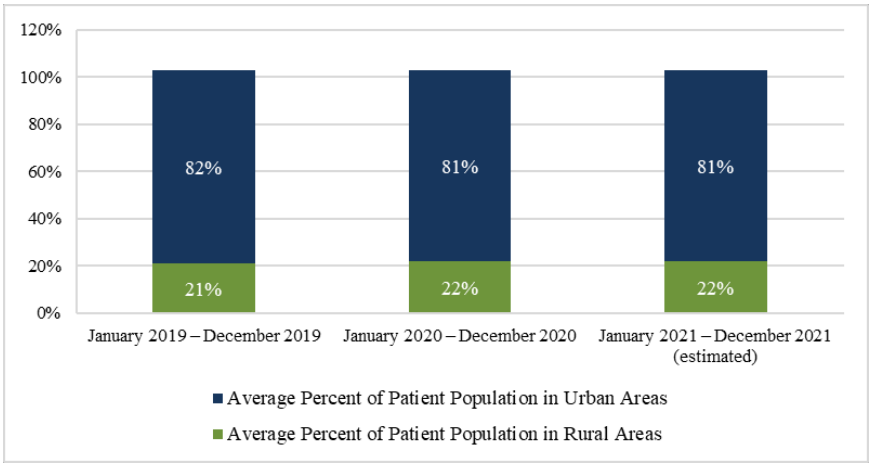


Figure 3: Average Percent of Full-Time Equivalent Field Staff and Clinical Supervisor Positions that were Terminated/Resigned or that were Filled

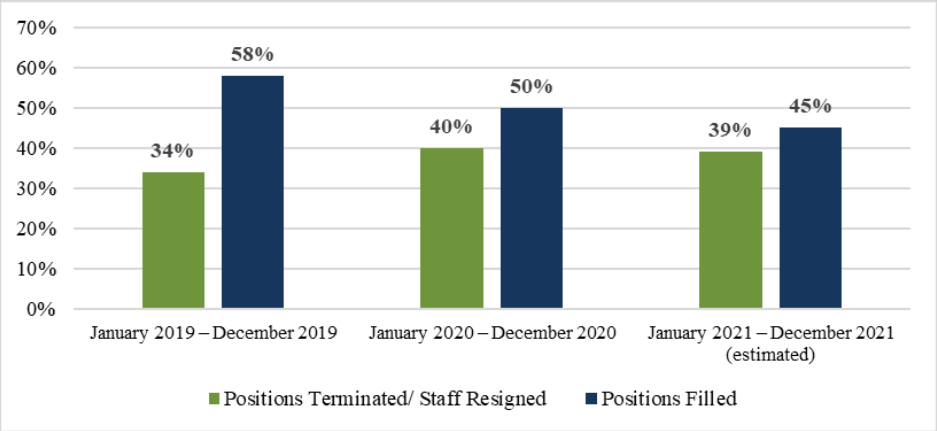
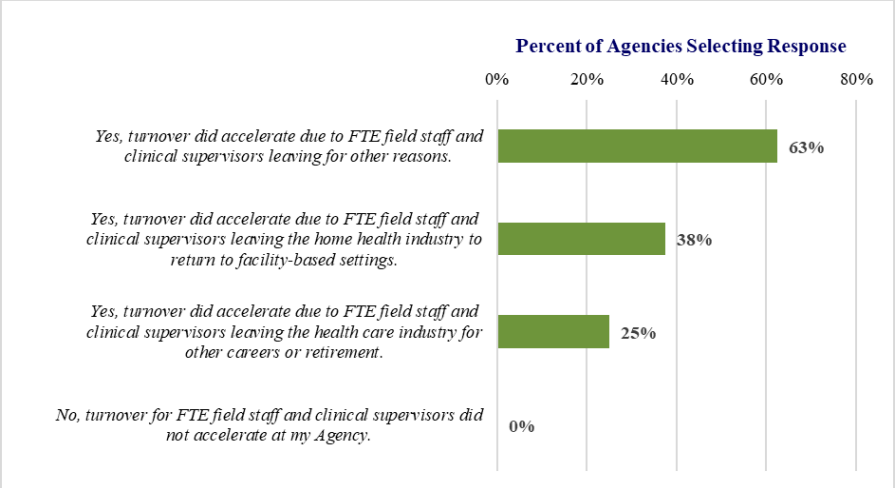
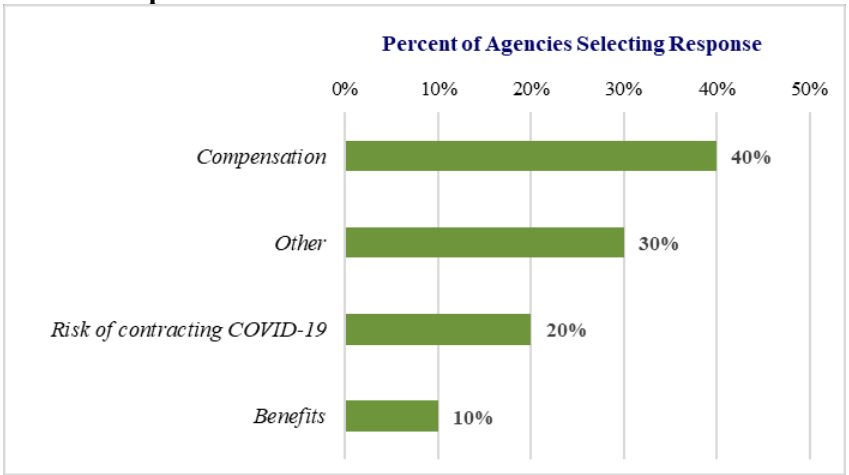


Figure 4: Reason for Turnover if Turnover for Full-Time Equivalent Field Staff and Clinical Supervisors Accelerated from CY 2019-2020 at Home Health Agencies



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 5: Primary Reason if Full-Time Equivalent Field Staff and Clinical Supervisors Left for Other Healthcare Sector Jobs



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 6: Average Percent of Full-Time Equivalent Field Staff and Clinical Supervisors

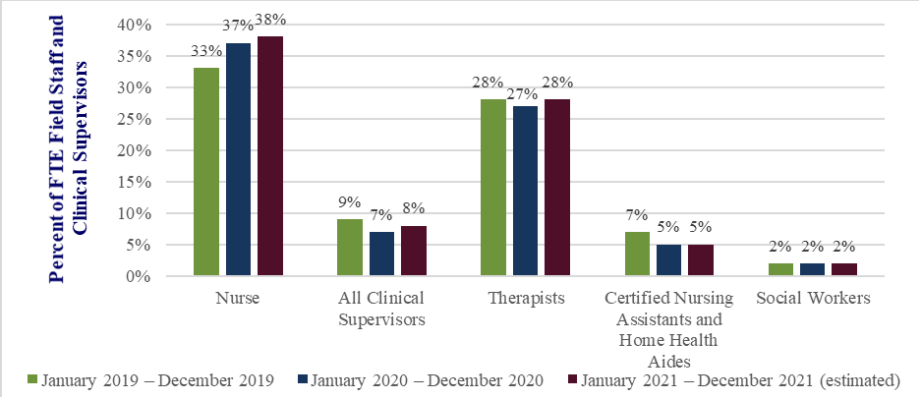


Figure 7: Average Percent of Visits Staffed by Full-Time Equivalent or Contract Field Staff and Clinical Supervisors

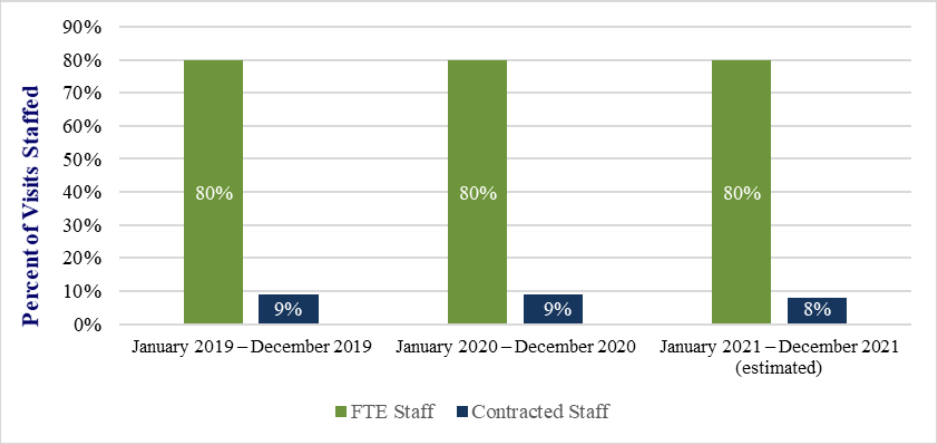
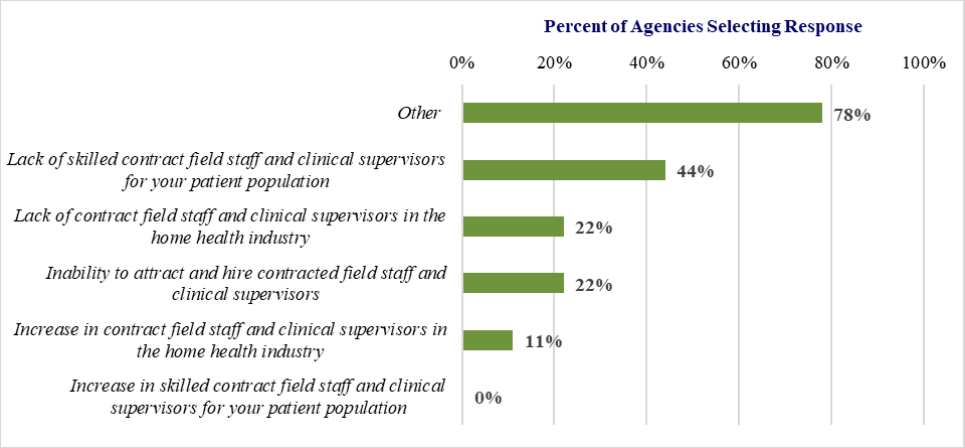


Figure 8: Factors Affecting Changes in the Mix of Contracted Field Staff and Clinical Supervisors



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 9: Average Racial Distribution of Full-Time Equivalent Field Staff and Clinical Supervisors

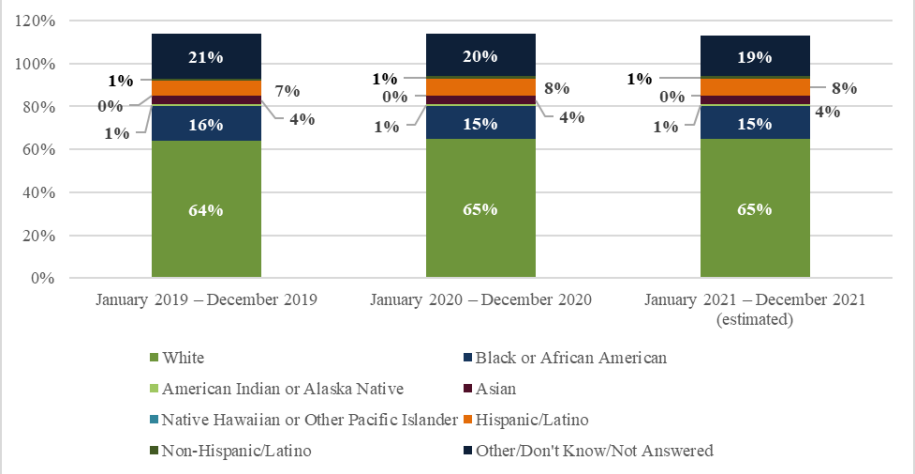


Figure 10: Average Portion of Full-Time Equivalent Field Staff and Clinical Supervisors by Gender Designation

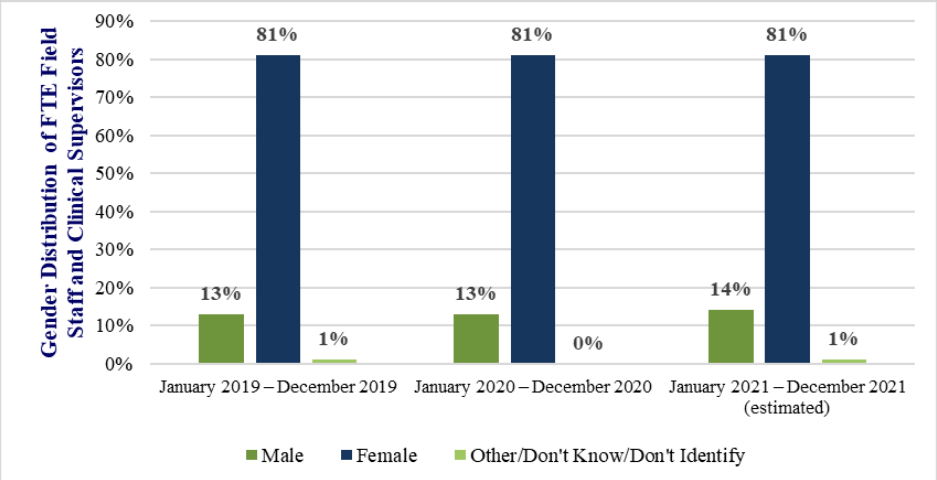


Figure 11: Average Age Distribution of Full-Time Equivalent Field Staff and Clinical Supervisors

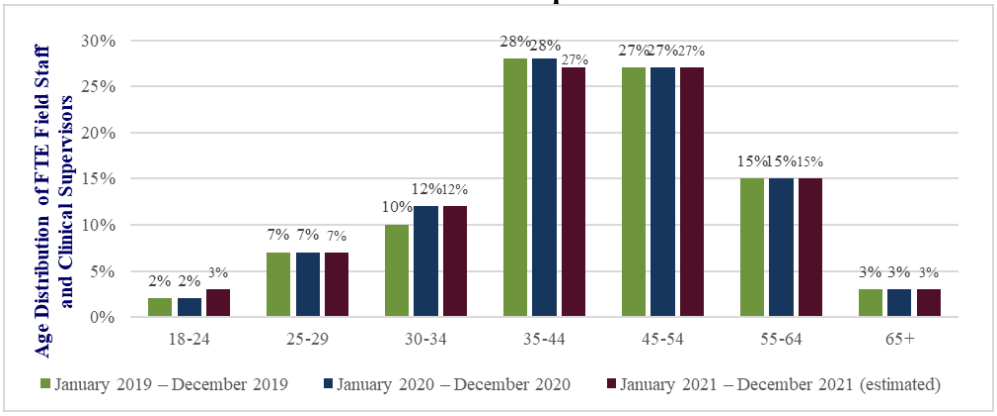


Figure 12: Average Payer Mix of Responding Member Agencies

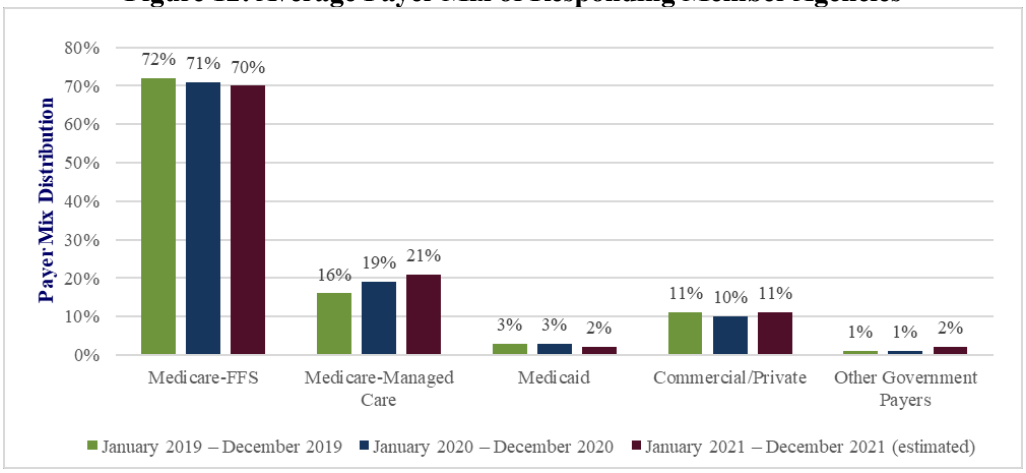


Figure 13:Percent of Unfilled Positions for Field Staff and Clinical Supervisors

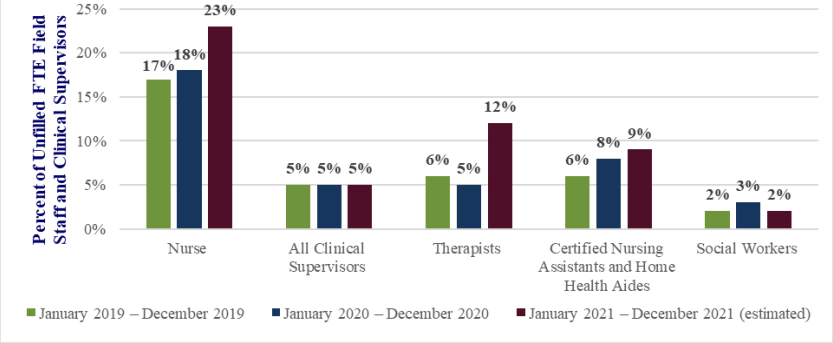


Figure 14: Percent of Annual Overtime Hours Relative to Base Salary

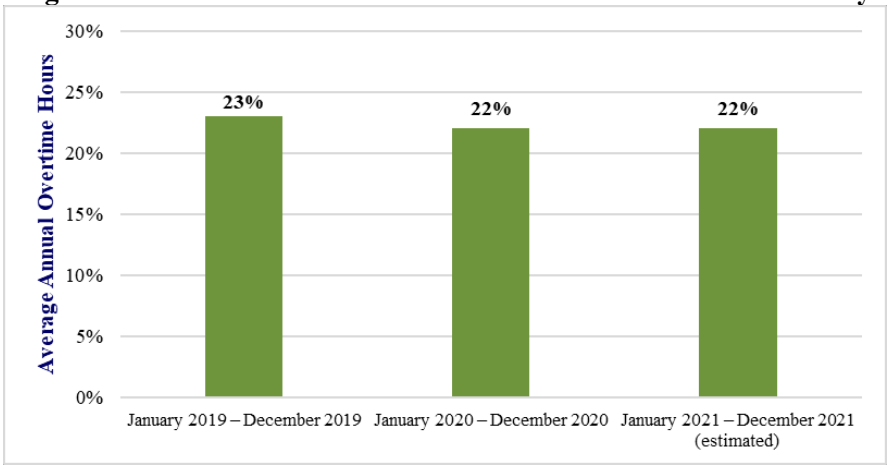


Figure 15: Average Number of Recruiters at Home Health Agencies