August 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1780-P
P.O Box 8013
Baltimore, MD 21244-8013

Re: **CMS-1780-P: Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements**

Dear Administrator Brooks-LaSure,

The Partnership for Quality Home Healthcare ("PQHH" or the "Partnership") appreciates the opportunity to submit comments on the Calendar Year (CY) 2024 Home Health Prospective Payment System (HH PPS) Proposed Rule (the "Proposed Rule"). We submit the following comments and recommendations as necessary to avoid unavoidable disruptions in patient care for Medicare beneficiaries. We believe that CMS's approach to applying behavioral 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. Unfortunately, we are gravely concerned that CMS's Proposed Rule would severely undermine the Medicare home health benefit.

The Partnership submitted an early comment letter, on July 28, 2023, to sound the alarm for CMS regarding the state of the home health industry and the devastating impact further Medicare payment cuts would have in 2024. Home health providers continue to oppose CMS's methodological approach to calculating Patient Driven Groupings Model (PDGM) behavioral adjustments, and we urge CMS to reconsider the methodology it finalized last year. Nonetheless, these comments focus on the impact that cuts imposed under this methodology have had in 2023 and will have going forward if CMS continues its current course. Access to

home health is already diminished. If CMS cuts payments further as proposed for 2024, access will be decimated.

We are commenting on provisions in this Proposed Rule including payment cuts associated with CMS' implementation of the PDGM and proposals related to the payment update, wage index, and case-weights, and the disastrous combined effect CMS's payment proposals would have on patient access and care delivery. 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 Quality Reporting Program (HH QRP) and the expanded Home Health Value-Based Purchasing (HHVBP) Model and in response to CMS's Request for Information (RFI) on access to home health aide services.

## I. Introduction

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. Home health is preferred by beneficiaries over institutional care, produces high quality outcomes, and provides tremendous value to the Medicare program. The popularity of health care in the home has only increased in recent years, particularly as older adults and their family members became comfortable seeking care from the convenience of their home via telehealth. But the Medicare home health benefit is not merely convenient; it is a lifeline, bringing clinicians to homebound beneficiaries where they live. The availability of home health services means Medicare beneficiaries can stay in their homes and avoid nursing home stays, and it allows hospitalized beneficiaries to return home with the support they need to recover. All Medicare beneficiaries should have access to home health care when they need it. Unfortunately, access to home health care is declining under current CMS policy.

1. Beneficiaries are Struggling to Access Home Health Care

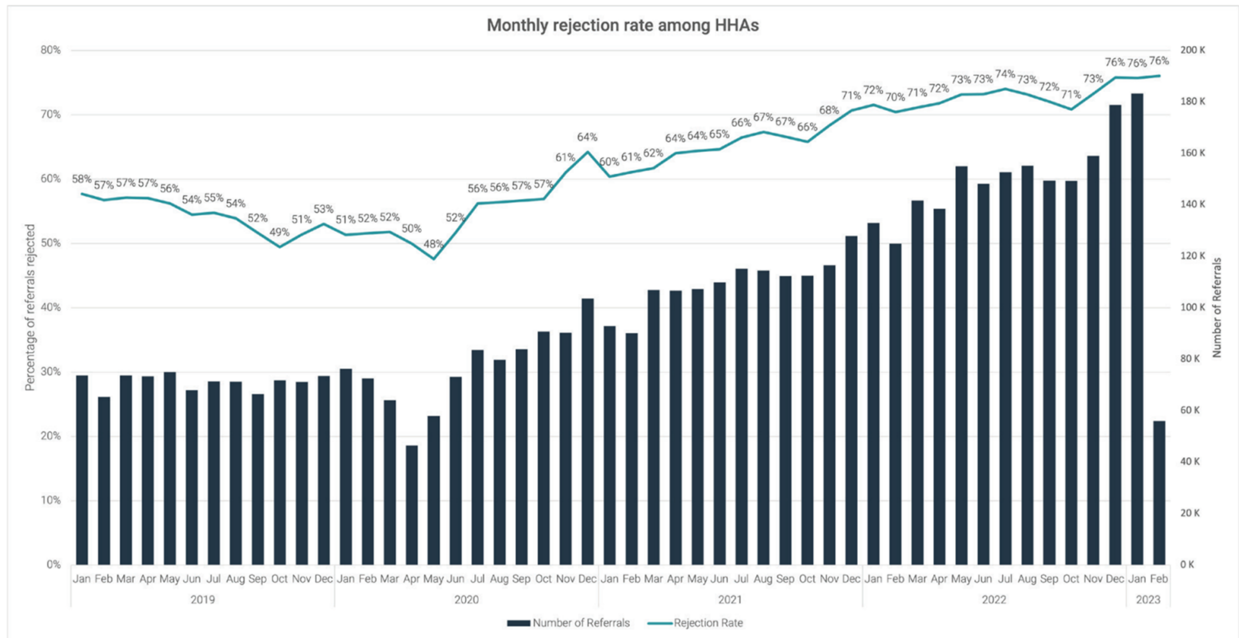
Unfortunately, multiple data sources show that it is becoming harder, not easier, for Medicare beneficiaries to access home health. Patients who need home health are spending longer than clinically necessary in hospital beds, waiting to be discharged, due to the difficulties of finding home health agencies (HHAs) with capacity.

WellSky and CarePort care transition solutions support hospitals as they assist patients with post-acute care selection. Their data show that both the total number of referrals to home health, and the likelihood that a home health agency will turn down a referral, are increasing. See Table 1 below. A recent analysis of CarePort's data found that, "while HHAs are receiving a higher volume of referrals overall, the number of referrals sent per patient also continues to increase as acute providers struggle to secure post-acute care for their patients in a timely manner. Furthermore, rejection rates to HHAs hit an all-time high at an average of 76% in December 2022, up from 54% in 2019."[1] The need for home health is greater than ever

[1] The evolution of care: An annual care delivery report, available at https://info.wellsky.com/rs/596-FKF-634/images/2023_Evolution_of_Care_Report.pdf.

(demonstrated by the increase in HHA referral volume), but hospital discharge planning data show it is harder than ever to place patients, unnecessarily increasing hospital average length of stay.

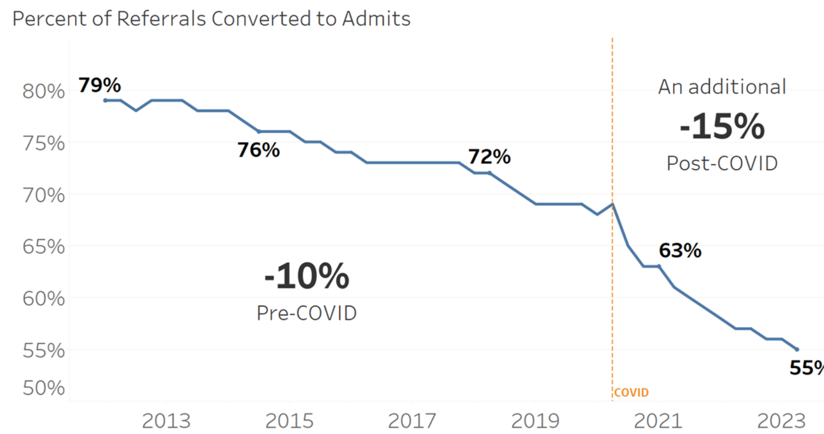
**Table 1**




*Source: July 25, 2023 WellSky Evolution of Care report, available at: https://careporthealth.com/about/results/the-evolution-of-care-2023/*

Data from Homecare Homebase (HCHB) tells a similar story. HCHB is an Electronic Health Record and Agency Management home health platform used for almost half (44 percent) of the home health industry by visit volume. Whereas CarePort's data includes information on hospital patients before home health intake paperwork is started, information captured by HCHB starts when HHAs take steps to bring on referred patients. Their data (discussed in more detail in HCHB's own comment letter) indicate that only 55 percent of referrals for home health actually convert to home health admissions. See Table 2. This suggests a large volume of patients who need home health are not getting it. While the percent of home health referrals converted to home health admissions had been declining steadily even before PDGM, the rate of decline increased significantly with PDGM and the pandemic.

**Table 2**

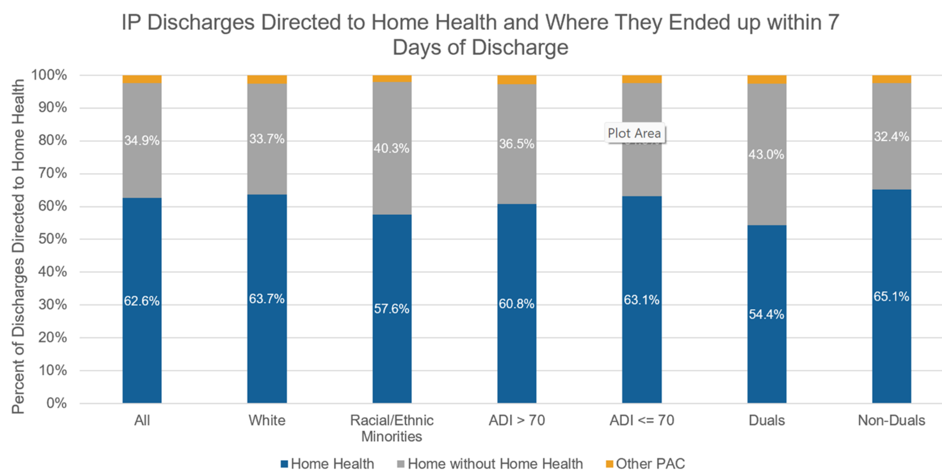



*Source: HCHB data, as presented in HCHB comments on this Proposed Rule.*

Both datasets show it is getting harder, not easier, for beneficiaries to get home health care.

While access to home health is declining across the board, data also show inequitable access for disadvantaged populations. CareJourney, a healthcare analytics platform that helps drive clinical performance improvements for health care providers, analyzed 2022 data and identified differences across racial and socioeconomic groups in home health conversion rates, indicating that minorities and dual-eligible individuals have a harder time accessing home health than their white beneficiaries. These findings suggest CMS should explore ways to strengthen access to home health, especially for vulnerable beneficiaries.

**Table 3**

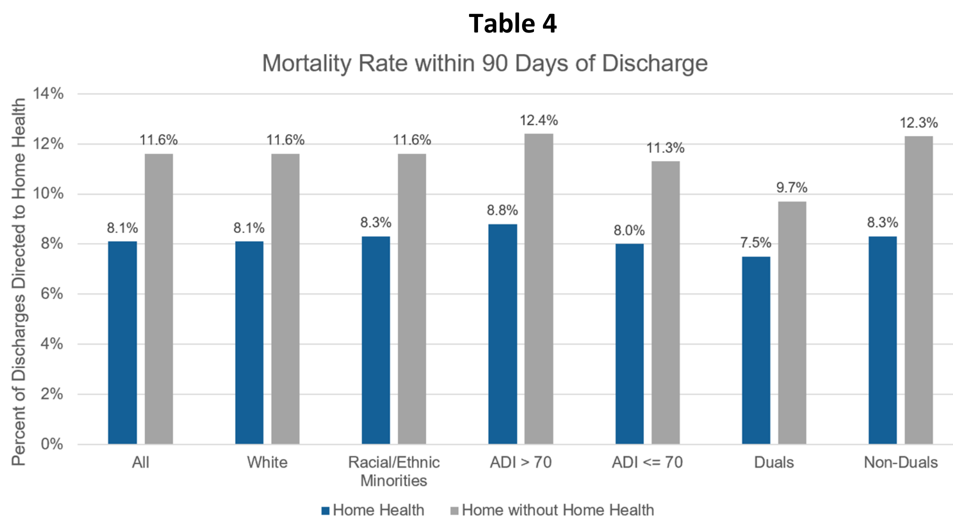



*CareJourney analysis shared with PQHH, included here with permission.*

2. Access to Home Health is Vital

As noted above, home health is a vital benefit, not a convenience. Not being able to access home health when it is ordered has dire consequences. The fact that not all beneficiaries referred to home health receive it has created distinct cohorts of patients referred for home health: beneficiaries who receive it and beneficiaries who do not. CareJourney has analyzed these cohorts to understand the impact of not getting home health when it is ordered. Among other findings, CareJourney found that for those referred to home health, actually receiving home health care substantially reduces mortality within 90 days of a hospital discharge. See Table 4.

**Table 4**




**Source**: CMS Virtual Research Data Center
**Data**: 2022 inpatient claim files filtered for STAC claims (see methodology slides for how each discharge location is coded and how conversions are calculated). Discharge data based on Q1-Q3 2022 data

Property of CareJourney Confidential and Proprietary

CMS should be doing everything it can to *improve* access to home health or at the very least stabilize access to care, which is faltering in the face of PDGM. Unfortunately, the proposed cuts for 2024 and beyond will only make matters worse.

3. Rate Reductions Decrease Access to Care

CMS already recognizes the clear connection between access to care and payment rate reduction. In a recent proposed rule advanced by the Biden Administration to improve access to Medicaid services, including access to home and community-based services (HCBS), CMS discusses the need for analysis when states engage in "rate reductions or payment restructurings" in order to avoid hindering access to care.[2] Within the Medicaid program, CMS proposes that aggregate reductions to any particular benefit category cannot exceed 4 percent in order to be considered nominal payment adjustments that will be unlikely to diminish access

[2] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27960, 28025-28036 (May 3, 2023).

to care.[3] CMS emphasizes the need for state Medicaid agencies to conduct further analysis regarding the sufficiency of proposed payment rates after reduction or restructuring in order to avoid reducing access to care. Given the tenuous state of access to home health under current levels, CMS should proceed with caution in moving forward with further Medicare payment rate reductions, consistent with its proposed policy regarding Medicaid rate-setting. Year over year cuts to home health explain the access issues demonstrated in the charts discussed above.

4. HHAs are Struggling with Labor Costs and Shutting Down Capacity in the Face of Cuts

Home health administrators and clinicians report continued recruitment challenges, with home health aides, nurses, and therapists all being hard to retain and near-impossible to hire. HHAs report losing nurses to other care settings or traveling status, where pay is higher. Hospital discharge planners and HHA personnel alike report that lack of home health capacity, or lack of capacity to deliver specific nursing or therapy services that a patient needs, meaning patients stay in the hospital longer than necessary or leave without a plan to receive the care they need. Patients desperately want to be at home, and HHAs and their clinicians passionately want to deliver these needed services, but crushing year after year cuts have pushed many home healthcare providers to reduce service areas and to and past the brink of closure. The juxtaposition between the reduced reimbursement and increasing wages is untenable. As discussed in detail below, the home health market basket itself has not kept up with wages for nurses. The combined impact of wage growth exceeding rate updates, and CMS applying permanent adjustment rate reductions offsetting updates, has been disastrous. As shown in Table 5 below, the 2023 permanent adjustment more than wiped out the HH market basket increase, leading to a lower base payment rate in 2023 than HHAs received in 2022. It is impossible for HHAs to keep up with labor market forces in this environment, and reports from all over the country announced HH service area reductions and HHA closures in 2023.[4]

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[3] *Id*. at 28088, proposed 42 CFR § 447.203(c)(1)(ii).

[4] Examples of HHA closures and service area reductions from around the country: CHI Mercy (Oregon) (https://www.nrtoday.com/family/health/mercy-health-closes-home-health-care-cuts-staff/article_033db75a-da43-11ed-be44-c7e65e6ae216.html); Panhandle Health District (Idaho) (https://www.krem.com/article/news/health/hayden-panhandle-health-district/293-78b97887-7582-45c2-9a33-8222fbe4ed31); TRINITY HEALTH OF NEW ENGLAND AT HOME (https://www.westernmassnews.com/2022/09/06/trinity-health-home-closure-leads-nearly-60-employee-layoffs/); Southeast Health (Missouri) (https://www.kfvs12.com/2023/07/14/southeasthealth-announces-closure-home-health-services-cape-stoddard-counties/); MVI Home Care (Ohio) (https://www.wfmj.com/story/48024639/sources-longtime-valley-business-closes-doors-unexpectedly); Oahu Home Healthcare (Hawaii) (https://www.hawaiipublicradio.org/the-conversation/2022-12-28/closure-of-home-health-company-highlights-statewide-staffing-challenges); CABELL HUNTINGTON HOSPITAL INC (West Virginia) (https://www.wsaz.com/2023/03/10/cabell-huntington-hospitals-outpatient-surgery-center-close/); HOSPICE & HOMECARE OF JUNEAU (Alaska) (https://www.juneauempire.com/news/hospice-and-home-care-of-juneau-closing-wednesday/); NorthBay Health (California) (https://www.thereporter.com/2023/02/28/northbay-health-to-close-health-at-home-service/); Community Home Health & Hospice (Washington) (https://www.columbian.com/news/2023/apr/13/community-home-health-hospice-closing-vancouver-longview-facilities/).

Comments on this Proposed Rule submitted by HCHB discuss disturbing trends including a six-fold increase in HHAs needing to turn patients away specifically due to lack of clinical staffing. If CMS continues down this path, HHAs will not have the staff they need to care for Medicare beneficiaries in need.

CMS must take these very concerning trends into consideration as it moves forward.

## II. Impacts of PDGM Permanent and Temporary Adjustments

CMS is proposing drastic cuts to home health in 2024 and planning for devastating temporary adjustments in future years.

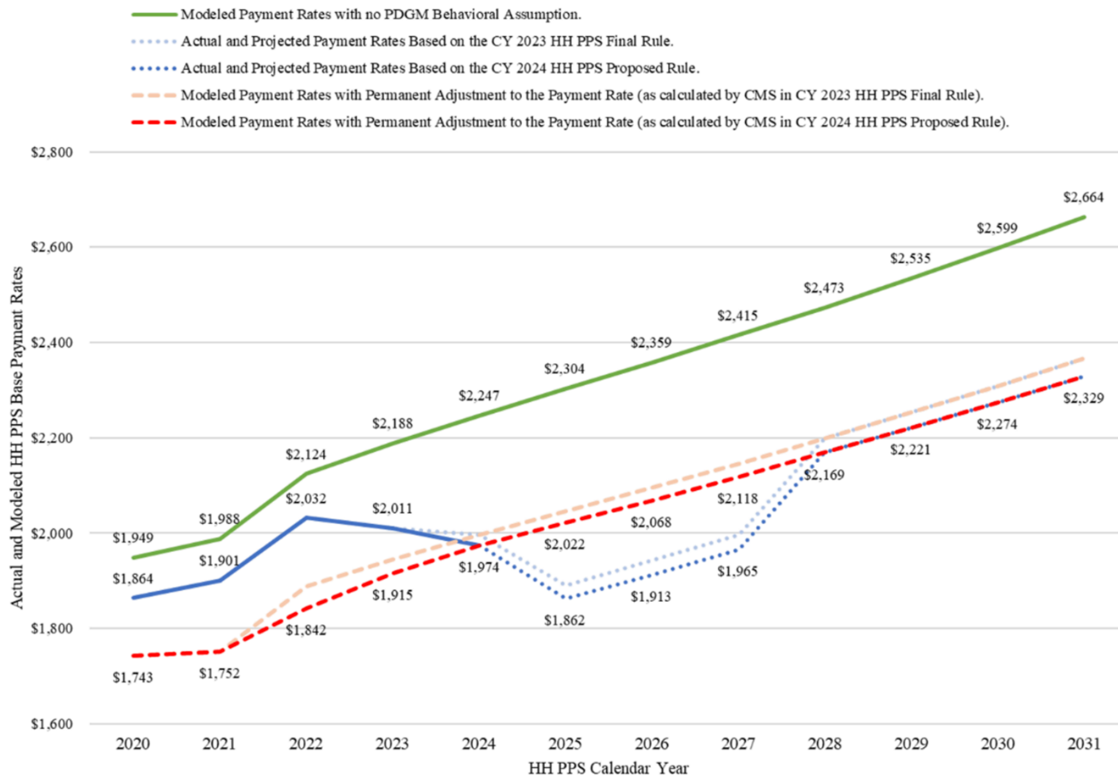
### 1. Continuing to Rapidly Reduce Medicare Home Health Rates Cannot be Justified

CMS proposes to apply a −5.653 percent permanent adjustment to the CY 2024 national, standardized 30-day payment rate, stating that this adjustment is needed to offset the increase in estimated aggregate expenditures for CY 2022 based on the impact of the differences between assumed and actual behavior changes, and to account for the permanent adjustment of −3.925 percent taken in CY 2023 rulemaking.

Despite acknowledging that the full permanent adjustment “may be burdensome for some providers”, CMS believes applying the full -9.36 percent permanent adjustment (via an additional -5.635 cut) in CY 2024 “would [1] potentially reduce any future permanent adjustments, [2] stem the accrual of the temporary payment adjustment dollar amount, and [3] would help fulfill the statutory requirements. . .” Each of these justifications is dogmatically bureaucratic and shows complete disregard for the on-the-ground realities for home health patients and the providers trying to meet their needs.

First, CMS suggests implementing the full permanent adjustment in 2024 as a means to reduce future permanent adjustments. On the chart below, the faded red line shows the impact of the full permanent adjustment as calculated in last year’s final rule (-7.85 percent) being applied starting in 2024, whereas the bright red line shows the impact of the proposed -9.36 percent permanent adjustment starting in 2024. See Table 5. This red line projects base payment amounts for future years, assuming permanent adjustments do not increase beyond the currently proposed levels. But as CMS acknowledges, its methodology means the permanent adjustment amount can continue to be revisited for years to come, likely meaning the red line on this chart will be pushed lower over time. Bringing payment levels to the full permanent adjustment level (the current red line) in 2024 will not stop future permanent adjustments based on CMS’s current methodology. To the contrary, steep cuts will drive changes that could exacerbate these cuts, due to the downward spiral discussed later in this letter.

**Table 5**




Second, CMS seeks to "stem the accrual" of dollars that will eventually be clawed back through temporary adjustments. Table 5 includes a blue dotted line projecting the impact on home health payments were CMS to apply temporary adjustments to collect the more than $3.4 billion it has calculated through 2022, plus additional amounts associated with the current 2023 payment year. Even assuming stability in the permanent adjustment (which appears unlikely given CMS's current approach), if and when CMS seeks to impose temporary adjustments, it will realistically need to spread such adjustments out over many years. CMS has not yet proposed a schedule for temporary adjustments, but Table 5 presents a doomsday scenario in which CMS would claw back temporary adjustments over just three years by imposing drastic and devastating cuts. Dobson| DaVanzo & Associates (Dobson| DaVanzo) analysis indicates that temporary adjustments imposed on a rushed, three-year timeline would result in more than $1.36 billion being clawed back in each year, representing 8.2 percent in additional payment cuts. Any future approach to imposing temporary adjustments would mean CMS pays less than the permanent adjustment level, which is already unsustainable. Fast-tracking payment cuts would produce absurd results and devastating impacts for HHAs and their patients in the real world.

We appreciate that CMS has *not* proposed temporary adjustments in the Proposed Rule, but CMS's rhetoric supporting rushed implementation of cuts and its proposal to reduce rates steeply to the full permanent adjustment level is unnecessary, unjustified, and unrealistic.

Rushing to implement behavioral adjustments will only further destabilize the home health benefit and access to care, which is already at record low levels, as discussed above. Implementing cuts on the trajectory in Table 5, starting with cuts CMS has proposed for 2024, would destroy the home health benefit. CMS must not move forward on this path.

2. Permanent and Temporary Adjustment Threaten Provider Solvency

Cuts of the proposed magnitude would not be merely "burdensome for some providers" as CMS suggests; they would be devastating. CMS states that, given statements made in previous rulemaking, "home health agencies have had some time to consider this proposed rate reduction." But merely forewarning sizable cuts does not make them manageable for providers.

Imposing a -9.36 percent permanent adjustment in 2024 as proposed would dramatically increase the number of home health agencies with negative margins, even under the rosiest of projections using CMS's own data. As PQHH has discussed repeatedly with CMS, calculating Medicare margins based on flawed cost reports produces inflated margins and does not realistically reflect HHA operating margins. Unlike other sectors, HH all-payer margins are significantly lower than Medicare FFS margins. Nonetheless, the table below replicates CMS's methodology for assessing HHA margins (overstating true margins), in order to further demonstrate the impact of the proposed rule on HHAs. In 2022, before CMS began implementing permanent adjustments, 16.2 percent of home health agencies had negative margins (according to CMS's margin methodology). As shown in Table 6, this percentage jumped to 21.2 percent in 2023, when CMS made further payment cuts under PDGM authority. If additional cuts are applied as proposed, more than one quarter (26.5 percent) of home health agencies operating today are projected to have negative margins in 2024. Even under the currently proposed permanent adjustment, the percentage of agencies with negative margins will continue to grow in years to come. This trend will continue as CMS's policy is fully implemented, with a massive destabilization of the home care sector as the logical outcome.

Given that the PQHH believes that the flawed margin analysis is fueling a defective overall analysis of the fiscal health of the home health sector, this analysis is even more troubling because it likely means that the impact on margins is much more dire.

**Table 6: Projected Analysis Based on Proposed Rule**

| Medicare Margins and Percent of HHAs with Negative Margins 2022 - 2031 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **ALL AGENCIES** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** | **2030** | **2031** |
| Total Medicare Margin | 25.3% | 21.6% | 17.9% | 17.7% | 17.4% | 17.2% | 16.9% | 16.7% | 16.5% | 16.2% |
| Percent Agencies with Negative margins | 16.2% | 21.2% | 26.5% | 26.8% | 27.0% | 27.3% | 27.7% | 28.0% | 28.4% | 28.9% |
| Number of Agencies | 5,367 | 5,367 | 5,367 | 5,367 | 5,367 | 5,367 | 5,367 | 5,367 | 5,367 | 5,367 |

*SOURCE: Dobson | DaVanzo analysis of 2022 Medicare Cost Reports*

CMS has the ability to stabilize home health, rather than driving more HHAs into the red. Keeping rates steady by delaying implementation of additional permanent adjustments would allow for a greater level of fiscal stability.

CMS's eagerness to cut home health payments dramatically in 2024 therefore seems driven by a desire to avoid the need, under its interpretation of the law, to make more cuts in the future. This race to implement cuts is devoid of any assessment of how these cuts will impact patients and providers. This is a reckless policy approach.

Rather than racing to implement cuts in furtherance to "help fulfill the statutory requirements," CMS should continue to exercise its discretion to implement both permanent and temporary adjustments in a time and manner determined appropriate (Social Security Act Sec. 1895(b)(3)(D)). CMS should seriously consider the access issues discussed above and take time to stabilize the home health benefit before proceeding to suggest further cuts. CMS can and should assess the impact of cuts, and keep year-over-year reductions minimal, to prioritize restoring access to home health rather than striving to impose cuts as quickly as possible. Without a moderated approach, the impact of 2024 payment cuts will be detrimental, as discussed further below.

## III. The Home Health Prospective Payment System

The Partnership supports Medicare payments that are accurate, predictable, and support access to high quality home healthcare. However, we are very concerned that CMS' proposal for a further significant permanent reduction to the 30-day home health payment rate and future additional temporary reductions outlined in the CY 2024 Proposed Rule are in significant conflict with these goals. The payment reductions applied by CMS for CY 2023 are already having a significant impact on care delivery. The additional cuts proposed for CY 2024 will have devastating consequences for both patients and providers. Furthermore, as the analysis in Section II (above) demonstrates, these payment reductions are already impacting access to care for Medicare beneficiaries under an already fragile Medicare home health benefit. In the interest of ensuring a viable home health benefit for Medicare beneficiaries, we urge CMS not to finalize these proposed reductions.

CMS implemented the PDGM in CY 2020. 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 original -4.36 percent behavioral adjustment and the current (CY 2023) -3.95 percent permanent adjustment in the CY 2024 rates; (2) implement a new permanent adjustment of -5.65 percent (total -9.36 percent in permanent adjustments) that results in a significant permanent rate reduction; and (3) advance future temporary adjustments in the payment rates for CY 2020, CY 2021, and CY 2022 totaling negative $3.5 billion. Together, the Partnership estimates the current and future payment adjustments will reduce payments by $25 billion over a 10-year period between 2020 and 2029 stripping critical resources from providers that are needed for patient care. This total reflects the cumulative impact of the -4.36 reduction due to assumed provider behaviors implemented in CY 2020, the cumulative impact of the permanent adjustment for CY 2023 and CY 2024 (as

proposed), and a $4.1 billion reduction due to the temporary reductions to reconcile CY 2020, CY 2021, CY 2022 and projected CY 2023 aggregate payments.

As we explained in comments to the 2023 proposed rule[5] as summarized below, the Partnership finds that these payment reductions are technically flawed and not legally supported. More worrisome, as CMS continues to apply its methodology, which relies on an obsolete and far less accurate payment system to set a ceiling on current and future payments, these rate reductions appear to increase with CMS' analysis of each successive year of data creating a downward spiral in reimbursement impacting patient care access. As a result, these policies are increasingly degrading this important Medicare benefit and causing financial harm to providers while undercutting patient care and quality at a time when in-home care is an essential and increasingly preferred option for many patients, families, and dedicated caregivers.

In addition to the significant reductions in payment applied in this and recent rules, other aspects of the home health payment system and proposed changes are causing disparate and adverse impacts on providers which have the effect of magnifying the -5.65 percent cut to the 30-day payment rate. These include a home health market basket which fails to reflect the rising costs of providing care, particularly for labor as staff shortages continue; changes in case-mix weights and functional scoring which penalize providers treating the sickest patients; and the lower labor-share and wage index changes from CY 2023. Finally, CMS' failure to address significant projection errors in the market basket forecasts underlying the 2021 and 2022 payment rates means that home health providers have effectively incurred another payment cut of -5.2 percent creating enormous financial challenges in the current and evolving economic environment.

In short, the steep cuts and high degree of uncertainty around reimbursement year to year makes it very difficult for home health providers to operate in the current environment and labor market and effectively care for their patients. The Partnership urges CMS to withdraw its proposal for further permanent adjustments to reduce payments in CY 2024.

1. Permanent and Temporary Adjustments

The Partnership recognizes that CMS is required by law 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 or considered the impact its policies have on patient care and the viability of the Medicare home health benefit. The agency's approach has resulted in a significant cut in payment for CY 2023 and a new proposal for further steeper cuts in CY 2024 making payment levels far lower than what the law requires and was contemplated by the Congress.

[5] Comments of the Partnership for Quality Home Healthcare to 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, Submitted August 16, 2022.

*a. Background*

The Social Security Act (the Act)[6] 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 Act[7] 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 HH 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 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 law[8] requires the Secretary to eliminate the use of therapy thresholds in the case-mix system for CY 2020 and beyond.

*b. Legal and Policy Concerns of the Partnership*

The Partnership maintains its belief, as expressed in comments to the CY 2023 home health rulemaking, that CMS' 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 does not align with the requirements of the statute or its intent to ensure budget neutral payment rates. As we stated in comments to the 2023 proposed rule, 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, 2021, and now 2022 claims payments to establish an artificial target amount or ceiling 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

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[6] Section 1895(b)(3)(A) of the Social Security Act.

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

[8] Section 1895(b)(4)(B)(ii) of the Social Security Act.

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.

We refer the agency to the detailed legal analysis of CMS' proposal associated with the CY 2023 home health proposed rule prepared by King & Spalding and attached to our comments to the CY 2023 home health PPS proposed rule (as referenced above). This legal analysis concludes that CMS' proposals on both permanent and temporary adjustments are unlawful and violate specific statutory commands. Below we provide a summary of key legal deficiencies of CMS' methodology which include[9]:

- The Secretary's final rule violates Congress's statutory commands and substitutes the Secretary's own policy preferences for those of Congress. *First*, although the rule purports to implement Congress's instruction to measure the difference on aggregate expenditures of assumed and actual behavior changes, the final rule does not measure either assumed or actual behavior changes at all, and it certainly does not calculate the difference of their impact on aggregate expenditures. *Second*, although Congress instructed the Secretary to redistribute aggregate expenditures and hold its change budget neutral, the final rule unlawfully rebases home health payment rates to reduce overall expenditures. *Third*, although Congress commanded the Secretary to remove therapy as a factor in determining payment rates, the final rule ties the payment adjustment to the amount of therapy actually provided.

- Instead of ensuring budget neutrality and accepting Congress's constraints on the new payment methodology to redistribute expenditures away from therapy and to ensure an approach to care that focuses on all of the patient's clinical needs, the Secretary's final rule cuts payments because home health agencies have predictably provided fewer therapy sessions. In taking this approach, the final rule violates the Medicare statute's plain language and arbitrarily and capriciously sets payment rates at a level that will result in substantial financial harm to numerous home health agencies across the country.

Based on this analysis, the Partnership continues to believe that CMS' approach to determining both permanent and temporary adjustments is not legally sufficient. We urge CMS to withdraw its proposals included in last year's CY 2023 rulemaking and the current CY 2024 Proposed Rule for both permanent and temporary adjustments and develop and propose a new methodology that aligns with statutory requirements.

*c. Technical Concerns with CMS' 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 briefly reiterate technical comments and concerns on

[9] Complaint filed in National Association of Homecare & Hospice v. Becerra in U.S. District Court for the District of Columbia, Case 1:23-cv-01942, Filed 07/05/23.

the agency's proposed approach. These comments and concerns were detailed in the report by Dobson| DaVanzo attached to the partnership's comments to the CY 2023 home health proposed rule (as referenced above).

To assess whether the PDGM 30-day budget neutral payment amount for CY 2020, CY 2021, and CY 2022 maintained budget neutrality with the implementation of PDGM, CMS analyzed 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. CMS' approach was to analyze the data to determine if the CY 2020, CY 2021, and now CY 2022 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.

CMS' methodology relies entirely on a simulation of payments under the pre-PDGM system using partial claims data from the most current year under the PDGM system. This is an approach that 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 system accurately and without a high level of estimation error is not reasonable.

CMS clearly recognized this challenge in the fiscal year (FY) 2023 Skilled Nursing Facility (SNF) PPS Final Rule[10], where it used 2019 data (from prior to the introduction to a new payment model) to address similar issues to avoid what the agency termed an "underestimation" of payments under the PDPM and avoid what CMS termed an "overcorrection". Yet for home health payments, CMS finalized an approach resulting in this same underestimation and overcorrection based on a statutory interpretation that is itself flawed, as discussed previously.

Other key technical concerns include:

- ***Therapy Visits:*** The flaws in CMS' methodology are most obvious and impactful 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 and change in distribution in the volume of therapy visits. Therefore, CMS' use of CY 2020 and CY 2021 data to estimate what payments would have been without the implementation of PDGM is fundamentally flawed as the data CMS uses reflects the effects of PDGM not the absence of it. This is likely also true for 2022. CMS acknowledges and corrects for this methodological flaw for a similar budget neutrality methodology addressed in the FY 2023 SNF PPS Proposed and Final Rule where CMS states:

[10] 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).

> *"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."*

The Partnership also questions why CMS did not make behavioral assumptions about therapy utilization in the original CY 2020 regulations for PDGM. 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 therapy volume is a factor that has no impact on case-mix and aggregate payments under PDGM and thus was not relevant to a determination of budget neutrality under the law. That is, CMS only focused on behavioral assumptions that related to potential increased payments (i.e., Low Utilization Payment Adjustments (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.

- ***Accepted Diagnosis Items:*** Under PDGM, roughly 40 percent of the diagnoses previously allowed for under the former 60-day payment system are not accepted as primary diagnoses. This systematic change likely impacted the coding behavior of providers under the new system, ultimately leading to an inaccurate simulation by CMS of the clinical domain under the 60-day payment system using CY 2020, 2021, and now 2022 data. 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.

- ***Early v. Late Visits:*** Due to 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, 2021, and 2022 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.

- ***Missing OASIS Items:*** 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.

All of the above points reveal the absurdity of CMS' approach where each analytic point acts cumulatively to show how the CMS assumptions of budget neutrality compound to work against home health providers as opposed to addressing the budget neutrality of the new payment system.

The most concerning aspect of CMS methodology is that each time CMS has applied it to a new year of data it results in additional cuts in reimbursement in the form of permanent and temporary adjustments. This outcome is not surprising given CMS is essentially applying an artificial ceiling on the payment rate under PDGM based on an obsolete and far less accurate payment system that for each passing year reflects less the incentives and clinical treatment patterns that CMS itself wanted to advance through its implementation of PDGM. As shown in Table 7 below, the annual growth in the permanent adjustment has been significant.

**Table 7: Annual Percent Increase in Permanent Adjustment**

| Calendar Year | Adjustment |
|---|---|
| 2020 | -6.52 |
| 2021 | -7.85 |
| 2022 | -9.36 |

It is evident that the payment reductions resulting from this disconnect between PDGM and the former pre-2020 payment model in establishing a ceiling on the rate will only become more acute with each year. In addition, as many providers feel the impacts of the reductions in CY 2023 and as proposed in CY 2024, they will be forced to make changes in care delivery to continue operating. As a result, the level of cuts will only accelerate in response to the agency's circular approach. Compounding this, the percentage increase of the temporary adjustments applied in fee-for-service (FFS) will be pushed higher as Medicare Advantage assumes a greater portion of the total Medicare population. Given that CMS expects to apply this methodology through the CY 2026 data year and make reductions well beyond that given the data lag, the future of the home health benefit is highly uncertain. This approach promises to quickly degrade this critical Medicare benefit to a point where patients' access to the type of in-home skilled care and services previously available may no longer be possible.

*d. Partnership Recommendation*

CMS' proposed additional permanent adjustment of negative -5.65 percent, bringing the total permanent adjustment applied to the home health 30-day payment rate to negative -9.36 percent, 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 FFS and Medicare Advantage (MA). The unprecedented magnitude of these reductions and the uncertainty and instability they create cannot be simply absorbed by home health providers without an impact on patient care and access.

Given the legal and technical deficiencies summarized above, and the significant adverse impact on providers and patients, the Partnership recommends that CMS withdraw its proposal and not apply any proposed or previously applied permanent adjustments to the home health payment rates in CY 2024. CMS should review the law and propose a new methodology that aligns with the statutory requirements. In addition, as a general policy matter, the Partnership believes

CMS should never apply steep cuts in the Medicare program in a single year, but rather phase-in over many years.

2. Annual Payment Rate Update for CY 2024

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. Home health providers continue to face challenges with staffing shortages and a dramatic increase in the cost of labor and other resources necessary to deliver care to our patients. However, annual increases to the home health payment rates in recent years, which are based on forecasts of the home health market basket, have not kept pace with cost increases. In addition, CMS' forecasts of the market basket have been woefully inaccurate in the recent past resulting in a negative -5.2 percent forecast error for 2021 and 2022 according to the agency's own data. This is effectively another cut in reimbursement as dramatic cost increases in those years have not receded.

The significant increase in providers' costs and the inaccuracy of recent updates compounds the intense financial pressure that providers are experiencing and impacts access to care for patients. CMS' proposal to further reduce the 30-day payment amount by -5.65 percent (total negative permanent adjustment of -9.36 percent) eliminates any benefit from the proposed annual payment update to address these escalating costs and current workforce and other challenges. Finally, we note that the shortfalls created by the annual payment updates are cumulative over time, exacerbating the financial instability that home health providers face one year to the next.

The law[11] 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 +2.7 percent. This increase reflects the effects of a 3.0 percent market basket increase minus a -0.3 percent productivity adjustment. However, the net impact related to the changes in payments under the HH PPS for CY 2024 is estimated to be negative -$375 million (or -2.2 percent) due to other policies and a permanent adjustment which offsets this increase. We also note that the CY 2023 30-day payment amount of $2,010.69 decreases to $1,974.38 in CY 2024 under the Proposed Rule.

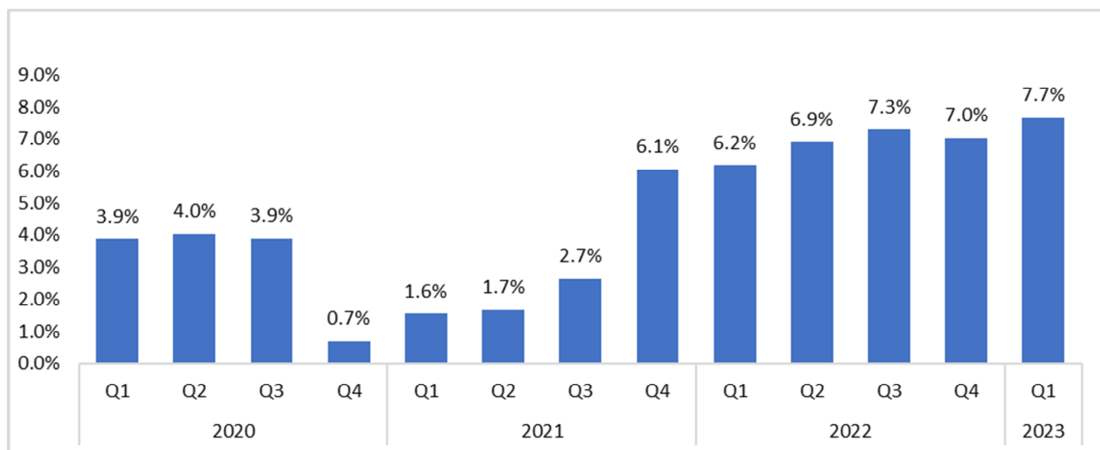
As noted above and in our comments to the CY 2023 home health proposed rule, the Partnership continues to be concerned that the market basket and annual update factors in recent years do not align with increases in home health providers' staffing costs and other costs

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

of care. While inflation is not at the unprecedented levels of 2022, The recent 12-month average of the consumer price index (CPI-U) (minus energy and food) through June 2023 measures at 4.8 percent[12], a level well above the market basket rate of growth of 3.0 percent (or payment update of 2.7 percent) for CY 2024.  Our reading of the available economic data is that it is not clear at this point if inflation will rise or fall going forward. If so, this sets up a continued round of underestimates going forward compounding our concerns expressed above.

As detailed in Table 8 below, Bureau of Labor Statistics (BLS) data on recent growth in wages for nurses, a critical component of the home health clinical team, shows a wage inflation rate for nurses of 7.66 percent for the first quarter of 2023, continuing a trend of high wage growth in recent years well in excess of the home health market basket.

**Table 8[13]: Quarterly Growth (Year-over-Year) in Nursing Staff Hourly Wages, 2020-2023**




*Source Analysis of BLS data by Dobson| DaVanzo*

Some of the Partnership's members have reported annual wage increases of 10 percent to be competitive in the labor market.  An annual update factor of 2.7 percent for CY 2024 does not reflect the higher wage growth which has characterized the current labor market, nor does it reflect the federal government's own data on wage growth presented above.

The disconnect between the annual update and actual price growth is exacerbated by increased demand for services resulting from staffing shortages, staff turnover from employer competition, and burnout. To address this, our members continue to increase hourly rates and offer competitive compensation through various incentives such as signing bonuses, performance bonuses, tuition assistance, and student loan payments.

[12] Bureau of Labor Statistics, https://www.bls.gov/news.release/pdf/cpi.pdf.

[13] Bureau of Labor Statistics:  https://www.bls.gov/oes/current/oes291141.htm.

*Recommendation:* The Partnership recommends that CMS apply the annual update factor based on the market basket for CY 2024, however, we urge CMS to do more to ensure that this important feature of the PPS more accurately reflects price trends and the cost of providing care.

3. Forecast Error in the Home Health Market Basket

As discussed above, CMS' forecasts of the market basket, which are used to annually update the home health payment rates, have significantly under-estimated actual price growth in the recent past. The forecast error of negative -5.2 percent for the 2021 and 2022 annual updates effectively acts as another cut in reimbursement for home health providers as the cost of providing care remains high. The Partnership believes that CMS should correct for this error in home health payments going forward in CY 2024 to ensure accurate rates that reflect the true cost of care.

Public data[14] from CMS' Office of the Actuary demonstrates that the actual price inflation experience in the market was not reflected in the forecasts of the market basket updates applied for home health payments in CYs 2021 and 2022. Historically, the market basket forecasts used by CMS to update home health payments have been relatively accurate over time, however, the more recent volatility in the economy and unprecedented surge in labor costs during 2021 and 2022 was beyond what CMS' forecast methodology could accurately account for. As shown in the table below, the forecast error in the home health market basket for CYs 2021 and 2022 resulted in a shortfall in the annual payment rate updates for those years of 5.2 percent. Though not yet final, we note that the latest CMS forecast data for CY 2023 is already showing an under-estimate of -0.4 percent indicating a further deterioration of home health payments this year.

**Table 9: Market Basket Forecast Error in CY 2021 through CY 2022**

| MB Forecast Error Impact | CY 2021 | CY 2022 | Cumulative |
|---|---|---|---|
| Actual Market Basket | 4.1% | 6.3% | 10.7% |
| HH PPS Projected Market Basket (Used in Final Rules) | 2.3% | 3.1% | 5.5% |
| **Difference** | **1.8%** | **3.2%** | **-5.2%*** |

*Actual cumulative compounded forecast error over the two-year period, *Source: Dobson| DaVanzo*

The Partnership encourages CMS to consider methods to better ensure the accuracy of its market basket forecasts for future updates so that payment rates more accurately reflect the rising costs of care delivery. We also believe that there should be more transparency regarding

[14] Available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata.

the forecast methodology. While the technical details regarding structure and composition of the market basket are described fully by CMS, the methodology behind the forecast that is actually used to annually update payments is opaque. This forecast methodology would benefit from increased transparency and stakeholder input.

With respect to CY 2021 and CY 2022, we believe the unprecedented magnitude of the forecast error over these two years warrants special consideration to avoid significant long-term underfunding of the home health benefit and to help address current workforce challenges and rising labor costs. As shown in Table 10 below, the forecast error associated with these two years results in an approximately $11 billion underpayment by Medicare over a ten-year period. We ask that CMS use its authority to implement a one-time forecast error correction for 2021 and 2022 to account for the significant shortfall in those years. This correction would be applied to CY 2024 payment rates based on the best available data at the time of the final rule.

**Table 10: Projected Impact of 5.2 Forecast Market Basket Error in CY 2021 through CY 2030**

| Total Payments | Impact of CY 2021 and CY 2022 Forecast Error |
|---|---:|
| 2021 | -$285,512,085 |
| 2022 | -$867,452,091 |
| 2023 | -$871,874,624 |
| 2024 | -$1,115,186,361 |
| 2025 | -$1,161,316,235 |
| 2026 | -$1,225,352,343 |
| 2027 | -$1,273,931,221 |
| 2028 | -$1,342,554,653 |
| 2029 | -$1,394,931,985 |
| 2030 | -$1,449,139,655 |
| **Total** | **-$10,987,251,254** |

*Source: Dobson | DaVanzo*

We note that CMS has applied a forecast error correction policy in Medicare previously, most notably for SNF payments in FY 2004 where the policy was adopted in large part because prior updates (FYs 2000 through 2002) did not reflect unexpectedly higher labor expenses. The cumulative shortfall in the SNF updates preceding the implementation of the policy was 3.26 percent, significantly less than the current 5.2 percent shortfall for home health providers in these two years.

We recognize that the forecast correction policy for SNFs is a permanent policy. However, we believe that efforts by CMS to refine their forecast methodology in the future, and application of a one-time correction to account for the significant forecast error in CYs 2021 and 2022, will help address both short and long-term concerns related to the underfunding of home health payments. The additional funding levels will help providers to hire and retain staff and be competitive in their local labor markets with hospitals, nursing homes, and even non-health care employers. More importantly, such a policy will support improved access to care as Medicare's

payments will more accurately reflect the current costs of these critical in-home services which millions of beneficiaries depend on each year.

*Recommendation:* The Partnership recommends that CMS finalize a one-time forecast error correction to account for the underestimates of the market basket for CYs 2021 and 2022. This correction would be applied to CY 2024 payments. We also recommend that CMS explore options to improve the accuracy of its forecasts and make its current forecasting methodology transparent to the public.

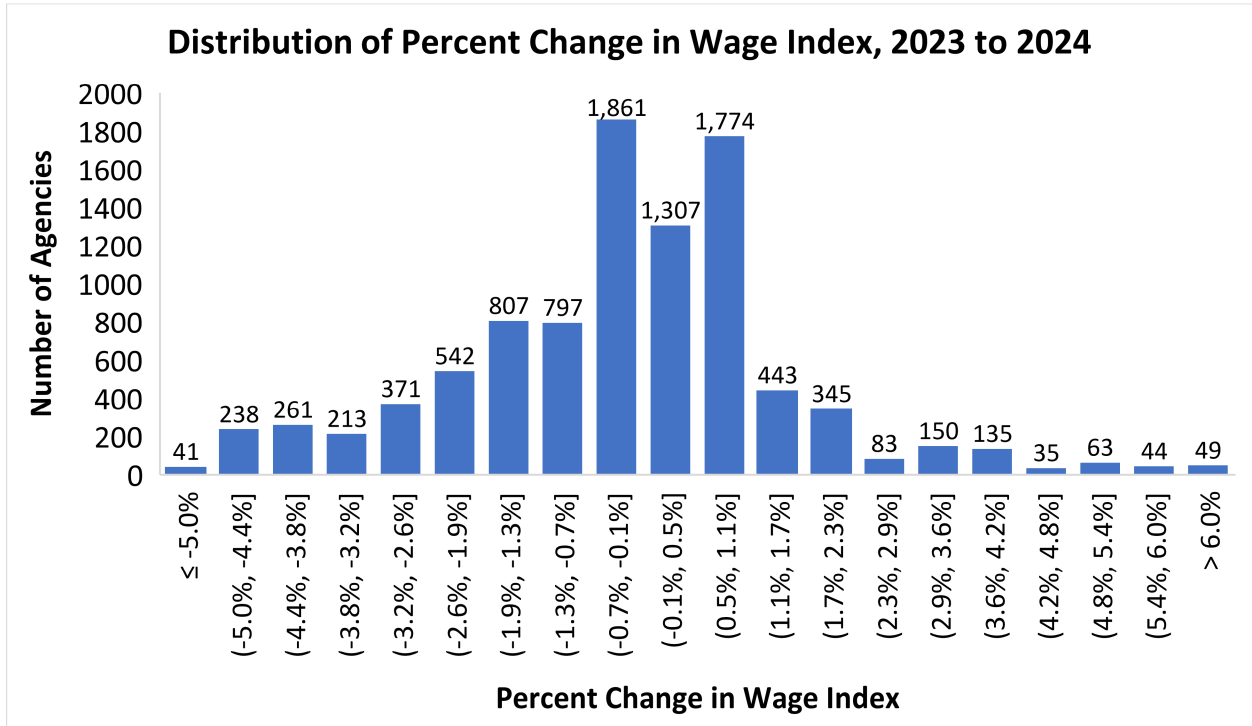
4. Wage Index / Labor Share

The Partnership believes that the wage index should be updated annually to reflect the most recent data on geographic wage differences across the country. However, we are concerned that the proposed wage index changes from CY 2023 to CY 2024, combined with the decrease in the labor share, results in substantial payment variances and a far greater impact on home health providers than in past years. The cumulative effect of these changes and the proposed permanent adjustment of negative -5.65 percent only magnify this adverse impact.

For CY 2024, CMS proposes to base the HH PPS wage index on the FY 2024 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2019, and before October 1, 2020 (FY 2020 cost report data). Based on existing regulations, the proposed CY 2024 HH PPS wage index would not take into account any geographic reclassification of hospitals but would include the 5-percent cap on wage index decreases established in the CY 2023 HH PPS final rule. In addition, the labor share of the payment rates for CY 2024 is proposed to be 74.9 percent (reduced from 76.1 percent) based on the rebasing of the market basket cost weights using cost report data from 2021.

The distributional effects of these proposed changes for CY 2024 are significant and stand in contrast to prior years. These payment reductions create hardship for all providers. For a large number of providers, the reduction in payment is even more severe and exacerbates the financial challenges associated with the proposed permanent adjustment of negative -5.65 percent. Table 11 and 12 below detail the impact of the proposed updates to the wage index and for CY 2024 showing the large number of providers facing significant negative impacts.

**Table 11**



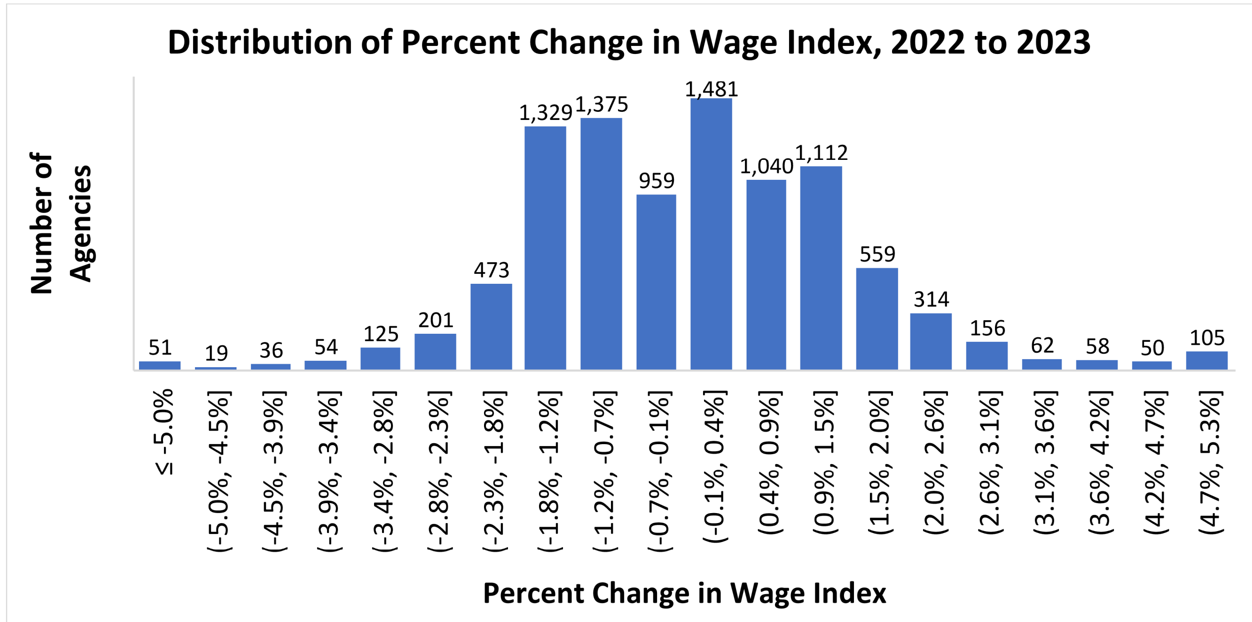

*Source: Dobson| DaVanzo*

**Table 12: Home Health Providers Significantly Impacted by Wage Index Change in CY 2024***

| Count | Number | Percent |
|---|---|---|
| Number of HH Providers with change >/= -5.0% & < -4.4% | 601 | 6.3% |
| Number of HH Providers with change >/= -5.0% & < -2.0% | 4,815 | 50.4% |
| Total Number of Agencies | 9,559 | **** |

*Source Dobson| DaVanzo*

**Table 13**




*Source: Dobson| DaVanzo*

**Table 14: Home Health Providers Significantly Impacted by Wage Index Change in CY 2023**

| Count | Number | Percent |
|---|---|---|
| Number of HH Providers with change >/= -5.0% & < -4.4% | 73 | 0.8% |
| Number of HH Providers with change >/= -5.0% & < -2.0% | 735 | 7.7% |
| Total Number of Agencies | 9,559 | **** |

*Source Dobson| DaVanzo*

In contrast to CY 2024, Table 13 and Table 14 show the impact of the wage index change finalized in last year's (CY 2023) final rule. As can be seen from the tables, the changes (and associated payment impact) are significantly more impactful in this year's CY 2024 Proposed Rule compared to CY 2023 with thousands more providers facing material decreases in wage index values. The substantial decreases in payments for so many providers under this year's proposed wage index update is a concern for the Partnership, particularly as it is applied on top of the -5.65 percent permanent adjustment pushing payments to unsustainable levels for these providers.

We also question whether the 2020 cost report data, collected during the first year of the COVID-19 pandemic is accurate and adequately reflects current relative labor costs given the unique nature of that period. While we understand that this data is audited by CMS, we suggest that CMS validate the data for aberrant year to year trends that may be distorting the wage index values.

*Recommendation:* Given the significant adverse impact of the CY 2024 wage index update on a large component of the home health provider community, the Partnership recommends that CMS not apply the permanent adjustment in CY 2024 to avoid the cumulative effect of multiple reimbursement cuts that will only harm patient access and care delivery. In addition, we recommend that CMS validate the 2020 cost report wage data collected during the pandemic to ensure it does not reflect aberrant trends.

5. 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 2024 using data from 2022 to ensure that PDGM accurately reflects home health resource use. In general, the Partnership supports annual recalibration of the case-mix weights to ensure payments reflect current trends in care delivery and are as accurate as possible.

However, like the wage index update discussed above, we are concerned that the proposed changes from CY 2023 to CY 2024 to the case mix weights and functional scoring, results in substantial payment variances and has a significant financial impact on many providers. The cumulative effect of these proposed changes, along with the wage index update, and the proposed permanent adjustment of -5.65 percent will have devastating consequences for many home health providers and the patients they serve.

In the Proposed Rule, CMS explains that annual recalibration of the PDGM case-mix weights ensures that the case-mix weights reflect, as accurately as possible, current home health resource use and changes in utilization patterns. To generate the proposed recalibrated CY 2024 case-mix weights, CMS used CY 2022 home health claims data with linked OASIS data (as of March 17, 2023). According to CMS, these data are the most current and complete data available at the time of the Proposed Rule, though CMS notes that the proposed recalibrated case-mix weights will be updated based on more complete CY 2022 claims data for the final rule.

In reviewing the proposed recalibrated case-mix weights and functional scoring, a number of Partnership members have projected steep declines in payment, particularly those that provide care to a high acuity patient population. For various patients falling into certain PDGM classification categories, the changes in the case-mix weights result in significantly lower payments, especially given the cumulative effects of other proposed changes to the HH PPS. Similarly, proposed changes to the functional scoring result in much lower payments for many cases compared to CY 2023.

Importantly, the cumulative effect of these routine adjustments will have a major impact on payment for specific types of patients, including those with the most acute care needs. For example:

1. For an 87-year-old stroke patient in the Cape Girardeau Missouri/Illinois metropolitan statistical area (MSA) with a high level of functional impairment and multiple chronic conditions falling into the PDGM “Neuro Rehab” category, payments will decline by 6 percent from CY 2023 to CY 2024. From CY 2022 to

CY 2024, when CMS first applied the permanent adjustment of -3.95 percent, payment for this patient will decline by a full 11 percent.

2. For a 90-year-old patient with a hip fracture in the Philadelphia, Pennsylvania MSA requiring significant multidisciplinary rehabilitation therapy, having a high level of functional impairment, and diabetes falling into the PDGM "MS rehab" category, payments will decline by -4.8 percent from CY 2023 to CY 2024. From CY 2022 to CY 2024, payment for this patient will decline by -8.4 percent.

These are only two of numerous examples of such stark changes across the PDGM classification system and various MSAs. We are very concerned that, while PDGM was intended to provide incentives to care for those with the most acute needs, the changes in the proposed rule will have the opposite effect.

The example above illustrates how the effects of multiple routine updates proposed by CMS for CY 2024 exacerbate the proposed permanent adjustment of -5.65 percent and will impact both home health providers and patients. The steep declines in payment for certain case mix categories (HIPPS codes) associated with complex resource intensive and other patients will serve to negatively impact access to care for those that need it the most.

CMS' high level impact analysis showing an aggregate -2.2 percent decrease in payments does not in any way convey the substantial adverse impact that the Proposed Rule will have on large portions of the provider community, different geographic areas, and patients needing care in the home. To demonstrate a more accurate picture of the effect of this Proposed Rule, we have provided a detailed analysis in the following section.

*Recommendation:* The Partnership supports recalibration of the case-mix weights using updated data, however, the Partnership recommends that CMS not apply the permanent adjustment in CY 2024 to avoid the cumulative effect of multiple reimbursement cuts that will only harm patient access and care delivery.

6. Financial Impact of CY 2024 Payment Changes

As discussed above, in addition to the significant reductions in payment proposed in this Proposed Rule and already applied by the CY 2023 final rule, other aspects of the home health payment system and proposed changes are causing disparate and adverse impacts on providers which have the effect of magnifying the cuts to the 30-day payment rate. These include a home health market basket which fails to reflect the rising costs of providing care, particularly for labor as staff shortages continue; changes in case-mix weights and functional scoring which penalize providers treating the sickest patients; and the lower labor-share and wage index changes for CY 2024. Unfortunately, the impact analysis presented in the Proposed Rule relies solely on broad averages that do not show the full extent of the harm resulting from the proposed policies.

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 2024 is estimated to be -$375 million (-2.2 percent). The $375 million decrease in estimated payments for CY 2024 reflects the effects of the proposed CY 2024 home health payment update percentage of 2.7 percent ($460 million increase), an estimated 5.1 percent decrease that reflects the effects of the permanent behavior adjustment ($870 million decrease) and an estimated 0.2 percent increase that reflects the effects of an updated outlier fixed dollar loss threshold ($35 million increase). We note that the CY 2023 30-day payment amount of $2,010.69 decreases to $1,974.38 in CY 2024 under the Proposed Rule policies.

CMS' analysis of the aggregate impact of the Proposed Rule raises concerns for the Partnership because its reliance on 2022 claims data provides a static view of provider case-mix and other factors critical to assessing its impact. We note that, with the data in its information management systems, HCHB has estimated the impact of the Proposed Rule to be -2.66 percent[15] based on more recent claims from CY 2023. By CY 2024, when the additional proposed reductions apply, the actual aggregate impact may be even higher.

In addition, CMS' impact analysis addresses average payment changes across broad classes of home health providers. However, it fails to show the extent of the downward impact on payments and re-distributional effects that will adversely impact thousands of home health providers in CY 2024 under the Proposed Rule. Below and in the attached report from Dobson| DaVanzo, the Partnership provides data detailing the harmful effects of these proposals on home health providers. Tables 15 through 18 include the following data based on analysis of 2022 home health claims.

- Table 15 shows the range of payment impacts across home health care providers for CY 2024 resulting from the Proposed Rule.

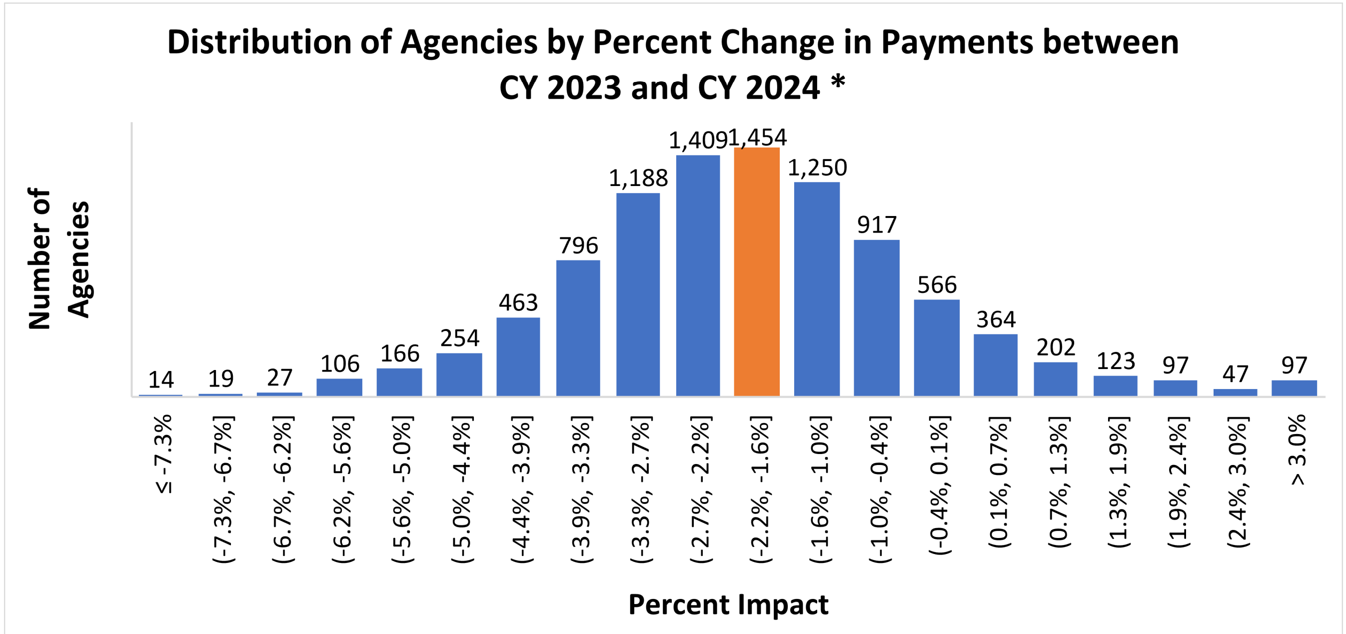
- Table 16 provides the average payment impact by state.

- Table 17 shows the average payment impact for the ten states with the highest percent reduction in payments. It also provides detail for the range of provider level payment impacts within those ten states.

- Table 18 provides a simple count of providers above and below the average Impact of the Proposed Rule.

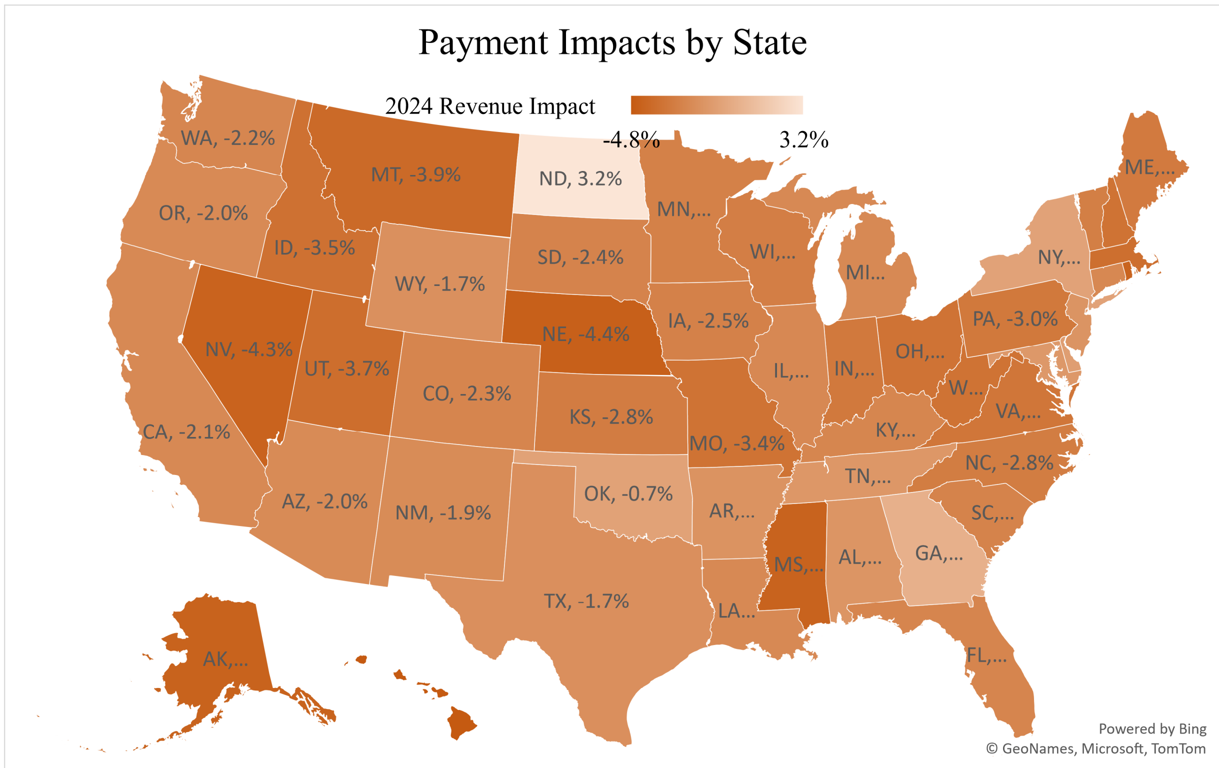
[15] Homecare Homebase, LLC, Modeled Overall Impact of Proposed Rule, July 2023.

**Table 15**




*Source: Dobson| DaVanzo*

**Table 16**




*Source: Dobson| DaVanzo*

**Table 17: Top 10 states by Highest Percent Reduction in CY 2024 Payments**

| State | Number of HHAs | Percent Impact of 2024 Proposed Payments | Range of Agency Impacts (min-max) | Range of Agency Impacts (5th - 95th percentile) |
|---|---|---|---|---|
| HI | 12 | -4.8% | -7.1% , -3.7% | -6.5% , -3.8% |
| NE | 62 | -4.4% | -6.6% , 1.2% | -5.9% , -2.3% |
| AK | 14 | -4.3% | -5.1% , -2.6% | -4.9% , -2.8% |
| MS | 43 | -4.3% | -5.3% , -2.6% | -5.1% , -3.3% |
| NV | 162 | -4.3% | -6.8% , 0.0% | -5.7% , -2.0% |
| RI | 21 | -4.2% | -4.7% , -0.5% | -4.6% , -2.6% |
| MT | 23 | -3.9% | -4.8% , -1.5% | -4.8% , -2.2% |
| UT | 86 | -3.7% | -6.5% , -1.2% | -5.2% , -2.2% |
| MA | 165 | -3.6% | -7.1% , 3.7% | -4.5% , 1.7% |
| ID | 47 | -3.5% | -5.2% , -2.1% | -4.4% , -2.3% |
| **All HHAs** | **9,559** | **-2.2%** | **-29.0% , 33.8%** | **-4.6% , 1.0%** |

*Source: Dobson| DaVanzo*

**Table 18: Providers Above and Below Average Impact of Proposed Rule**

| | | |
|---|---|---|
| Number of Providers Impact > -2.2% | 5,240 | 54.8% |
| Number of Providers Impact < -2.2% | 4319 | 45.2% |
| Total Number | 9,559 | *** |

*Source: Dobson| DaVanzo*

These data demonstrate the significant number of providers with substantial negative payment impacts far exceeding the average aggregate payment impact of -2.2 percent determined by CMS or impacts by broad classes of providers identified in the agency's impact analysis. They also show how the broad redistribution of payments between CY 2023 and CY 2024 combined with the large permanent adjustment significantly impacts many providers, including those in rural states. We caution that this analysis is based on CY 2022 Medicare claims data made available by CMS. Partnership members report more significant impacts based on their own modelling of available CY 2023 claims. In addition, analysis of payments (revenues) addresses only one side of the financial challenges facing providers as significantly higher costs for labor and other care resources intensify these challenges.

A -2.2 percent reduction is already not sustainable without impacting access to care, quality, and the very nature of the Medicare home health benefit. However, reductions across many states of between four and five percent on average, and for many providers approaching eight percent will mean that many will need to reduce service areas, curtail access and services, or leave the Medicare program. This not only impacts Medicare FFS patients but also those enrolled in MA and Medicaid. The Partnership encourages CMS to look beyond broad averages

and aggregate impacts in assessing the impact of its proposals for CY 2024. A more granular view of the payment impact provides a clearer picture of the harmful effects this Proposed Rule would have in CY 2024 if finalized.

Finally, while CMS is not proposing to implement temporary adjustments in CY 2024, we note our concern that CMS may apply such adjustments in future years. On top of the steep permanent adjustments already proposed or applied, these temporary adjustments would result in further severe reductions in payments to home health providers and harm to patient care and access. For example, the attached report from Dobson| DaVanzo estimates there are currently $4.1 billion in outstanding temporary adjustments including CY 2023. Were CMS to aggressively attempt to apply temporary adjustment to capture these dollars over just three years (CYs 2025, 2026, and 2027) it would need to apply an approximately -8.2 percent adjustment in those years in addition to the permanent adjustment. Pursuit of such a policy would clearly result in outsized reductions that would have extreme adverse effect on home health providers and patients.

*Recommendation:* CMS policy decisions should not be guided by an impact analysis that is based on broad averages that do not provide a realistic view of the impact on providers and patients. Based on the data presented on the ongoing deterioration of access in Section I, the payment impact analysis above detailing the wide-ranging cumulative and distributional effects of the proposed -5.65 percent permanent adjustment and various routine payment updates, and our standing legal and technical concerns, the Partnership reiterates its recommendation that CMS not finalize its proposal for a permanent adjustment in CY 2024 and eliminate the permanent adjustment applied for CY 2023. Additionally, the Partnership believes that CMS, as a matter of general policy, should implement steep cuts over a period of many years to mitigate destabilizing effects on providers and prevent patient harm.

## IV. Re-basing and Revising of the Home Health Market Basket

The Partnership supports periodic rebasing and revising of the home health market basket so that both the cost category weights, and the various price proxies or indices used to measure price growth accurately reflect the resource costs necessary to provide home health care. An accurate market basket is critical to ensuring providers' payments reflect the cost of care from year to year.

However, we are concerned that the recent dramatic growth in labor costs is not reflected in the cost report data used by CMS impacting the accuracy of the compensation cost weight and labor share. As we note above, we are also concerned that the methodology and data used by CMS does not reflect providers' experience with changes in costs of labor and other resource inputs. Finally, while we appreciate the detailed information published by CMS on the structure of the market basket, the data and methodology underlying the forecasts used to actually update payments for a calendar year is not similarly transparent.

For the CY 2024, CMS proposes to rebase and revise the home health market basket to reflect a 2021 base year using 2021 Medicare cost report data for Medicare-participating freestanding

home health providers. CMS notes that this is the most recent, complete set of Medicare cost report data available.

CMS proposes to rebase the cost weights, or base year for the structure of costs, from 2016 to 2021 without making any other major changes to the methodology. CMS is also proposing to revise its use of certain price proxies, particularly in the area of labor. Comparing results from the 2016 and 2021 based market baskets, the resulting historical and projected growth rates are very similar as shown in Table 19 below using data from the Proposed Rule.

**Table 19: Comparison of the 2016-Based Home Health Market Basket and the Proposed 2021-Based home health Market Basket, Percent Change 2019-2026**

| | 2016-based Home Health Market Basket | Proposed 2021-based Home Health Market Basket | Difference (Proposed 2021-based less 2016-based) |
|---|---|---|---|
| **Historical:** | | | |
| CY 2019 | 2.6 | 2.4 | -.02 |
| CY 2020 | 2.2 | 2.1 | -.01 |
| CY 2021 | 4.1 | 3.9 | -.02 |
| CY 2022 | 6.3 | 6.2 | -.01 |
| **Average (2019 to 2022)** | 3.8 | 3.7 | -.01 |
| **Forecast:** | | | |
| CY 2023 | 4.5 | 4.6 | .01 |
| CY 2024 | 3.1 | 3.0 | -.01 |
| CY 2025 | 2.9 | 2.8 | -.01 |
| CY 2026 | 2.8 | 2.8 | 0.0 |
| **Average (2023 to 2026)** | 3.3 | 3.3 | 0.0 |

*Source: Table B32 of the Proposed Rule, IHS Global Inc. 1st Quarter 2023 forecast with historical data through 4th Quarter 2022*

Given the relatively minor changes in price proxies and cost weights within an overall structure that is unchanged, it is not surprising that the resulting historical and projected growth rates are very similar between the 2016 and 2021 market baskets. The similar results between 2019 and 2022 offer little comfort, however, when the actual payment updates for this period were established based on forecasts that fell significantly short of actual price growth. As Table 20 below shows, CMS' forecasts underlying the annual payment rate updates were -3.9 percent below final actual price growth for this same period.

**Table 20: Market Basket Forecast Error Percent 2019-2026**

| | Payment Update/Forecast | Final/Actual Health Market Basket | Difference |
|---|---|---|---|
| CY 2019 | 3.0 | 2.6 | +0.4 |
| CY 2020 | 2.9 | 2.2 | +0.7 |
| CY 2021 | 2.3 | 4.1 | -1.8 |
| CY 2022 | 3.1 | 6.3 | -3.2 |
| **Total Difference +/-** | | | **6.1** |
| **Net Difference** | | | **-3.9** |

*Additive/non-compounded total difference, *Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata*

The Partnership understands that historically, forecasts of the market basket may be lower than actual for some years and higher for others, however, the significant forecast errors in 2021 and 2022 will not likely be offset for generations leading to a chronic underfunding of the benefit. We again encourage the agency to explore improvements in its methodology for forecasting the home health market basket and to make its forecasting methodology transparent to the public. It is concerning that this component of the PPS is opaque given its critical importance in establishing payments year to year.

Regarding CMS' proposal for revising and rebasing of the home health market basket, we are concerned with the accuracy of the updated compensation cost weight given its decline from 76.1 percent in CY 2023 to 74.9 percent in CY 2024. Partnership members have experienced the most dramatic cost growth in labor in recent years. As shown in Section III above, the BLS data shows wage growth for home health generally and nurses specifically to be growing at rates in excess of the home health market basket.

We are particularly concerned that the 2021 cost report data and resulting cost weight for compensation may not be accurate. This could be due to the fact that this data preceded the time period (in 2022) when much of that dramatic growth in labor costs occurred. It may also be due to inaccuracies in the underlying reported costs, including how providers reported contract labor costs (e.g., in the administrative and general cost center which would not be captured in the compensation cost weight or in direct salaries which would). If the reduction in the labor-related share is not accurate it will impact the accuracy of the market basket and annual payment updates. More importantly, it will inappropriately reduce payment rates in higher wage index areas that have some of the most competitive labor markets.

We suggest that CMS ensure the accuracy of the compensation weight and underlying 2021 cost report data, including ensuring that it is consistent with available 2022 data, to avoid distortions in payment. CMS should consider making adjustments to the cost weights prior to the next five-year periodic rebasing if it finds the 2021 cost data does not accurately reflect recent trends in the growth of labor costs relative to other costs.

*Recommendation:* The Partnership recommends that CMS ensure the accuracy of the compensation cost weight before finalizing its proposal to rebase and revise the home health market basket. In addition, we again recommend that CMS explore improvements in its methodology for forecasting the home health market basket and make that methodology transparent to the public.

## V. Home Health Quality Reporting Program (HH QRP)

In the Proposed Rule, CMS proposes to adopt two measures and remove one existing measure. It proposes to remove two OASIS items and proposes to begin public reporting of four measures in the HH QRP. Furthermore, CMS proposes to close gaps in health equity and to codify its 90 percent data submission threshold policy. In general, the Partnership does not object to these proposals, but with further elaboration below we discuss our particular concerns with adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date, beginning in 2025.

Before then, however, the Partnership notes its appreciation that CMS recognizes the value of home health care in improving quality and concurs with this specific statement in the preamble:

> "Home health care can positively impact functional outcomes. There is evidence the provision of home care services can lead to statistically significant improvements in function and successful discharge into the community…. Home health services, delivered by a registered nurse positively impacted patient Quality of Life and clinical improvement in dressing lower body and bathing activities of daily living, meal preparation, shopping and housekeeping and instrumental activities of daily living."[16]

The Partnership does not object to the adoption of the Functional Discharge Score (DC Function) measure starting in 2025 for all the reasons CMS explains in its discussion, including that "home health can … provide valuable information in determining treatment decisions throughout the care continuum, the need for therapy service, and discharge planning, as well as provide information to consumers about the effectiveness of care delivered."[17] We share CMS' view that "functional status can serve as a vital component in informing the provision of health care and thus indicate home health quality of care."[18] And we also agree with measure testing results indicating that the DC Function measure captures the most probable determination of actual outcomes based on the directionalities and strengths of correlation coefficients detailed in CMS Table C2.[19]

The Partnership further supports removal of the "Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That

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[16] 88 *Fed. Reg*. 43,725 (July 10, 2023).

[17] *Id*. at 43,726.

[18] *Id*. at 43,726 and 43,727.

[19] *See Id*.

Addresses Function" measure from the 2025 QRP. Like CMS, the Partnership believes the proposed DC Function measure better measures functional outcomes than the current Application of Functional Assessment/Care Plan measure.

But the Partnership cannot support adoption of the requirement for HHAs to report OASIS assessment data for the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date beginning in 2025.

Partnership member companies remain in full compliance with CMS' omnibus staff vaccination requirements and actively promote vaccine adoption. We understand the protective value provided by COVID-19 vaccines and boosters, especially in older and more vulnerable populations like those we serve. Further, we believe the measure would play a laudable role in facilitating patient care and care coordination during the discharge planning process.

However, the burden of investigating, documenting and reporting on this measure should not fall on the HHA. If finalized as proposed, CMS would essentially be outsourcing the policing and compliance of patient vaccination statuses to HHAs. This is a role and function that more properly resides with the patient's primary care physician (PCP). HHAs, through QRP measures and already lengthy OASIS information collection requirements, cannot serve as CMS' eyes and ears on every aspect of the patient's clinical experience, especially on vaccine status information that resides elsewhere in the patient's care continuum.

Other health care providers, in particular the patient's PCP, who is more likely to have current medical record and vaccination status information, are far better positioned to report to CMS on an individual patient's vaccination status than an HHA. Accordingly, we urge CMS to withdraw its proposal to require HHAs to report OASIS assessment data for the COVID-19 vaccine. We do support, however, CMS' proposals to remove two OASIS items no longer necessary for collection, the M0110 – Episode Timing and M330 – Therapy Needs items.

The Partnership does not object to CMS' proposal to begin public reporting and display of the (1) Transfer of Health (TOH) Information to the Provider – Post Acute Care (PAC) Measure (TOH-Provider) and (2) Transfer of Heath (TOH) Information to the Patient – Post Acute Care (PAC) measure (TOH-Patient) assessment-based measures.

Finally, with respect to the QRP, the Partnership does not object to the proposal to apply the 90 percent threshold requirements established in the CY 2016 HHA PPS rule to the submission of standardized patient assessment data, since this is essentially a restatement and codification of current practice and regulation.

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

As the Partnership has noted to CMS and to the public, it remains supportive and enthusiastic about CMS' expansion of the Home Health Value-Based Purchasing (HHVBP) Model to all 50 states, territories, and the District of Columbia. Furthermore, the Partnership does not object to CMS' proposals to replace certain measures, to change the weights of individual measures, or to update the Model baseline year to CY 2023 for all applicable measures in the proposed measure

set. Likewise, the Partnership supports CMS' proposal to add an additional opportunity to request a reconsideration of the annual Total Performance Score (TPS) and payment adjustment.

The Partnership also shares CMS' general approach to harmonization across quality improvement programs, and in particular its proposal to make the applicable measure set beginning with the CY 2025 performance year and subsequent performance years. We agree that the proposed changes will align the measures used in the expanded HHVBP Model with the measures in the QRP and with those publicly reported on Home Health Compare. We share CMS' view that this alignment will support comparisons of provider quality and streamline HHA's data capture and reporting processes.

With respect to health equity in the expanded model, the Partnership appreciates the additional time CMS proposes to give HHAs to learn the requirements of the expanded model. We believe the two-year time period to gather performance data and study the effects of the model on health equity outcomes is appropriate before incorporating changes.

Notwithstanding our generally positive predisposition to HHVBP's expansion, we do express caution that adjusted and expanded measure sets and OASIS reporting requirements represent to some of our member companies a "moving of the goalposts." That is, HHAs make adjustments to improve performance and its TPS in one performance year, only to be directed to adjust its clinical and operational systems in the next. The Partnership believes that a more stable, less disruptive, measure set, and OASIS reporting regime, would better allow HHAs to deliver continuous performance improvements.

Finally, as the Partnership notes elsewhere in this letter, increasing MA enrollment can create ripple effects elsewhere in the system, including HHVBP. For example, an HHA's improvement scores for hospital and emergency department (ED) use could diminish if the HHA is left with mostly FFS enrollees in its denominator. FFS patients tend to be older, and sicker, than their MA counterparts, thus compromising an HHA's potential to make meaningful improvement gains year over year.

## VII. RFI on Access to Home Health Aides

The Partnership appreciates the opportunity to provide feedback on CMS' RFI for Access to Home Health Aide Services, and its effort to better understand challenges facing HHAs and beneficiaries in providing and accessing home health aide services under Medicare. The shortage of aide services is a longstanding, complex situation tied to reimbursement anomalies and other factors at work that fail to provide HHAs with the financial resources to recruit, retain, and deliver aide services. Our comments do not respond to each specific inquiry in the RFI, but more generally assess the difficult history and reality of a flawed financial incentive system.

Broadly speaking, the Partnership believes that current challenges in providing home health aide visits under the Medicare HHA benefit can be addressed by (1) improving payment system incentives for HHAs to provide aide services; (2) providing education, guidance and training to HHAs, Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations

(MAOs) on ways to incorporate aide services into Medicare's skilled services benefit; and (3) exploring alternative models of providing Medicare-covered aide services outside of the current payment system. Finally, we offer insights into the effectiveness of coordination between Medicare and Medicaid with respect to the provision of aide services.

*3. Improving Payment System Incentives*

First and fundamentally, HHAs must be given the financial resources necessary to provide aide services for which no adequate payment has existed since before the transition to prospective payment. Since adoption of prospective payment in the late 1990s, funding resources for aide services have been effectively eliminated. More recent HHA payment system reforms, including PDGM, have continued to fail to price-in reimbursement for aide services, forcing HHAs to respond by focusing on delivering skilled services, a fact the U.S. District Court for the District of Columbia recognized in noting the "complex market forces, including Medicare's fixed reimbursement scheme, that impact HHAs' willingness or ability to provide certain services."[20] It is fair to say that every incarnation of the HHA PPS has failed to provide funding resources for aide services.

HHAs are independent market participants that exercise their own discretion in responding to payment system incentives. The decline in the provision of aide services is a rational reaction to a payment system that incentivizes other, skilled services over those provided by aides. The problem is not the HHA's "refusal" to provide aide services. The Medicare aide services deficit is more fully a result of PPS failures over time. HHAs need adequate financial resources and reasonable incentives to provide aide services, and PPS systems have not provided them. The lack of aide availability in Medicare's benefit is, in predominant part, directly attributable to PPS shortcomings. If CMS wishes to improve access to aide services under Medicare, it must provide the financial resources for HHAs to recruit, train, retain and deploy individuals in a challenging and costly market for labor – resources not provided or accounted for under PDGM.

Some stakeholders have argued that HHAs can and should use their margins under FFS Medicare to extend the volume of services to patients, including the incorporation of aide services. But those margins, as we discuss elsewhere in this letter, are increasingly spent on subsidizing financial shortfalls in Medicaid and MA. It is critical to understand that HHAs cannot operate in revenue silos and must respect the marketplace as a whole. The Partnership urges CMS to carefully consider this reality in setting expectations or policy with respect to the supply of aide services.

*4. Education, Guidance and Training*

If or when PDGM incentives are adjusted to allow for the provision of aide services, the Partnership believes it will be critical for CMS to provide education, training and guidance to HHAs, the MACs, and to MAOs on the nature and extent of its expectations with respect to the provision of non-skilled aide services in conjunction with other HHA disciplines. For example,

[20] *Johnson, et al., v. Becerra*, 1:22-cv-03024 (D.D.C April 5, 2023) at 16.

education and guidance will be needed to direct HHAs, MACs, and MAOs on when substitution of occupational therapy or physical therapy for aide services may be appropriate, as the former disciplines encourage and improve self-care skills and the latter maintains dependency. Once incentives are aligned to support both skilled and non-skilled care, CMS should educate and create guidance for providers, administrators, and payors on the appropriate mix of services that beneficiaries should receive.

*5. Alternative Policy Options*

If PDGM remains static, CMS could consider alternative payment models through the Center for Medicare and Medicaid Innovation (CMMI) that adequately fund aide services through another reimbursement mechanism. We are encouraged that the recently announced Guiding an Improved Dementia Experience (GUIDE) model is examining innovative ways to provide and pay for services that aim to improve life quality for beneficiaries living with dementia and their caregivers. The Partnership sees potential in novel programs like GUIDE that may offer pathways to more adequate payment mechanisms that intentionally include aide services.

*6. Medicare and Medicaid Coordination*

Approximately 20 percent of beneficiaries are dually eligible for Medicare and Medicaid. Better coordination is needed for this population, as Medicaid allows personal care assistants to perform services not limited to Medicare-covered services. In four states (Oregon, Illinois, Pennsylvania, and Indiana) funding for personal care assistants is available not just for dual eligible, but for Medicare-only beneficiaries as well. Other programs exist under the Older Americans Act (OAA) to support beneficiaries in their homes, regardless of their beneficiary status.

The Partnership believes that CMS or another Department of Health and Human Services (HHS) agency should further study the totality of Medicare, Medicaid, and OAA programs available to beneficiaries that provide aide services and make recommendations for filling gaps accordingly in consultation with HHAs, states, and beneficiary organizations.

## VIII. Conclusion

Medicare beneficiaries are entitled to home health services, yet ample data show that access to this care is declining based on deepening rate cuts. CMS should be alarmed. On the contrary, proposing steep new payment reduction shows a shocking disregard for the impact cuts are having and will have for patients and their caregivers.

CMS must assess the on-the-ground realities for patients, clinicians, and HHAs and finalize a 2024 HH PPS that allows the sector to stabilize, rather than perpetuating a downward spiral. Finalizing the rule as proposed will continue the demise of the home health benefit, to the detriment of beneficiaries, particularly the most vulnerable.

**Given the challenges and legal and technical deficiencies discussed above, and the significant adverse impact on providers and patients, the Partnership urges CMS to withdraw its**

**proposed application of permanent adjustment to home health payment rates in CY 2024. To further support appropriate payment rates, the Partnership asks CMS to ensure that the HH market basket more accurately reflects price trends and the cost of providing care. The Partnership recommends that CMS finalize a one-time forecast error correction to account for the underestimates of the market basket for CYs 2021 and 2022. The cumulative effect of multiple reimbursement cuts will only harm patient access and care delivery. CMS should proceed with caution in setting final policy for 2024.**

Sincerely,

Joanne E. Cunningham
Chief Executive Officer
Partnership for Quality Home Healthcare

# Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2024 HH PPS Proposed Rule

***Assessing the Impact of CMS' Proposed Behavioral Adjustments under PDGM and the Future of Access to Home Health Services***

Submitted to: Partnership for Quality Home Healthcare (PQHH)

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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 2024 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, and the CY 2024 HH PPS Proposed Rule. We also draw from our work in prior rule making cycles.

Outlined below are key conclusions from our analysis.

1. **CMS' 2024 HH PPS Proposed Rule data are not sufficient for a precise replication of CMS' impact analysis of the CY 2024 proposed payments.** Unlike in prior rule making cycles, CMS did not make available the "current law" (CY 2023) payments to allow modelling of CY 2024 proposed payment impacts. Yet, these data are critical for a complete assessment of the agency-level distributional impact of the CY 2024 HH PPS proposed policies.

2. **CMS projects that CY 2024 payments will result in aggregate payment reductions of 2.2 percent across all agencies, however significant variation in agency-level impacts exist, with percent impacts ranging between -4.6% (95th percentile) to 1.0% (5th percentile).** This variation in agency-level impacts is largely driven by the fluctuation in the wage index between CY 2023 and CY 2024. The observed variation in agency-level impacts is also driven in part by the proposed CY 2024 case-mix recalibration.

3. **The HH PPS Market basket updates are not reflective of actual price trends in the HH industry, likely because it fails to account for home health specific price changes on a real-time and industry specific basis.** For instance, while CMS proposes a market basket increase of 3.0 percent in CY 2024, data from the Bureau of Labor and Statistics (BLS) indicates that hourly nurse wages grew by 7.7% in Q1 of 2023 compared to the Q1 of 2022. Analysis of the projected and actual market basket for CY 2021 and CY 2022 indicates a cumulative forecast error of 5.2 percent, which if uncorrected could result in -$11 billion in lost payments for HHAs over a 10-year period.

4. **In the absence of any corrective action, we estimate that CMS' existing and proposed permanent and temporary behavioral adjustments could lead to a reduction of approximately $25 billion in home health payments between CY 2020 and CY 2029. This represents more than one year's worth of home health payments.** The total $25 billion reduction reflects the cumulative impact of the -4.36 reduction due to assumed provider behaviors implemented in CY 2020, the cumulative impact of the permanent adjustment for CY 2023 and CY 2024, and a $4.1 billion reduction due to the temporary reductions to reconcile CY 2020, CY 2021, CY 2022 and CY 2023 aggregate payments.[2] Further, the temporary and permanent

[1] CMS DUA 54747.

[2] Note that CMS states in the CY 2024 HH PPS proposed rule that a $3.4 billion reduction is required to reconcile CY 2020, 2021, and 2022 payments. We (Dobson | DaVanzo) further estimate that an additional $643 million would be required to reconcile CY 2022 payments.



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reductions combined could result in roughly 40 percent of home health agencies having negative margins if temporary adjustments were implemented over a three-year period between CY 2025 and CY 2027.

The extensive scale of the proposed CY 2024 and future payment reductions to home health agencies threatens the viability of many home health providers. These proposed reductions will also pose challenges for providers to succeed in the recently expanded Home Health Value-Based Purchasing (HHVBP) Model and newly available benefits including Medicare's Home Intravenous Immune Globulin (IVIG). As providers have less financial reserve due to the payment reductions, they may be less incentivized to take on the risks of participating in these new innovative models of care.


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## 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 2024 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 2023 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, and available claims data.

Effective January 1, 2020, the CMA 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).

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 Final rule, CMS finalized using the methodology first proposed in CY 2022 to assess budget neutrality. From this methodology, the agency finalized a -3.925 percent permanent adjustment to the 30-day payment rate (half of the finalized 7.85 percent adjustment, initially proposed at −7.69 percent) and sought 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. Finally, in the CY 2024 HH PPS Proposed rule, CMS is proposing an additional permanent adjustment of -5.653 percent in CY 2024, which includes the remaining -3.925 percent not applied to the CY 2023 payment rate and additional adjustment to reflect actual behavior changes in CY 2022. CMS also calculated additional temporary adjustments of approximately $3.4 billion to reconcile retrospective overpayments in CYs 2020, 2021, and 2022.

For CY 2024 home health agencies are projected to experience a reduction of $375 million in payments (or a -2.2 percent reduction), which includes a -5.1 percent overall payment reduction due to the permanent adjustment, a 0.2 percent increase reflecting effects of the fixed-dollar loss ratio (FDL) updates, and a 2.7 percent payment update reflecting the market basket update reduced by a productivity adjustment.



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## Detailed Findings

### 1. Insufficient Data Made Available by CMS

We commend CMS for making case data available through the CY 2024 Proposed Rule CMS OASIS-LDS impact files, but we note that the data provided are not sufficient to replicate CMS' analysis of the distributional impact of the proposed payment adjustments to providers of interest.

**Projected CY 2023 claims-level payments that CMS used to create the impact table in the proposed rule are not provided.**

In the CY 2024 Proposed Rule CMS OASIS-LDS PDGM impact file, CMS provided projected case-level CY 2024 payments based on CY 2022 home health claims data adjusted to reflect the CY 2024 payment update, permanent behavior adjustment and FDL update.

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 2022 data to project the CY 2023 payments. The complete CY 2023 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 2024 payments of $15.5 billion from CMS' OASIS-LDS dataset. Yet, from the proposed rule, we calculated that projected CY 2024 payments would have had to be $16.67 billion and CY 2023 payments of $17.05 billion to equate to an $375 million (or a 2.2 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 2024 payments. The actual adjustments CMS applied are not clear to us at this time. We note that in the CY 2020 rule making cycles CMS provided much of this information and directly provided data on agency-level impacts.

### 2. Impact of the CY 2024 HH PPS Proposed Rule on HHA Revenues

#### IMPACT OF CY 2024 HH PPS PROPOSED PAYMENT RATES ON HHA MEDICARE REVENUES

CMS projects in the CY 2024 HH PPS that home health agencies will experience a reduction of $375 million (or a -2.2 percent reduction) in payments between CY 2023 and CY 2024. This reduction includes an overall -5.1 percent reduction[3] due to the permanent behavioral adjustment, a 0.2 percent increase for the FDL and a 2.7 percent payment update (inclusive of the market basket update adjusted for the MPF).

[3] As CMS notes in the CY 2024 HH PPS proposed rule, the -5.653 percent permanent reduction is applied to the base payment but after accounting for fully paid cases, LUPAs, PEP cases and outlier cases, the permanent adjustment results in a 5.1 percent overall payment reduction.



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### *METHODOLOGY*

We examined the impacts of the CY 2024 HH PPS proposed payment rates on HHA revenues by comparing current law (Dobson | DaVanzo estimated CY 2023) payments to the projected CY 2024 payments provided by CMS in the OASIS LDS files through the following steps.

*Step 1*: We obtained CY 2024 projected case-level payments from the CY 2024 CMS OASIS-LDS impact file dataset. We then aggregated the cases for each agency using the provider CCN and determined the CY 2024 payments for each agency.

*Step 2:* We modeled CY 2023 payments for each case using case mix, wage index, and visit information included in the OASIS LDS impact file. Modeled case payments accounted for the following types of episodes:

- Standard Cases: We determined CY 2023 claim-level payments by adjusting the CY 2023 standard base payment rate by case mix and the labor portion by wage index.
- Partial Episode Payment (PEP) Cases: We proportionally adjusted the CY 2023 case payment by the length of stay of the episode.
- Outlier Cases: We estimated an outlier add-on payment using a 0.8 loss sharing ratio applied to the difference between imputed episode costs (from the LDS OASIS dataset) and the outlier threshold.
- Low Utilization Payment Adjustment (LUPA) Cases: We estimated episode payments by applying the CY 2023 per visit payments to the visit information in the LDS OASIS dataset for each agency.

*Step 3:* We calculated the projected revenue change by determining the difference between the estimated CY 2023 payments and the projected CY 2024 payments for each agency.

We note that the total CY 2024 payments determined from the CY 2024 CMS OASIS-LDS impact dataset were short of the projected CY 2024 payments that would have resulted in a -$375 million reduction in payments following a -2.2 percent reduction. We calculated that CY 2024 payments of $15.6 billion and CY 2023 payments of $15.9 billion equate to a -$342 million (or a -2.1 percent) reduction in payments over the two years. We therefore applied adjustments at the agency level such that the CY 2023 and CY 2024 payments differences for each agency summed up to a $375 million reduction. For each agency, we first determined the proportion of the agency's calculated payment reduction as a fraction of the overall payment reduction determined from the OASIS-LDS dataset. We then applied that proportion to the overall projected reduction of $375 million to determine the adjusted payment reduction. We used the same method to adjust the CY 2023 and CY 2024 payments for each agency.


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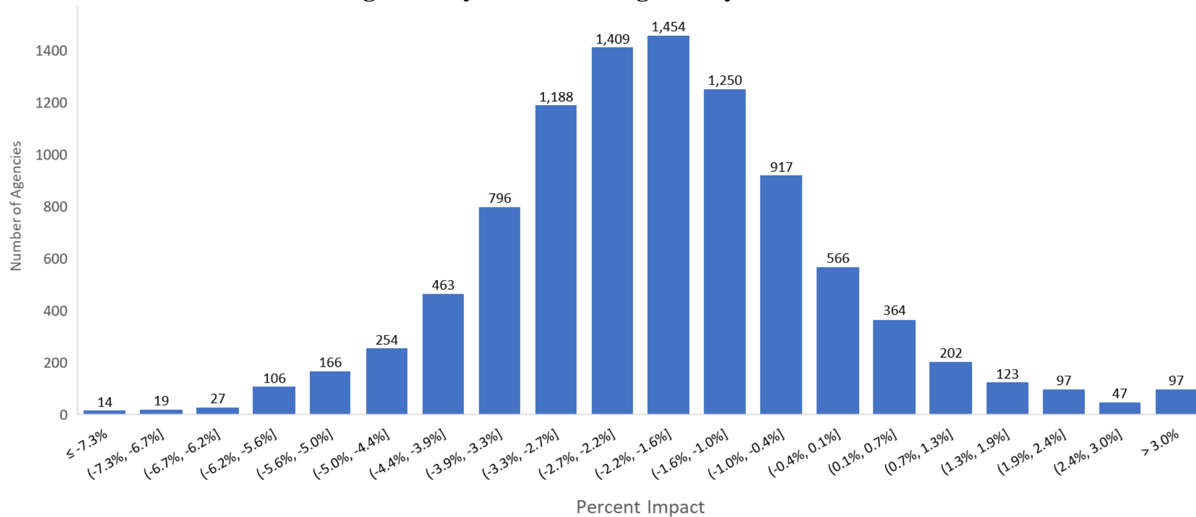
*RESULTS*

## Agency Impacts

When comparing the percent impact (i.e., the percent change between CY 2023 and projected CY 2024 budget neutral payments) at the agency level, we find that home health agencies have impacts that are roughly normally distributed around the average impact of 2.2 percent. The percent impact ranges between -29.0% to 33.8% with a 5th and 95th percentile range of -4.6% and 1.0%. We also estimate that roughly 45 percent of HHAs in 2024 will have larger negative payment reductions than -2.2 percent. The full distribution of projected agency percentage impacts is shown in **Exhibit 1** below.

**Exhibit 1: Distribution of Agencies by Percent Change in Payments between CY 2023 and CY 2024**




*Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 59233*

## 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 a higher percent reduction compared to agencies in urban areas. These results are shown in **Exhibit 2**.

**Exhibit 2: Percent Impact between CY 2023 and CY 2024 for Agencies in Rural vs. Urban Areas**

| Location | Percent of Agencies | Percent of Cases | Projected 2024 Payment Impact | Percent Impact |
|---|---|---|---|---|
| Rural | 15% | 14% | -$47,817,596 (13%) | -2.4% |
| Urban | 85% | 86% | -$326,907,178 (87%) | -2.2% |
| **Grand Total** | **100%** | **100%** | **-$375,000,000 (100%)** | **-2.2%** |

*Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 59233*

## State Impacts

In **Exhibit**s **3** and **4** below, we show the projected revenue changes for each state. Results show that while CMS estimates an aggregate reduction of -2.2 percent, the top 10 states with the highest percent reduction in payments are projected to experience average percent reductions ranging from -4.8 percent to -3.5 percent—reductions that are much larger than the overall percent impact of -2.2 percent.



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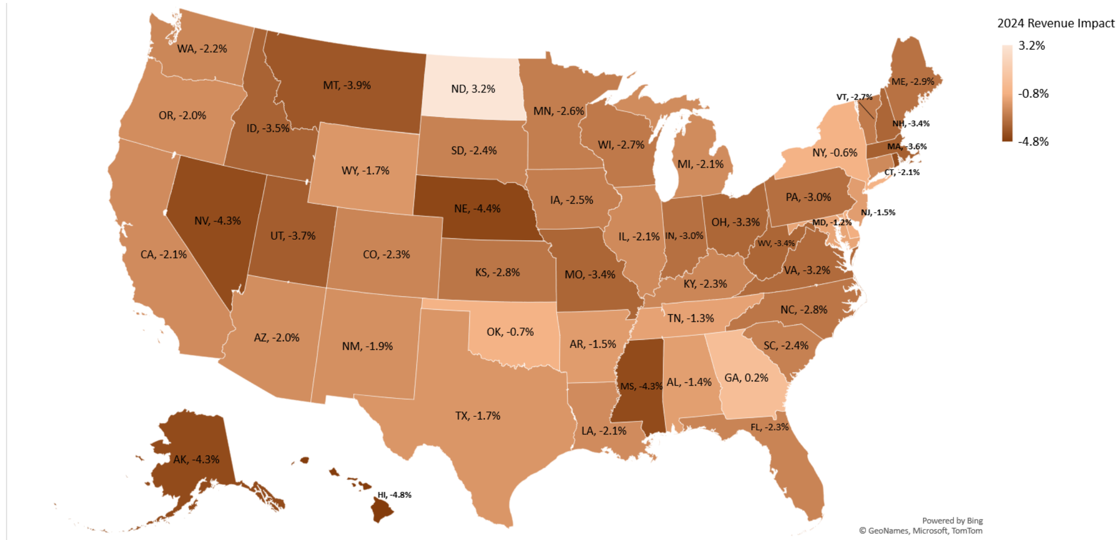
**Exhibit 3: Top 10 States with Highest Projected Revenue Changes between CY 2023 and CY 2024**[4]

| State | Number of HHAs | Case Count | 2023 Simulated Total Case Payment | 2024 Total Case Payment | Impact of 2024 Proposed Payments | Percent Impact | Range of Agency Impacts (Min-max) | Range of Agency Impacts (5th - 95th percentile) |
|---|---|---|---|---|---|---|---|---|
| HI | 12 | 9,187 | $24,303,708 | $23,137,309 | ($1,166,399) | -4.8% | -7.1%, -3.7% | -6.5%, -3.8% |
| NE | 62 | 38,318 | $78,222,857 | $74,755,231 | ($3,467,626) | -4.4% | -6.6%, 1.2% | -5.9%, -2.3% |
| AK | 14 | 8,038 | $19,653,166 | $18,809,224 | ($843,943) | -4.3% | -5.1%, -2.6% | -4.9%, -2.8% |
| MS | 43 | 189,412 | $297,722,623 | $284,971,231 | ($12,751,392) | -4.3% | -5.3%, -2.6% | -5.1%, -3.3% |
| NV | 162 | 108,134 | $233,058,224 | $223,134,780 | ($9,923,444) | -4.3% | -6.8%, 0.0% | -5.7%, -2.0% |
| RI | 21 | 25,601 | $57,393,900 | $54,972,475 | ($2,421,424) | -4.2% | -4.7%, -0.5% | -4.6%, -2.6% |
| MT | 23 | 12,588 | $23,453,159 | $22,547,333 | ($905,826) | -3.9% | -4.8%, -1.5% | -4.8%, -2.2% |
| UT | 86 | 60,083 | $120,397,194 | $115,980,584 | ($4,416,610) | -3.7% | -6.5%, -1.2% | -5.2%, -2.2% |
| MA | 165 | 254,118 | $576,617,629 | $555,973,154 | ($20,644,475) | -3.6% | -7.1%, 3.7% | -4.5%, 1.7% |
| ID | 47 | 36,829 | $70,674,726 | $68,224,858 | ($2,449,868) | -3.5% | -5.2%, -2.1% | -4.4%, -2.3% |
| **All** | **9,559** | **8,321,990** | **$17,045,454,545** | **$16,670,454,545** | **($375,000,000)** | **-2.2%** | **-29.0%, 33.8%** | **-4.6%, 1.0%** |

*Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 59233*

**Exhibit 4: Distribution of Projected Revenue Changes by State, between CY 2023 and CY 2024**




*Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 5923*

## IMPACT OF THE CY 2024 PROPOSED WAGE INDEX

We examined the changes in the average wage index for each home health agency using the data on CY 2022, CY 2023, and CY 2024 wage indices for each case available in the CMS OASIS LDS dataset.

In **Exhibits 5** and **6** below, we show the percent change in wage index between CY 2022 and CY 2023 and CY 2023 and CY 2024 for each agency. As shown, there is significant volatility in the wage index, despite the recently introduced -5 percent cap. For instance, between CY 2023 and CY 2024, more than half of the agencies had a larger negative percent reduction than -2.0 percent, and yet in comparison only 7.7 percent of agencies did so between CY 2022 and CY 2023.

[4] Numbers may not add up due to the effects of rounding.



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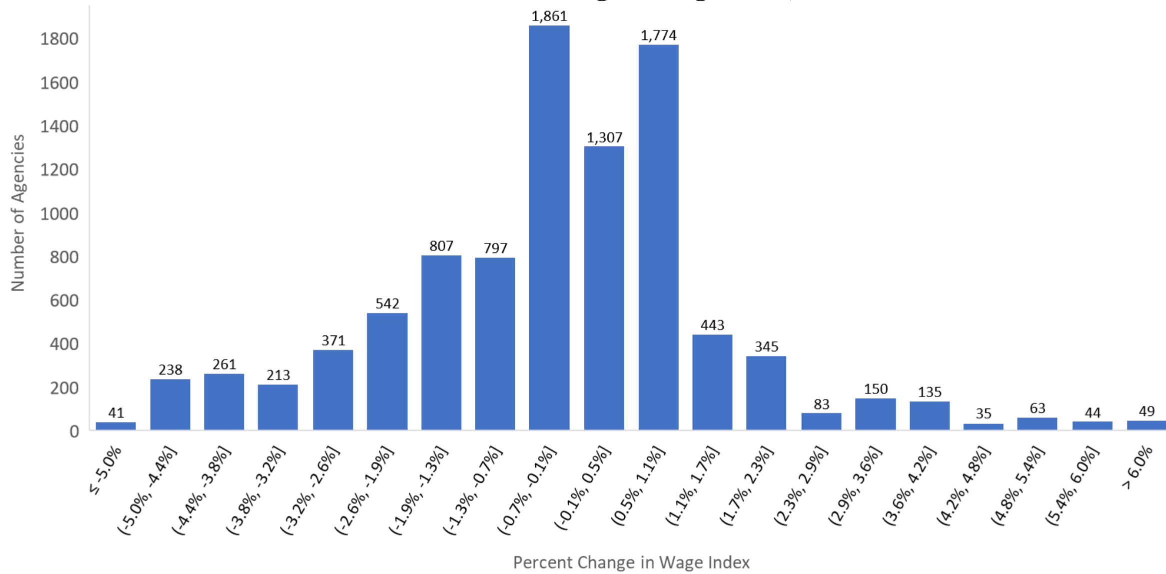
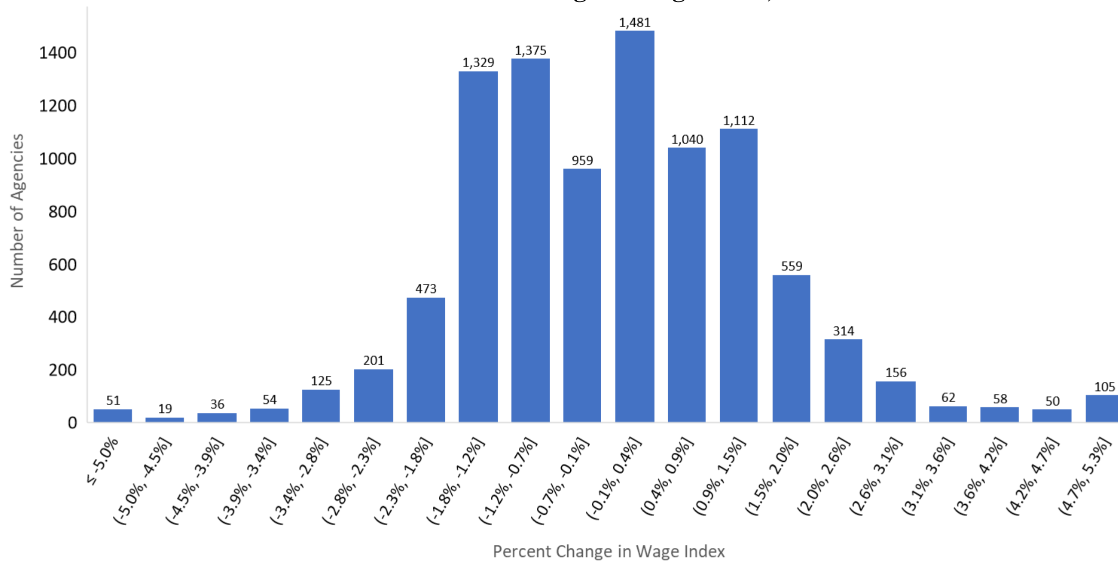
**Exhibit 5: Distribution of Percent Change in Wage Index, CY 2023 to CY 2024**




| Threshold* | Number of HHAs | Percentage |
|---|---|---|
| Agencies with >= -5.0% & < -4.4% change | 601 | 6.3% |
| Agencies with >= -5.0% & < -2.0% change | 4,815 | 50.4% |

**Not included in chart*

**Exhibit 6: Distribution of Percent Change in Wage Index, CY 2023 to CY 2024**




| Threshold* | Number of HHAs | Percentage |
|---|---|---|
| Agencies with >= -5.0% & < -4.4% change | 73 | 0.8% |
| Agencies with >= -5.0% & < -2.0% change | 735 | 7.7% |

*Source: Dobson | DaVanzo analysis of OASIS LDS Files for CY 2024 HH PPS Proposed Rule, DUA 59233*

**Not included in chart*



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## 3. Impact of the Existing and Proposed Permanent Reductions and Future Temporary Reductions

### IMPACT OF THE PROPOSED TEMPORARY REDUCTIONS FOR CY 2020 THROUGH CY 2023 PAYMENT RECONCILIATION

In addition to the proposed permanent behavioral adjustment, CMS also calculated temporary reductions of $3.4 billion that would be required to reconcile CY 2020, CY 2021, and CY 2022 aggregate payments to budget neutral levels. CMS further indicates in the CY 2024 HH PPS Proposed Rule that they are not applying the temporary reduction to the CY 2024 payments and instead will propose a temporary adjustment factor in future rulemaking.

Finally, because only half of the permanent adjustment was applied to the CY 2023 payment rate, we estimated the temporary adjustment that would be required to offset for such increases in the estimated aggregate expenditures for CY 2023. We developed these estimates based on the methodology CMS uses to determine overpayments for CYs 2020 through CY 2022 in the CY 2024 Proposed Rule as described below.

#### *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 2024 levels through the following steps.

*Step 1*: We estimated the volume of home health episodes in CY 2023 by inflating the CY 2022 volume using the CBO baseline projected changes in Medicare part A enrollment.[5]

*Step 2*: Next, we obtained the CY 2023 budget neutral rate with assumed and actual behavior changes from the CY 2023 Final Rule as follows:

1) The CY 2023 budget neutral rate with assumed behavior changes is the CY 2023 standardized 30-day payment rate of $2,010.69 (which applies only half of the permanent behavior adjustment), and

2) We obtained the CY 2023 budget neutral rate with actual behavior changes by multiplying the recalculated CY 2022 base payment rate of $1,841.55[6] by the CY 2023 case-mix weights recalibration neutrality factor, the wage index budget neutrality factor and payment update.

*Step 3*: We then calculated the total CY 2023 payments with assumed and actual behavior changes by multiplying the projected volume (from *Step 1)* by the payment rates with assumed and actual behavior changes (from *Step 2)*. We estimated CY 2023 overpayments of $643 million from the difference between total payments with assumed and actual behavior changes.

[5] CBO Baseline Medicare, May 2023. https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf.

[6] Obtained from CMS' analysis in the CY 2024 HH PPS Proposed Rule.



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#### *RESULTS*

In total, we estimated temporary reductions of $4.1 billion would be required to reconcile CY 2020, CY 2021, CY 2022, and CY 2023 aggregate payments to budget neutral levels. This represents a reduction of 24.5 percent ($4.1 billion/ $16.7 billion) to the CY 2024 projected payments.

### OVERALL IMPACT OF CY 2024 HH PPS PROPOSED RULE REDUCTIONS AND FUTURE REDUCTIONS: IMPACT TO HHA REVENUES

In aggregate, we estimate that the payment reductions due to behavioral adjustments will lead to an approximate reduction of $25 billion in cumulative home health-related payments in the period between 2020 through 2029. This amount includes the cumulative impacts of the CY 2020 -4.36 percent behavioral adjustment, the cumulative impacts of the CY 2023 and CY 2024 permanent adjustments, and a $4.1 billion reduction due to temporary adjustments for CY 2020, CY 2021, CY 2022, and CY 2023. We note that this assumes that there are no further permanent reductions after CY 2024, although it is likely that CMS could calculate additional permanent reductions as new data becomes available.

#### *METHODOLOGY*

We determined the impact of the assumed behavioral, permanent, and temporary adjustments on home health payments between 2020 and 2029 through the following steps.

*Step 1*: We obtained the volume of home health episodes in CY 2020, CY 2021, and CY 2022 from 100% Medicare FFS claims data and estimated the volume of home health episodes in CY 2023 and beyond by inflating the CY 2022 volume using the CBO baseline projected changes in Medicare part A enrollment.

*Step 2*: Next, we obtained the CY 2020 through CY 2024 base payment rates from the respective Final Rules and projected payment rates for CY 2025 and CY 2029 by assuming that the base payment rates in subsequent years would be inflated using CMS' forecasts of the HH PPS market basket, less assumed productivity adjustments.

*Step 3*: We also modeled base payment rates for CY 2020 through CY 2029 without any behavioral adjustments by excluding the -4.36 percent behavioral adjustment in CY 2020 and permanent adjustments in CY 2023 and CY 2024.

*Step 4*: We determined the impact of the assumed behavioral, permanent, and temporary adjustments as the difference in total payments with and without any behavioral adjustments. Total payments with behavioral adjustments for CY 2020 through CY 2029 were calculated by multiplying the projected volume (in *Step 1)* by the base payment rates with behavioral adjustments (in *Step 2).* Total payments without behavioral adjustments for CY 2020 through CY 2029 were calculated by multiplying the projected volume (in *Step 1)* by the base payment rates without behavioral adjustments (in *Step 3).*



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### *RESULTS*

The results of our analysis are shown in **Exhibit 7**.

**Exhibit 7: Projected Impact of Behavioral Adjustments in CY 2020 through CY 2029**

| Total Payments | Impact of BA |
|---|---|
| 2020 | ($699,933,751) |
| 2021 | ($705,823,319) |
| 2022 | ($766,304,099) |
| 2023 | ($1,499,483,870) |
| 2024 | ($2,616,280,420) |
| 2025 | ($2,724,403,981) |
| 2026 | ($2,874,694,185) |
| 2027 | ($2,988,650,510) |
| 2028 | ($3,149,653,923) |
| 2029 | ($3,272,567,415) |
| **Total Impact of Permanent Adjustments (CY 2020-CY 2029)** | **($21,297,795,473)** |
| **Total Impact of Temporary Adjustments (If applied between CY 2020-CY 2029)** | **($4,082,326,332)** |
| **Total Impact of Permanent and Temporary Adjustments (CY 2020-CY 2029)** | **($25,380,121,805)** |

*Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 59233*

## OVERALL IMPACT OF CY 2024 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 2024 Medicare margins. Our analyses to determine home health agency Medicare margins are based on the MedPAC and CMS methodologies, as best as we understand them, and our results are closely aligned with other benchmarks produced using the same methodologies.

### *METHODOLOGY*

*Step 1*: We first extracted data from the 2022 cost reports, the most recent cost report data available.[7] We then extracted the Medicare PPS payments and corresponding costs from the 2022 Medicare Cost Reports.

*Step 2*: We calculated 2022 Medicare margins by (1) calculating Medicare PPS net income by subtracting costs from Medicare PPS payments, and (2) dividing Medicare PPS net income by Medicare PPS payments using the formula illustrated below.

$$2022\ Medicare\ Margins = \frac{Medicare\ PPS\ payments - Medicare\ PPS\ Costs}{Medicare\ PPS\ Payments}$$

*Step 3*: To determine the 2023 and 2024 Medicare margins, we modeled Medicare payments for each agency for 2023 by increasing 2022 payments by 0.7 percent and for 2024 payments by

[7] Cost reports. CMS. (n.d.). Retrieved August 03, 2023, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.



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reducing modeled 2023 payments by 2.2 percent. We identified these payment updates from the CY 2023[8] HH PPS proposed rule and CY 2024 HH PPS proposed rule.[9]

We modeled costs by increasing 2022 costs by the market basket updates identified from annualized Home Health Agency market basket data published by CMS.[10]

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 assumed that temporary reductions due to 2020 to 2023 overpayments would be applied over a 3-year period from 2025 to 2027, equating to payment reductions of $1.36 billion each year between 2025 and 2027. We calculated the percent reduction in revenues by dividing the overpayments for each year by projected 2024 payments obtained from the CMS LDS OASIS files, equating to a reduction of 8.2% each year. 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*.

#### *RESULTS*

As shown in **Exhibit 8**, the percentage of HHAs with negative Medicare margins will increase from 16.2 percent in CY 2022 to 26.5 percent in 2024 due to the proposed CY 2024 payments. Further, the additional payment reductions due to temporary adjustments of $4.1 billion could result in 40 percent of HHAs experiencing negative Medicare margins by 2027.

**Exhibit 8: Percent of Home Health Agencies with Negative Medicare Margins**

| | Percent of HHAs with Negative Medicare Margins | | | | | |
|---|---|---|---|---|---|---|
| | **2022** | **2023** | **2024** | **2025*** | **2026*** | **2027*** |
| **All Agencies** | 16.2% | 21.2% | 26.5% | 38.8% | 39.1% | 39.5% |

*Source: Dobson | DaVanzo Analysis of 2022 Medicare Cost Reports*

**Includes temporary reductions*

## 4. Analysis of HH PPS Market baskets

### HH PPS MARKET BASKETS MAY NOT BE REFLECTIVE OF ACTUAL PRICE TRENDS IN THE HH INDUSTRY

In the CY 2024 HH PPS proposed rule, CMS proposes a 3.0 percent market basket update. However, this does not reflect the actual price trends in the industry as the market basket composite index is determined on a 4-quarter rolling average basis—failing to account for home health specific price changes on a real-time basis.

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[8] CY 2023 HH PPS Proposed Rule, 85 FR 70298. 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.

[9] CY 2024 HH PPS Proposed Rule, 87 FR 37600. Available at: https://www.federalregister.gov/documents/2023/07/10/2023-14044/medicare-program-calendar-year-cy-2024-home-health-hh-prospective-payment-system-rate-update-hh.

[10] 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.



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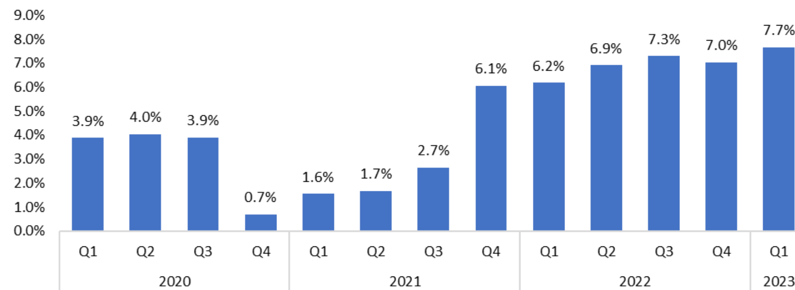
For example, while CMS proposes a 3.0 percent market basket update for CY 2024, BLS data shows that nursing staff wages will grow by 7.7 percent in Q1 2023 compared to Q1 2022. These results are shown in **Exhibit 9**.

**Exhibit 9: Quarterly Growth (Year-over-Year) in Nursing Staff Hourly Wages, 2020-2023**




*Source: Bureau of Labor Statistics*[11]

## IMPACT OF THE CY 2021 AND CY 2022 FORECAST ERROR ON FUTURE PAYMENTS

We determined the impact of the 5.2 percent forecast error on home health payments between 2021 and 2030 through the steps outlined below.

### *METHODOLOGY*

<u>*Step 1*</u>*:* We obtained the projected market basket rates used by CMS in the CY 2021 HH PPS[12] and CY 2022 HH PPS[13] Final Rules and compared them to the actual market basket rates subsequently published by CMS for the respective years.[14] We then calculated actual and projected market basket cumulative rates for CY 2021 and CY 2022 as follows:

- *Actual market basket cumulative rate* – We determined the cumulative actual market basket rate by multiplying the actual market basket increase of 4.1% in CY 2021 (104.1% of CY 2020) by the actual market basket increase of 6.5% in CY 2022 (106.3% of CY 2020), yielding a 10.7% cumulative market basket rate ((104.1% * 106.3%) - 1 = 10.7%); and
- *CMS projected market basket cumulative rate* –Using the same methodology, we determined the cumulative projected market basket rate by multiplying the projected market basket increase of 2.3% used in the CY 2021 NPRM (102.3% of CY 2020) by the projected market basket increase of 3.1% used in the CY 2022 NPRM (103.1% of CY 2021), yielding a 5.5% cumulative market basket rate ((102.3% * 103.1%) - 1 = 5.5%).

As illustrated in ***Exhibit 9***, the forecast error of 5.2% is the difference between the actual cumulative market basket rates and the projected cumulative market basket rates as identified in Final Rules.

[11] https://data.bls.gov/cew/apps/table_maker/v4/table_maker.htm#type=1&year=2022&qtr=A&own=5&ind=6216&supp=0

[12] 85 FR 70298: https://www.federalregister.gov/documents/2020/11/04/2020-24146/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home.

[13] 86 FR 62240: https://www.federalregister.gov/documents/2021/11/09/2021-23993/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home.

[14] https://www.cms.gov/files/zip/market-basket-history-and-forecasts.zip.



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**Exhibit 9: Market Basket Forecast Error in CY 2021 through CY 2022**

| MB Forecast Error Impact | CY 2021 | CY 2022 | Cumulative |
|---|---|---|---|
| Actual Market Basket | 4.1% | 6.3% | 10.7% |
| HH PPS Projected Market Basket (Used in Final Rules) | 2.3% | 3.1% | 5.5% |
| **Difference** | **1.8%** | **3.2%** | **5.2%** |

*Source: Dobson | DaVanzo Analysis*

Step 2: We then calculated the current and projected home health payments for CY 2021 through CY 2030 by multiplying the standard base payment rates by the projected volume of fully paid home health cases for each year and adjusting for PEPs, LUPA and Outlier payments. We obtained the payment rates for CY 2021 through CY 2023 from Final Rules and applied the projected market basket update rates, less assumed productivity adjustments, to obtain payment rates for CY 2024 through CY 2030. The steps for the analysis are described below:

***Step 2a: Base Payment Rates (P)***

- **Base Payment Rates for CY 2021 through CY 2023.** We obtained base payment rates for CY 2021 through CY 2023 from the published Final Rules for each respective year.
- **Base Payment Rate for CY 2024.** In the CY 2023 HH PPS Final Rule, CMS indicated it would need to apply a -7.85% permanent prospective adjustment to the CY 2023 base payment rate to offset increased estimated aggregate expenditures, but the agency only finalized half (-3.925%) of the proposed permanent adjustment. We applied an additional -5.653% in permanent behavioral adjustments to the CY 2024 base payment rate as stated by CMS in the CY 2024 HH PPS Proposed Rule.
- **Base Payment Rates for CY 2025 through CY 2030.** Next, we modelled payments for CY 2025 through CY 2030 by assuming that the base payment rates in subsequent years would be inflated using CMS' forecasts of the HH PPS market basket, less assumed productivity adjustments.[15]

***Step 2b: Home Health Case Volume (Q)***

- **Volume of Home Health Cases for CY 2021 through CY 2030.** We projected the volume of home health cases from CY 2021 through CY 2030 using the growth rate of Medicare Part A beneficiaries provided by the CBO and the CY 2020 home health volume of cases as a base.[16]

***Step 2c: Total Medicare Payments (P x Q)***

- **Total Payments for CY 2021 through CY 2030.** To determine total payments for each year, we multiplied the base payment rate for each year (Step 1b) by the respective volume of fully paid estimated home health cases (Step 1c). From the HH Claims data[17], we identified that fully paid cases are 86 percent of all cases. We then adjusted the total payments for fully paid cases for non-fully paid cases including PEPs, LUPAs and outliers to determine payments for all cases. From the HH Claims data[18], we determined that 91 percent of payments in CY 2021 are fully paid cases, therefore

[15] We assumed that no further adjustments due to the wage index or case mix budget neutrality factor are made for CY 2025 through CY 2026.

[16] CBO Baseline Medicare, May 2023. https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf.

[17] Dobson | DaVanzo Analysis of HH PPS Claims Data Under DUA RIF 54757

[18] Dobson | DaVanzo Analysis of HH PPS Claims Data Under DUA RIF 54757



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total payments for all cases can be obtained by dividing the payments for fully paid cases by 91 percent.

- **Payment Adjustments for CY 2025 through CY 2027.** In the CY 2023 HH PPS Final Rule, CMS indicated it would need to make temporary adjustments of offset payments it assessed as over-payments. In the CY 2023 HH PPS Final Rule. CMS calculated temporary adjustments of -$873,073,121 for CY 2020, -$1,211,002,953 in CY 2021. In the CY 2024 HH PPS Proposed Rule, CMS calculated temporary adjustments of -$1,355,208,655 for CY 2022. We estimated that CMS would identify additional temporary adjustments of -$643,041,603 for CY 2023, yielding a total of -$4,082,326,332 in temporary adjustments. We assumed CMS would apply these reductions over 3 years from CY 2025 to CY 2027 at -$1,360,775,444 each year and applied these reductions to the total payments.

*Step 3*: We estimated current and projected home health payments for CY 2021 through CY 2030 by multiplying the base payment rates by the projected volume of home health cases for each year. In this scenario we used the base payment rates determined by applying the actual market basket update rates for CY 2021 and CY 2022 and keeping all other inputs constant. We then followed the same steps in Step 1 to determine the alternative total payments.

*Step 4*: We calculated the impact of the forecast error as the difference between total payments based on projected market basket forecasts, as calculated in *Step 1*, and total payments based on actual market basket updates, alternative payments, as calculated from *Step 2*.

### RESULTS

We calculated a cumulative impact of $10.99 billion in underpayments to home health agencies over the 10-year period CY 2021 through CY 2030 due to the forecast errors in CY 2021 and CY 2022. Results are summarized in ***Exhibit 10***, below.

**Exhibit 10: Projected Impact of 5.2 Forecast Market Basket Error in CY 2021 through CY 2030**

| Total Payments | Impact of CY 2021 and CY 2022 Forecast Error |
|---|---:|
| 2021 | -$285,512,085 |
| 2022 | -$867,452,091 |
| 2023 | -$871,874,624 |
| 2024 | -$1,115,186,361 |
| 2025 | -$1,161,316,235 |
| 2026 | -$1,225,352,343 |
| 2027 | -$1,273,931,221 |
| 2028 | -$1,342,554,653 |
| 2029 | -$1,394,931,985 |
| 2030 | -$1,449,139,655 |
| **Total** | **-$10,987,251,254** |

*Source: Dobson | DaVanzo Analysis*



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