



August 16, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1766-P
P.O Box 8013
Baltimore, MD 21244-8013

Re: **CMS-1766-P: Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and 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 2023 Home Health Prospective Payment System (HH PPS) Proposed Rule published at 87 *Federal Register* 37600 on June 23, 2022 (the “Proposed Rule”).¹ We submit the following comments to offer constructive feedback and recommendations that we believe will help avoid substantial disruptions in patient care for Medicare beneficiaries. We continue to believe that the proposed methodology for determining behavioral assumptions and adjustments is deeply flawed and will severely reduce access to skilled home health services for years to come.

As a national coalition of skilled home healthcare providers, we appreciate the fact that the Centers for Medicare & Medicaid Services (CMS) has traditionally 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). The payment reductions proposed in this rule conflict with the law and will be disastrous for patient access and care delivery and will undermine CMS’ broader goals to advance health equity and quality improvement. We urge CMS to review and incorporate the important considerations outlined below before finalizing the rule and when considering future rulemaking. We offer comments on the Home Health Prospective Payment System, the Home Health Quality

¹ 87 Fed. Reg. 37600 (June 23, 2022), *available at* <https://www.federalregister.gov/documents/2022/06/23/2022-13376/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home>.

Reporting Program (HH QRP), the expanded Home Health Value-Based Purchasing (HHVBP) Model, and other key areas.

I. The Home Health Prospective Payment System

The Partnership believes that Medicare payments should be accurate, predictable, and support access to high quality home healthcare. However, the proposed permanent reduction to the 30-day home health payment rate and future additional reductions outlined in the CY 2023 home health PPS Proposed Rule significantly conflict with these goals and will have devastating consequences for both patients and providers. In the interest of ensuring a viable home health benefit for Medicare beneficiaries, we urge CMS not to finalize these proposed reductions.

In CY 2020, CMS implemented the 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 utilization. In the Proposed Rule, CMS proposes to (1) maintain its negative 4.36 behavioral adjustment in the CY 2023 rates; (2) implement a new methodology aimed at ensuring budget neutrality that results in a significant permanent rate reduction; and (3) advance future temporary adjustments in the payment rates to strip billions of additional dollars from providers that are needed for patient care.

As we explain in detail below and in the attachments, the Partnership finds that these payment reductions are technically flawed and not legally supported. More importantly, these policies will result in financial harm to providers and undercut patient care and quality at a time when in-home care is an essential option for many patients due to the ongoing COVID-19 pandemic and is increasingly preferred by many patients, families, and dedicated caregivers. Finally, the costs of providing that care are increasing faster than Medicare's payments due to well-documented staffing shortages and surging costs for staffing, fuel, medical supplies, and other patient care related resources, a view supported by data from the government's own Bureau of Labor and Statistics (BLS).

We have included detailed analysis and findings on these issues for CMS' consideration below in the attached report² and labor study³ from Dobson|DaVanzo & Associates, LLC (Dobson|Davanzo). We have also included an analysis from King & Spalding⁴ addressing legal concerns with CMS' approach to both the permanent and temporary payment adjustments outlined in this rule. Finally, we include comments and recommendations on the annual payment update and other proposed policies related to the payment system.

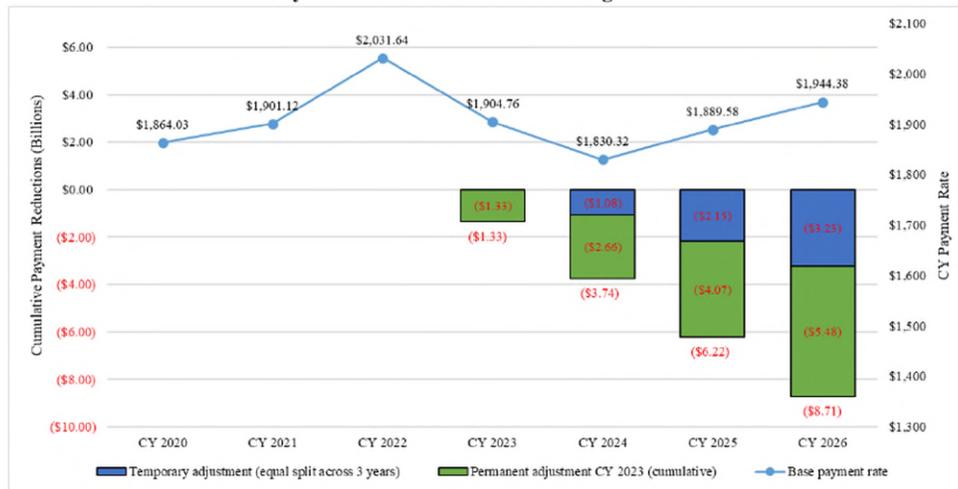
² See attached as Appendix A: Dobson|DaVanzo & Associates, LLC, EVALUATION OF MEDICARE HOME HEALTH SERVICES UNDER PDGM AND IMPLICATIONS FOR CY 2023 HH PPS PROPOSED RULE, Aug. 15, 2022.

³ See attached as Appendix B: Dobson|DaVanzo & Associates, LLC, HOME HEALTH LABOR COST SURVEY, Aug. 16, 2022.

⁴ See attached as Appendix C: King & Spalding, MEMO RE: ANALYSIS OF STATUTORY AUTHORITY FOR PROPOSED UPDATE TO HOME HEALTH PAYMENT SYSTEM RATE, Aug. 15, 2022.

As shown in the chart below (methodological assumptions for which are included in Exhibit 15 of Appendix A), the Proposed Pule would result in a base payment in CY 2024 that is lower than the rate was in CY 2020, and it would remove a cumulative \$8.71 billion from home health payments through CY 2026.

Exhibit 15: Projected Cumulative Impact of PDGM Behavioral Adjustments to HHA Revenues and Medicare Payment Rates from CY 2023 through CY 2026



Note: The payment reductions are displayed to illustrate the cumulative impact of the payment reductions between CY 2023 and CY 2026. Accordingly, the temporary adjustments accrue to \$3.23 billion by CY 2026, although they are temporary one-time reductions for each year. In contrast, the permanent adjustment applied to the CY 2023 base payment rate continues to accrue over time.

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

a. Annual Payment Rate Update for CY 2023 / Increases to Staffing and other Costs of Care

The Partnership supports the application of an annual update to the home health payment rates. These updates are critical to ensuring that home health providers have the necessary resources to provide high quality care to their patients as costs increase from year to year. Currently, well-documented staffing shortages and dramatic increases in the cost of labor, fuel, medical supplies, and other resources necessary to deliver care have created challenges for home health providers. We are concerned that annual increases to the home health payment rates based on the current market basket have not kept pace with recent cost increases. The significant increase in such costs adds to financial pressure on providers already facing numerous challenges and impacts access to care for patients. CMS' proposal to reduce the 30-day payment amount by 7.69 percent eliminates any benefit from the proposed annual payment update to meet these challenges. Finally, we note that the shortfalls created by the annual payment rates not keeping pace with increasing costs are cumulative over time, intensifying the turmoil home health providers face one year to the next.

The law⁵ 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 Proposed Rule provides for an annual update factor of 2.9 percent. This increase reflects the effects of a 3.3 percent market basket increase minus a 0.4 percent productivity adjustment. Net effects of an updated outlier fixed dollar loss (FDL) threshold (\$40 million decrease) would have resulted in a \$520 million increase in aggregate payments to home health providers. However, the proposed permanent adjustment to the 30-day payment amount of negative 7.69 percent results in a decrease in payments of negative 4.2 percent (or \$810 million).

Similar to our comments to the CY 2022 home health proposed rule, the Partnership continues to be concerned that the market basket and annual update factors in recent years do not align with increases in home health providers' staffing costs and other costs of care. Inflation is at unprecedented levels with recent 12-month average of the consumer price index (CPI-U) measured at 8.5 percent.⁶ Our most recent analysis of price growth for staffing and other costs of delivering care shows that the home health market basket is not reflective of the actual price trends experienced by providers.

The Partnership commissioned Dobson|DaVanzo to investigate changes in the home health labor markets of member agencies.⁷ This study is an update to an August 2021 study of home health wage trends attached to our comments to the CY 2022 proposed rule. This 2022 update was conducted in response to current economic volatility from the continuing impact of the COVID-19 pandemic and the resultant shifts in the workforce, supply chain constraints, and inflationary pressures impacting home health providers.

As detailed in the study and in the chart below, the United States Bureau of Labor Statistics (BLS) recently found a home health overall wage inflation rate of 5.2 percent for the first quarter of 2022. Similarly, the updated 2022 home health labor survey discussed in the study found clinician-specific inflation rates ranging from 3.8 percent for therapists to 5.1 percent for nurses over a comparable time frame. A very important point to note is that BLS found that hospital employee wages are increasing faster than those of the home health workforce. This finding means that home health agencies will be forced to increase wages for clinical staff more quickly than in prior years in order to be competitive in their local labor markets. An annual update factor of 2.9 percent for CY 2023 does not reflect this higher wage growth and will disadvantage home health providers in the labor market.

⁵ Section 1895(b)(3)(B) of the Social Security Act.

⁶ 12-month rate of change of CPI-U for all urban consumers (United States City Average) ending July 2022, BLS.

⁷ See Appendix B.

**Bureau of Labor Statistics Home Health
 Average Hourly Wage Y/Y by Quarter**

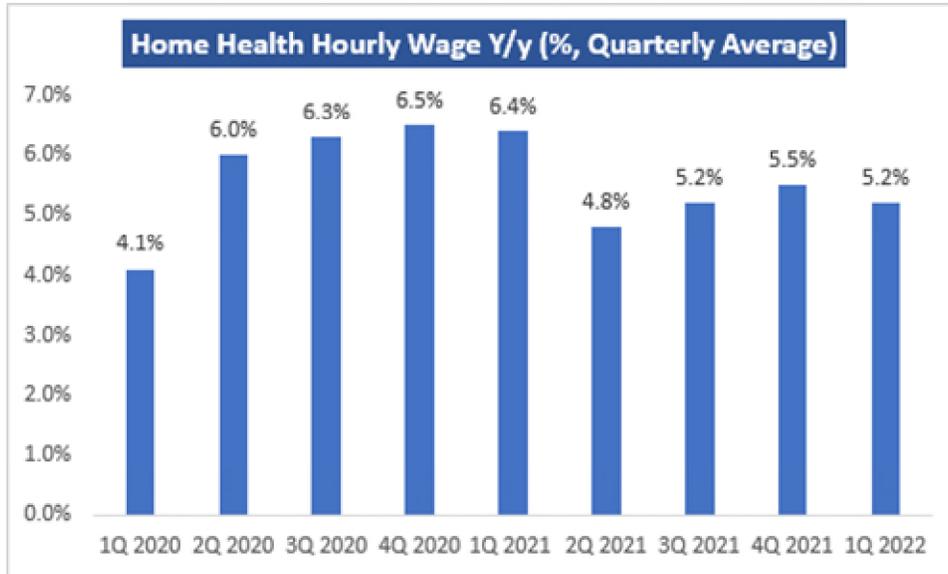


Exhibit 1a of attached study (Appendix B), Information Source: BLS

Adding to the challenges of unexpected wage increases and inflation, home health providers are currently facing increased demand for services resulting from staffing shortages due to an insufficient supply of clinicians and staff turnover from employer competition. With inflationary pressures from the economy and staffing challenges within the healthcare sector, home health agencies have limited options to respond. As the study points out, a majority of Partnership members are faced with having to turn away patient referrals due to the inability to maintain staffing. To address this, our members have had to increase hourly rates and offer competitive compensation through offering incentives, such as signing bonuses, performance bonuses, tuition assistance, and student loan payments.

Also included in the attached study is a measure of two-year wage growth for nursing wages for Partnership members. In the chart below, this is compared to growth for all home health care as measured by the BLS. It is clear from this data the extent to which Partnership members have experienced rapid wage growth over the past several years in excess of both BLS' measure and the combined Medicare payment updates for those two years of 4.6 percent.

Two-Year Quarterly Compounded Wage Growth (2020 & 2021)	
Partnership Nursing Wages	14.5 percent
BLS All Home Health Care	11.5 Percent

Exhibit 1h of the attached study (Appendix B), Information Source: BLS

The attached study also highlights the increasing labor cost pressures home health agencies are currently facing. These results are well documented in contemporary news articles discussing the staffing shortages across the health system. We also note other significant inflationary

pressures involving other components of care delivery such as in medical supplies and gasoline, a key resource for delivery of in-home care, particularly in rural areas. For example, the cost of fuel over the past 12 months has increased by 44 percent on average, as measured by the BLS.⁸ This dramatic price growth is not reflected in the proposed update for CY 2023.

In conclusion, the Partnership is very concerned that updates to the home health payment rates have not kept pace with recent price trends and are likely not to in the future. We urge CMS to consider the attached study which details the updated survey and analyses conducted by Dobson|DaVanzo for 2022 and presents additional findings and analyses not discussed above.⁹ Further, as we advised in our comments to the CY 2022 rule, we recommend that CMS comprehensively assess all aspects of the market basket to ensure that it reasonably forecasts annual price increases and is sensitive to periods of economic instability. It is critical that Medicare home health payments keep pace with evolving trends in the price of labor, goods, and services to ensure access for patients and the delivery of high-quality care.

b. Proposed Permanent and Temporary Adjustments

The Partnership recognizes that CMS has a legal obligation to analyze and address the budget neutrality of home health payments as part of the implementation of PDGM in 2020 and beyond. However, we believe that CMS has not adhered to those requirements, resulting in a proposal to establish payments for CY 2023 and beyond at a level far lower than what the law requires and was contemplated by the Congress.

The Social Security Act (the Act)¹⁰ required the Secretary to calculate a standard prospective payment amount (or amounts) for 30-day units of service that end during the 12-month period beginning January 1, 2020, in a budget neutral manner, such that estimated aggregate expenditures under the HH PPS during CY 2020 are 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 service. In addition, the law required that in calculating the standard prospective payment amount (or amounts), the Secretary make assumptions about behavior changes that could occur as a result of the implementation of PDGM and the change to a 30-day unit of service.

The Act¹¹ also requires the Secretary to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures under the home health PPS beginning with 2020 and ending with 2026. The law further requires the Secretary to provide for one or more permanent increases or decreases to the home health payment amount (or amounts) for these years, on a prospective basis, to offset for these increases or decreases in estimated aggregate expenditures. In addition, the law requires the Secretary to provide for one or more temporary increases or decreases to the payment amounts

⁸ BLS Series: Gasoline, Unleaded regular, per gallon/3.785 liters in U.S. city average, average price, not seasonally adjusted – 12-month percent change for July 2022, (Series ID: APU000074714).

⁹ See Appendix A.

¹⁰ Section 1895(b)(3)(A) of the Social Security Act.

¹¹ Section 1895(b)(3)(D) of the Social Security Act.

for these years to offset for increases or decreases in estimated aggregate expenditures. The law requires all adjustments to be made on a prospective basis through notice and comment rulemaking at a point in time determined by the Secretary. Finally, the law¹² requires the Secretary to eliminate the use of therapy thresholds in the case-mix system for CY 2020 and beyond.

However, CMS' proposed methodology for annually determining the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures and the related proposed permanent and temporary adjustments do not align with the requirements of the statute or its intent to ensure budget neutral rates. The agency makes no attempt to compare the behaviors assumed by CMS in establishing the initial payment amounts for CY 2020 and the actual behavior observed on aggregate expenditures. Rather, CMS' proposal merely reprices 2020 and 2021 claims payments to establish an artificial target amount and reduces the 30-day payment amounts under PDGM to meet that target. It does this largely by adjusting payments downward for a reduction in therapy utilization, a factor that has no impact on aggregate expenditures and is contrary to the law. CMS' overall approach conflicts with the basic requirements of the statute. In effect, rather than ensuring the payment amounts are budget neutral, it constitutes an unauthorized rebasing of the 30-day payment amount.

CMS asserts in the Proposed Rule that it "continue[s] to believe that the best reading of the law requires us to retrospectively determine if the 30-day payment amount in CY 2020 resulted in the same estimated aggregate expenditures that would have been made if the change in the unit of payment and the PDGM case-mix adjustment methodology had not been implemented." However, CMS offers no explanation for how its proposed methodology meets the requirements of the statute. It is clear from the attached legal analysis that it is not the case and that the one assertion offered by CMS in the Proposed Rule is inconsistent with what the agency actually proposed.

A detailed legal analysis of CMS' proposal developed by King & Spalding is attached to this comment letter.¹³ This legal analysis concludes that CMS' proposals on both permanent and temporary adjustments are unlawful and would be vulnerable to a legal challenge under the Administrative Procedure Act. Key elements of the attached legal analysis include:

- CMS' Proposed Rule violates three separate statutory commands: The proposal ignores the statutory provision it purports to be implementing by failing to correct its assumptions about how home health agencies would change behaviors in response to the new payment system. It also violates the statute's budget-neutrality command by reducing overall aggregate expenditures. Third, it uses therapy thresholds to determine payment despite the statute's mandate to eliminate this practice.
- If ultimately adopted, CMS' rule would be arbitrary and capricious. In reaching its desired policy result to cut payments and reduce aggregate expenditures, the agency

¹² Section 1895(b)(4)(B) of the Social Security Act.

¹³ See Appendix C.

has treated similarly situated parties differently, relied on factors which Congress has not intended, failed to consider important aspects of the problem, and offered an implausible explanation for its decision that runs counter to the evidence before the agency.

- CMS' Proposed Rule violates notice and comment rulemaking. To provide notice and comment, an agency must provide the public with the relevant data and technical studies on which it relies to form decisions. Here, CMS has relied on a data model and specific set of manipulated data to calculate adjustments but declined to disclose to the public both the data model and the post-manipulation data. Commenters have thus been unable to replicate and test the CMS' findings and conclusions.

Based on this analysis, the Partnership concludes that CMS' approach is not legally sufficient. We urge CMS to withdraw the proposal included in the Proposed Rule for both permanent and temporary adjustments and develop and propose a methodology that aligns with statutory requirements. Below and in the attached report by Dobson|Davanzo,¹⁴ we discuss an alternate methodology that can be used and aligns with the statutory requirements. While CMS' proposed approach is unlawful, the section below and in the attached report also addresses technical flaws including those detailed in the Partnership's comments to the CY 2022 proposed rule.

c. Technical Concerns with Proposed Methodology

While the Partnership has fundamental concerns with how CMS interprets the statute related to its proposed methodology for determining permanent and temporary adjustments to home health payments, we nevertheless wish to share technical comments and concerns on the agency's proposed approach. We note that our effort to do so is hampered by the limited data and information provided by CMS regarding its methodology.

To assess whether the PDGM 30-day budget neutral payment amount for CY 2020 and CY 2021 maintained budget neutrality with the implementation of PDGM, CMS analyzes data from these years. 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 and CY 2021 30-day payment amounts 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 and CY 2021 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 uses actual CY 2020 and CY 2021 30-day period claims data to simulate 60-day episodes and then estimates what CY 2020 and CY 2021 payments would have been under the 153-group case-mix

¹⁴ See Appendix A.

system and 60-day unit of payment. CMS provides an overview of its methodology for simulating payments under the 153-group case-mix system and 60-day periods in the Proposed Rule.

As discussed in the Proposed Rule, CMS indicates that, based on its analysis and methodology, aggregate payments to home health providers were higher in CY 2020 and CY 2021 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 calculates a percent change between the average payment amounts and determined that for CY 2020 and CY 2021 combined, the 30-day base payment rate was approximately 7.69 percent higher than it should have been relative to budget neutral payments (meaning compared to the current -4.36 percent behaviorally adjusted payment rate).

In addition, CMS calculates a temporary (retrospective 60-day) adjustment for CY 2020 and CY 2021 by determining the difference between the estimated aggregate expenditures from all 30-day periods using its imputed 30-day base payment rate, and the aggregate expenditures for all 30-day periods using the actual 30-day base payment rate for the same year.

CMS proposes to offset the increase in estimated aggregate expenditures for CYs 2020 and 2021 by applying a negative 7.69 percent permanent adjustment to the CY 2023 base payment rate. CMS also signals its intent to implement a temporary adjustment of approximately negative \$2.0 billion to reconcile retrospective overpayments in CYs 2020 and 2021. While CMS does not make projections in the Proposed Rule, we estimate that, based on CMS' methodology, the agency is likely to identify an additional \$1.2 billion in excess payments associated with CY 2022 in next year's proposed rule.

Beyond its stark departure from what the statute requires (which we address above), 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 "underestimation" of payments under the Patient Driven Payment Model (PDPM) and avoid what CMS termed an "overcorrection" leading to an inaccurate calculation of parity (budget neutrality) between PDPM and the prior payment model for SNFs (RUG-IV). Yet, for home health payments, CMS proposes to adopt an approach resulting in this same overcorrection based on a statutory interpretation that is itself flawed, as discussed previously. We address specific areas of concern below and in the attached report from Dobson|DaVanzo.¹⁵

¹⁵ See Appendix A.

Therapy Visits under PDGM

A key area where the flaws in CMS' approach are most obvious is in the area of therapy visits. The data from CY 2020 and CY 2021 show that the change to PDGM with the elimination of therapy thresholds and from a 60-day episode to 30-day period was accompanied by an overall reduction in volume of therapy visits and a marked change in the distribution of therapy visits (see below and exhibits 2 and 3 in attached report by Dobson|Davanzo (Appendix A)).

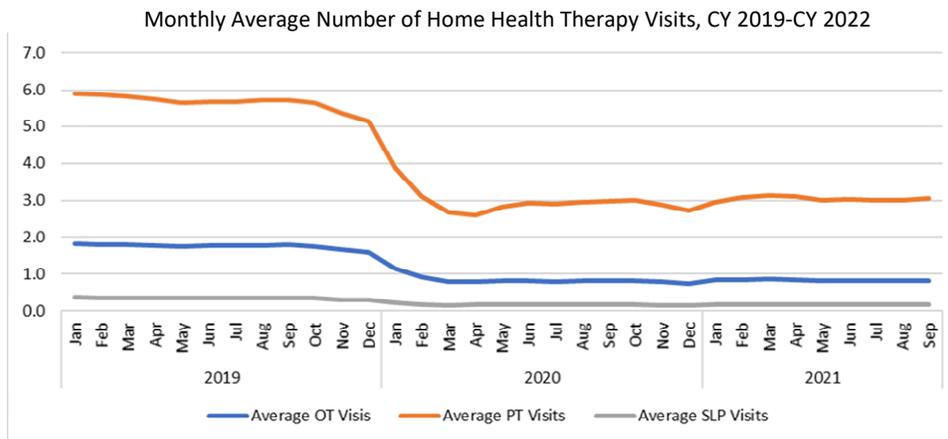


Exhibit 4 of attached report (Appendix A), Information Source: Dobson | DaVanzo Analysis of HH Claims in DUA RIF 54757

Therefore, CMS' use of CY 2020 and CY 2021 data to estimate what CY 2020 case-mix and payments would have been without the implementation of PDGM and is fundamentally flawed as the data reflects the effects of PDGM not the absence of it. It is also contradictory to the basic notion of budget neutrality as called for by MedPAC¹⁶ and as defined in other CMS regulations. 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 therapy thresholds as a determinant of case-mix and payments.

CMS acknowledges and corrects for this methodological concern for similar budget neutrality methodologies addressed in the FY 2023 SNF PPS Proposed and Final Rules. CMS states that:¹⁷

“Given this reduction in therapy provision since PDPM implementation, we found that using patient assessment data collected under PDPM would lead to a significant underestimation of what RUG-IV case-mix and payments would have been (for example, the Ultra-High and Very-High Rehabilitation assignments are not nearly as prevalent using PDPM-reported data), which would in turn lead to an overcorrection in the parity adjustment.”

¹⁶ MedPAC, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY, Chapter 8: Home Health Services (March 2022). Accessed August 2, 2022 at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch8_SEC.pdf.

¹⁷ CY 2023 SNF PPS Final Rule, 87 Fed. Reg. 47527 (Aug. 3, 2022).

However, for home health, CMS takes a very different approach. In addressing this issue in the Proposed Rule, CMS states that alternate methodologies suggested by commenters to the CY 2022 proposed rule (such as that offered by the Partnership) “controlled for certain actual behavior changes (for example, the reduction in therapy visits) and this is not in alignment with what the statute requires at section 1895(b)(3)(D)(i) of the Act where we must examine actual behavior change.” In explaining the statutory requirement, CMS fails to include the key phrase “on estimated aggregate expenditures” at the end of its sentence. Likewise, its methodology fails to identify any behavioral effect associated with the change in therapy visit utilization and payments under PDGM. As a matter of law, and as a practical matter, no such relationship exists because Congress eliminated therapy thresholds under PDGM, and payments do not vary with the number of visits.

Finally, while CMS’ approach makes no attempt to reconcile actual “assumed” behavior, as noted above and in the attached legal brief from King & Spalding,¹⁸ the Partnership questions why CMS did not make behavioral assumptions about therapy utilization in the original CY 2020 regulations. That is, given the reduction in therapy visits was the most obvious and predictable result of the implementation of PDGM, why did CMS not include a behavioral assumption for this effect for 2020. The reason, we assume, is that a factor that had no impact on payments under PDGM was not relevant to a determination on budget neutrality and, in any case, is not quantifiable for the same reason. CMS only focused on assumptions that related to potential increased payments (i.e., LUPAs, clinical group coding, comorbidity coding). This inconsistency calls into question the intent of CMS’ current methodology given it effectively works to rebase the payment rates downward rather than ensure budget neutral payments.

Issues leading to analytic bias

In addition to the concerns discussed above, there are other methodological issues with how CMS combines the CY 2020 and CY 2021 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. These are discussed below.

Under PDGM, roughly 40 percent of the diagnoses previously allowed for under the 60-day payment system are not accepted as primary diagnoses.¹⁹ 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 and 2021 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. CMS also appeared to exclude a large number of claims due to differences in Outcome and Assessment Information Set (OASIS) requirements beginning in 2020 which may have biased the results.

¹⁸ See Appendix C.

¹⁹ PDGM Clinical Groups and Diagnosis Codes, *available at* <http://kb.barnestorm.biz/KnowledgebaseArticle51498.aspx>.

Also, 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 and 2021 data overrepresent early visits in a 60-day system, possibly leading to CMS estimating lower aggregate payments under the 60-day payment system than otherwise would have occurred. This distortion is obviously biased against home health providers.

Finally, a number of OASIS items relevant to payment under the former Home Health Resource Group (HHRG) model became voluntary after 2020. It is unclear how CMS assigned claims to an HHRG in its analysis when that data was not available other than by simply excluding these claims from their analysis, further biasing the results. CMS does not provide its analytical decision rules regarding such cases, however, excluding them or assigning an inaccurate HHRG could bias the results

The impact of COVID-19

Over the past several years, the COVID-19 pandemic has had far reaching effects on the health system, including on home health providers. The pandemic impacted both the number and type of patients receiving services at various times while creating immense challenges in care delivery that continue to this day. The Partnership believes that CMS must continue to examine the COVID-19 pandemic's impact on the data used to establish the proposed permanent and temporary adjustments.

The attached report from Dobson|Davanzo²⁰ notes that the reduction in therapy visits began before the COVID-19 public health emergency (PHE) was declared in January 2020—indicating that HHA providers were already experiencing significant declines in therapy visits under PDGM. Thus, the PDGM effect on therapy is likely not a COVID-19 effect, but rather a result of the incentives of PDGM. However, the pandemic may very well have influenced case-mix and coding or other factors that impact the data CMS relies on in the Proposed Rule to evaluate provider behavior, budget neutrality, and determine permanent and temporary adjustments.

In the Proposed Rule, CMS asserts its belief that their proposed methodology best controls for the effects of the COVID-19 PHE because its analysis compares two aggregate expenditure amounts derived from the same 2020 claims data. The agency then solicits comments on how the COVID-19 PHE may have impacted service provision in a manner not reflected in that proposed methodology and its expectation that commenters provide empirical evidence to support their position on how the COVID-19 PHE affected provider behavior.

Unlike the SNF PPS Proposed and Final Rules which offer detailed analysis on the effects of the COVID-19 pandemic on utilization and case-mix, options for including or not including COVID-19

²⁰ See Appendix A.

cases in the analysis, and finalize an approach that controls for the effects of COVID-19 pandemic, the Home Health Proposed Rule makes only general assertions in this area, provides no analysis, and places the onus on commentors to do complex analysis that CMS itself has done for other Medicare rules. The Partnership believes that CMS should thoroughly evaluate the impact of the COVID-19 pandemic on such an important payment change, as CMS has done in multiple other payment rules in FY 2023.²¹

Transparency of Data and Information related to the Proposed Rule

This Proposed Rule applies an unprecedented series of significant and adverse payment adjustment to home health providers that will have devastating consequences for patient care and access. The proposed payment adjustment is based on a complex mathematical analysis of CMS administrative data. Given the gravity and complexity of this Proposed Rule, the Partnership questions how CMS could provide so little information and data on how the adjustments are derived.

After issuance of the Proposed Rule, the Partnership and other stakeholders requested additional data and information from CMS to allow us to understand and replicate the analysis to more meaningfully comment on the proposed methodology and resulting permanent and temporary adjustments. CMS responded that the data released with the rule and information contained in it were sufficient to do that.

The Partnership disagrees with the agency's position. We note the following:

- In developing the CY 2020 proposed rule implementing PDGM, which included a similar determination of budget neutrality, CMS provided far more data for the public to consider the rule. In particular, using HHRG data, CMS provided a data file with 60-day (HHRG) episodes converted to 30-day PDGM periods. This data was critical to the simulations CMS relied on to determine aggregate expenditures and budget neutrality. However, CMS provides no such file for the current CY 2023 Proposed Rule. Stakeholders expected this data to be provided and the notion that the complex data matching (OASIS to claims) can be achieved in the short window of the comment period to create this simulation is not reasonable.
- With regard to the critical matching of OASIS to claims data underlying CMS' simulations and analysis, the OASIS data for 2021 is not currently available to the public. CMS cannot, therefore, assert that stakeholders have all the data they need.
- CMS' mathematical formula and inputs for determining the adjustments are unclear. For example, if one divides the \$14,297,150,005 in expenditures (with "assumed behaviors") from Table 13 by the 7,618,061 actual 30-day periods determined by CMS

²¹ See, e.g., the discussion of changes to Medicare Severity Diagnosis-Related Group (MS-DRG) classifications and relative weights in the FY 2023 Hospital Inpatient PPS Final Rule, 87 Fed. Reg. 48891 (Aug. 10, 2022); see also the discussion of recalibrating the PDP Parity Adjustment due to the effects of the COVID-19 PHE in the FY 2023 SNF PPS Final Rule, 87 Fed. Reg. 47527 (Aug. 3, 2022).

(Page 37618), the product is not the 30-day payment rate listed in that table. It may be that CMS is calculating an average payment across all 30-day periods inclusive of Low Utilization Payment Adjustments (LUPAs), Partial Episode Payments (PEPs), and Outliers. However, the data inputs and method by which CMS does this is unclear and not outlined anywhere in the Proposed Rule.

- Each step of CMS' mathematical calculations is not clearly laid out in the Proposed Rule. The general narrative outlining the steps does not lead the public to the results in Tables 13, 14 and 15 of the Proposed Rule. We note that the SNF PPS Proposed Rule provided detailed spreadsheets showing the data and mathematical calculations (order of operation) used to develop the proposed "parity" adjustment to achieve budget neutrality under PDPM. It is not clear why something comparable could not be shared for home health to guide stakeholders through the complex calculations underlying the temporary and permanent adjustments. The Partnership requested this type of tool from CMS, but, as described in the attached Dobson|Davanzo (Appendix A) Report, it was not provided.

The Partnership finds the lack of transparency associated with the Proposed Rule troubling, particularly given the magnitude of the proposed adjustments and the fact that other CMS rules issued this year on similar issues provide far more data and information on how the agency determined budget neutrality adjustments.

d. Alternate Methodological Approaches

Given the Partnership's significant legal and technical concerns with the methodology outlined in the Proposed Rule, we discuss several alternatives for CMS to consider below. We urge CMS to closely examine the first alternative which aligns closely to the requirements of the statute and was suggested in our comments to the CY 2022 Home Health Proposed Rule.²² In addition to conforming with the statute, we believe this approach results in a more accurate and less biased approach. A second approach is also included were CMS to have a different view of the legal requirements.

Under this first alternative methodology, CMS would utilize 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. This approach reflects what CMS "assumed" in establishing the initial payment rates.

Following this approach, CMS would then compare "actual" CY 2020 and CY 2021 30-day episode payments to the projected CY 2020 and CY 2021 30-day episode payments used by CMS to set CY 2020 payment rates (again, based on data from CY 2018 60-day episodes converted to 30-day episodes). In addition, the approach examines the actual changes in provider coding

²² Partnership for Quality Home Health Care, Comments to: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update (CMS-1747-P), August 27, 2021.

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).

Unlike CMS' approach, this methodology aligns with the statute as it allows for a true comparison of "assumed" versus "actual" behavior on aggregate expenditures. The result of that comparison would then be used to determine any permanent or temporary adjustments (increases or decreases) for an applicable year. This methodology is discussed further in the attached report by Dobson|Davanzo.²³

The attached report from Dobson|Davanzo also outlines a second alternative approach to determining both permanent and temporary adjustments. The Partnership offers this alternative because CMS' current view of its legal requirements on this matter are not clear to stakeholders and understanding that the agency's view of those requirements could evolve in response to comments. The approach may also be appealing to CMS as it reflects the agency's own methodology used for a different Medicare payment system.

The approach outlined below is modeled after the methodology that CMS itself proposed and finalized for fiscal year (FY) 2023 Skilled Nursing Facility (SNF) PPS payments²⁴ which, in a similar fashion, aims to ensure that the new payment model for SNFs (PDPM) implemented in FY 2020 is budget neutral to the system in effect prior to that year (Resource Utilization Groups IV, RUGS IV). As detailed in the attached report this alternative approach relies on the following steps:

1. Determine budget neutral counterfactual total aggregate payments under the former 60-day payment system: To calculate the counterfactual payments, Dobson|Davanzo used the percentage of cases in each HHRG group in FY 2019 and multiplied these percentages by the total number of FY 2020 cases. They then multiplied the number of cases for each 2019 HHRG group by the CY 2020 60-day payment rate, obtained from the CY 2020 HH PPS Final Rule;
2. Obtain actual total payments under PDGM in CY 2020 (30-day payment system);
3. Calculate the permanent adjustment factor (Step 2 subtracted by Step 1).

This methodology is based on the idea that budget neutrality analyses should be conducted under the assumption that all else remains the same except the specific policy modeled (i.e., the introduction of PDGM). It seeks to avoid overcorrecting for exogenous changes in therapy utilization. The use of CY 2019 data on the percentage of cases by HHRG group more accurately reflects CMS' initial assumptions about behavior and eliminates the need to model other behavioral shifts that occurred due to the implementation of PDGM as they are captured in the aggregate expenditures determined in step 2 above.

²³ See Appendix A.

²⁴ Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Quality Reporting Program and Value-Based Purchasing Program Final Rule, 87 Fed. Reg. 47502 (Aug. 3, 2022).

Results from the attached analysis of 2020 data (see exhibit 5 in Appendix A) indicate that CY 2020 PDGM payments were approximately 2.5 percent below budget neutral levels. This percentage shifts to 2.4 percent if COVID-19 cases are excluded.

Based on these results, the current behaviorally adjusted payment rates are too low and should be increased by approximately a 2.5 percent permanent adjustment in 2023, thus offsetting a portion of the initial behavioral adjustment percentage of negative 4.36 percent applied for CY 2020 through 2022. This is consistent with the law given Congress contemplated both increases and decreases resulting from this requirement. In addition, following this same methodology for 2020, the proposed temporary adjustment is incorrectly determined and would need to be recalculated for 2020 to return underpayments by Medicare to providers. Finally, while the analysis in the report utilizes 2020 data, we understand that 2021 (and future years through 2026) data would need to be analyzed using this approach and factored into the results consistent with legal requirements.

The Partnership encourages CMS to utilize the first methodology outlined above which we believe aligns with its statutory obligation to evaluate assumed versus actual behavior on estimated aggregate expenditures. For the second approach, the agency could consider this methodology based on how it ultimately views the requirements of the statute.

e. Impact of Proposed and Temporary Adjustments

Millions of Medicare beneficiaries rely on the Medicare home health benefit for skilled nursing and rehabilitation services in the comfort and safety of their homes. The ongoing COVID-19 pandemic and PHE has shown how critical it is to have a viable home health benefit as beneficiaries' preferred site of care and to avoid risk of infection and other adverse outcomes associated with institutional settings. However, the magnitude of the payment reductions established in this Proposed Rule will have devastating consequences for the benefit and patients' access to care in the home.

According to the Proposed Rule's economic impact analysis, the net impact related to the changes in payments under the home health PPS for CY 2023 is estimated to be negative \$810 million (-4.2 percent). According to CMS' analysis, this reflects the payment update percentage of 2.9 percent (\$560 million increase), an estimated 6.9 percent decrease for effects of the permanent budget neutrality adjustment of 7.69 percent (\$1.33 billion decrease), and certain effects of updating the outlier policy. However, CMS' analysis of the one-year effect of the rule fails to capture the true impact of the policies and methodologies CMS is advancing in the rule which will have an impact for years to come. This includes the cumulative effects of the permanent and temporary adjustments and continued underestimation of the home health costs increases in the market basket over time.

As shown in the attached report from Dobson | Davanzo,²⁵ in the aggregate, we estimate that the permanent and temporary adjustments outlined in this Proposed Rule could lead to a reduction

²⁵ See Appendix A.

in payments of approximately \$8.7 billion for home health providers from 2023 through 2026. This amount includes the \$5.3 billion due to permanent adjustments, \$2.0 billion due to temporary adjustments for CY 2020 and CY 2021, and an estimated \$1.2 billion due to temporary adjustments for CY 2022. We note that this is in addition to the negative 4.36 percent payment adjustment applied to home health rates in CY 2020 for assumed behavioral changes associated with PDGM that equates to \$2.43 billion in aggregate reductions between CY 2020 and CY 2023.

The chart below shows the estimated increase in the number of home health providers that would experience negative Medicare margins with the application of the proposed negative 7.69 percent permanent adjustment and illustrates how those numbers would increase with the application of future temporary adjustments for 2020 through 2022. It is clear that the cumulative effect of all the proposed payment reductions, if taken at once, would be highly disruptive to day-to-day operations and would represent a rebasing effect such that overall Medicare margins could turn negative.

Percent of Home Health Providers with Negative Medicare Margins

Percent with negative margin	2022 Calculation	2023 Projection	2023 less \$2.0B	2023 less \$2.0B & \$1.2B
Total	20.9%	30.0%	45.0%	55.9%
Urban	21.2%	30.3%	44.9%	56.0%
Rural	20.9%	31.8%	48.5%	57.5%
Unknown	15.7%	21.5%	36.3%	48.6%

Exhibit 16 of attached report (Appendix A), Information Source: Dobson | DaVanzo Analysis of Medicare fee-for-service margins

The true picture of the financial consequences of these reductions is much more severe when factoring in overall margins which encompass revenues from Medicaid, Medicare Advantage, and commercial payers. A 2015 study²⁶ conducted by Avalere for the Partnership showed overall margins were significantly below Medicare fee-for-service (FFS) margins. At that time, overall margins for publicly traded home health companies were measured at 2.4 percent. While the Partnership does not have more current data on overall margins, changes in payer mix since 2015 have had an impact on home health providers' overall revenues. In particular, the significant growth of Medicare Advantage enrollment combined with the plans' historically lower payments and more limited coverage for home health services compared to traditional Medicare FFS, has negatively impacted revenues.

Medicare Advantage enrollment has grown considerably and is projected to encompass 47.9 percent of Medicare beneficiaries in 2023.²⁷ As a result, it has assumed a much larger (and similar) proportion of the patients served by Medicare certified home health providers which impacts their revenues. Current all-payer margins are likely far lower than the Medicare

²⁶ Avalere, HOME HEALTHCARE MARGINS: COMPARISON OF PUBLIC COMPANY FINANCIALS TO THE MEDPAC MARGIN ESTIMATE, March 2015.

²⁷ 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, Table IV.C1.

Payment Advisory Commission's (MedPAC's) reported margins or that analyzed for the chart above (consistent with the Avalere analysis), particularly given the recent dramatic cost increases for labor, fuel, and other resources described above. Thus, the number of home health providers with negative all-payer margins will be significantly higher than shown in the table above, particularly as Medicare Advantage and commercial plans move pricing for home health services even lower in response to CMS' proposed reductions in fee-for-service. A financial impact of this magnitude will have consequences for care delivery and access for beneficiaries enrolled in both traditional Medicare fee-for-service and Medicare Advantage.

In addition to the adverse consequences for patients posed by this Proposed Rule, we note that these reductions are incompatible with CMS' broader policy objectives for quality and health equity. The Partnership supports CMS' initiatives in this area and would like to see the agency successful in advancing them.

We note that in the CY 2022 Final Rule,²⁸ CMS estimates the overall economic impact of the expanded HHVBP model for CYs 2023 through 2027 to be an estimated \$3.4 billion in total savings through a reduction in rehospitalizations and improved quality. It is unrealistic for CMS to reduce payments (and thus, the resources available for care) to home health providers by \$8.7 billion during this same period and expect improved quality and an additional \$3.4 billion in savings as a result.

In addition, CMS' efforts to advance health equity and eliminate avoidable differences in health outcomes experienced by people who are from health-disadvantaged communities or medically underserved will be critically weakened in the area of home health by the proposed payment reductions in this rule. We applaud CMS for its new process to evaluate policies for their impact on health equity and suggest that CMS closely examine the impact these significant payment reductions will have on disadvantaged populations and areas (e.g., rural and inner city).

f. Partnership Recommendation

CMS' proposed permanent and temporary adjustments will be devastating to home health providers and the patients they serve, particularly at a time when the Medicare program and its beneficiaries need a viable and sustainable benefit for in-home skilled services for both fee-for-service and Medicare Advantage. The magnitude of these reductions and the uncertainty and instability they create cannot be absorbed by home health providers without an impact on patient care and access.

The Partnership recommends that CMS withdraw its proposal applying permanent and temporary adjustments to the home health payment rates in CY 2023 and propose a new methodology in future rulemaking, such as the first alternative outlined in this comment letter, that aligns with the statutory requirements.

In addition, CMS has solicited comments in the Proposed Rule asking stakeholders for their recommendations regarding how and when CMS should apply the temporary adjustments

²⁸ 86 Fed. Reg. 62244, Table 1 (Nov. 9, 2021).

identified in the rule. Given that CMS' proposed approach to both permanent and temporary adjustments is unlawful, we believe CMS should redetermine these adjustments, whether positive or negative, before considering how to adjust the payment rates. As a general matter, the Partnership believes CMS should never make significant reductions to payment rates without a phase-in to protect patient access and care delivery.

g. Proposed Permanent Cap on Year-to-Year Wage Index Decreases

The Partnership supports CMS' proposed permanent cap on wage index decreases, which supports stability in Medicare's payments for home health services from year to year. The proposed rule notes that several commenters to last year's CY 2022 proposed rule²⁹ stated that providers should be protected against substantial payment reductions due to dramatic reductions in wage index values from one year to the next. The Partnership commented in support of such a policy in the CY 2022 proposed rule and appreciates CMS' responsiveness in making the current proposal.

The proposal would, for CY 2023 and subsequent years, apply a permanent 5 percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. CMS makes clear that, under its proposal, a geographic area's wage index for CY 2023 would not be less than 95 percent of its final wage index for CY 2022, regardless of whether the geographic area is part of an updated core based statistical area (CBSA), and that for subsequent years, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior year.

The Partnership supports this proposal and encourages CMS to finalize the policy in the Final Rule. As we have commented earlier in this letter, sudden and substantial decreases in providers' payments from year to year can have a devastating impact on patient access and care delivery. Often these changes are the result of the Office of Management and Budget's (OMB) delineation of geographic areas, hospitals' wage practices, or Medicare geographic classification of hospitals and do not correlate with home health providers' experience in the local labor market. This policy mitigates such decreases when they occur and provide greater stability in providers' payments over time.

h. Home Health Case-mix Weights, Functional Scoring, and LUPA Thresholds

CMS proposes to recalibrate the PDGM case-mix weights, LUPA thresholds, and functional levels for CY 2023 using data from 2021 to ensure that PDGM accurately reflects home health resource use. 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.

In the Proposed Rule, CMS explains that the annual recalibration of the PDGM case-mix weights ensures that payments reflect, as accurately as possible, current home health resource use and changes in utilization patterns. To generate the proposed recalibrated CY 2023 case-mix weights, CMS used CY 2021 home health claims data with linked OASIS data (as of March 21,

²⁹ 86 Fed. Reg. 62285.

2021). According to CMS, these data are the most current and complete data available at the time of the Proposed Rule. CMS believes that recalibrating the case-mix weights using data from CY 2021 would be reflective of PDGM utilization and patient resource use for CY 2023 and the agency indicates that the proposed recalibrated case-mix weights will be updated based on more complete CY 2021 claims data for the final rule. Finally, to ensure the updated case-mix weights are budget neutral, CMS applies a case-mix weight budget neutrality factor for CY 2023 of 0.9895.

The Partnership supports recalibration of the case-mix weights using data from 2021. In our comments to the CY 2022 proposed rule, we expressed concerns with use of the 2020 data given the effects of the COVID-19 PHE on utilization and care delivery, which could result in payment distortion. We believe that use of the 2021 data will provide for more accurate payments under PDGM and recommend CMS finalize its proposal to recalibrate the case-mix weights.

II. Collection of Data on the Use of Telecommunications Technology Under the Medicare Home Health Benefit

As stated in the Proposed Rule, collecting data on the use of telecommunications technology on home health claims would allow CMS to analyze the characteristics of the beneficiaries using services furnished remotely and broaden CMS' understanding of the social determinants that affect who benefits most from these services.

The Partnership has consistently urged CMS to recognize the value of services provided using telecommunications technologies. Especially during the PHE, member organizations have used this technology to improve care provided to beneficiaries. While CMS is proposing to collect information on telemedicine services on home health claims, it is not proposing to pay for these services, nor does CMS assess the burden associated with this proposal.

CMS solicits comments on three new G-codes for home health services furnished using: synchronous telemedicine (real-time two-way audio and video); audio-only synchronous telemedicine; and remote patient monitoring. While use of these codes would not be limited, CMS states that use of telecommunications technology would not generally be appropriate for home health aide services.

Partnership companies advise that, in many cases, a home health aide who is in-person with a patient plays a critical role in connecting the patient to a specialist via telemedicine. If the proposed G-codes would not allow for a home health aide to provide care while working remotely with a specialist, the Proposed Rule is out of step with how technology is enhancing home health care. For example, in the context of Medicare Advantage, a wound care nurse can participate remotely in a visit where an aide is in-person providing various services. CMS should seek to support this type of care, as well as care provided remotely without an aide in-person, in traditional Medicare.

CMS seeks comments on whether there are other common uses of telecommunications technology under the home health benefit that would warrant additional G-codes that would be

helpful in tracking the use of such technology in the provision of care. In commercial areas, Partnership members understand that health plans have studied telehealth and collected qualitative data on its effectiveness. CMS should support effective use of telemedicine and related technologies in home health not just by collecting data on its use but by considering options for paying appropriately for virtual services.

III. Home Health Quality Reporting Program (HH QRP)

a. Proposal to require HHAs to submit all-payer OASIS data

CMS proposes to end the suspension of the collection of OASIS data for non-Medicare and non-Medicaid patients under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and to require HHAs to report all payer OASIS data for purposes of the HH Quality Reporting Program (QRP) beginning with the CY 2025 program year. The Partnership is concerned that this proposal is ill timed, burdensome, and costly, and that it will divert critical resources from patient care. In addition, we question whether CMS has met the statutory threshold for expanding OASIS completion and submission for non-Medicare and non-Medicaid patients.

As CMS notes in the Proposed Rule, Congress enacted section 704 of the MMA, which suspended the legal authority of the Secretary to require HHAs to report OASIS information on non-Medicare and non-Medicaid patients until after the Secretary submits a report to Congress that examined potential use of that data and the Secretary publishes final regulations on CMS' collection and use of those data. Based on the findings in the report, CMS determined that the suspension of OASIS collection for non-Medicare patients and non-Medicaid patients would continue due to the burden imposed on providers with expanded collection of OASIS and given CMS systems and associated case-mix and outcomes reports were not designed to include private pay patients. CMS also acknowledged at the time that it would be inappropriate for CMS to collect non-Medicare and non-Medicaid patient OASIS data and not use it.

As explained in the Proposed Rule, CMS now believes that collecting OASIS data on all home health patients regardless of payer source would better align its data collection requirements with other provider types, provide the most accurate representation of the quality of care furnished by HHAs, and allow for comparison of performance on quality measures across post-acute care (PAC) settings. CMS also asserts in the Proposed Rule that it has addressed previous privacy and data security concerns and systems limitations, through modernization of its systems and adoption of the Internet Quality Improvement and Evaluation System (IQIES). As a result, CMS is proposing that for the CY 2025 HH QRP, the expanded reporting would be required for all patients regardless of payer source beginning January 1, 2024, one year from the effective date of a final rule for CY 2023.

The Partnership does not support this proposal and recommends that CMS continue the suspension on collection and submission of OASIS data for non-Medicare and non-Medicaid patients. Expanding the OASIS collection effort creates costs and burden at a time when home health providers are already facing multiple significant challenges associated with the continued COVID-19 pandemic, severe staffing shortages, surging costs (as described earlier in this letter),

and proposed and future payment cuts that CMS advances in this same rule. We are at a loss to understand how CMS can ignore this broader context and propose this expansion at the current time.

In the Proposed Rule, CMS acknowledges increased burden but notes that many providers already collect and process OASIS on non-Medicare and non-Medicaid patients and the benefits for quality. We believe that CMS has misjudged the additional burden created by this proposal. We also note that while some home health providers do collect OASIS data for this population of patients, it is an added burden to document, submit, and manage the data through CMS' IQIES and the Quality Reporting Program process.

In addition, many providers do not currently submit this data for non-Medicare and non-Medicaid patients at all and would need to absorb the full cost of assessment and submission of OASIS for these patients. Due to shortages in nurses and other clinical staff, this requires home health providers to divert critical staff needed for care delivery. As a result, this proposal will have a direct impact on patient care and providers' ability to provide access to care in their communities. We also note that many providers that are required by the state to be Medicare-certified even though they do not provide skilled home health care to Medicare and Medicaid patients, will now be required to complete and submit OASIS where they did not previously. This creates a significant cost and an obstacle for such agencies to enter the market and provide needed services. For example, some states require agencies that deliver Medicaid home and community-based services under the private duty nursing benefit to enroll in Medicare.³⁰

As noted above, we have concerns that CMS' estimate of the burden resulting from this proposal is significantly understated. First, the estimate significantly undercounts the time required to complete an OASIS. For example, in the impact analysis contained in the Proposed Rule,³¹ CMS estimates that the Start of Care (SOC) OASIS, the largest category of assessments performed, requires 57.3 minutes. Many Partnership members capture specific data on the time required to complete assessments. This time is captured as (1) "In-home Time" to complete the OASIS, and (2) "Extra Documentation Time" to complete full documentation of the OASIS and ensure all necessary fields are complete for submission. For an SOC OASIS, our members report a range of 90 minutes to 152 minutes for completion. This is almost 60 percent higher than CMS' estimate at the low end of the range and more than 165 percent higher at the high end of that range.

In addition, the dollar value per hour for wages and benefits underlying the estimate relies on dated information and is too low. CMS obtained mean hourly wages for clinical staffing categories from the U.S. Bureau of Labor Statistics' May 2020 National Occupational Employment and Wage Estimates. CMS then added 100 percent of those amounts to account for overhead and fringe benefits and computed a weighted clinician average hourly wage of \$79.41. This amount is based on data from the first year of the COVID-19 pandemic and thus, it predates the dramatic increases in labor costs that have impacted the U.S. health system, including home health providers, in 2021 and 2022. It also does not account for premium wages,

³⁰ Social Security Act 1905(a)(8); 42 CFR 440.80.

³¹ 87 Fed. Reg. 37674.

overtime, use of nurse staffing agencies, and other increased labor costs spurred by the current healthcare staffing shortage. CMS' estimate makes no effort to account for this more recent growth in labor costs.

As a result, we believe that CMS' total burden and dollar cost estimates are incorrect. We urge CMS to incorporate a more reasonable estimate of the time required to complete OASIS and to account for the recent dramatic growth in labor costs whether actuarially or through more current data.

As we have noted above, providers are facing severe staffing shortages and surging costs for labor, fuel, medical supplies, and other care related resources, while continuing to face challenges in care delivery associated with the ongoing pandemic. These factors all impact staff and other resources available for care delivery. In addition, this Proposed Rule would reduce providers' payments by 6.9 percent in 2023 while forecasting billions of dollars in additional reductions in payments for 2024 and beyond, further constraining providers' ability to offer access and care to their patients. Providers are also engaged in implementing home health VBP. Home health providers simply do not have the resources to prepare and implement this expanded requirement leading up to January 1, 2024. We strongly encourage CMS to consider the broader set of factors impacting the provision of home health care and continue the suspension on collection and submission of OASIS for this population.

CMS believes that requiring HHAs to report OASIS data on all patients will provide the agency with the most robust and accurate reflection of the quality of care delivered to Medicare beneficiaries as compared with non-Medicare patients. However, CMS does not adequately explain how that is the case or what analysis it bases that claim on. As a result, we do not believe that CMS has met the statutory threshold for expanding collection and submission of OASIS to non-Medicare and non-Medicaid patients.

While we recognize that CMS has authority to establish various requirements for participation in Medicare, the law sets a high standard for applying such requirements. Section 1891(o)(6) of the Social Security Act establishes that home health providers must meet "the conditions of participation specified in section 1891(a) and such other conditions of participation as the Secretary may find necessary *in the interest of the health and safety of individuals who are furnished services by such agency or organization*" (emphasis added). The language of this provision is not superfluous but rather requires the agency to demonstrate that expanding collection and submission requirements for OASIS is necessary to ensure the health and safety of home health patients. While CMS asserts that this additional data might be useful for various quality initiatives, the agency has not explained how or why, or shared any data indicating that CMS has tested the use of non-Medicare and non-Medicaid data in those programs to demonstrate the necessity of including it. In addition, adding a burdensome and costly administrative requirement at a time when CMS is proposing to dramatically cut payments and home health providers are already struggling with staff shortages and other challenges undermines the health and safety of home health patients.

The present requirement that applies to the Medicare fee-for-service, Medicare Advantage, and Medicaid populations provides sufficient data to support CMS quality related programs. The

benefits of this proposal to expand the requirement have not been established and the reasons offered in the Proposed Rule certainly do not outweigh the increased burden and adverse impact on providers and patient care. As home health providers continue to experience numerous challenges associated with proposed payment cuts, COVID-19, staffing, and surging costs for care resources, the Partnership urges CMS not to finalize this proposal.

If CMS does intend to finalize the proposal despite our recommendation, it should first re-evaluate its burden estimate to more accurately account for the time and cost needed to complete the OASIS. In addition, CMS should delay the requirement for at least more three years (CY 2028) given current economic conditions and the severe staffing shortage among home health providers. During that period, CMS should also reexamine and update the findings in the 2006 report to Congress based on updated data on payer-mix that includes a significantly expanded Medicare Advantage population.

b. RFI on health equity in the HH QRP

The Partnership shares CMS' goal of closing the equity gap and applauds the Administration for its focus on addressing disparities in health outcomes. 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.

We appreciate CMS's interest in work to bridge cultural gaps between home health personnel and patients and to identify barriers to access to care in communities that home health providers serve, as well as CMS's interest in public comment on related conceptual domains and quality measures. As noted in comments on the CY 2022 proposed rule, the Partnership believes data and analytics can offer a window into post-acute providers to see the challenges and barriers some patients confront when accessing care and can help ameliorate less than ideal outcomes by deploying data to address gaps in access and/or care quality.

IV. Expanded Home Health Value-Based Purchasing (HHVBP) Model

CMS is proposing to: update the home health baseline year to CY 2022 for all providers that are certified by Medicare before January 1, 2022; revise the definitions of *HHA baseline year* and *Model baseline year*; and change the HHVBP Model baseline year from CY 2019 to CY 2022 for the CY 2023 performance year and subsequent years.

The Partnership understands that replacing CY 2019 with CY 2022 as the HHVBP Model baseline year would allow benchmarks and achievement thresholds to be established using data from after the most acute phase of the COVID-19 PHE. While CMS indicates this would provide a more appropriate basis for assessing performance under the expanded HHVBP Model than the CY 2019 pre-PHE period, the Proposed Rule does not discuss this change in the context of CMS' proposed rate reductions relative to the CY 2022 payment year. If CMS measures performance against CY 2022, and also finalizes substantial cuts in subsequent performance years, it will be difficult for HHAs to demonstrate improvement.

CMS' proposed payment cuts threaten the quality improvement gains demonstrated in the HHVBP Model, and if finalized, may severely limit the capacity for the Expanded HHVBP Model to produce the results and savings currently projected. CMS must consider the impacts that substantial payment cuts would have on the Model.

CMS also requests comments on whether to consider incorporating adjustments into the expanded HHVBP Model to reflect the varied patient populations that HHAs and tie health equity outcomes to payment adjustments under the HHVBP Model. As noted in comments above, the Partnership is committed to addressing health equity and believes health equity should be integrated and aligned across CMS programs.

V. Conclusion

The Partnership appreciates the opportunity to submit comments on this important CY 2023 Proposed Rule. We commend CMS' efforts to improve health equity and propose changes to the wage index to promote stability in payments from year to year.

However, we urge CMS to address what we believe to be fundamental legal and methodological flaws in its assessment of budget neutrality for PDGM, and to ensure that payments in 2023 and beyond will support Medicare beneficiaries' access to the skilled services they need in their homes. CMS' proposed approach results in an unstable and adverse reimbursement environment for the next decade that will undermine CMS' own efforts to advance health equity and quality through value-based purchasing, post-acute payment reform, and other initiatives. Finally, we ask CMS to reconsider its proposal to expand OASIS collection at a time when home health providers are facing numerous economic and other challenges in delivering care to their patients.

We look forward to continuing to work with CMS in our efforts to provide quality health care services to Medicare beneficiaries.

Re: CMS-1766-P
August 16, 2022
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Sincerely,

A handwritten signature in blue ink that reads "Joanne Cunningham". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Joanne Cunningham
Chief Executive Officer
Partnership for Quality Home Healthcare
202-684-5497
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Appendix A
Dobson|Davanzo report

Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2023 HH PPS Proposed Rule

Assessing the Impact of CMS' Interpretation of Budget Neutrality Under PDGM and the Future of Access to Home Health Services

Submitted to: Partnership for Quality Home Healthcare (PQHH)

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Monday, August 15, 2022

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Executive Summary

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 2023 Home Health Prospective Payment System (HH PPS) Proposed Rule. For our study, we analyzed available Medicare claims data under our Research Identifiable File (RIF) Data Use Agreement (DUA),¹ data made available by CMS, the CY 2023 HH PPS Proposed Rule, the Skilled Nursing Facility (SNF) PPS Proposed and Final Rules. We also draw from our work in prior rule making cycles.

We find that CMS' interpretation and methodology for the assessment of PDGM budget neutrality, as outlined in the CY 2023 HH PPS Proposed Rule, is critically flawed, and has several implications for the viability of home health agencies. We calculate that the proposed policies will result in projected payment reductions of up to \$8.7 billion between CY 2023 and CY 2026.

Outlined below are key conclusions from our analysis.

- 1. CMS' 2023 HH PPS Proposed Rule data are not sufficient for an accurate assessment of the impacts of the proposed rule and the agency's budget neutral calculations.** Unlike in prior rule making cycles (prior to CY 2022), CMS did not make available the "current law" payments to allow modelling of CY 2023 proposed payment impacts—and these data are critical for an accurate assessment of the distributional impact of the CY 2023 HH PPS proposed policies. Additionally, CMS did not make available the repriced CY 2020 or CY 2021 data with payments under the old system, which again limits our ability to accurately examine the agency's budget neutrality methodology. Finally, we are unable to develop a CY 2021 dataset of home health episodes to examine the agency's budget neutrality methodology, as CMS has not yet made available the CY 2021 Outcome and Assessment Information Set (OASIS) data that we would need to link to the claims data.
- 2. CMS' assessment that CY 2020 base payments were too high is incorrect because the methodology to assess budget neutrality is critically flawed.** The Bipartisan Budget Act (BBA) of 2018² mandated that CMS apply "behavioral adjustments" to account for changes in provider behaviors and 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" and apply adjustments to offset the differences. That is, the law mandated that CMS implement PDGM in a budget neutral manner, although it did not specify all standards or processes for determining budget neutrality.

¹ CMS DUA 54747.

² BBA of 2018, H.R.1892. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/1892>.

Interpretation of budget neutrality under similar circumstances is informative. For instance, we note that MedPAC³ and CMS in the CY 2023 Skilled Nursing Facility (SNF PPS) Proposed Rule⁴ interpret budget neutrality to mean that the “*payments under PDGM neither raise nor lower aggregate home health care spending relative to spending that would have occurred without the new model’s implementation.*” This interpretation contradicts the agency’s interpretation in the CY 2023 HH PPS proposed rule. Based on this contradictory interpretation, CMS’ proposed methodology for assessing budget neutrality in the CY 2023 HH PPS proposed rule uses CY 2020 data to determine payments that would have occurred under the prior 60-day system. We find that this methodology is inherently flawed as CY 2020 data are distorted by the effects of the COVID-19 PHE and PDGM, as the payment system (PDGM) shifted incentives away from therapy visits. Our analysis of CY 2020 data indicates that the combined effects of PDGM implementation and to a lesser extent the PHE drove a 29.7 percent reduction in CY 2020 therapy visits. Since case-mix under the prior 60-day system was driven by therapy visits, CMS cannot accurately determine what the CY 2020 payments would have been had PDGM not been implemented.

Moreover, CY 2020 HH payments were already reduced by statutorily mandated behavioral adjustments of -4.36 percent to account for the assumption that providers would adjust documentation and coding practices to maximize reimbursement under PDGM. Given that these reductions were implemented to account for the provider behaviors that would increase payments under PDGM, the agency must similarly make upward adjustments to account for the PDGM-driven reduction in therapy visits that ultimately lower the CY 2020 budget neutral payment targets. Using this same logic, CMS uses a methodology for parity adjustment in the CY 2023 SNF PPS Proposed and Final Rule that accounts for any Patient Driven Payment Model (PDPM) (PDPM)-driven reduction in therapy.

3. Alternative approaches for assessing budget neutrality. As CMS cannot plausibly use CY 2020 data to determine case-mix weights and aggregate payments that would have been made under the prior 60-day payment system in the absence of PDGM, we propose two approaches consistent with CMS’ authority for achieving budget neutrality under PDGM.

- *Methodology 1:* Comparing the 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).
- *Methodology 2:* Applying the PDPM parity adjustment methodology in the CY 2023 SNF PPS Proposed and Final Rule to CY 2020 PDGM data. Based on this approach, we found that CY 2020 PDGM payments were approximately 2.5 percent below budget neutrality (with COVID-19 cases included) and 2.4 percent below budget neutrality with COVID-19 cases excluded.

³ MedPAC Report to Congress. Chapter 8: Home health care services (March 2022 Report). Available here: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch8_SEC.pdf.

⁴ CY 2023 SNF PPS Proposed Rule. 87 FR 22720. Available at: <https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

- 4. In the absence of any corrective action, we estimate that CMS’ proposed permanent and temporary behavioral adjustments could lead to a reduction of approximately \$8.7 billion in home health payments between CY 2023 and CY 2026.** The total \$8.7 billion reduction reflects a \$5.5 billion reduction in PDGM payments for CY 2023 through CY 2026 due to the permanent base payment (-7.69 percent) adjustment in CY 2023, an approximate \$2.0 billion reduction due to the proposed temporary reductions to reconcile CY 2020 and CY 2021 aggregate payments, and an estimated additional \$1.2 billion to reconcile CY 2022 aggregate payments.⁵ These reductions are in addition to the \$2.4 billion reduction in payments from CY 2020 through CY 2023 that home health agencies will experience as a result of the 4.36 percent payment reduction in CY 2020 due to assumed provider behavioral changes. Further, the temporary and permanent reductions combined could result in more than half of home health agencies having negative margins, with a disproportionate impact to rural agencies.

The dramatic scale of the proposed CY 2023 and future payment reductions to home health agencies threatens the viability of many home health providers (especially those in rural and medically underserved areas) who continue to remain on the frontlines of the COVID-19 PHE. These proposed reductions will also pose challenges for providers to succeed in the recently expanded Home Health Value-Based Purchasing (HHVBP) Model and other attempts to reform PAC (Post-Acute Care) delivery such as in Unified PAC PPS.

⁵ Note that CMS states in the CY 2023 HH PPS proposed rule that a \$2.0 billion reduction is required to reconcile CY 2020 and CY 2021 payments. We (Dobson | DaVanzo) further estimate that an additional \$1.2 billion would be required to reconcile CY 2022 payments.

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 2023 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 through CY 2022 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, available claims data, the SNF PPS Proposed and Final Rules, 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. When implementing PDGM in the CY2020 Final Rule, CMS prospectively reduced the HH PPS base rate from the budget-neutral calculated level by 4.36 percent. CMS indicated that this rate reduction was based on analytic assumptions on how providers might change their behavior once PDGM was implemented (behavioral assumptions). In the CY 2020 Final Rule, CMS described three underlying assumptions to determine the behavioral adjustment:

- 1) for one-third of Low Utilization Payment Adjustment (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;
- 2) HHAs will change documentation and coding practices and use the highest paying diagnosis code as the principal diagnosis code (payment optimized clinical coding); and
- 3) 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 otherwise would have been received if CMS had only used the OASIS diagnosis codes for payment.

The CY 2021 HH PPS rule made limited changes to PDGM and in the CY 2022 HH PPS rule CMS sought comment and alternative approaches to the methodology the agency used to assess budget neutrality. In the CY 2023 HH PPS Proposed rule, CMS proposes using the methodology first proposed in CY 2022 to assess budget neutrality. From this methodology, the agency proposes to apply a -7.69 percent permanent adjustment to the CY 2023 base payment rate and seeks comment on how to implement an additional temporary adjustment of approximately \$2.0 billion in future years to reconcile retrospective overpayments in CYs 2020 and 2021. For CY 2023 home health agencies are projected to experience a reduction of \$810 million in payments (or a -4.2 percent reduction), which includes a -6.9 percent overall payment reduction due to the permanent adjustment, a -0.2 percent reduction reflecting effects of the fixed-dollar loss ratio (FDL) updates, and a 2.9 percent payment update reflecting the market basket update reduced by a productivity adjustment.

As defined in the CY 2020 HH PPS Final Rule:

- For any given PDGM year, the permanent prospective adjustment is applied to the standard base payment amount to reflect what the 30-day base payment amount should have been in order to achieve the same estimated aggregate expenditures as obtained from the simulated 60-day episodes.
- The temporary adjustment then offsets for the increase in estimated aggregate expenditures between the actual aggregate 30-day payments and aggregate payments obtained from the recalculated budget neutral payment rates.

Detailed Findings

1. Insufficient Data Made Available by CMS

We commend CMS for making case data available through the CY 2023 Proposed Rule CMS OASIS-LDS impact files, but we note that the data provided are not sufficient to model the distributional impact of the proposed payment adjustments to providers of interest and understand the methodology for determining budget neutrality.

In the CY 2023 Proposed Rule CMS OASIS-LDS PDGM impact file, CMS provided projected case-level CY 2023 payments based on CY 2021 home health claims data adjusted to reflect the CY 2023 payment update, permanent behavior adjustment and FDL update. These data are limited in two important ways:

1) **Projected CY 2022 payments that CMS used to create the impact table in the proposed rule are not included.**

To model the impacts of the proposed payments on home health revenues, we would need to know the specific adjustments that the agency applied to the CY 2021 data to project the CY 2022 payments. The CY 2022 data are currently not available as the year is not complete and we would require another 2 to 3 months for run-out after year end.

Additionally, we determined total CY 2023 payments of \$16.1 billion from CMS' OASIS-LDS dataset. Yet, from the proposed rule, we calculated that projected CY 2023 payments would have had to be \$18.5 billion and CY 2022 payments of \$19.3 billion to equate to an \$810 million (or a 4.2 percent) reduction in payments over the two years. This gap suggests that CMS applied additional adjustments beyond the payment parameters in the available data to estimate CY 2023 payments. The actual adjustments CMS applied are not clear to us at this time.

2) **Actual CY 2021 30-day case payments are not included, nor are 60-day counterfactual payments for the CY 2021 data that CMS used to assess budget neutrality included.**

Regarding the budget neutrality assessment, we note that while we have CY 2020 claims and OASIS data available, the CY 2021 OASIS data has not yet been made available by CMS to complete the linkage between CY 2021 claims data and CY 2021 OASIS data. In addition, while CMS provides information in the proposed rule that outlines the methodology including assumptions and exclusions for their budget neutrality assessment, there are additional assumptions that the agency makes when combining the 30-day episodes into 60-day episodes that the agency does provide.

For instance, under PDGM, data collection at certain time points for 23 existing OASIS items is optional.⁶ It is not clear how CMS deals with the unreported OASIS elements that are required for determining case-mix under the 60-day payment system. In addition, roughly 40 percent of the diagnoses⁷ previously allowed for under the 60-day payment system are not accepted as primary diagnoses; it is not clear how CMS accounts for these changes when determining what the

⁶ CMS, OASIS Memorandum. Accessed August 2nd 2022 here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D1-Update-Memorandum.pdf>

⁷ 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-pdgm-most-overlooked-aspects/>.

counterfactual payment under the 60-day system would have been for CY 2020 or CY 2021 PDGM data.

Further, the CY 2022 Proposed Rule CMS OASIS-LDS impact file, where CMS used actual CY 2020 data to model CY 2022 projected payments did not include the actual CY 2020 30-day case payments, nor did it include the 60-day counterfactual payments for the CY 2020 data that CMS used to assess budget neutrality for that year.

We note that in rule making cycles prior to CY 2022 CMS provided much of this information. The data CMS provided in other rule making cycles is summarized in the **Exhibit 1** below.

Exhibit 1: Data and Variables Provided by CMS for CY 2020 through CY 2023 Rule Making Cycles

Proposed Rule	Data Source	Elements Provided
2020	2018 60-day episode claims	<ul style="list-style-type: none"> - 60-day episodes and 30-day episodes with simulated CY 2020 payments with all behavioral assumptions applied - HHA Agency level impact file with simulated CY 2020 payments for 60-day and 30-day episodes
2021	2019 60-day episode claims	<ul style="list-style-type: none"> - 60-day episodes and 30-day episodes with simulated CY 2021 payments
2022	2020 30-day episode claims	<ul style="list-style-type: none"> - 30-day episode cases with simulated CY 2022 payments - Not provided: 60 day-episode cases; CY 2021 Payments to match CY 2022 payments for impact analyses
2023	2021 30-day episode claims	<ul style="list-style-type: none"> - 30-day episode cases with simulated CY 2023 payments - Not provided: 60 day-episode cases; CY 2022 payments to match CY 2023 payments for impact analyses

Source: Dobson | DaVanzo Analysis of CMS Impact Files

We also note that we, along with PQHH, submitted a request to CMS on July 6, 2022, for additional data. Our request was denied, with CMS stating that the OASIS-LDS dataset they provided and the information in the rule was enough to replicate the agency’s analyses in the CY 2023 HH PPS Proposed Rule. In contrast, as described above, additional data are required to be able to accurately examine CMS’ methodology for assessing budget neutrality and to accurately determine the impacts of the CY 2023 HH PPS proposed payment rates on home health revenues. We also note that calculating the counterfactual 60-day payments would be exceedingly difficult to accomplish within the 60-day comment period given the insufficient data provided.

2. Examining CMS' Interpretation of PDGM Budget Neutrality

The Bipartisan Budget Act (BBA) of 2018⁸ 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) was 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.⁹ 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”¹⁰ 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 2023 Proposed Rule (87 FR 37600),¹¹ CMS provides a description of the methodology and results from analyses the agency uses to assess budget neutrality during the first two years of PDGM (CY 2020 and CY 2021).

CMS interprets the actual behavior changes to encompass both the assumed behavior changes previously outlined in the CY 2020 HH PPS Final Rule, and other behavior changes, as well as interactions between behaviors not identified when the budget neutral 30-day payment amount for CY 2020 was determined. As CMS states in the CY 2023 HH PPS Proposed Rule, other behavior changes not previously outlined in the rule include the decline in therapy visits observed under PDGM. CMS therefore adjusts the HH PPS budget neutral payments to account for any provider behavior changes observed under PDGM.

However, we note that MedPAC interprets budget neutrality to mean that payments under the PDGM are equal to payments that otherwise would have occurred under the old 60-day payment system. According to MedPAC, “*The BBA of 2018 requires that payments under the PDGM be budget neutral (neither raise nor lower aggregate home health care spending) relative to spending that would have occurred without the new model's implementation.*”¹² Our interpretation, detailed below, is consistent with MedPAC's interpretation.

⁸ BBA of 2018, H.R.1892. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/1892>.

⁹ Underlined by Dobson | DaVanzo for emphasis.

¹⁰ Section 51001(a)(2)(D)(i) of the BBA of 2018. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/1892>.

¹¹ CY 2023 HH PPS Proposed Rule, 87 FR 37600. Available at: <https://www.federalregister.gov/documents/2022/06/23/2022-13376/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home>.

¹² MedPAC Report to Congress, Chapter 8: Home Health Services. Accessed August 2, 2022 at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch8_SEC.pdf.

Further, CMS interprets budget neutrality in the CY 2023 SNF PPS Proposed and Final Rule in an analogous manner to that called for by MedPAC and in practice since the Inpatient Prospective Payment System (IPPS) was set in place in 1983. CMS states in the CY 2023 SNF PPS Proposed Rule¹³ that the methodology for calculating budget neutrality is such that, “total estimated payments under PDPM would be equal to total actual payments under RUG-IV, assuming no changes in the population, provider behavior, and coding.”

The interpretation of budget neutrality by MedPAC and CMS in the CY 2023 SNF PPS Proposed Rule contradicts CMS’ interpretation of budget neutrality in the CY 2023 HH PPS Proposed Rule. According to CMS, the nearly 29.7 percent reduction in therapy visits under PDGM is deemed a behavioral change for which agencies are penalized. As we argue below, this assumption is misguided as it lowers the budget neutral target well below previous definitions of budget neutrality and places HHAs in an untenable position of “catch up” between 2020 to 2026. This is similar to the Sustained Growth Rate (SGR) of the Medicare Physicians Fee Schedule (MPFS) which placed financial pressures on physicians that ultimately rendered the MPFS unsustainable and required a congressional “fix.”

In addition, as CMS finalized behavioral adjustments of -4.36 percent to the CY 2020 PDGM amount to account for the assumption that providers would adjust documentation and coding practices to maximize reimbursement under PDGM. It would have been expected that the agency would similarly make upward adjustments to account for the PDGM-driven reduction in therapy visits that ultimately lower the counterfactual CY 2020 budget neutral payments. CMS’ asymmetrical approach (adjusting down for increased payments and not adjusting up for decreased payments) seems inconsistent and possibly biased against home health agencies.

CMS METHODOLOGY FOR DETERMINING BUDGET NEUTRALITY

To assess whether the PDGM 30-day budget neutral payment amount for CY 2020 maintained budget neutrality with the implementation of PDGM, 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 to 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 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.

CMS determined that the estimated aggregate expenditures under the 60-day payment system were lower than the actual estimated aggregate expenditures under the PDGM. The agency then recalculated what the CY 2020 30-day base payment rate should have been to equal aggregate expenditures determined using the simulated CY 2020 60-day episodes. CMS calculated the permanent prospective adjustment from the difference between the actual 30-day payment rate and the recalculated payment rate. CMS used the same methodology to determine the permanent prospective adjustment required for the CY 2021 data.

¹³ CY 2023 SNF PPS Proposed Rule. 87 FR 22720. Available at: <https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

Additionally, CMS calculated a temporary retrospective adjustment for CY 2020 and 2021 aggregate payments by determining the difference in aggregate payments between the estimated aggregate expenditures from all 30-day periods using the recalculated 30-day base payment rate and the aggregate expenditures for all 30-day periods using the actual 30-day base payment rate for the same year.

CMS determined that to offset the increase in estimated aggregate expenditures for CYs 2020 and 2021, CMS would need to apply a -7.69 percent permanent adjustment to the CY 2023 base payment rate as well as implement a temporary adjustment of approximately \$2.0 billion to reconcile retrospective overpayments in CYs 2020 and 2021.

WHY CMS BUDGET NEUTRALITY ASSESSMENT METHODOLOGY IS FUNDAMENTALLY FLAWED

As we noted in our technical report last year, a few critical issues warrant examination with regard to the agency's proposed methodology for assessing budget neutrality.

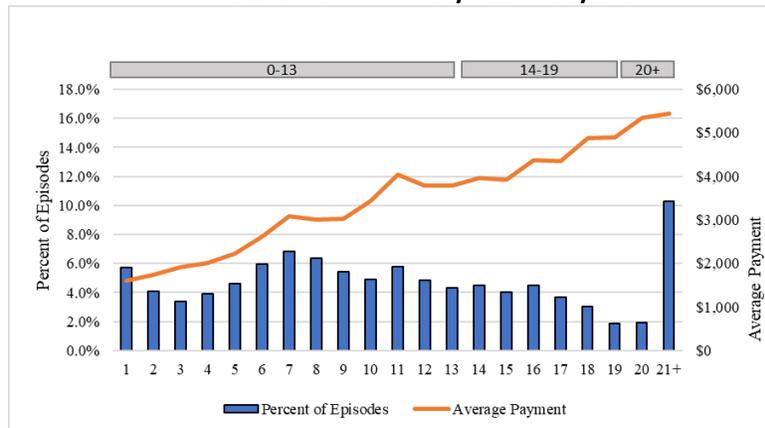
PAYMENT INCENTIVE-DRIVEN SHIFT IN THERAPY UTILIZATION

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 or CY 2021 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 home health utilization in CY 2020 making aggregate payments made under the 30-day PDGM in CY 2020 incomparable to simulated payments that would have been made under the 60-day system in CY 2020 in absence of the payment system change.

Prior to PDGM, under the 60-day payment system, case-mix weight and payments were largely driven 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. Under PDGM, CMS, as an explicit matter of public policy as called for by legislation, eliminated these therapy thresholds and our analysis of the CY 2020 data shows that therapy visits fell by 29.7 percent 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 2**, therapy visits under the 60-day payment system in CY 2019 tended to cluster around the therapy thresholds (0-13, 14-19, 20+) used to adjust payments. As can be observed, 10.3 percent of 60-day episodes had 21 or more therapy visits, while more than half had at least 10 therapy visits.

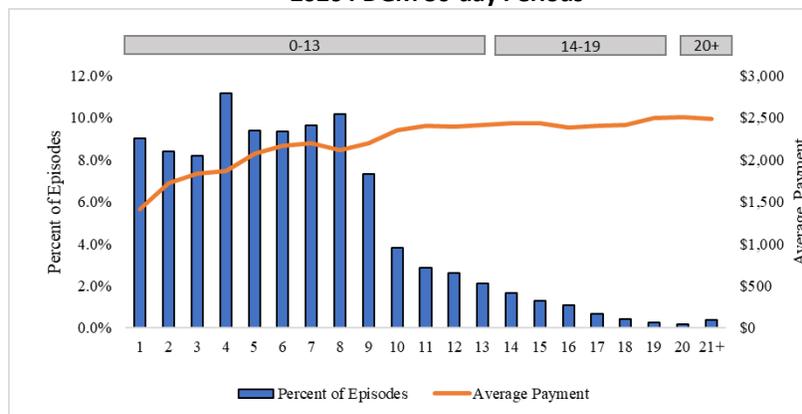
Exhibit 2: Percent of Episodes and Average Payments by Therapy Visits Under 2019 HH PPS 60-day Unit of Payment



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 3**. 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 3: 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, CMS’ use of CY 2020 data to estimate what CY 2020 case-mix and payments would have been without the implementation of PDGM is fundamentally flawed, and it is contradictory of the basic notion of budget neutrality as called for by MedPAC and as defined in other CMS regulations. 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.

CMS acknowledges similar therapy reductions in the FY 2023 SNF PPS Proposed and Final Rules. CMS states that:^{14,15}

“Between October 2019 and December 2019, the 3 months after PDPM implementation and before the onset of the COVID-19 PHE, the average number of therapy minutes SNF patients received per day dropped to approximately 68 minutes per utilization day, a decrease of approximately 27 percent.”

“Given this reduction in therapy provision since PDPM implementation, we found that using patient assessment data collected under PDPM would lead to a significant underestimation of what RUG-IV case-mix and payments would have been (for example, the Ultra-High and Very-High Rehabilitation assignments are not nearly as prevalent using PDPM-reported data), which would in turn lead to an overcorrection in the parity adjustment.”

Further, under this compelling logic, CMS explicitly does not penalize SNFs for the precipitous decline in therapy visits driven by PDPM implementation, instead the agency uses a parity adjustment methodology that does not reflect for the payment system-driven decline in therapy visits associated with PDGM. That is, CMS does not “overcorrect” for the strong incentives set in place by the new SNF PPS (PDPM).

As outlined in the statute, CMS is obligated to implement temporary and/or permanent adjustments to offset **either increases or decreases** in HHA payments.

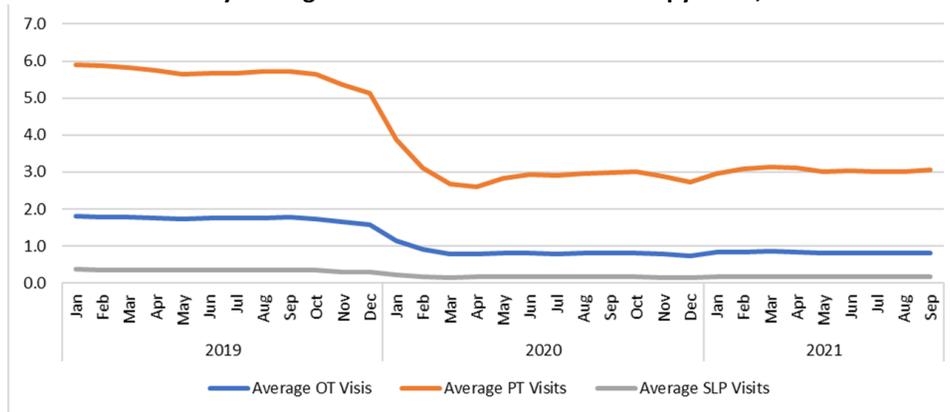
IMPACT OF COVID-19 PHE ON THERAPY UTILIZATION

Exhibit 4 shows the average monthly home health therapy visits by discipline in CY 2020. As shown by the data in **Exhibit 4**, 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. Thus, the PDGM effect on therapy is not a COVID effect, but rather a PDGM effect.

¹⁴ CY 2023 SNF PPS Proposed Rule, 87 FR 22720; <https://www.federalregister.gov/d/2022-07906/p-193>.

¹⁵ CY 2023 SNF PPS Proposed Rule, 87 FR 47502; <https://www.federalregister.gov/documents/2022/08/03/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

Exhibit 4: Monthly Average Number of Home Health Therapy Visits, CY 2019-CY 2021



Source: Dobson | DaVanzo Analysis of HH Claims in RIF DUA 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, causing a lower counterfactual, supposed budget neutral 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 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.

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 without first calculating the correct counterfactual 2019 case mix as illustrated in the SNF HH PPS PDPM parity adjustment methodology. This PDGM-driven reduction in therapy calls for an upward adjustment to preserve budget neutrality as called for in the statutory language described above.

3. Proposed Approaches for PDGM Budget Neutrality Assessment

As CMS cannot plausibly use CY 2020 data to determine case-mix weights and aggregate payments that would have been made under the prior 60-day payment system in the absence of PDGM, we propose two approaches consistent with CMS' authority for achieving budget neutrality under PDGM.

Methodology 1: Comparing the 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).

Methodology 2: Applying the PDPM parity adjustment methodology the agency used in the CY 2023 SNF PPS Proposed and Final Rule to CY 2020 PDGM data.

METHODOLOGY 1

We propose that CMS assess budget neutrality by comparing the 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 would align with the notion that under budget neutrality CMS must determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures in CY 2020. Note that we discuss budget neutrality in terms of average payment which is not influenced by changes in case volume.

We note that we attempted to assess budget neutrality using this methodology in our CY 2022 HH PPS Proposed Rule Technical Report last year. However, as indicated by CMS in the CY 2022 HH PPS Final Rule, the data we obtained that CMS used to set CY 2020 payment rates (based on data from CY 2018 60-day episodes converted to 30-day episodes) included the full behavioral assumptions (8.01 percent) as opposed to the half that was finalized for CY 2020 (4.36 percent).

The data sets we previously used to assess budget neutrality using this methodology are described below.

- Preliminary 2020 claims are available to Dobson | DaVanzo under CMS Research Identifiable File (RIF) Data Use Agreement (DUA) 54757.
- Historical projections of PDGM using 2018 data and including both a regrouping of HH PPS cases to PDGM as well as the full behavioral assumptions made available in the CY2020 OASIS-LDS file, Data Use Agreement 53367.¹⁶ This dataset was issued as a companion to the CY2020 Final Rule.

We believe that CMS has the appropriate data with half and not full behavioral assumptions that they can use to assess budget neutrality using this methodology.

¹⁶ Note that as CMS converted 60-day episodes to 30-day episodes, 9.5 percent 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.

METHODOLOGY 2

Alternatively, CMS could assess budget neutrality using a methodology similar to the parity adjustment methodology the agency uses in the CY 2023 SNF PPS.

To assess PDMG budget neutrality for CY 2020 PDGM payments we used the SNF parity adjustment methodology outlined in the CY 2023 SNF PPS Proposed and Final Rules through the following steps.

1. Determine budget neutral counterfactual total payments (60-day payment system)

To calculate the counterfactual payments, we used the percentage of cases in each HHRG group in CY 2019 and multiplied these percentages by the total number of CY 2020 cases. We then multiplied the number of cases for each 2019 HHRG group by the CY 2020 60-day payment rate, obtained from the CY 2020 HH PPS Final Rule.

2. Obtain actual total payments under PDGM in CY 2020 (30-day payment system)

3. Calculate the budget neutral adjustment factor (Step 2 – Step 1)

This methodology also 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. The use of CY 2019 data on the percentage of cases by HHRG group eliminates the need to model other behavioral shifts that occurred due to the implementation of PDGM.

The above steps are described in detail below.

1. Determining budget neutral counterfactual total payments (60-Day Payment System) for CY 2020 using CY 2019 case mix as the baseline

We defined the budget neutral counterfactual payments using the following steps below.

Step 1: Define the subset of home health cases to be used in the budget neutrality assessment. We defined two groups of cases. One group of all CY 2020 cases including those with COVID-19 as a primary or secondary diagnosis on the claim and another group without COVID-19 diagnoses. As budget neutrality requires a comparison of payments for the same set of cases, we calculated a multiplier (0.58842) to convert actual CY 2020 30-day episodes to 60-day episodes using the data provided by CMS in the CY 2022 HH PPS Proposed and Final Rule.¹⁷ The CY 2020 data we used includes all 30-day episodes to date (as of April 2022) without any exclusions.¹⁸

Step 2: Define the time period for the assessment. We defined the time period¹⁹ for this analysis as the 12 months in 2020 for PDGM data and the 12 months in 2019 for data under the 60-day payment system.

¹⁷ CY 2022 HH PPS Proposed Rule, 86 FR 35874 <https://www.federalregister.gov/d/2021-13763/p-157>.

¹⁸ In the CY 2022 HH PPS proposed rule CMS noted that the final dataset, after converting CY 2020 30-days episodes to 60-day episodes, included 7,441,602 actual 30-day periods of care and 4,378,823 simulated 60-day episodes of care for CY 2020. Also note that CMS excluded close to 9% of cases with missing data or those that could not be grouped into 60-day episodes.

¹⁹ Note that in the CY 2023 SNF PPS proposed rule, CMS defines a control period from Oct. 2019-Apr. 2020, and Apr. 2021 through Sept. 2021 as PDPM was implemented Oct 2019. However, this period would not be applicable for PDGM as PDGM was implemented in January 2020 thus 2019 data would belong to the old 60-day system.

Step 3: Calculate the proportion of cases in each HHRG group in CY 2019. We then used 2019 home health claims available to Dobson | DaVanzo under CMS RIF DUA 54757 to determine the number of 60-day cases in each HHRG group as well as the percentage of cases in each HHRG group under the 60-day 153-HHRG group system.

Step 4: Calculate the number of cases in each HHRG group for counterfactual CY 2020 cases. We then multiplied the total number of cases from Step 1 with the proportion of cases in each HHRG group from step 3 to obtain the number of cases in each HHRG group for counterfactual CY 2020 cases. This step ensures that the counterfactual case mix primarily driven by therapy remains constant between CY 2019 and CY 2020.

Step 5: Determine the counterfactual payments. We first determined the counterfactual payment rate for each HHRG group by adjusting the CY 2020 60-day payment rate²⁰ for case mix and accounting for the rural add-on, Partial Episode Payments (PEP), Outlier Cases and LUPAs. We then multiplied the total cases in each HHRG group by the counterfactual 2020 HHRG payment as illustrated below.

2. Obtain actual total payments under PDGM in CY 2020 (30-day payment system)

We determined the actual total payments under PDGM by obtaining the claim payments for the same exact subset of cases as used in determining the counterfactual payments.

3. Calculate the budget neutral adjustment factor (Step 2 – Step 1)

We determined the budget neutral adjustment factor by comparing aggregate actual CY 2020 payments from Step 2 to the aggregate counterfactual budget neutral payments from step 1.

²⁰ Note that CMS provided a 60-day standard payment rate in the CY 2020 HH PPS Final Rule because of 60-day claims that began late in CY 2019 that continued to be paid under the 60-day payment rate in CY 2020.

FINDINGS FROM METHODOLOGY 2

We determined that there would have been 5,377,880 60-day episodes from the 9,139,452 total 30-day episodes in CY 2020 without any exclusions. After excluding COVID-19 cases, there would have been 5,206,075 60-day episodes for 8,847,478 30-day episodes.

Results from our analysis indicate that CY 2020 PDGM payments were approximately 2.5 percent below budget neutrality (with COVID-19 cases included) and 2.4 percent below budget neutrality with COVID-19 cases excluded as shown in **Exhibit 5** below. These results are comparable to CMS’ results in their analysis of budget neutrality in the CY 2023 SNF PPS.

Exhibit 5: PDGM Budget Neutrality Assessment Using the SNF Parity Adjustment Methodology

All Cases					Cases Excluding COVID-19				
	Counterfactual Payments	CY 2020 Actual Payments	Payment Difference	Percent Difference		Counterfactual Payments	CY 2020 Actual Payments	Payment Difference	Percent Difference
Fully Paid Case Payments	\$15,070,828,298				Fully Paid Case Payments	\$14,589,367,263			
LUPA Case Payments*	\$271,186,559				LUPA Case Payments	\$261,933,481			
PEP Case Payments	\$291,051,349				PEP Case Payments	\$281,753,261			
Outlier Case Episode Payments	\$638,148,574				Outlier Case Episode Payments	\$617,761,926			
Outlier Add-On Payments**	\$417,210,635				Outlier Add-On Payments	\$403,867,075			
Total Payments***	\$16,688,425,416	\$16,276,736,137	-\$411,689,279	-2.467%	Total Payments	\$16,154,683,007	\$15,759,292,822	-\$395,390,184	-2.448%
Total Cases	5,377,880	9,139,452			Total Cases	5,206,075	8,847,478		

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

ANALYTIC LIMITATIONS

We note that the counterfactual analyses shown above do not account for the LUPA add-on which could increase total counterfactual payments. The above counterfactual payments do not account for the quality reporting penalties which would decrease total counterfactual payments. However, as CMS reported that approximately 11.2 percent (1,286 of the 11,444) active Medicare-certified HHAs did not receive the full annual percentage increase due to quality reporting penalties, the impact of quality reporting penalties (a reduction of 2 percent from the full base payment) on the counterfactual payments is likely insignificant. Finally, we also assumed that counterfactual outlier payments would have been 2.5 percent of total payments. To the extent that outlier add-on payments are less than 2.5 percent of total payments then the counterfactual total payments are overstated, and to the extent that the outlier add-on payments are over 2.5 percent then the counterfactual total payments are understated.

4. Impact of the CY 2023 HH PPS Proposed Rule on HHA Revenues

IMPACT OF CY 2023 HH PPS PROPOSED PAYMENT RATES ON HHA MEDICARE REVENUES

For CY 2023, CMS projects in the CY 2023 HH PPS that home health agencies will experience a reduction of \$810 million (or a -4.2 percent reduction) in payments between CY 2022 and CY 2023. This reduction includes an overall -6.9 percent reduction²¹ due to the permanent behavioral adjustment, a -0.2 percent reduction for the FDL and a 2.9 percent payment update (inclusive of the market basket update adjusted for the MPF).

METHODOLOGY

We examined the impacts of the CY 2023 HH PPS proposed payment rates on HHA revenues by comparing current law (Dobson | DaVanzo estimated CY 2022) payments to the projected CY 2023 payments provided by CMS through the following steps.

Step 1: We obtained CY 2023 projected case-level payments from the CY 2023 CMS OASIS-LDS impact dataset. We then aggregated the cases for each agency using the provider CCN and determined the CY 2023 payments for each agency.

Step 2: We determined each agency's ownership; facility type; and location using the publicly available data from CMS.

Step 3: We obtained the CY 2023 payment parameters applicable to each agency type using the parameters outlined in the impact table in the CY 2023 HH PPS Proposed Rule. For instance, we identified that free-standing, government owned agencies in urban areas on average experienced a 4 percent reduction in payments between CY 2022 and CY 2023.

Step 4: We simulated what the CY 2022 payments for each agency using the payment parameters obtained in step 3 applied to the CY 2023 payments from step 1.

Step 5: We calculated the projected revenue change by determining the difference between the estimated CY 2022 payments and the projected CY 2023 payments.

Step 6: We note that the total CY 2023 payments determined from the CY 2023 CMS OASIS-LDS impact dataset were short of the projected CY 2023 payments that would have resulted in an \$810 million reduction in payments following a 4.2 percent reduction. We calculated that CY 2023 payments of \$18.5 billion and CY 2022 payments of \$19.3 billion equate to an \$810 million (or a 4.2 percent) reduction in payments over the two years. We therefore adjusted the \$16.1 billion in CY 2023 payments calculated from the OASIS-LS data provided to equal \$18.5 billion and applied corresponding adjustments at the agency level. For each agency, we first determined the proportion of the agency's CY 2022 to CY 2023 payment reduction as a fraction of the overall payment reduction determined from the OASIS-LDS dataset. We then applied that proportion to the overall

²¹ As CMS notes in the CY 2023 HH PPS proposed rule, the 7.69 percent permanent reduction is applied to the base payment but after account for fully paid cases, LUPAs, PEP cases and outlier cases, the permanent adjustment results in a 6.9 percent overall payment reduction.

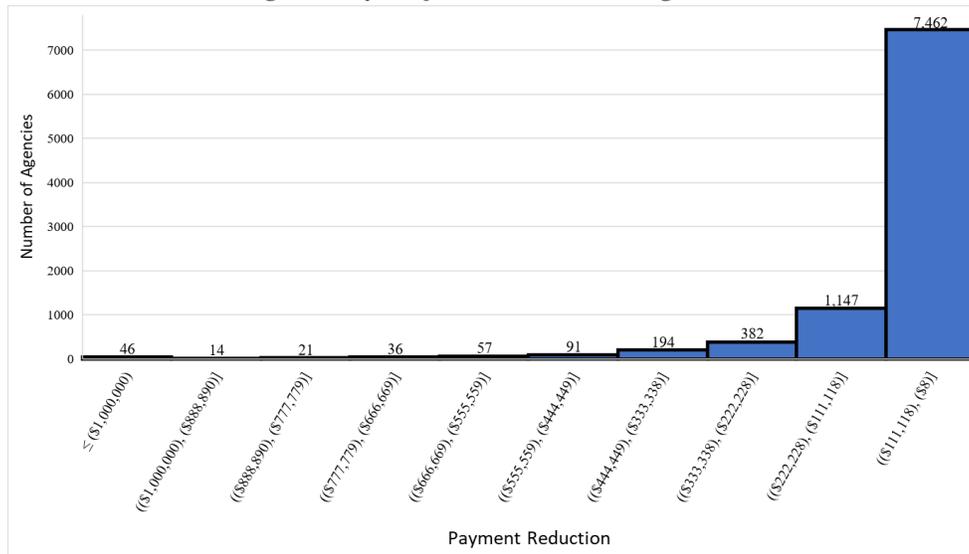
projected reduction of \$810 million to determine the adjusted payment reduction. We used the same method to adjust the CY 2022 and CY 2023 payments for each agency.

RESULTS

Provider Impacts

When comparing current law payments to projected CY 2023 budget neutral payments at the agency level, we find that the majority of home health agencies are projected to have a -\$111,118 or less change in annual revenue, although 46 agencies are projected to have a -\$1 million or more change in revenue; the full distribution of projected agency revenue change is shown in **Exhibit 6** below.

Exhibit 6: Distribution of Agencies by Projected Revenue Change between CY 2022 and CY 2023



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

Rural vs. Urban Impacts

We also examined the distribution of projected revenue changes for agencies in rural versus urban areas. We found that agencies in rural areas represent 15 percent of the agencies and cases and will experience 9.8 percent of the total reduction in payments between CY 2022 and CY 2023. These results are shown in **Exhibit 7**.

Exhibit 7: Projected Revenue Change between CY 2022 and CY 2023 for Agencies in Rural vs. Urban Areas

Location	Number of Agencies	Total 2023 Case Count	2022/2023 Adjusted Payment Difference
Rural	1,416 (15.0%)	1,306,845 (14.6%)	-\$79,640,961 (9.8%)
Urban	8,034 (85.0%)	7,619,391 (85.4%)	-\$730,359,039 (90.2%)
Grand Total	9,450 (100.0%)	8,926,236 (100.0%)	-\$810,000,000 (100.0%)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

State Impacts

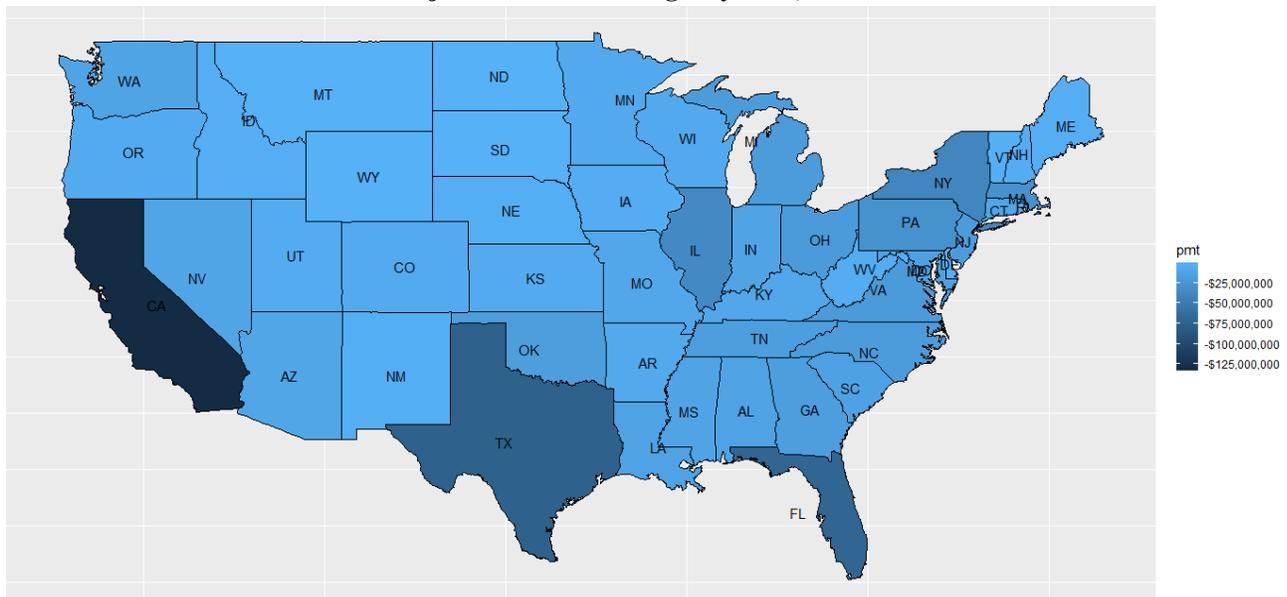
We also found that the top 10 states with the greatest reductions in payments will experience payment reductions of \$476 million—an amount that is more than half the overall payment reductions for all providers between CY 2022 and CY 2023. These results are shown in **Exhibit 8** below and the results for projected revenue changes for all states are shown in **Exhibit 9**.

Exhibit 8: Top 10 States with Highest Projected Revenue Changes between CY 2022 and CY 2023²²

State	Number of HHAs	Total 2023 Case Count	CY 2022 to CY 2023 Adjusted Payment Difference
CA	1,619	1,121,660	(\$133,209,572)
TX	1,627	944,537	(\$76,411,370)
FL	877	795,548	(\$70,706,247)
NY	110	336,891	(\$39,774,574)
IL	532	386,883	(\$36,089,720)
PA	263	312,025	(\$29,492,218)
MA	174	277,322	(\$28,792,823)
VA	218	241,894	(\$21,426,603)
OH	366	245,886	(\$20,568,280)
NC	160	243,586	(\$19,995,472)
Total for top 10 states	5,946	4,906,232	(\$476,466,881)
Total for all other states	3,504	4,020,004	(\$333,533,118)
Overall Total	9,450	8,926,236	(\$810,000,000)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

Exhibit 9: Distribution of Projected Revenue Changes by State, between CY 2022 and CY 2023



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

²² Numbers may not add up due to the effects of rounding.

IMPACT OF THE PROPOSED TEMPORARY REDUCTIONS FOR CY 2020 AND CY 2021 PAYMENT RECONCILIATION

In addition to the proposed permanent behavioral adjustment, CMS also calculated that temporary reductions of \$2.0 billion would be required to reconcile CY 2020 and CY 2021 aggregate payments to budget neutral levels. CMS further indicates in the CY 2023 HH PPS Proposed Rule that they are not applying the temporary reduction to the CY 2023 payments and instead seek to solicit comments on how best to collect the temporary payment adjustment of approximately \$2.0 billion for CYs 2020 and 2021.

METHODOLOGY

We estimated the magnitude of the impact of the temporary reductions to individual HHA revenues in CY 2024 and future years, we assumed that payments in CY 2024 and beyond would remain at CY 2023 levels through the following steps.

Step 1: First, we determined the proportion of the proposed \$2.0 billion temporary reduction as a share of the total CY 2023 payments. Our results showed that the temporary reduction represents 10.9 percent of CY 2023 payments.

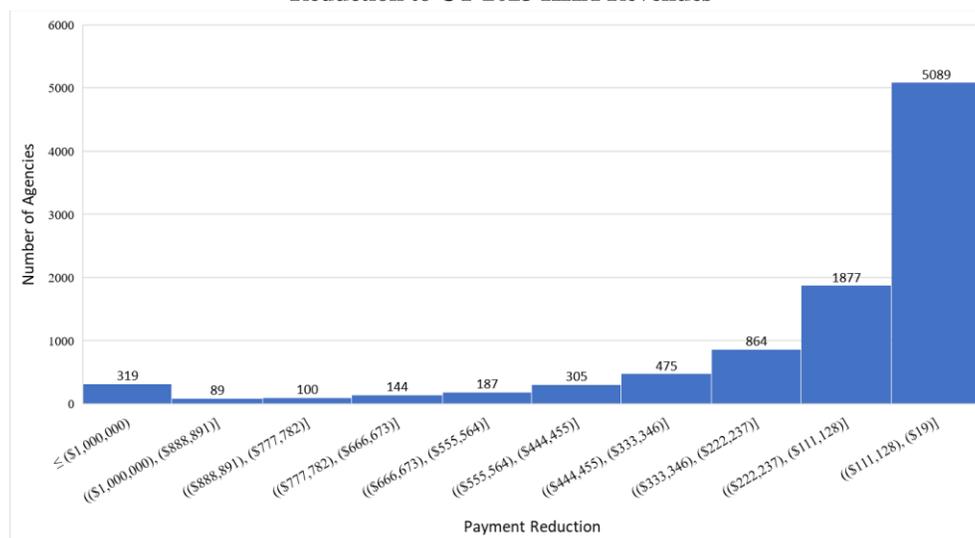
Step 2: We then applied a 10.9 percent reduction to each agency’s CY 2023 payments to determine the revenue impact of the proposed temporary reduction, with the assumption that future payments remain at CY 2023 levels/dollars.

RESULTS

Provider Impacts

Exhibit 10 below shows the distribution of projected revenue impacts of the CY 2020 and CY 2021 temporary reduction. We find that more agencies (319) are projected to have a -\$1 million or more change in revenue due to the temporary adjustment in comparison to the permanent adjustment (shown in **Exhibit 6**).

Exhibit 10: Distribution of Projected Impact of CY 2020 and CY 2021 Temporary Reduction to CY 2023 HHA Revenues



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

State Impacts

We also found that the top 10 states with the greatest temporary reductions in payments will experience reductions of \$1.2 billion—an amount that is more than half the overall temporary reductions for all providers. These results are shown in **Exhibit 11** below.

Exhibit 11: Top 10 States with Highest Projected Temporary Reductions due to the CY 2020 and CY 2021 Reconciliation

State	Number of HHAs	Total 2023 Case Count	Impact CY 2020 and CY 2021 Temporary Adjustment in CY 2023 dollars
CA	1,619	1,121,660	(\$325,829,392)
TX	1,627	944,537	(\$192,667,932)
FL	877	795,548	(\$171,952,111)
NY	110	336,891	(\$96,988,137)
IL	532	386,883	(\$88,420,560)
PA	263	312,025	(\$71,709,923)
MA	174	277,322	(\$69,377,896)
VA	218	241,894	(\$53,409,260)
OH	366	245,886	(\$51,244,406)
NC	160	243,586	(\$51,333,054)
Total for top 10 states	5,946	4,906,232	(\$1,172,932,671)
Total for all other states	3,504	4,020,004	(\$848,063,908)
Overall Total	9,450	8,926,236	(\$2,020,996,579)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

IMPACT OF ADDITIONAL ESTIMATED TEMPORARY REDUCTIONS FOR CY 2022 PAYMENT RECONCILIATION

Finally, because no previous adjustments were applied to the CY 2022 payment rate, using CMS' temporary reductions for CY 2020 and CY 2021 we estimated the temporary adjustment that would be required to offset for such increases in the estimated aggregate expenditures for CY 2022.

METHODOLOGY

We used the following methodology.

Step 1: First, we determined the proportion of the CY 2020 and CY 2021 temporary reduction as a share of the respective total calendar year payments. For instance, the proposed CY 2020 temporary adjustment represents 5.2 percent of CY 2020 payments, and the CY 2021 temporary reduction represents 6.5 percent of CY 2021 payments.

Step 2: To remain conservative, we then estimated that CY 2022 temporary reductions would be 6.5 percent of CY 2022 payments equating to a \$1.2 billion estimated reduction.

RESULTS

State Impacts

Similar to the impacts of the CY 2023 HH PPS payment rate and the impact of the CY 2020 and CY 2021 temporary reduction, we found that the top 10 states with the greatest temporary reductions in payments will experience more than half the overall CY 2022 temporary reductions for all providers. These results are shown in **Exhibit 12** below.

Exhibit 12: Top 10 States with Highest Projected Temporary Reductions due to the CY 2022 Reconciliation

State	Number of HHAs	Total 2023 Case Count	Impact CY 2022 Temporary Adjustment in CY 2023 dollars
CA	1,619	1,121,660	(\$194,811,237)
TX	1,627	944,537	(\$115,194,882)
FL	877	795,548	(\$102,809,029)
NY	110	336,891	(\$57,988,565)
IL	532	386,883	(\$52,866,068)
PA	263	312,025	(\$42,874,889)
MA	174	277,322	(\$41,480,585)
VA	218	241,894	(\$31,933,043)
OH	366	245,886	(\$30,638,691)
NC	160	243,586	(\$30,691,694)
Total for top 10 states	5,946	4,906,232	(\$701,288,683)
Total for all other states	3,504	4,020,004	(\$507,051,799)
Overall Total	9,450	8,926,236	(\$1,208,340,482)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

OVERALL IMPACT OF CY 2023 HH PPS PROPOSED RULE REDUCTIONS AND FUTURE REDUCTIONS: IMPACT TO HHA REVENUES

In aggregate, we estimate that the payment reductions due to behavioral adjustments could lead to an approximate reduction of \$8.7 billion for home health-related payments from 2023 through 2026. This amount includes the \$5.3 billion due to permanent adjustments, \$2.0 billion due to temporary adjustments for CY 2020 and CY 2021, \$1.2 billion due to temporary adjustments for CY 2022. We note that this is in addition to the 4.36 payment cut due to assumed provider behavioral changes that equate to \$2.43 billion in aggregate reductions between CY 2020 and CY 2023.

METHODOLOGY

We determined the impact of the 6.9 percent permanent adjustment on home health payments between 2023 and 2026 through the following steps.

Step 1: We calculated the projected home health payments with behavioral adjustments for CY 2024 through CY 2026. Based on the Congressional Budget Office’s (CBO) baseline of May 2022, home health payments are projected to remain flat between CY 2023 and CY 2024 and increase by 5.9 percent between CY 2024 and CY 2025 and then remain flat between CY 2025 and CY 2026.^{23,24}

Step 2: We estimated the aggregate payments without behavioral adjustments for CY 2024 through CY 2026 by increasing the total payments with behavioral adjustments by 6.9 percent. Note that reverse percentage derivation of payments without behavioral adjustments requires further adjustments to the 6.9 percent increase. We further adjusted the payments without behavioral adjustments by 0.2 percent to account for this.

RESULTS

These results are shown in **Exhibit 13**.

Exhibit 13: Projected Impact of 6.9 Percent Permanent Behavioral Adjustment in CY 2023 through CY 2026

Year	CBO Projected Home Health Payments	Percent Growth	Total Payments with -6.9 percent Behavioral Adjustment (BA)	Total Payments without -6.9 percent Behavioral Adjustment (BA)	Difference between total payments with and without BA
2023	\$17,000,000,000		\$18,475,714,286	\$19,806,428,572	(\$1,330,714,286)
2024	\$17,000,000,000	0.00%	\$18,475,714,286	\$19,806,407,794	(\$1,330,693,508)
2025	\$18,000,000,000	5.88%	\$19,562,521,009	\$20,971,490,605	(\$1,408,969,596)
2026	\$18,000,000,000	0.00%	\$19,562,521,009	\$20,971,490,605	(\$1,408,969,596)
Aggregate Impact of behavioral adjustments 2023-2026					(\$5,479,346,986)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

²³ Baseline budget projections as of May 22, 2020. Congressional Budget Office. (2022, May 05). <https://www.cbo.gov/system/files/2022-05/51302-2022-05-medicare.pdf>.

²⁴ Note that these growth rates are reflective of both price and quantity.

As we described earlier in this report, in the CY 2023 HH PPS NPRM, CMS proposes an additional \$2.0 billion temporary reduction to reconcile CY 2020 and CY 2021 payments. We also calculate an additional \$1.2 billion in temporary reductions to reconcile CY 2022 payments. In total, all these reductions combined could lead to a reduction of \$8.7 billion in payments to home health agencies between CY 2023 and CY 2026 as shown in **Exhibit 14** below.

Exhibit 14: Projected Combined Impact of PDGM Behavioral Adjustments from CY 2023 through CY 2026

	Payment Reduction
Aggregate Impact of projected temporary adjustments CY 2020 and CY 2021	(\$2,020,996,579)
Aggregate Impact of estimated temporary adjustments CY 2022	(1,208,340,482)
Aggregate Impact of permanent adjustments CY 2023-CY 2026	(\$5,479,346,986)
Total	(\$8,708,684,047)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

OVERALL IMPACT OF CY 2023 HH PPS PROPOSED RULE REDUCTIONS AND FUTURE REDUCTIONS: IMPACT TO HHA REVENUES

We also modeled the impact of the proposed permanent and temporary reductions to standard 30-day payment rates between CY 2024 to CY 2026 through the following steps.

METHODOLOGY

Step 1: We assumed that the standard 30-day base payment rates will be updated each year from CY 2024 to CY 2026 by 2.9 percent (the CY 2023 update).

Step 2: We assumed CMS will apply the combined \$3.2 billion total reduction due to temporary adjustments (including an estimated \$1.2 billion in reductions for CY 2022), evenly across the 3 years between CY 2024 and CY 2026. For each year between CY 2024 and CY 2026 overall payments will reduce by approximately \$1.07 billion.

Step 3: We estimated the percent reduction in payment rates for each year between CY 2024 and CY 2026 by dividing the payment reduction in each year by the projected payments for that year. The percent reduction is 5.8 percent in CY 2024 and 5.2 percent in CY 2025 and CY 2026. We further inflated the percent reduction obtained by 0.79 percent to account for LUPAs, PEPs and Outlier Cases. The 0.79 percent is obtained from the difference between the proposed permanent reduction in CY 2023 and overall payment reduction (6.9 percent vs. 7.69 percent). We determined that payment rates will decrease by a temporary reduction of 6.6 percent in CY 2024 and by 6.3 percent in CY 2025 and CY 2026.

Step 4: We determined the standard payment rate amount for each year as follows.

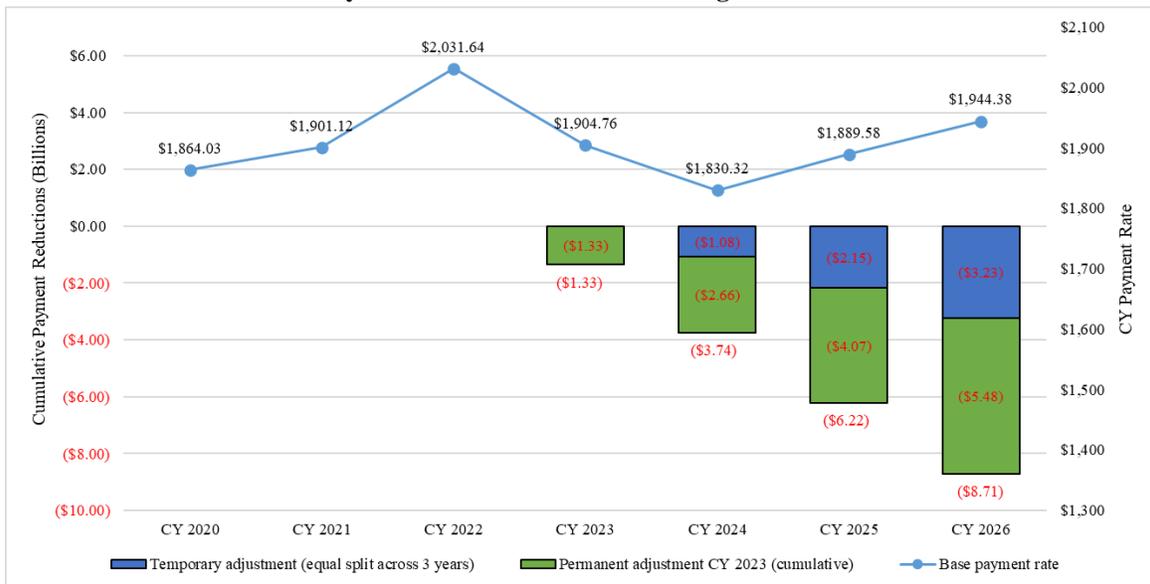
- For CY 2024, the combined 2.9 percent payment update and estimated 6.6 percent temporary reduction results in a decrease of the payment rate to \$1,830.32.
- For CY 2025, we first exclude the 6.1 percent temporary reduction from the CY 2024 payment rate (since it is a temporary one-year reduction). We then update the CY 2024 rate without the temporary reduction by the combined payment update and temporary payment adjustment for CY 2025. This results in a payment rate of \$1,889.58.

- We apply the methodology for CY 2025 to determine the CY 2026 payment rate and determine CY 2026 payment rates of \$1,944.38.

RESULTS

As shown in **Exhibit 15**, the cumulative total reduction due to temporary adjustments of \$3.2 billion for CY 2020 through CY 2022 reconciled in CY 2024 and beyond with result in further reductions to the payment rates below CY 2023 levels.

Exhibit 15: Projected Cumulative Impact of PDGM Behavioral Adjustments to HHA Revenues and Medicare Payment Rates from CY 2023 through CY 2026



Note: The payment reductions are displayed to illustrate the cumulative impact of the payment reductions between CY 2023 and CY 2026. Accordingly, the temporary adjustments accrue to \$3.23 billion by CY 2026, although they are temporary one-time reductions for each year. In contrast, the permanent adjustment applied to the CY 2023 base payment rate continues to accrue over time.

Source: Dobson / DaVanzo Analysis of HH Claims in LDS DUA 58177

OVERALL IMPACT OF CY 2023 HH PPS PROPOSED RULE REDUCTIONS AND FUTURE REDUCTIONS: IMPACT TO HHA MARGINS

We modeled the impact of the proposed permanent and temporary reductions to CY 2023 Medicare margins.

METHODOLOGY

Step 1: We first extracted data from the 2020 cost reports, the most complete data available.²⁵ Specifically, we extracted data reported on forms 1728-94 and 1728-20, depending on filing date. We then extracted the Medicare PPS payments and corresponding costs from the 2020 Medicare Cost Reports.

Step 2: We calculated 2020 Medicare margins by (1) calculating Medicare PPS income by subtracting costs from Medicare PPS payments, and (2) dividing Medicare PPS income by Medicare PPS payments using the formula illustrated below.

$$2020 \text{ Medicare Margins} = \frac{\text{Medicare PPS payments} - \text{Medicare PPS Costs}}{\text{Medicare PPS Payments}}$$

Step 3: To determine the 2021 to 2023 Medicare margins, we modeled Medicare payments for each agency for 2021 by increasing 2020 payments by 1.9 percent, 2022 payments by increasing modeled 2021 payments by 3.2 percent, and 2023 payments by decreasing modeled 2022 payments by 4.2 percent. We identified these payment updates from the CY 2021²⁶ and CY 2022 HH PPS²⁷ Final Rules and from the CY 2023 HH PPS proposed rule.²⁸

We then modeled costs by increasing 2020 costs by 3.1 percent, 2022 costs by increasing modeled costs payments by 4.5 percent, and 2023 cost by increasing modeled 2022 costs by 3.2 percent – with percentages identified from annualized Home Health Agency market basket data published by CMS.²⁹

We then calculated the Medicare margins from each year using the same formula as in *Step 2* above.

Step 4: To model the impact of temporary adjustments, we calculated a scaler by dividing PPS payments from the extracted Medicare Cost Report data by baseline payments in the NPRM (\$15,426,001,171 / \$19,285,714,286 = 80.0%). We applied this scaler to the temporary adjustments and allocated the results to individual agencies based on the modeled PPS payments. We then calculated the Medicare margins using the same formula in *Step 2*.

Step 5: We determined the counts and percentages of agencies with negative and positive for each scenario in *Step 2* and *Step 4*.

²⁵ Cost reports. CMS. (n.d.). Retrieved August 12, 2022, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>.

²⁶ CY 2021 HH PPS Proposed Rule, 85 FR 70298. Available at: <https://www.federalregister.gov/documents/2020/11/04/2020-24146/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home>

²⁷ CY 2022 HH PPS Proposed Rule, 86 FR 35874. Available at: <https://www.federalregister.gov/d/2021-13763/p-157>

²⁸ CY 2023 HH PPS Proposed Rule, 87 FR 37600. Available at: <https://www.federalregister.gov/documents/2022/06/23/2022-13376/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home>.

²⁹ Market basket data. CMS. (n.d.). Retrieved August 12, 2022, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>.

RESULTS

As shown in **Exhibit 16**, the percentage of HHAs with negative Medicare margins will increase from 20.9 percent in CY 2022 to 30.0 percent in 2023 due the proposed CY 2023 payments. Further, the additional payment reductions due to temporary adjustments of \$3.2 billion could result in more than half (55.9 percent) of HHAs experiencing negative Medicare margins. Our results also show that the payment reductions will disproportionately impact rural agency Medicare margins. Specifically, while we estimate that a smaller proportion of rural agencies have negative Medicare margins as compared to urban agencies in 2022, we found that more rural agencies will have negative Medicare margins following the proposed permanent and temporary payment reductions.

Exhibit 16: Percent of Home Health Agencies with Negative Medicare Margins

	Percent of HHAs with Negative Medicare Margins			
	2022	Impact of CY 2023 Permanent Adjustment	Impact of CY 2023 Temporary Adjustment for CY 2020 and CY 2021 Reconciliation (\$2.0B)	Impact of CY 2023 Temporary Adjustment for CY 2020, CY 2021, and CY 2023 Reconciliation (\$2.0B and \$1.2B)
Total	20.9%	30.0%	45.0%	55.9%
Urban	21.2%	30.3%	44.9%	56.0%
Rural	20.9%	31.8%	48.5%	57.5%
Unknown	15.7%	21.5%	36.3%	48.6%

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 58177

Conclusion

We find that, as proposed, CMS' interpretation and assessment of PDGM budget neutrality could place the home health industry under enormous financial shock, with small and rural providers being at highest risk of being significantly affected by the financial disruptions. The -7.69 permanent behavioral adjustment to the CY 2023 base payment rate equates to payment reductions of approximately \$1.3 billion (or a 6.9 percent reduction in payments) in CY 2023. Further, the -7.69 permanent behavioral adjustment to the CY 2023 base payment rate compounds over time between CY 2024 and CY 2026 and could represent a total \$5.5 billion reduction in PDGM payments for CY 2023 and future years (2024-2026). In addition, CMS proposes temporary reductions of more than \$2.0 billion to reconcile CY 2020 and CY 2021 PDGM payments, and we estimate that the agency would implement an additional \$1.2 billion³⁰ to reconcile CY 2022 payments. Overall, HHA payments between CY 2023 and CY 2026 would decrease by approximately \$8.7 billion. It is worth noting that this is in addition to the already implemented behavioral adjustments due to assumed provider behavior changes that we estimated to equate to a reduction of \$2.4 billion between CY 2020 to CY 2023.

Given these significant payment decreases, many home health agencies (especially agencies in rural areas) may not be able to maintain operations and others would need to alter the way they provide care to maintain financial viability, likely in ways that reduce beneficiary access to home care. We find that for instance, the temporary and permanent reductions combined could result in more than half of home health agencies having negative margins, with a disproportionate impact to rural agencies.

These changes would occur during a time where CMS is expanding the Home Health Value-Based Purchasing (HHVBP) Model and other attempts to reform PAC (Post-Acute Care) delivery are on the horizon such as a Unified PAC PPS. It will be important for CMS to carefully analyze the financial consequences of the agency's interpretation of budget neutrality under PDGM implementation on home health providers, continued beneficiary access, PAC market stability and successful performance in any alternative payment models such as HHVBP.

³⁰ Note that CMS states in the CY 2023 HH PPS proposed rule that a \$2.0 billion reduction is required to reconcile CY 2020 and CY 2021 payments. We (Dobson | DaVanzo) further estimate that an additional \$1.2 billion would be required to reconcile CY 2022 payments.

Appendix B
Dobson|Davanzo labor study

Home Health Labor Cost Survey

Inflationary wage impacts on home health agency labor costs as of 2022 with implications for the future



Dobson DaVanzo & Associates, LLC Vienna, VA 703.260.1760 www.dobsondavanzo.com

Home Health Labor Cost Survey

Inflationary wage impacts on home health agency labor costs as of 2022 with implications for the future

Submitted to:

Partnership For Quality Home Healthcare (PQHH)

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Tuesday, August 16, 2022 —*Final Report*

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Executive Summary

The Partnership for Quality Home Healthcare (PQHH) commissioned Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) to investigate changes in the home health labor costs of member agencies. This study is an update to an August 2021 study of home health wage trends. This 2022 update was conducted in response to current economic volatility from the continuing impact of the COVID-19 pandemic and the resultant shifts in the workforce, supply chain constraints, and inflationary pressures due, in part, to the war in Ukraine. In addition, and very importantly, fiscal, and monetary policy changes (such as increases in short term interest rates) are exerting new pressure with unknown outcomes.

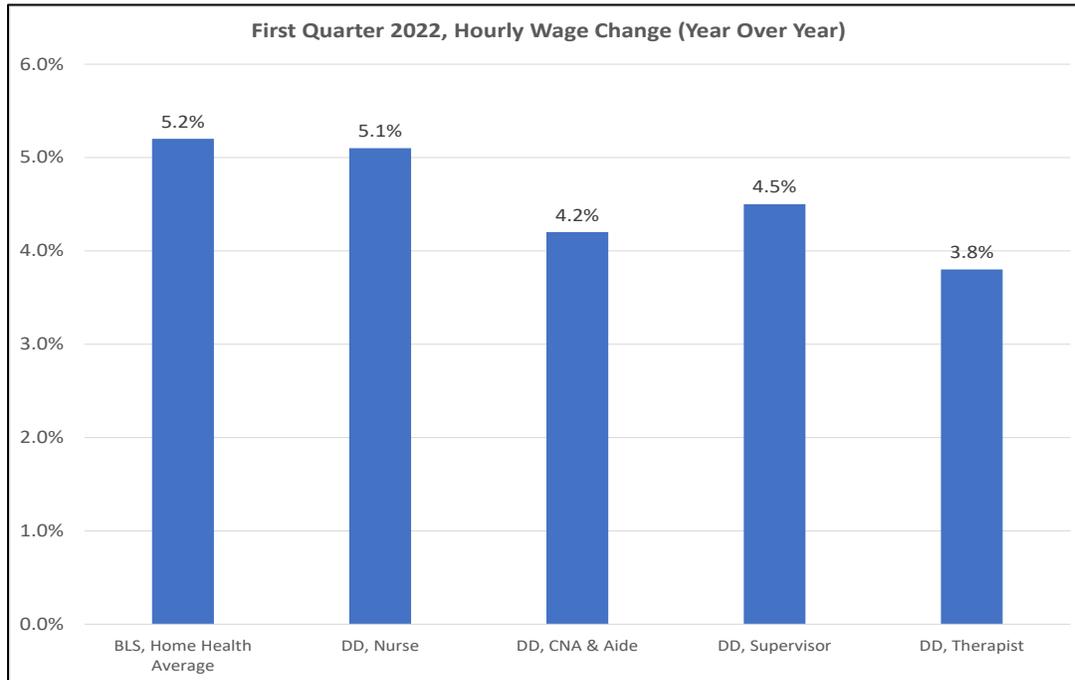
In the August 2021 study, we estimated that “the average percent increase in wages is expected to rebound at 3.5%.” At the time, the Centers for Medicare and Medicaid Services (CMS) and the federal government believed that the current inflation was temporary and that our estimate was too high. While our estimate was higher than the general belief at the time, it turned out to be low relative to our current findings

As illustrated in *Exhibit ES-1*, the United States Bureau of Labor Statistics (BLS) recently found a home health overall wage inflation rate of 5.2% for the 1st quarter 2022. Also shown in ES-1 below, our updated 2022 home health labor survey found clinician-specific inflation rates ranging from 3.8% for therapists to 5.1% for nurses.

The BLS also found that hospital employee wages are increasing faster than those of the home health workforce. This finding means that home health agencies likely will be forced to increase wages for clinical staff more and more quickly than in prior time periods in order to be competitive.

Executive Summary

Exhibit ES-1. Average Hourly Wage Year Over Year Inflation for 1Q2022



Source: Dobson | DaVanzo Analysis of BLS and PQHH Survey Data

According to individual confidential stakeholder interviews and survey results, the difficulty of maintaining operations during unexpected increases in wage inflation rates, home health agencies are currently being challenged to meet increasing demand for services by the following two factors:

1. Insufficient supply of clinicians; and
2. Home health staff turnover from employer competition.

These factors are briefly discussed below.

1. Insufficient supply of clinicians. Prior to the COVID-19 pandemic, employment demand in the home health industry increased steadily. During the pandemic, some clinicians exited health care, either permanently or temporarily, leaving home health agencies with an average of 59% filled positions during first-quarter 2022, as reported in our current 2022 survey. Reasons cited for exiting the industry include retirement, burn-out, vaccine mandates, and risk of developing COVID-19.

Executive Summary

2. Staff turnover from competing offers from other employers. The insufficient supply of clinicians is not just experienced by home health agencies but is experienced by providers throughout the spectrum of health care. For home health agencies, more than half of participants in the current 2022 survey reported increased turnover from the prior year due to certain clinicians exiting the health care sector altogether. In addition, over half of respondents also reported increased turnover for clinicians shifting employment to other care settings. Moreover, individual confidential interviews of key stakeholders indicated that turnover within home health is fueled by recruiting efforts of facility-based providers which can offer higher compensation.

With inflationary pressures from the economy and staffing challenges within the healthcare sector, home health agencies may have limited response options, especially given regulatory constraints. Response options identified by survey respondents and key stakeholder interviews include the following:

- **More denials of referrals** – Having to turn away referrals is related to the inability to hire clinicians. This response choice was selected by 71% of survey participants as a factor affecting the number of services that could be provided. This factor was also identified during key stakeholder interviews.
- **Increased costs to recruit and retain staff**– In addition to increasing hourly rates, home health agencies are often seeking to offer competitive compensation through offering incentives, such as signing bonuses, performance bonuses, tuition assistance, and student loan payments.

We note that some healthcare providers are able to respond to short-term supply shortfalls with contract and PRN professionals, but that these clinicians represent only a small proportion of home health staff members --about 3% for contracted field staff and about 2% for PRN employees. However, volatility in current HHA contract compensation rates has nearly doubled in recent months, according to an interviewee.

Conclusion

Results from our quantitative survey and qualitative interviews highlight the increasing labor cost pressures home health agencies are currently facing. These results are consistent with contemporary news articles that observe tight labor conditions generally with more jobs available than individuals seeking employment.

Responses by home health agencies to labor challenges include increased utilization of non-FTE workers and large signing bonuses, and yet capacity constraints in the current labor climate were reported to have led to significant increases in turned-away referrals. Some

Executive Summary

Medicare beneficiaries are especially impacted by reduced access to care as agencies focus service delivery in more dense geographic areas to increase efficiency.

The wage pressures associated with the current labor climate may be experienced, if not increased, over the long-term. Interview participants indicated that some health care staff are exiting clinical practice permanently due to early retirement or a change in career. As a result, provider inability to meet short-term wage demands will likely mean reduced home health capacity into the future. Home health agencies are working to meet demand for medical services in a labor climate that has “never been so tight: a record 1.9 jobs are available for every unemployed person.”¹

Reduced home health care capacity may disproportionately impact Medicare beneficiaries. CMS is a major payer in the health care sector, but beneficiaries may experience reduced access as Medicare payments lag environmental changes. Without a nimble response to a volatile labor situation, continued CMS reliance on methodologies that are appropriate only in a stable labor climate could result in barriers to access to home health care for Medicare beneficiaries.

Our survey instrument was designed to answer three questions:

1. What were the actual 2021 labor cost increases faced by PQHH membership?

The cumulative impact of the increases in 2020 and 2021 wages reported by survey respondents and reported by the BLS are very much larger than the cumulative payment increases for home health care agencies over the same time frame.

2. Will these rates of increase continue in 2022?

Survey data provided by participants indicate that wage inflation is continuing into 2022. These quantitative data are consistent with qualitative data provided during key stakeholder interviews. This finding is also consistent with the BLS estimates.

3. Will wage rate increases continue to play an outsized role in the 2022 HHA labor segment?

As wage increases are continuing into the third year, the 2022 home health agencies will likely continue to experience both staffing pressures and volatility calling for innovative recruiting and retention strategies noted by our respondents.

¹The Economist. 2022, June 4. Finance and Economics.

Introduction

The Partnership for Quality Home Healthcare (PQHH) commissioned Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) to update the 2021 Home Health Labor Cost survey which examined the state of home health labor costs for PQHH member organizations and investigated the impacts of the COVID-19 PHE.

Since the fielding of the 2021 Home Health Labor Cost survey, home health providers have continued to experience unprecedented financial pressures as a result of the ongoing inflationary environment combined with the COVID-19 PHE-driven workforce shortages² and supply chain issues and federal monetary and fiscal policy changes. Although the BLS continues to report rising inflation³, CMS home health payment updates do not accurately reflect these pressures. In the CY 2023 HH PPS proposed rule for instance, CMS proposes a market basket update factor of 3.3 percent⁴—a slight increase compared to 2.6 percent in CY 2022 HH PPS final rule⁵—although far below the reported nationwide rates of inflation.

In the 2021 Home Health Labor Cost survey, we correctly concluded that CMS had underestimated recent and future wage increases by using outdated historical data averaged over several years of low inflation. The survey also correctly indicated that the pressures exerted on HHA labor segment incentive pay were very much a part of overall wage inflation. Specifically, we estimated that *“the average percent increase in wages was expected to rebound at 3.5% in 2021 – an increase higher than the increase observed in*

² <https://khn.org/news/article/pandemic-fueled-home-health-care-shortages-strand-patients/>

³ <https://www.bls.gov/opub/ted/2022/consumer-prices-up-8-6-percent-over-year-ended-may-2022.htm>

⁴ <https://www.federalregister.gov/documents/2022/06/23/2022-13376/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home>

⁵ <https://www.federalregister.gov/documents/2021/11/09/2021-23993/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home>

Introduction

2019.”⁶ At the time, this observation ran contrary to government reports and private forecasts indicating that increased labor costs and other sources of inflation were temporary, and not of long-term concern. While CMS echoed the same predictions of a short-lived inflationary period in their CY 2022 HH PPS proposed rule, PQHH members thought otherwise at that time and indicated that, if anything, our survey results underestimated actual inflation. Indeed, inflationary pressures, especially on home health wages, continued to build later in 2021 and in 2022.

The goal of the 2022 survey is to continue collecting more current and trending data from the PQHH membership about increased labor costs, turnover among staff, and reasons for high staff turnover. This survey provides information critical to understanding the implications of the rapidly evolving US healthcare labor conditions on PQHH members’ ability to recruit and employ the personnel necessary to fulfill organizational missions and meet the increasing demand for home health services. This survey is also intended to provide CMS and other policy makers with more timely information on home health wage growth—an important component of federal payment policies.

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 reported, and all data reported based on the responses of at least 5 agencies that responded to the survey. In addition, weighting was performed to take into account the size dispersions among all home health providers nationally. After such weighting for agency size, no individual provider’s data can be identified, and no individual provider’s data represents more than 25 percent on a weighted basis of that statistic. 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 herein should be used solely for its intended 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.

⁶ Dobson DaVanzo & Associates, LLC (2021). *Home Health Labor Cost Survey. Understanding the impact of the COVID-19 Public Health Emergency (PHE) on home health agency labor costs.* Report Submitted to PQHH.

Methodology

To create the 2022 PQHH Labor Cost survey instrument, we analyzed the 2021 PQHH Labor Cost survey to identify and select relevant survey items. The key questions queried in the current study are:

1. What were the actual 2021 labor cost increases faced by PQHH membership?
2. Will these rates of increase continue in 2022?
3. Will wage rate increases continue to play an outsized role in the 2022 HHA labor segment?

Through an iterative development process as well as beta testing to update the survey, PQHH members provided feedback on the content of our survey as it was developed. Changes to the draft instrument were made to ensure clarity, as well as increase access to the requested information. Participants were required to input data and respond to open-ended questions. Several questions about staffing compositions were clarified to incorporate clinical and paraprofessional staff and employment types (i.e., contractual, full-time employment).

The survey contains several questions about industry organization, staff turnover, wages, benefits, and other labor costs relative to the provision of home health services for 2019 through 2022. We also pose a series of qualitative questions as to the impact of inflation on HHAs' ability to recruit and maintain labor. Directions to submit the survey via FTP and instructions not to share their links with any other respondents were provided. Dobson | DaVanzo provided technical assistance via email and phone throughout this period.

All data analyses were conducted using Microsoft Excel. Dobson | DaVanzo downloaded survey data in a Microsoft Excel file and quality checks were performed. We followed up with agencies with aberrant or missing data.

We note that the panel of participating PQHH members is not identical to the panel of members participating in the 2021 survey report. Depending on the survey items, the

Methodology

number of responding PQHH members varied across select questions. We excluded from our analysis any question that did not meet the basic response requirements as noted by anti-trust guidance and regulatory standards. As our analysis was based on responses obtained which are not necessarily reflective of the national HHA labor sector, we weighted each response to account for the size dispersions among all home health providers nationally to better reflect the national dynamics.

To fully address the questions above, we also conducted individual confidential stakeholder interviews to gain insight about the current level of inflation for wages and other labor-related costs, and to determine if the rising labor costs noted in last year's survey had continued. We sought to determine if HHA labor segments are functioning in such a way as to allow PQHH members to identify, recruit and maintain an appropriate labor force to meet an expanding demand for their services.

The purpose of the stakeholder interviews was to collect qualitative data. The interview component was introduced to provide context to quantitative data responses and to enhance our understanding of the dynamics of the current operating environment. An experienced interviewer who has frequent contact with individuals from various health care sectors on an ongoing basis was selected to conduct these interviews. The questions were open-ended. As noted in this report, the interviews augmented the survey results by providing context to the relationships between labor segments, inflation, delivery of care, and the development of relevant payment policies

Survey and Interview Results

Results Overview

Six PQHH member organizations responded at least in part to the 2022 Labor Cost survey, and five industry leaders additionally participated in the interviews. Responding members represented home health agencies in the vast majority of all states and regions in the country. All respondents are well versed in clinical and operational aspects of home care delivery.

Below we present survey results on wage inflation, factors impacting home health labor supply and demand, and the demographics of home health agencies.

Wage Forecasts for Home Health Staff in 2022

In this section, we set the stage with a discussion of the results on home health labor costs from the Bureau of Labor Statistics (BLS). Throughout the section, we compare results from our study to those found by the BLS.⁷ We end this section with BLS data on hospital wage inflation to show how the hospital labor segment could affect the home health labor segment.

HOME HEALTH INDUSTRY WAGE INFLATION (BLS)

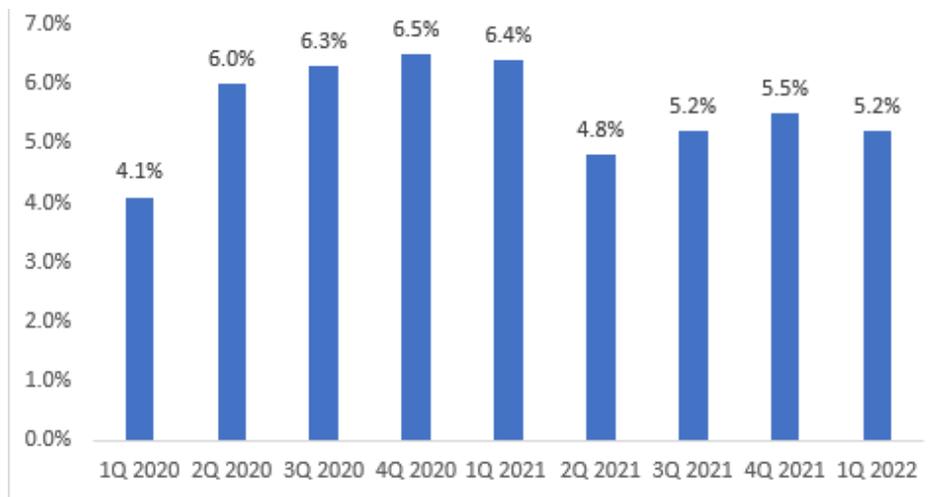
Exhibit 1a shows the Bureau of Labor Statistics (BLS) home health average hourly wage percent changes year-over-year by quarter. As shown in the graph, the inflation in home health hourly wages increases rapidly from 4.1 percent in the first quarter of 2020 to 6.5

⁷ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook*, Home Health and Personal Care Aides, at <https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm>.

Survey Results

percent in the 4th quarter of 2020. We then observe a slight decrease in wage inflation between the first and second quarter of 2021, followed by a period of increase between the second quarter of 2021 (4.8 percent) and the 1st quarter of 2022 (5.2 percent). This finding suggests continued wage inflation in the home health labor segment and is consistent with previous estimates, but somewhat below the over 9 percent national average inflation estimate as of July 2022.

Exhibit 1a: Home Health Average Hourly Wage Y/Y by Quarter



Source: Bureau of Labor Statistics

WAGE INFLATION: NURSES

Exhibit 1b shows comparable statistics for PQHH respondents' average hourly wages for nurses. Similar to the trends in overall wage inflation from BLS in Exhibit 1a., inflation in nurse hourly wages increases in first quarter of 2020, dips in first and second quarter 2021, and rebounds to 4.6 percent in fourth quarter 2021 and 5.1 percent in first quarter 2022. The endpoints of both Exhibit 1a and 1b are about 5 percent.

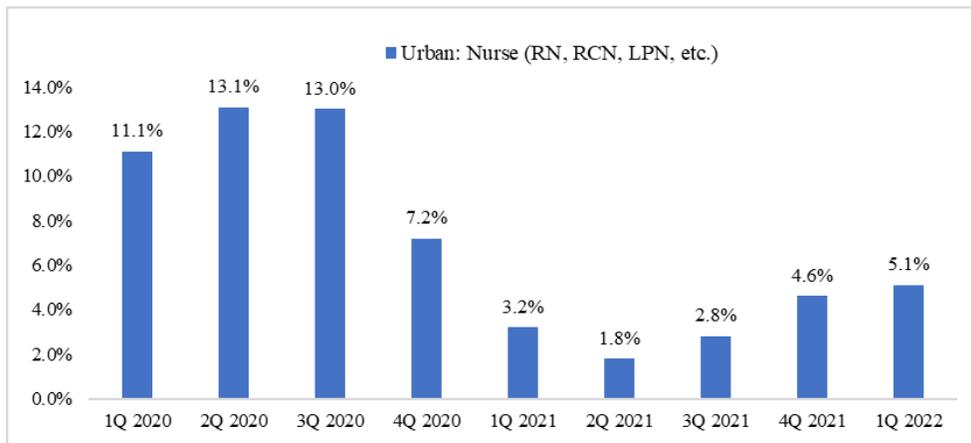
These results are almost twice the estimates from last year's survey which predicted a 3.5 percent wage growth rate for the 2022 timeframe. Our results lie under those of BLS but reflect the BLS national trend rates. Working from this logic, the BLS data for 2020 and 2021 show a cumulative inflationary impact very much higher than the CMS payment increases cumulated over the same time frame.

It is important to note that inflation rates are cumulative over time. For instance, if inflation in year 1 increases by 5.0%, in year 2 increases by 6.4%, and in year 3 increases

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by 5.8%, then the sum of 3-year increases results in a cumulative 17.2% inflation. Similarly, if CMS underestimates wage increases year after year, the miscalculation is cumulative in effect as well. This distinction is important during periods of increasing inflation as we are now experiencing.

Exhibit 1b: Average Percent Change in Hourly Wages for Nurses, Y/Y by Quarter

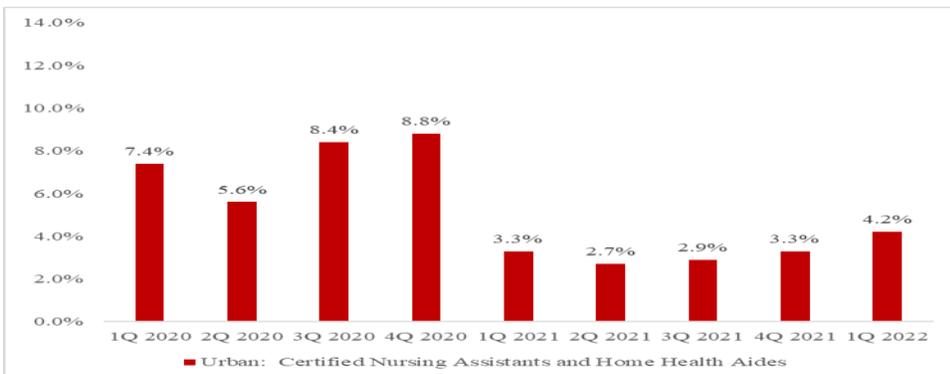


Note: Responses are based on nurses employed in urban areas.

WAGE INFLATION: CERTIFIED NURSING ASSISTANTS AND HOME HEALTH AIDES

As with Exhibits 1a and 1b, similar trends were noted in Exhibit 1c. Certified nursing assistants and home health aides saw a 4.2% growth year-over-year for the first quarter of 2022.

Exhibit 1c. PQHH Respondents' Certified Nursing Assistants and Home Health Aides Average Hourly Wage Y/Y by Quarter



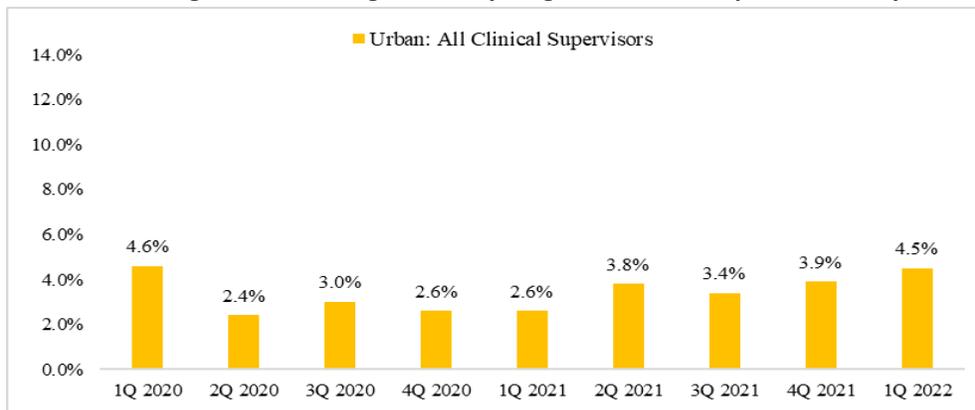
Note: Responses based on CNAs and Home Health Aides employed in urban areas.

Survey Results

WAGE INFLATION: CLINICAL SUPERVISORS

As shown in **Exhibit 1d**, inflation in hourly wages for Clinical Supervisors did increase as rapidly as for nurses, CNAs, and home health aides in 2020. However, wage inflation demonstrated for clinical supervisors began to increase markedly during the period from the fourth quarter of 2021 to the first quarter of 2022—growing from 3.4 percent to 4.5 percent in the first quarter 2022.

Exhibit 1d: Average Percent Change in Hourly Wages for Clinical Supervisor Y/Y by Quarter

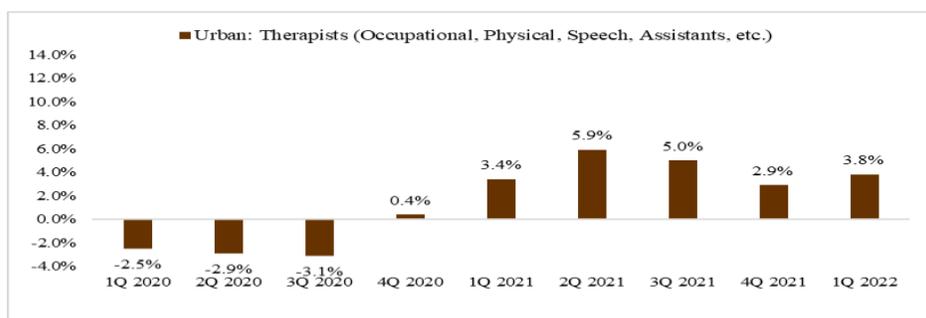


Note: Responses are based on Clinical Supervisors employed in urban areas.

WAGE INFLATION: THERAPISTS

Exhibit 1e shows the changing dynamics in the home health industry for therapy services. The first three-quarters, beginning with first quarter 2020 (-2.5%) and ending with the third quarter of the same calendar year (-3.19%), may show an overcorrection regarding the decline in therapy visits experienced during the 2020 calendar year, which over corrected in 2021.

Exhibit 1e: Average Percent Change in Hourly Wages for Therapists, Y/Y by Quarter



Survey Results

Note: Responses are based on therapists employed in urban areas.

OVERALL HOSPITAL LABOR WAGE INFLATION (BLS)

Exhibit 1f shows BLS reported hourly wage growth for hospitals. Similar to BLS reported wage inflation for home health labor (in **Exhibit 1a**), **Exhibit 1f** shows that hospital wage inflation increased in the second quarter of 2020, and dipped in the third quarter of 2020 and the second quarter of 2021, followed by a resurgence to highs of 7.9 percent in fourth quarter 2021 and 7.4 percent in first quarter 2022. These results suggest there will be upward pressures on home health industry labor wages in 2022, if not beyond as hospitals and home health agencies compete for the same staff.

Exhibit 1f: Hospital Hourly Wage Y/Y by Quarter



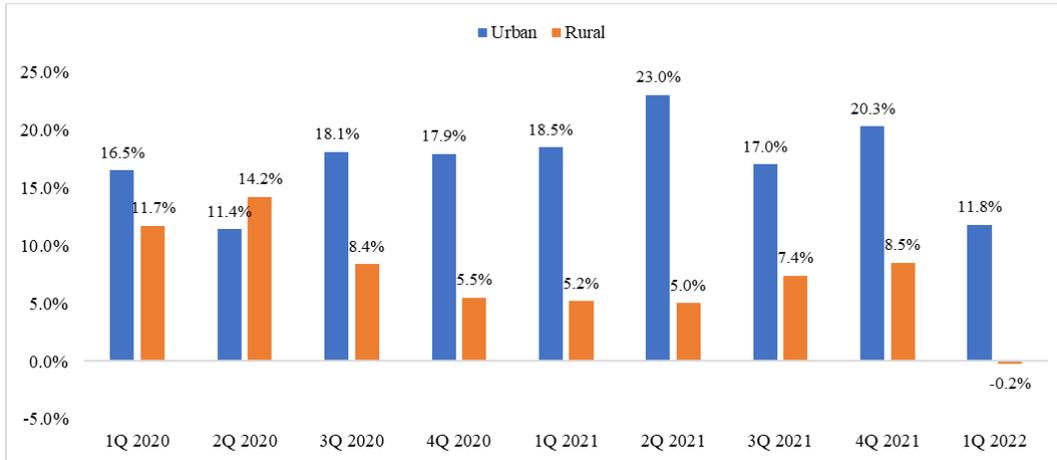
Source: Bureau of Labor Statistics

Growth in Administrative, General and Other Expenses

Exhibit 1g shows the percent change in administrative, general, and other expenses from 2020 to 2022 for PQHH respondents operating in both urban and rural areas. Administrative, general and other expenses are defined as administrative support, financial services, medical supplies, rubber and plastics, telephone, professional fees, other products and other services. As shown, the percent increase more than doubled in second-quarter 2021 at 23.0% compared to 11.4% in second-quarter 2020.

Survey Results

Exhibit 1g: Average Percent Change in Administrative, General and Other Expenses



As a final point, **Exhibit 1h** shows the cumulative change in nursing wages for 2020 and 2021 reported by PQHH respondents compared to cumulative overall home health care wages reported by the BLS.

As shown in the exhibit, the two year quarterly compounded wage growth rate for 2020 and 2021 reported by PQHH respondents is 14.5 percent compared to 11.5 percent reported by BLS. In comparison, the cumulative Medicare payment update for 2020 and 2021 is 4.6 percent. These measures indicate that PQHH members have experienced significantly greater increases in wage costs than corresponding reimbursement, with wage costs increasing 3.0 percentage points higher than rates reported by BLS and more than triple the Medicare payment update.

Exhibit 1h: Two Year Quarterly Compounded Wage Growth (2020 & 2021) from the PQHH Labor Market Survey as Compared to BLS and the Medicare Payment Update

Two Year Quarterly Compounded Wage Growth (2020 and 2021)	
Partnership Nursing Wages	14.5%
BLS All Home Health Care	11.5%
Medicare HH PPS Payment Update	4.6%

Source: BLS, PQHH Labor Cost Survey, CY 2023 HH PPS Proposed Rule

Survey Results

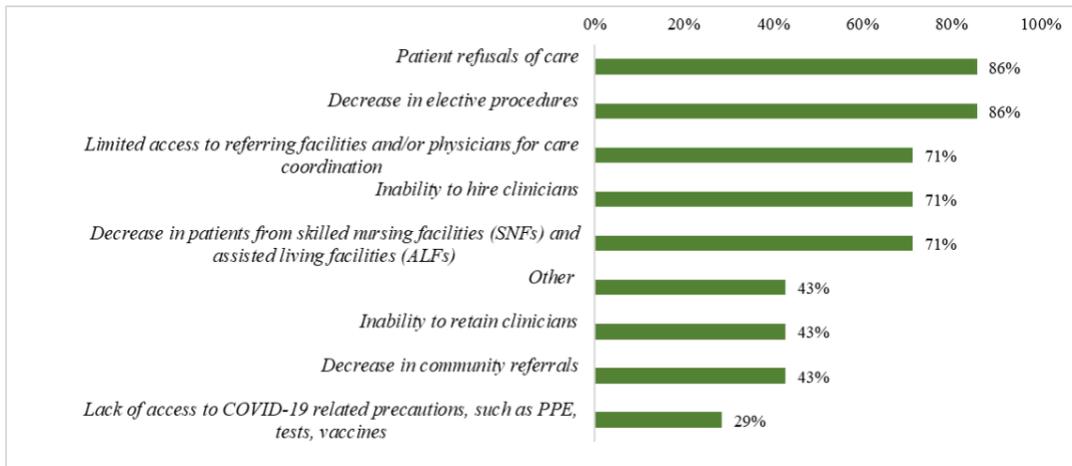
Factors Affecting Home Health Supply and Demand

FACTORS AFFECTING CHANGES IN DEMAND FOR HOME HEALTH SERVICES

Exhibit 2 shows the factors home health agencies reported as driving the reductions in home health care services provided between CY 2019 and CY 2020. The majority of agencies (86 percent) indicated that they experienced reductions in the number of home health episodes rendered between 2019 and 2020 because patients either refused care or because of the reduction in elective procedures.

Seventy one percent of agencies also cited that they experienced reductions because they had limited access to referring facilities and physicians for care coordination, could not hire clinicians, and/or experienced a reduction in referrals from SNFs and assisted living facilities.

Exhibit 2: Factors Affecting Changes in the Number of 30-day Periods or 60-day Episodes Delivered by Home Health Agencies in CY 2020 as Compared to CY 2019



Note: Respondents could choose more than one response item.

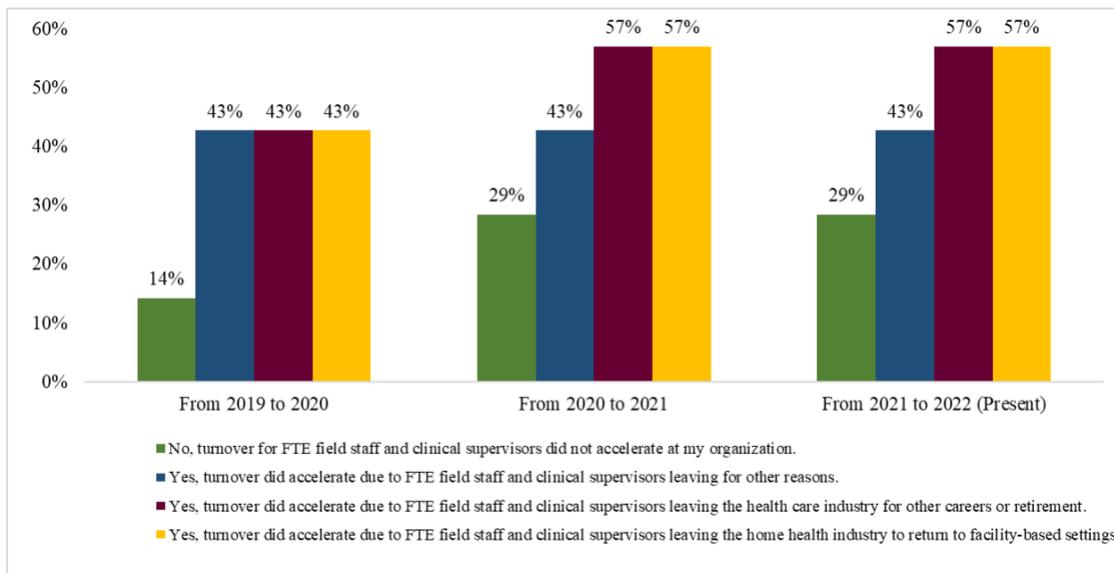
REASONS FOR STAFF TURNOVER

As shown in **Exhibit 3**, 71 percent of the surveyed agencies responded that the turnover rates accelerated from 2020 to 2022 (29% reported that turnover did not accelerate at their organizations in both periods). Between 2020 and 2021, the majority (57 percent) of agencies reported that their staff and supervisors left the home health industry for other careers, retired, or sought employment at facility-based settings. This is in contrast to agency responses for reasons for turnover between 2019 and 2020, where surveyed

Survey Results

agencies indicated that staff and clinical supervisors were equally likely to leave for other careers, retire, seek employment at facility-based settings or leave for other reasons.

Exhibit 3: Reasons for Turnover if Turnover for FTE Field Staff and Clinical Supervisors Accelerated from CY 2019-2022 at Home Health Agencies



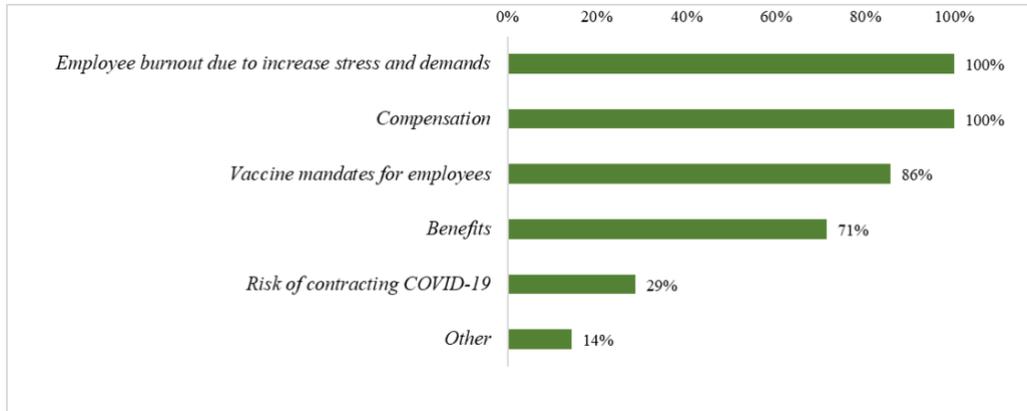
Note: Respondents could choose more than one response item.

REASONS FOR MOVING TO OTHER HEALTHCARE SECTOR JOBS

Among agencies that indicated that staff and clinical supervisors left for other healthcare sector jobs, all agencies indicated that employee burn-out and compensation were the primary factors why staff and clinical supervisors left. 86 percent of the agencies also indicated that the vaccine mandates for employees were a key driver for staff migrating to other healthcare sector jobs. These results are shown in **Exhibit 4** below.

Exhibit 4: Primary Reason if FTE Field Staff and Clinical Supervisors Left for Other Healthcare Sector Jobs

Survey Results



Note: Respondents could choose more than one response item.

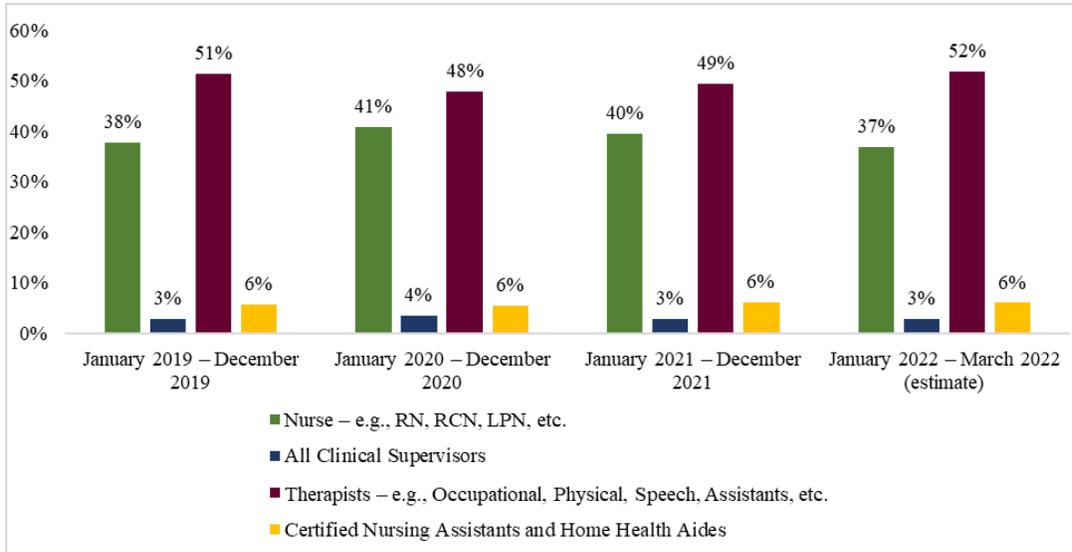
TRENDS IN FTE FIELD STAFF AND CLINICAL SUPERVISORS

As shown below in **Exhibit 5**, the composition of the home health workforce remained relatively constant between 2019 and 2022. Predominantly, therapists and nurses are in high demand in each period, comprising on average combined 89 percent of FTEs for the HHA workforce. Therapists comprise the largest share of the workforce (between 48 to 52 percent), while nurses comprise between 37 to 41 percent of the workforce. Clinical supervisors, CNAs and home health aides comprised a combined 9 to 10 percent of the HHA workforce between 2019 and 2022.

Given that nurses represent a large and generally increasing proportion of the HHA labor force, and interviewees stated that nurses are the most mobile members of the workforce, this leads to increasing challenges in maintaining the appropriate labor mix. The decrease in therapists in 2020 is likely driven by the removal of the payment system incentives to provide therapy and the COVID-PHE-driven reduction in therapy demand as elective services were canceled across the nation. The rebound in therapists after 2020 possibly reflects over correction after the initial therapy visit reduction.

Exhibit 5: Average Percent of Full-Time Equivalent Field Staff and Clinical Supervisors by Labor Category

Survey Results



Note: Data for social worker labor category were insufficient, thus excluded.

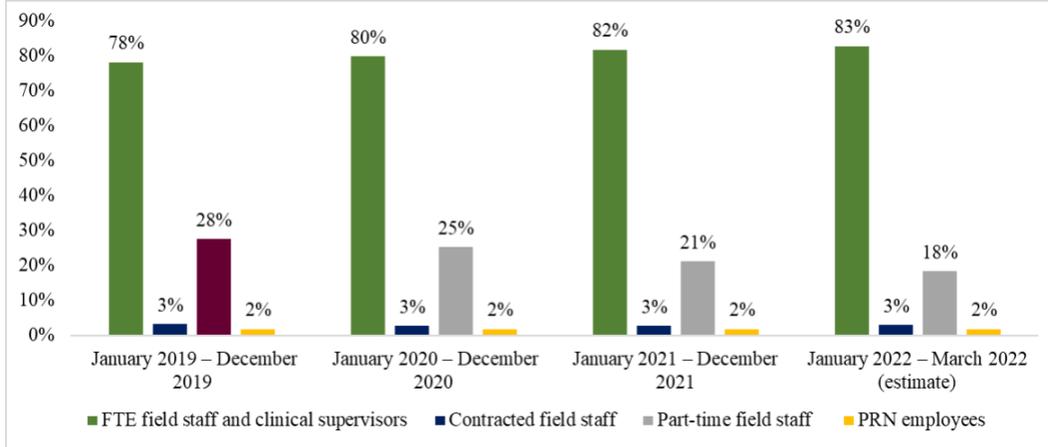
TRENDS IN PROPORTION OF SERVICES DELIVERED BY LABOR TYPE

Exhibit 6 shows the percentage of visits delivered by FTE field staff and clinical supervisors, contracted field staff, part-time staff, and Pro re Nata (PRN)⁸ employees. Between 2019 and 2022, FTE staff and clinical supervisors increasingly delivered a higher proportion of home health visits (growing from 78 percent in 2019 to 83 percent in 2022), while part-time staff delivered a lower and declining proportion of 17 percent in 2019 to 12 percent in 2022. Visits delivered by contracted field staff and PRN employees remained consistent at a combined 5 percent in each of the years. These are all relatively small changes but should be tracked over time as the impact of inflation plays out.

Exhibit 6: Percentage of Visits Staffed by FTE, Contracted, or Part-Time (Field Staff or Clinical Supervisors)

⁸ PRN are staff that are requested to work as needed.

Survey Results

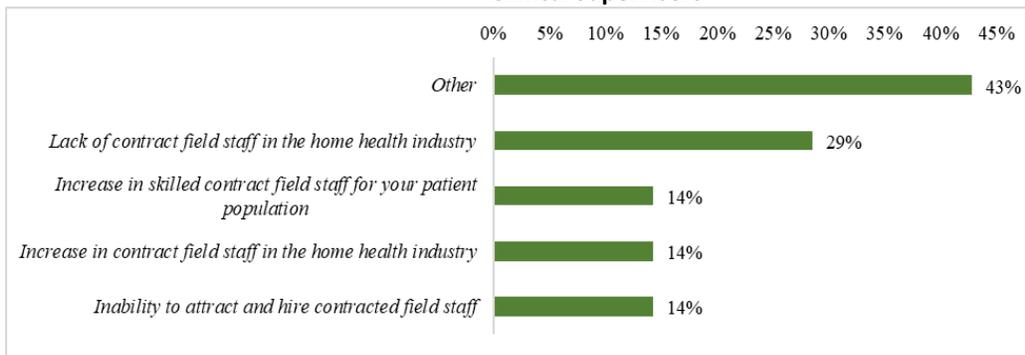


FACTORS AFFECTING CHANGES IN THE MIX OF CONTRACTED LABOR

Forty-three percent of responding members reported “other” reasons that are not included as the items comprising the main factors as shown below in **Exhibit 7**.

These other reasons include employee-to-contract ratios remaining flat and difficulties in attracting and retaining nurses during the pandemic and associated nursing shortage. Twenty-nine percent of the responding members selected lack of contract field staff in the home health industry as the main factor.

Exhibit 7: Factors Affecting Changes in the Mix of Contracted Field Staff and Clinical Supervisors



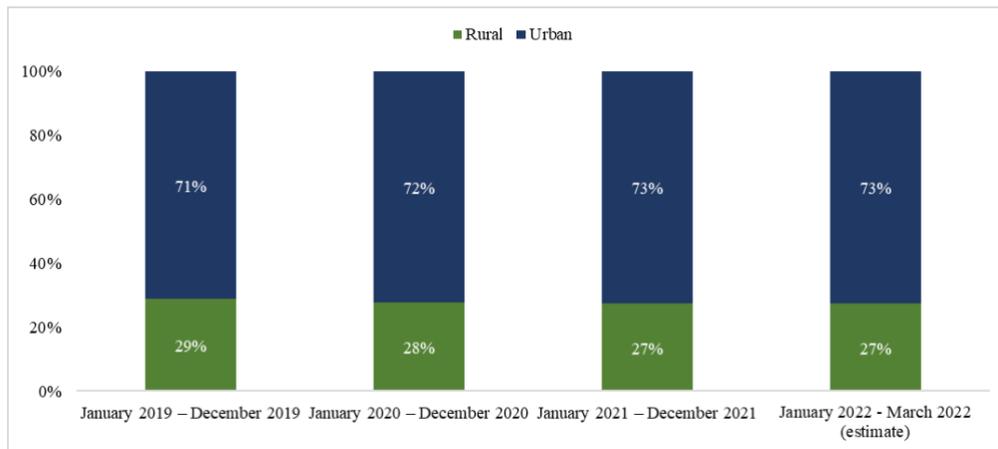
Home Health Agency Demographics

Survey Results

Average Percent of Patient Population by Geographical Distribution

Exhibit 8 shows a slight decline in the proportion of the patient population living in rural areas that surveyed agencies delivered care to. Between 2019 and 2022, the proportion of patients living in rural areas declined from 29 percent to 27 percent while the proportion of patients living in urban areas increased slightly from 71 to 73 percent. This shift is consistent with findings from our stakeholder interviews and warrants continued monitoring.

Exhibit 8: Average Percent of Patient Population by Geographical Distribution

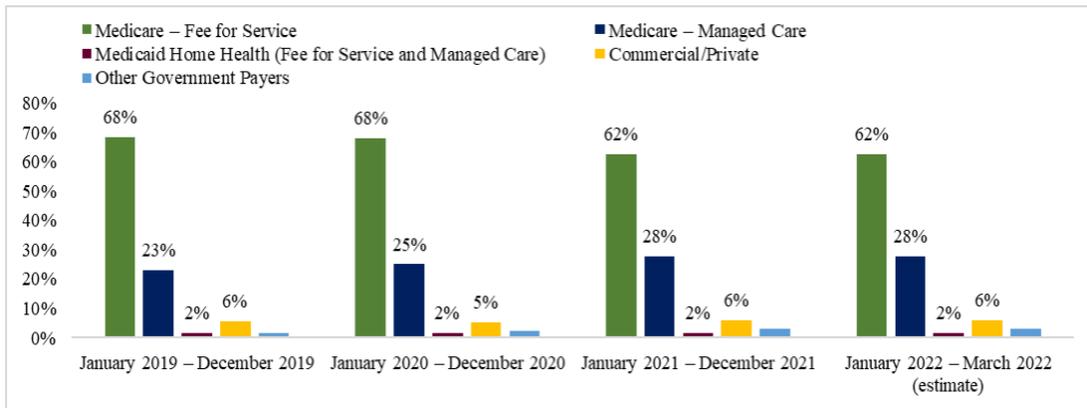


Average Payer Mix Distribution of FTE Field Staff and Clinical Supervisors

There were several noteworthy changes in the payer mix distribution of the home health workforce between 2019 and 2022, as shown below in **Exhibit 9**. Over the time period between 2019 through 2022, Medicare Advantage (MA) paid for an increasing proportion of services delivered by surveyed agencies—increasing from 23 percent in 2019 to 28 percent in 2020. In contrast, Medicare FFS paid for a decreasing proportion of services—declining from 68 percent in 2019 to 62 percent in 2020. The proportion of services paid for by other payers over the same period were stable.

Exhibit 9: Average Payer Mix of Responding Member Agencies

Survey Results



Industry Leader Interviews

This section summarizes the stakeholder discussion. We analyzed the stakeholder interviews. Each bolded statement is based on observations we heard. Discussion of these results is below.

Increasing Demand for Services

Home healthcare is an effective component of the healthcare continuum, and its cost-effectiveness is demonstrated by an increasing demand for services

The value of home health services is further demonstrated by the increasing complexity of patients served. “Upwards of thirty percent of people who seek home health don’t get in,” explained a CEO. Skilled services delivered in patients’ homes divert patients from hospital admissions and readmissions, as well as stays in skilled nursing facilities. “Home health is increasingly functioning as SNF [skilled nursing facility] diversion – we’re getting more critical patients,” noted one CEO. Demand has also increased due to fears of COVID-19 exposure at healthcare facilities and this demand is expected to remain elevated as patients have developed a preference for in-home care and HHAs have created the capacity to serve patients.

Labor Costs and Inflation

Given increasing demand for home care service, home health providers struggle to provide services in the current environment because of strong competition for health care professionals at all levels and associated staffing costs driven by tight labor conditions and continued inflation

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The impact of COVID-19 on health care professionals practicing across the health continuum continues to be profound because of fatigue, burn-out, and fear of contracting COVID-19. The pandemic increased the number of professionals leaving practice permanently through early retirement or career changes and temporarily for family-care responsibilities. Additionally, some professionals exited practice because of COVID-19 vaccine mandates. Potential candidates also had less interest in pursuing medical education as the pandemic created an environment in which individuals questioned the merits of health care careers relative to other career options.

The exodus of health care professionals from the field continues to create enormous competition among health care and non-healthcare sectors and leads to significant increases in employee compensation levels required to attract, train, and retain professionals. Compensation increases are especially notable for nurses, including LPNs. Staff departures necessitate increased use of part-time and on-call employees, which increases direct costs from higher wages and indirect costs associated with more significant management requirements. Clinical supervisors and directors of nursing also are experiencing high turnover, as the stress of supervising many nurses with great turnover is high.

Providers seek to manage intensifying compensation pressures with incentives, including bonuses, student loan forgiveness, continuing education opportunities, and wound care training. Merely increasing employee base wage rates would limit providers' flexibility to adjust to conditions should the environment stabilize.

Considering the broader economic context, provider costs are also rising due to general inflation rates which, in turn, worsen providers' financial situation. Fuel price increases have led to higher costs, investments in more economical vehicles, and home health staff not wanting to travel. As a result, rural areas are more difficult to serve.

Competition for nurses is expected to continue given reports of decreased nursing school enrollment. A supply shortage for LPNs is anticipated to be particularly significant.

Staffing Challenges

Staffing challenges are exacerbated because of the steep learning curves of professionals new to health care delivered in the home

Providing health services in patients' homes is a physically and mentally challenging practice. Contributing to the challenge is that services are often provided with significantly

Survey Results

greater independence without facilities' resources and backup support. Home health practice requires much critical thinking to respond to a wide range of medical and psychosocial needs in home environments of varying conditions. Successful home health practice requires greater knowledge of treatment options that typically comes with experience.

Experienced home health professionals may have relatively flat learning curves when changing HHA providers. One stakeholder opined, “the curve is steep for professionals newly entering home health practice from other sectors of service delivery – one full year of mentoring is often required for fully independent practice, noted another stakeholder.” Widely noted by stakeholders, home health is sufficiently complex that newly graduated professionals often lack the skills for home health practice.

CMS Payment Rates

The ability of home health providers to adapt to the current environment is limited because CMS payment rates are not adjusting to the reality of increasing labor costs and regulatory constraints

Providers seek to meet service demands by leveraging the RN labor shortage with LPNs and paraprofessionals. As other providers are following similar hiring practices – such as hospitals relying on LPNs more frequently – there is limited ability to implement such options.

Home health providers are also limited in options because of regulatory constraints. For instance, initial treatment encounters are required to be performed by RNs and therapists, rather than LPNs.

Providers are also responding to changes in the home health payment system, such as the recent shift to the Patient Driven Groupings Model (PDGM). Providers are modifying care delivery models to meet the criteria implicit in these payment models.

Increased Costs and Financial Stress

Providers have experienced increased costs due to labor shortages, inefficiencies associated with professional turnover, increased professional compensation, and inflationary pressures on other operating costs. Concurrently, Medicare has not shifted its payment levels accordingly. Pressure on home health margins may limit the ability of home health providers to compete for professionals in the current tight labor environment.

Some providers are responding to the current environment by trying to renegotiate rates with other payers and expanding to achieve cost savings through economies of

Survey Results

scale. Another strategy some providers reported is to seek service areas with dense populations for increased efficiencies, making rural populations susceptible to even further undersupply of services.

While providers are having some success with these strategies, diminished patient access is becoming evident. Traditionally, home health providers declined about 5% of referrals. Our respondents reported decline in referrals approaching 50% for some providers during certain periods.

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.
- As such, 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 individual averaged or aggregated data observation may not necessarily be indicative of activities in all or particular areas within the United States.

Conclusion

The results described above highlight the labor cost difficulties home health agencies, and many other industries, are facing in 2022. *The Economist's* June 4, 2022 observation that labor conditions have “never been so tight: a record 1.9 jobs are available for every unemployed person,”⁹ sets the context for understanding our survey results. Workforce and job environments for home health providers are in disarray. Approximately one-fifth of HHA visits are delivered by non-FTE workers, large signing bonuses are common, turnover and vacancy rates are at historic highs, and training needs for new employees are sizeable. As of June 2022, it is probable that inflation will remain relatively high for at least the near-term.

The inflation rate has reached new heights to 9.1%. It was not evident in last year's report that inflation is on the rise, but as of now, this topic dominates the discussion of how payers, providers, patients, and employees of the health care industry will interact in the future.

If payers such as CMS are to enable their provider partners to be competitive in a very aggressive health care labor environment, they must give more consideration to current economic evidence on inflationary trends. Not doing so could threaten patient access to care. For instance, survey respondents and interview participants alike noted significant increases in referrals having to be turned away due to lack of provider capacity. Another risk is the migration of health care employees to other economic sectors where wages are comparable or better and the work is less stressful and otherwise less demanding.

CMS's regulatory process is well developed and generally permits healthcare providers to deliver adequate amounts of quality care to patients. However, the CMS regulatory

⁹The Economist. 2022, June 4. Finance and Economics.

Conclusion

process for home health companies and other CMS covered providers is now being stressed.

This uncertainty applies to CMS as a major payer in the health care sector as its regulatory process was not designed to handle significant exogenous shocks to the overall economy that spill over to the health care sector.

As CMS considers its role as the major payer for HHA services, it may be confronted with pronounced structural changes in the home health labor segment that it is unfamiliar with. As salary increases advance and ramp up at an unprecedented rate, the current CMS market basket may not resemble the emerging dynamics of the health care labor segment.

Our survey results from both the preceding year and this year suggest that the HHA labor segment is currently fractured. While home health providers have been able to respond to volatility with short-term strategies, these short-term responses do not appear to be sustainable. In summary, our research found answers to our study questions:

1. What were the actual 2021 labor cost increases faced by PQHH membership?

The cumulative impact of the increases in 2020 and 2021 wages reported by survey respondents and reported by the BLS are very much larger than the cumulative payment increases for home health care agencies over the same time frame.

2. Will these rates of increase continue in 2022?

Survey data provided by participants indicate that wage inflation is continuing into 2022. These quantitative data are consistent with qualitative data provided during key stakeholder interviews. This finding is also consistent with the BLS estimates.

3. Will wage rate increases continue to play an outsized role in the 2022 HHA labor segment?

As wage increases are continuing into the third year, the 2022 home health agencies will likely continue to experience both staffing pressures and volatility calling for the types of innovative recruiting and retention strategies noted by our respondents.

Conclusion

Appendix C
King & Spalding legal analysis

TO: The Partnership for Quality Home
Healthcare
Mark D. Polston
Amy R. Upshaw
FROM: Alek Pivec
DATE: August 15, 2022
RE: Analysis of Statutory Authority
for Proposed Update to Home
Health Payment System Rate

This memorandum analyzes whether the proposal of the Secretary of Health & Human Services (“HHS”) and the Centers for Medicare & Medicaid Services (“CMS”) to permanently cut the prospective payment rate for home health agencies by 7.69% and to recoup \$2 billion in purported overpayments to home health agencies in 2020 and 2021 is a permissible exercise of statutory authority. CMS published this proposal on June 23, 2022 for notice and comment. *See* Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update, 87 Fed. Reg. 37,600. Comments close on August 16, 2022.

The memorandum concludes that the Secretary’s proposal is unlawful under the Administrative Procedure Act for at least three reasons.

First, CMS’s proposed rule violates three separate statutory commands: The proposal ignores the statutory provision it purports to be implementing by failing to correct its assumptions about how home health agencies would change behaviors in response to the new payment system. It violates the statute’s budget-neutrality command by reducing overall aggregate expenditures. And it uses therapy thresholds to determine payment despite the statute’s mandate to eliminate this practice.

Second, if ultimately adopted, CMS’s rule would be arbitrary and capricious. In reaching its desired policy result to cut payments and reduce aggregate

expenditures, the agency has treated similarly situated parties differently, relied on factors which Congress has not intended, failed to consider important aspects of the problem, and offered an implausible explanation for its decision that runs counter to the evidence before the agency.

And *third*, CMS's proposed rule violates notice and comment rulemaking. To provide notice and comment, an agency must provide the public with the relevant data and technical studies on which it relies to form decisions. Here, CMS has relied on a data model and specific set of manipulated data to calculate adjustments but declined to disclose to the public both the data model and the post-manipulation data. Commenters have thus been unable to replicate and test CMS's findings and conclusions.

Background

Home health agencies provide critical medical care and services to patients in their personal residences, rather than in a more traditional healthcare facility setting. When those patients are covered by Medicare, Medicare pays the agencies for services rendered.

Statutory guidelines govern how that payment is calculated, and those guidelines have varied over the years. Prior to 2020, therapy services played an important role in determining the amount a home health agency would be paid. But relying on therapy sessions to set payment levels faced criticism. In one report to Congress, for example, MedPAC urged the Secretary to revise its system to “no longer use the number of therapy visits as a payment factor” because doing so created “significant incentives to favor therapy patients, avoid high-cost nontherapy patients, and base the number of therapy visits on payment incentives instead of patient characteristics.”¹ According to MedPAC, “[a] revised system would reduce or eliminate these problems and encourage agencies to focus on beneficiary characteristics when setting plans of care.” *Id.* Later reports continued to flag this issue to Congress.²

Confronted with these concerns, Congress reformed the payment system in the Bipartisan Budget Act of 2018 to do what the MedPAC reports wanted: it removed therapy thresholds from the calculation effective in 2020. *See* 42 U.S.C. § 1395fff(b)(4)(B)(ii) (“[T]he Secretary shall eliminate the use of therapy thresholds . . . in case mix adjustment factors established under clause (i) for calculating payments under the prospective payment system . . .”). Instead, CMS adopted a patient-driven model under which payment would be linked to a variety of clinical characteristics,

¹ MedPAC, *Report to Congress* at 196 (Mar. 2011) https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar11_Ch08.pdf.

² *See, e.g.*, MedPAC, *Report to Congress* at 211 (Mar. 2016) https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-8-home-health-care-services-march-2016-report.pdf (recommending “that, beginning in 2018, Medicare eliminate the use of therapy as a payment factor in the home health prospective payment system” because it “may create financial incentives that distract agencies from focusing on patient characteristics.”).

including, for example, patient comorbidities. Congress also reduced the number of days in a unit of home health services from 60 to 30. 42 U.S.C. § 1395fff(b)(2)(B).

Congress understood that the change from a therapy-driven model to a patient-driven model and the change from a 60-day unit of service to a 30-day one would cause home health agencies to adjust how they treat patients. But Congress did not want either the changed unit of service or the switch from a therapy-driven model to affect aggregate expenditures.

To that end, the Bipartisan Budget Act instructed CMS to budget neutralize the statutory change. *See* 42 U.S.C. § 1395fff(b)(3)(A)(iv). The budget-neutrality provision required CMS to calculate a standard prospective payment amount for a 30-day unit of service such that the estimated aggregate expenditures would equal estimated aggregate expenditures had CMS continued with the 60-day unit of service. *Id.* § 1395fff (b)(3)(A)(iv). In making that calculation, however, CMS had to do more than just divide the 60-day unit of payment amount in half. Rather, Congress mandated that CMS “make assumptions about behavior changes that could occur as a result of” the unit change and the switch from therapy-based payment and incorporate those assumptions into the calculation to ensure budget neutrality. *Id.*

Acknowledging that predicting the future is hard, however, Congress provided that CMS should, for CYs 2020 through 2026, determine the difference between the effect on aggregate expenditures of assumed behavior changes as predicted and the effect on aggregate expenditures of *actual* behavior changes. 42 U.S.C. § 1395fff(b)(3)(D)(i). The Secretary should then adjust both forward and backward-looking payments to account for that difference. 42 U.S.C. § 1395fff(b)(3)(D)(ii)–(iii).

Over two separate rulemakings in 2018 and 2019, the Secretary calculated the budget-neutral standard amount both with and without assumed behavior changes. Accounting for the first variable, CMS calculated the total, aggregate expenditures that would occur under the existing methodology at \$16.6 billion. 84 Fed. Reg. at 60516. CMS then calculated what the 30-day payment amount would need to be to achieve that aggregate amount without adjusting for behavior assumptions, reaching a 30-day Budget Neutral Standard Amount of \$1,908.18 per 30-day unit of service. 84 Fed. Reg. at 60512.

Next CMS made three assumptions about behavior changes and modified the 30-day budget neutral amount to account for those changes. *Id.* at 60513. *See* 83 Fed Reg 56461. *First*, CMS assumed that home health agencies would change documentation and coding practices to put the highest paying diagnosis code as the principal diagnosis code. *Second*, CMS assumed that home health agencies would identify more comorbidities in their diagnoses, which could increase payment. And *third*, CMS assumed that home health agencies would provide 1 to 2 extra visits to receive a full 30-day payment, rather than receiving payment for a shorter period of care (a “low-utilization payment adjustment” or “LUPA”). Remarkably, CMS made

no assumption about how changes in the provision of therapy services would affect aggregate expenditures. Each of the agency's three assumptions required CMS to reduce the budget neutral standard amount. *See id.* at 60513. Predicting that these behavioral assumptions would apply to "half the 30-day periods," CMS applied a downward adjustment of 4.36% to result in a budget-neutral payment amount of \$1,824.99. *Id.* at 60518-19.

In the current proposed rule, CMS purports to be fulfilling its statutory duty to account for errors in its original behavioral assumptions in order to adjust forward and backward-looking payments. *See* 87 Fed. Reg. 37,600 (June 23, 2022). But instead of analyzing actual behavior changes to determine the difference on aggregate expenditures, the Secretary has proposed a measurement that completely ignores both assumed and actual behavior changes. Instead, the rule proposes the following steps. *First*, CMS uses actual claims data for 30-day periods postdating the Bipartisan Budget Act payment system, combines those units to simulate 60-day units of care, and then simulates what expenditures would have been under the previous therapy-driven payment model that pre-dated the Bipartisan Budget Act. *Second*, CMS compares the simulated payments to the actual payments made under the current payment system. And *third*, CMS recalculates the standardized prospective payment amount to make the actual payment equal the simulated payment. Although numerous commenters had previously pointed out problems with this methodology—namely that it does not account for behavioral changes or evaluate the accuracy of the original behavioral assumptions—CMS appears set on using this proposed methodology to calculate permanent and temporary rate adjustments. 87 Fed. Reg. 37600 (June 23, 2022). Based on this model, CMS plans to slash the prospective payment rate by 7.69% and demand back from home health agencies \$2 billion in purported overpayments made in 2020 and 2021. Instead of neutralizing budget expenditures to approximately \$16.6 billion, CMS's proposal reduces aggregate expenditures for 2020 to \$14.3 billion. It is estimated that CMS's proposal could lead to a reduction of approximately \$8.7 billion in home health payments between CY 2023 and CY 2026. Dobson | DaVanzo, *Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2023 HH PPS Proposed Rule: Executive Summary*, at 3.

Analysis

I. CMS's Proposal is Contrary to Law.

CMS's authority to act is governed by statute. In the Bipartisan Budget Act, Congress provided CMS straightforward instructions. *First*, the statute requires CMS to change its payment system to "eliminate the use of therapy thresholds" and reduce the number of days in a unit of service. 42 U.S.C. §§ 1395fff(b)(2)(B) & (b)(4)(B)(ii). *Second*, the statute demands that CMS keep aggregate expenditures neutral while shifting to the new model and to make assumptions about behavior changes to make that budget-neutral calculation. *Id.* § 1395fff(b)(3)(a)(iv). And *third*,

the statute directs CMS to, each year between 2020 and 2026, correct for its assumptions by determining the difference between assumed behaviors and actual behaviors on aggregate expenditures and adjusting backward- and forward-looking payments to account for that difference. *Id.* § 1395fff(b)(3)(D)

The proposed rule defies each of these commands. Despite purporting to calculate an adjustment for incorrect behavior assumptions, the proposed rule does not take behavior into account at all. Despite purporting to make this calculation as part and parcel of the overall instruction to neutralize the budget, CMS's proposal *reduces* aggregate expenditures. And despite purporting to merely "adjust" expenditures under the new payment system, CMS's proposal really just uses the old therapy-driven model to set payment. Because "no statute confer[s] authority" on CMS to issue the proposed rule, the "action is plainly contrary to law and cannot stand." *Michigan v. EPA*, 268 F.3d 1075, 1081 (D.C. Cir. 2001).

A. CMS's proposed adjustments are not based on corrections to previous behavioral assumptions as the statute requires.

CMS's responsibility in making payment adjustments under § 1395fff(b)(3)(D) is clear: Each year, the agency is to "determine the impact of differences between assumed behavior changes . . . and actual behavior changes on estimated aggregate expenditures." 42 U.S.C. § 1395fff(b)(3)(D)(i). Emphasizing that this duty is to make adjustments to correct for inaccurate behavior change assumptions made during the budget-neutrality calculation, the statute specifically refers back to the "assumed behavior changes (*as described in paragraph (3)(A)(iv)*)." *Id.* (emphasis added). Paragraph (3)(A)(iv) is the provision entitled "[b]udget neutrality for 2020." CMS then uses that calculated corrective amount to make adjustments to the standard prospective payment amount going forward to offset for such increases or decreases in estimated aggregate expenditures, 42 U.S.C. § 1395fff(b)(3)(D)(ii), and to make temporary adjustments retrospectively, § 1395fff(b)(3)(D)(iii).

The statutory directive makes a good deal of sense. In undertaking the budget neutrality calculation, CMS is forced to predict how home health agencies will respond to a new system. Predicting behaviors is hard. The behavior-assumption - adjustment calculation allows CMS to compare its predictions to reality and calculate the effect on aggregate expenditures that difference made. Recall, for example, that CMS assumed that home health agencies would provide 1 to 2 extra visits to receive a full 30-day payment. CMS accordingly reduced payment so that the provision of these extra days would not increase aggregate expenditures. If home health agencies, in fact, did *not* provide those extra days, though, then CMS's assumptions and reduction in payment would have been in error. Under (D)(ii) and (iii), CMS would then need to increase payment rates to account for the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures.

The HH Proposed Rule for CY 2023, however, does not evaluate the accuracy of CMS's behavioral assumptions, nor make adjustments based on any behavior-assumption adjustment. In fact, the rule does not calculate actual behavioral changes or the impact of actual behavioral changes on aggregate expenditures at all. Instead, the rule "estimate[s] what aggregate expenditures would be" if CMS applied the pre-Bipartisan Budget Act therapy-driven model with 60-day units of service to a year of claims data post-dating the effective date of the Bipartisan Budget Act. *See* 87 Fed. Reg. at 37615. The rule then compares this simulated amount to the amount that would be paid to the claims data under the operative patient-driven model with 30-day units of service. *Id.* Applying this methodology, CMS determined the amount paid in CYs 2020 and 2021 under the current patient-driven model was greater than if CMS had continued to apply the old model. CMS accordingly proposes to invoke its statutory authority under section 42 U.S.C. § 1395fff(b)(3)(D)(ii) to permanently cut rates by 7.69%. And CMS also proposes to invoke its statutory authority under 42 U.S.C. § 1395fff(b)(3)(D)(iii) to make a temporary adjustment to the standardized amount to recoup \$2 billion—the amount by which actual aggregate expenditures in CYs 2020 and 2021 exceeded what CMS estimates they would have been under the previous payment system. This proposal does not "determine the impact of differences between [previously calculated] assumed behavior changes . . . and actual behavior changes on estimated aggregate expenditures." *Id.* § 1395fff(b)(3)(D)(i).

Nor is this calculation a rough approximation of the impact of differences between assumed and actual behavior changes on estimated aggregate expenditures. Recall that CMS assumed home health agencies would (1) code patients to the highest paying categories, (2) result in more comorbidity assumptions, and (3) offer more days of service to meet the full 30-day payment encounters. If, in reality, none of those behavioral assumptions occurred and the only change was that, in 2020, home health agencies responded to Congress's switch away from a therapy-driven model by offering less unneeded therapy, then the proper course would be to *increase* the payment rate to account for the misguided assumptions. Under CMS's proposed model, however, CMS would ask how much it would have paid for this 2020 treatment under the therapy-driven model and how much it paid now. If, as one would expect, the reduced therapy meant that expenditures would have been less under the therapy-driven model, then CMS's proposed rule would *reduce* rates to account for that difference. CMS's methodology and the statutory command are irreconcilable.

As a federal agency, CMS has "only those authorities conferred upon it by Congress." *Michigan v. EPA*, 268 F.3d at 1081. The question is thus "whether Congress has delegated to the agency the legal authority to take the action that is under dispute." *Atlantic City Elec. Co. v. FERC*, 295 F.3d 1, 8 (D.C. Cir. 2002). It has not. The "statute meticulously lays out the formula that HHS must employ": calculate the difference between assumed behavior changes and actual behavior changes on estimated aggregate expenditures and to make adjustments based on that calculation. *Am. Hosp. Assoc. v. Becerra*, 142 S. Ct. 1896, 1898 (2022). CMS can

“point to no statute authorizing” its rate reductions that deviate so starkly from the difference in behavioral assumptions for which Congress commands CMS to account. *Atlantic City Elec. Co.*, 295 F.3d at 15. Because the rule “extends beyond the agency’s legitimate reach,” it is unlawful and vulnerable to vacatur by the courts. *National Federation of Independent Business v. OSHA*, 142 S. Ct. 661, 666 (2022).

B. CMS’s proposed adjustments violate the statutory command of budget neutrality.

Congress directed CMS to ensure that the Bipartisan Budget Act reforms are budget neutral. § 1395fff(b)(3)(A)(iv). But CMS’s proposed methodology, whether by accident or design, will have the effect of *reducing* aggregate expenditures. In 2019, CMS calculated that the total aggregate expenditures target for 2020 should be approximately \$16.6 billion to stay budget neutral. *See* 84 Fed. Reg. at 60512. Applying CMS’s initial behavior assumptions to reduce the payment rate, CMS ended up with total expenditures of \$15.2 billion. *See* 87 Fed. Reg. at 37,618. But instead of increasing payment to make up for this reduction, CMS’s proposed rule here would cut expenditures even further to approximately \$14.3 billion for 2020. *See* 87 Fed. Reg. at 37,618. A \$2 billion decrease in expenditures is not budget neutral. “HHS’s contrary interpretation of the statute . . . thus make[s] little sense given the statute’s overall structure.” *Am. Hosp. Assoc.*, 142 S. Ct. at 1899.

CMS is aware of this problem. Aside from the fact that these numbers are set forth in its own rules, commenters have also raised the issue. In commenting on the 2022 HH proposed rule, MedPAC, for example, stated that this reduction in expenditures was a good policy choice: “Medicare has long overpaid for home health care, and *lower payments* would better align payments with costs.” (emphasis added). MedPAC, Re: CMS-1757-P at 4 (Aug. 24, 2021). And in a separate rulemaking on pricing, CMS expressly acknowledged that changed behaviors—specifically a shift in the provision of therapy—would render its current methodology inaccurate and unworkable. 87 Fed. Reg. at 22,738 (recognizing that the current methodology “could lead to a potential overcorrection”).

CMS cannot disregard the budget neutrality framework and cut prices under the name of behavior adjustments. When Congress asks CMS to reduce payments, it does so explicitly. *See, e.g.*, American Taxpayer Relief Act of 2012, Pub. L. 112-240, § 632(a), 126 Stat. 2313, 2354-55 (2012) (“The Secretary shall . . . make reductions to the single payment that would otherwise apply under this paragraph for renal dialysis services. . . .”). Nor can CMS invoke any authority to rebase prices to purportedly bring them in line with costs. Congress likewise knows how to give that sort of command. *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. 111-148, § 3131, 124 Stat. 119, 427 (2010) (instructing the Secretary to adjust payment amounts to reflect, inter alia “the average cost of providing care per episode”); *Id.* § 3132, 124 Stat. 119, 430-432 (instructing the Secretary to “implement revisions to the methodology for determining the payment rates for routine home care and other

services included in hospice care” based on an analysis of, inter alia, cost data). Had Congress intended to reduce expenditures or reduce payment for specific services, then, “it presumably would have done so expressly as it did” in the past. *Russello v. United States*, 464 U.S. 16, 23 (1983). Here, not only is there silence as to what Congress wanted; there is a clear command. “With respect to payments for home health units of service furnished that end during the 12-month period beginning January 1, 2020, the Secretary shall calculate a standard prospective payment amount . . . such that the estimated aggregate amount of expenditures . . . is equal to the estimated aggregate amount of expenditures that otherwise would have been made under the system.” 42 U.S.C. § 1395fff(b)(3)(A)(iv).

C. CMS’s proposed adjustments ignore the statutory changes to the payment system made by Congress.

In enacting the Bipartisan Budget Act of 2018, Congress made two major changes to the way payments were calculated. It got rid of the therapy thresholds. And it cut the number of days in a unit of service in half.

The proposed rule, while purporting to be a behavioral adjustment, really just ignores the new payment system and applies the old one. CMS admits as much. Describing its proposed rule, CMS explains that it “calculates what the Medicare program would have spent had the [patient-driven model] not been implemented in CYs 2020 and 2021, assuming that [home health agencies] would have provided home health services in the same way they do under the [current model], compared to what actual home health expenditures were under the [patient-driven model] in CY 2020 and CY 2021.”³ In other words, CMS has applied the old payment model (the one Congress statutorily rejected), compared it to the new payment model, and decided it likes prices under the old payment model better. CMS then uses that method to propose “a -7.69% permanent adjustment to the 30-day payment rate in CY 2023 to ensure that aggregate expenditures under the new payment system . . . would be equal to what they would have been under the old payment system.”⁴

In effect, CMS is repricing all of the services *as if Congress had never passed the statute at all*. By sneaking in the old system and pricing services on that basis, CMS has violated the statute and ignored the important payment system changes Congress made.

The Secretary’s Proposed Rule for CY 2023 does not, in fact, apply the framework Congress built but rather is “a novel attempt to reconfigure Congress’s statutory scheme.” *Howard v. Pritzker*, 775 F.3d 430, 432 (D.C. Cir. 2015). Here, “Congress has enacted a comprehensive scheme and has deliberately targeted specific

³ CMS Newsroom, *CY 2023 Home Health Prospective Payment System Rate Update and Home Infusion Therapy Services Requirements Proposed Rule (CMS-1766-P)* (June 17, 2022), <https://www.cms.gov/newsroom/fact-sheets/cy-2023-home-health-prospective-payment-system-rate-update-and-home-infusion-therapy-services>.

⁴ *Id.*

problems with specific solutions.” *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 132 S. Ct. 2065, 2071 (2012) (quoting *Variety Corp. v. Howe*, 516 U.S. 489, 519 (1996) (Thomas, J., dissenting)). By ignoring its statutory constraints, CMS’s proposal is contrary to law and would warrant vacatur in the courts.

* * *

To put CMS’s proposed rule on payment adjustments in perspective, a hypothetical is illustrative. Consider a parent who aims to get her child to help with yard work. To incentivize a child to help, the parent proposes to pay \$10 for every bucket of rocks collected and \$5 for every bucket of weeds pulled. Each week, the dutiful child collects 3 buckets of rocks and 0 buckets of weeds, gaining \$30. As summer progresses and weed growth becomes more dire, the parent decides to switch the payment rate but keep weekly spending the same. The parent thus tries to figure out how much to pay. Assuming the kid might collect 1 bucket of weeds and 3 buckets of rocks based on a newly proportioned payment system, the parent lands on \$3 for every bucket of weeds and \$9 for every bucket of rocks. In reality, the child has already picked up all the rocks and so collects only 3 buckets of weeds, leading to a payment of \$27.

Applying the statutory assumption-adjustment provision, the parent would note that the difference between assumed behavior changes (3 buckets of weeds and 1 bucket of rocks) and actual behavior (3 buckets of weeds, no rocks) had a \$3 impact on estimated aggregate expenditures. Moving forward, the parent should adjust the payment rate for weed buckets upward by \$1, and the parent should pay the kid an extra \$3 to make up for the incorrect assumption.

What CMS’s proposal would do to that hardworking child, in contrast, is downright cruel. It would take the weeds and rocks picked up under the new pricing system—3 buckets of weeds and 0 buckets of rocks—and calculate how much the child would have been paid in the early summer days when buckets of weeds went for \$5. The answer? \$15. Because \$15 is less than the \$27 actually paid, CMS would make the kid fork over \$12 and reduce prospective payment for the buckets of weeds from \$9 to \$5.

Such a proposal has nothing to do with predicting the difference on aggregate expenditures of assumed and actual behavior changes, conflicts with the budget-neutrality rule, and reverts to the old payment system that Congress rejected. As the Supreme Court confirmed just this year, HHS is not free to ignore statutory constraints in setting forth payment rates. *See, e.g., Am. Hosp. Assoc.*, 142 S. Ct. at 1899 (holding HHS’s reimbursement rates “contrary to the statute and unlawful”). CMS’s proposal is contrary to law and should be vacated if challenged in court.

II. If Adopted, CMS's Rule Would Be Arbitrary and Capricious.

An agency rule may be arbitrary and capricious for multiple reasons. As an initial matter, agency action is arbitrary and capricious if it “treats similarly situated parties differently.” *El Rio Neighborhood Health Center, Inc. v. HHS*, 300 F. Supp. 2d 32, 42 (D.D.C. 2004). Moreover, an agency rule is arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The rule here is arbitrary and capricious under any measure.

A. CMS's rule treats similarly situated parties differently.

Applying the proposed methodology here would treat similarly situated parties differently. In addition to modifying the prospective payment system for home health agencies, CMS has also recently revamped the prospective payment system for skilled nursing facilities. *See* 86 Fed. Reg. at 19985 (noting that the new patient-driven payment model was implemented in 2019). Many of the changes resemble those made to the prospective payment system here. In particular, the old system relied heavily on therapy utilization; whereas, the new system relies more on patient characteristics. CMS planned to implement the new model for skilled nursing facilities “in a budget neutral manner,” just like the Bipartisan Budget Act demands in the home health agency context. 86 Fed. Reg. at 19985. After an initial analysis, CMS proposed a 46% adjustment. *See id.* (noting that the “analysis resulted in an adjustment factor of 1.46”).

Later, however, CMS proposed to make adjustments to its payment based on the difference between assumed behavior and actual behavior in the skilled-nursing facility context, just as it proposes to do here. Specifically, CMS noted that the new payment model “is impacting certain aspects of [Skilled Nursing Facility] patient classification and care provision. For example, through FY 2019, the average number of therapy minutes . . . patients received per day was approximately 91 minutes” but “[b]eginning almost immediately with [the new payment system] implementation . . . , the average number of minutes . . . patients received per day dropped to approximately 62.” 86 Fed. Reg. at 19986. Despite being predicted by commenters, the change came as a surprise to CMS which had predicted that “financial motives [w]ould not override the clinical judgment of a therapist or therapy assistant.” 86 Fed. Reg. at 19,986. Confronted with reality, however, CMS changed course: it recalibrated its adjustments to account for, among other things, “changes in therapy provision.” 86 Fed. Reg. at 19987. Although CMS “would typically utilize claims and assessment data from a given period under the new payment system, classify patients under both the current and prior payment model using the same set of data, compare aggregate payments under each payment model, and calculate an appropriate

adjustment factor to achieve budget neutrality,” the “significant changes in therapy provision” since implementation of the new model meant that this budget-neutrality calculation would no longer work and would instead lead to “a drastic underestimation” of what aggregate payments would have been under the previous system. 86 Fed. Reg. at 19,987.

These same behavioral changes are present here. The shift of payment incentives away from therapy visits, as well as the impact of COVID-19, “drove a 29.7% reduction in CY 2020 therapy visits.” Dobson | DaVanzo, *Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2022 HH PPS Proposed Rule: Summary of Findings from Dobson | Davanzo Reports Presentation to CMS*, at 6 (Sept 9, 2021). But instead of accounting for this changed behavior, as ordinary rules of fairness and the plain text of the statute command, CMS proposes a model that it itself has acknowledged is inaccurate.

CMS’s willingness to embrace a different model to account for actual behavior changes for Skilled Nursing Facilities makes it arbitrary and capricious for CMS to cling to its old model here. The same factors are at play: implementation from a therapy-driven payment model to a patient-driven model. And the real-world actions are similar: reduced therapy in both instances. If anything, the statutory command to adjust for actual behavior changes means that CMS should be more attune to those changes in the Home Health Agency context than in calculating payments for Skilled Nursing Facilities. If an agency makes an exception and departs from its old model to calculate budget neutrality “in one case, then it must either make an exception in a similar case or point to a relevant distinction between the two cases.” *Westar Energy, Inc. v. FERC*, 473 F.3d 1239, 1241 (D.C. Cir. 2007). CMS has made (and can make) no distinction. Its decision to treat similarly situated entities like Skilled Nursing Facilities differently is arbitrary and capricious on its face.

B. CMS has relied on factors it should not, failed to consider important aspects of the problem, and offered an implausible explanation for its calculation.

In addition to treating similarly situated parties differently—and the statutory defects—CMS’s decisionmaking and explanation both reveal the proposed rule to be arbitrary and capricious.

First, CMS’s decisionmaking considers factors it should not and fails to consider factors it should. Instead of analyzing the accuracy of its behavioral assumptions, CMS considered other factors in developing the new rates, namely the amount that would have been paid had CMS continued to apply the old pricing system. CMS failed to consider how the departure from a therapy-driven pricing model and the COVID-19 pandemic caused home health agencies to change behavior. *See* 87 Fed. Reg. at 376151 37616. The Bipartisan Budget Act, the APA, and the general principle of reasoned decisionmaking all demand more. CMS was to consider

the impact of the difference between the previously calculated assumed behavior changes on estimated aggregate expenditures and the impact of actual behavior changes on estimated aggregate expenditures and adjust for that difference. 42 U.S.C. § 1395fff(b)(3)(D). Where Congress has given an agency “strict instructions, clear criteria, and a duty,” failure to follow those instructions and to use “extraneous factors” is arbitrary and capricious action. *Cayuga Nation v. United States*, 2022 WL 910295, at *8 (D.D.C. Mar. 29, 2022); *see also Kakar v. United States Citizenship and Immigration Servs.*, 29 F. 4th 129, 135 (2d Cir. 2022). (When, as here, “an administrative record is insufficient to permit [the court] to . . . conclude that the agency has considered all relevant factors, remand is appropriate.”).

This failure to consider relevant factors cannot be chalked up to a methodological limitation. Commenters provided CMS with alternative methodologies to consider. One such comment proposed that CMS compare 2020 actual payments to the 2020 projected payments with behavior assumptions. *See Dobons | DaVanzo* at 10. Applying this method, the actual average case payment was approximately 1.4% below what it should be, indicating that some part of the behavioral assumptions did not hold. *Id.* CMS rejected this position, contending that it artificially limited consideration to the assumed behaviors from before. 87 Fed. Reg. at 37,616. But CMS failed to explain why its methodology, which failed to take into consideration any behaviors, more accurately abided by the statutory mandate. Aside from commenters, CMS has its own proposed methodology in the context of skilled nursing facilities. *See pp. 11-12, supra.* Instead of simply repricing under the old methodology, CMS plans to implement “an alternative recalibration methodology” that “provides a more accurate representation of what . . . payments would have been, were it not for the changes precipitated by [the new payment system’s] implementation. 87 Fed. Reg. at 22,738. The failure to realistically consider or distinguish these alternatives, which illustrate promising ways to implement the statutory mandate, constitutes arbitrary agency action. *Int’l Ladies’ Garment Workers’ Union v. Donovan*, 722 F.2d 795, 817 (D.C. Cir. 1983) (“[I]n addition to requiring rational consideration of alternatives, the APA demands an adequate explanation when these alternatives are rejected.”).

Second, the explanation given by the Secretary in the rule runs counter to the evidence that has been presented to the agency. Take the change in the provision of therapy services. Commenters explained to CMS “that there has been a large decrease in therapy utilization since the implementation of” the Bipartisan Budget Act payment system. 87 Fed. Reg. at 37615. CMS does not dispute that, as a factual matter, this behavior might have changed and that this would throw a wrench in its methodology. Indeed, it recognized exactly that in the context of skilled nursing facilities. *See pp. 11-12, supra.* Instead, CMS contended that, regardless of what is actually happening, the decrease in therapy utilization *should not be* happening because CMS “stated in the CY 2019 HH PPPs final rule . . . that the [new payment system] is not limiting or prohibiting the provision of therapy services” and thus home

health agencies “should continue to provide the most appropriate care to Medicare home health beneficiaries.” 87 Fed. Reg. at 37615. In other words, CMS’s response is to say that home health agencies are not changing their behaviors to respond to the incentives of the new payment system. But if *that* is true, then CMS’s job is easy: it calculated that changed behavior would require a 4.5% decrease in payment rates; in fact, there has been no changed behavior at all, so CMS should get rid of the 4.5% decrease.

The Secretary’s justifications do not hold water. *See Garland v. Ming Dai*, 141 S. Ct. 1669, 1679 (2021) (explaining that courts “remain bound by traditional administrative law principles, including the rule that judges generally must assess the lawfulness of an agency’s action in light of the explanations the agency offered for it rather than any *ex post* rationales a court can devise”); *see also Guertin v. United States*, 743 F.3d 382, 388 (2d Cir. 2014) (agency acted in an arbitrary and capricious manner by relying “on an explanation that r[an] counter to the relevant evidence presented to the agency”). The Secretary’s methodology simply cannot be supported as a difference in view or the product of agency experience. Here, the Secretary has left behind the words of the statute, the statutory scheme, and available methodologies to create a new payment scheme. As the D.C. Circuit confirmed just last month, CMS is not entitled to disregard statutory factors when calculating payment rates. *See American Clinical Laboratory Association v. Becerra*, 2022 WL 2760816, at *6 (D.C. Cir. July 15, 2022). The proposal is arbitrary and capricious.

III. CMS’s failure to disclose the data model on which it relies to calculate aggregate expenditures violates the APA’s notice-and-comment requirement.

Finally, CMS’s proposed rule violates the statutory requirement to operate through “notice and comment rulemaking.” 42 U.S.C. § 1395fff(b)(3)(D)(ii), (iii). “The APA requires an agency to publish ‘notice’ of ‘either the terms or substance of the proposed rule or a description of the subjects and issues involved,’ in order to ‘give interested persons an opportunity to participate in the rule.’” *American Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 236 (D.C. Cir. 2008) (quoting 5 U.S.C. § 553(b)-(c)). To satisfy APA notice and comment requirements, agencies must reveal not only the terms of the rule but also the “technical studies and data upon which the agency relies.” *Chamber of Commerce v. SEC*, 443 F.3d 890, 899 (D.C. Cir. 2006).

To arrive at its current proposal, CMS relied on two sets of critical information that it has refused to disclose to the public. *First*, in its model to determine the impact of assumed behavior changes on estimated aggregate expenditures, CMS disclosed a model to calculate the effect of assumed behavior changes to approximately -8.389%. 84 Fed. Reg. at 60513. CMS then applied a separate model to decrease the adjustment to -4.36%. *Id.* at 60518. But in doing so, CMS never disclosed how it actually calculated that revised amount. Without knowing the model, there is no way to replicate and check CMS’s work to determine whether the impact of assumed

behavior changes on aggregate expenditures was proper. And *second*, in the instant rule, CMS converts 30-day units to 60-day units to apply the old payment system. But in doing so, CMS made exclusions. While the public has claims data, it does not have the claims data as manipulated and used by CMS to run its methodology. *See, e.g.*, 87 Fed. Reg. at 37,616 (noting that commenters “raised concerns about the differing case-mix weight systems and that the data exclusions and assumptions made when creating the simulated 60-day episodes”). Again, without the actual 2020 claims data as it was used by CMS, the public is left only to guess at whether CMS’s calculations are accurate. In order to determine whether CMS is accurately determining the impact between the difference of assumed behavior changes and actual behavior changes on estimated aggregated expenditures, stakeholders must know the data and models used to calculate both the effect of assumed behavior changes and actual behavior changes. Without disclosing those exclusions and the actual 2020 claims data used CMS “developed a methodology that uses actual claims data for 30-day periods under the [current] 432-group case-mix model . . . to simulate 60-day episodes under the [previous] 153-group case-mix model . . . in order to estimate what aggregate expenditures would have been” if the older payment method were used today. 87 Fed. Reg. at 37,615.

The refusal to turn over this data alone warrants vacatur and remand. *See American Radio Relay League*, 524 F.3d at 240 (remanding to the agency to “make available for notice and comment the unredacted technical studies and data that it has employed in reaching its decisions”). “To allow an agency to play hunt the peanut with technical information, hiding or disguising the information that it employs is to condone a practice in which the agency treats what should be a genuine interchange as mere bureaucratic sport.” *Connecticut Light & Power Co. v. Nuclear Regulatory Commission*, 673 F.2d 525, 530 (D.C. Cir. 1982). CMS’s refusal to disclose this underlying data model to the public violates the statutory requirement to provide notice and comment.

CONCLUSION

The Secretary’s proposal conflicts with the statute it purports to implement, is arbitrary and capricious, and ignores notice-and-comment requirements. The proposed rule will thus be vulnerable to an APA challenge in court.