Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

August 26, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1803-P
P.O Box 8013
Baltimore, MD 21244-8013

Re: **CMS-1803-P: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies**

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) 2025 Home Health Prospective Payment System (HH PPS) Proposed Rule (the "Proposed Rule"). We believe that the Centers for Medicare & Medicaid Services (CMS) approach to applying permanent adjustments is deeply flawed and is reducing access to vital skilled home health services for Medicare beneficiaries.

As a national coalition of skilled home healthcare providers, we appreciate that CMS has traditionally recognized the value the high-quality Medicare home health care provides to patients, as well as the value it creates for the Medicare program as a lower cost setting for patients to receive skilled care. Unfortunately, we are gravely concerned that CMS' Proposed Rule would severely undermine the Medicare home health benefit. We submit these comments and recommendations as essential to preserving access to home health care.

Home health providers continue to oppose CMS' methodological approach to calculating Patient Driven Groupings Model (PDGM) behavioral adjustments, and we urge CMS to reconsider the methodology it finalized in 2022. Nonetheless, these comments focus on the impact that cuts imposed under this methodology have had in 2023 and 2024 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 2025, this disturbing trend will only continue.

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' 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 also offer comments on CMS' proposed condition of participation related to patient acceptance to service.

## 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. CMS' policy to suppress rates based on PDGM rate reductions has occurred during a time when Medicare home health care providers have been in short supply and home health agency's labor costs have increased dramatically.

### 1. Employment of Home Health Agency Skilled Care Staff is Stagnant

The Medicare Payment Advisory Commission (MedPAC) assesses employment data as a key indicator of access to home health care. Home health agencies continue to face staffing challenges for skilled care providers.

MedPAC's March 2024 Report to the Congress acknowledges that "[home health agencies] have reported that staffing shortages limit the volume of services they can provide, which in some areas may also contribute to declining use."[1] MedPAC presents "employment data on the broader medical home care sector (using a definition that includes Medicare [home health agencies], hospice, private duty, pediatric agencies, and other home care providers)" to conclude that *total employment* was higher in July 2023 than in February 2020, suggesting a post-pandemic recovery.

But even MedPAC acknowledges that the data they present "measure employment for a broader category of home care services than Medicare [home health agencies]." The North American Industry Classification System (NAICS) file that MedPAC relied on includes "personal care services, homemaker and companion services, medical equipment and supplies, counseling, 24-hour some care, dietary and nutrition services, audiology, and other specialized care". Analysis of the data by Dobson | DaVanzo (See full report at Appendix 1) indicate that employees in the "Home Health and Personal Care Aides" occupation category represent more than half (approximately 60 percent) of all employees for years 2019-2023 in the file MedPAC relied on, yet the "Home Health Aide" discipline represents *a much smaller* percent of visits per 30-day periods of care provided to Medicare FFS enrollees. Further, MedPAC's reported growth in total employment for the broader home health sector is largely driven by growth in "Home Health and Personal Care Aides".

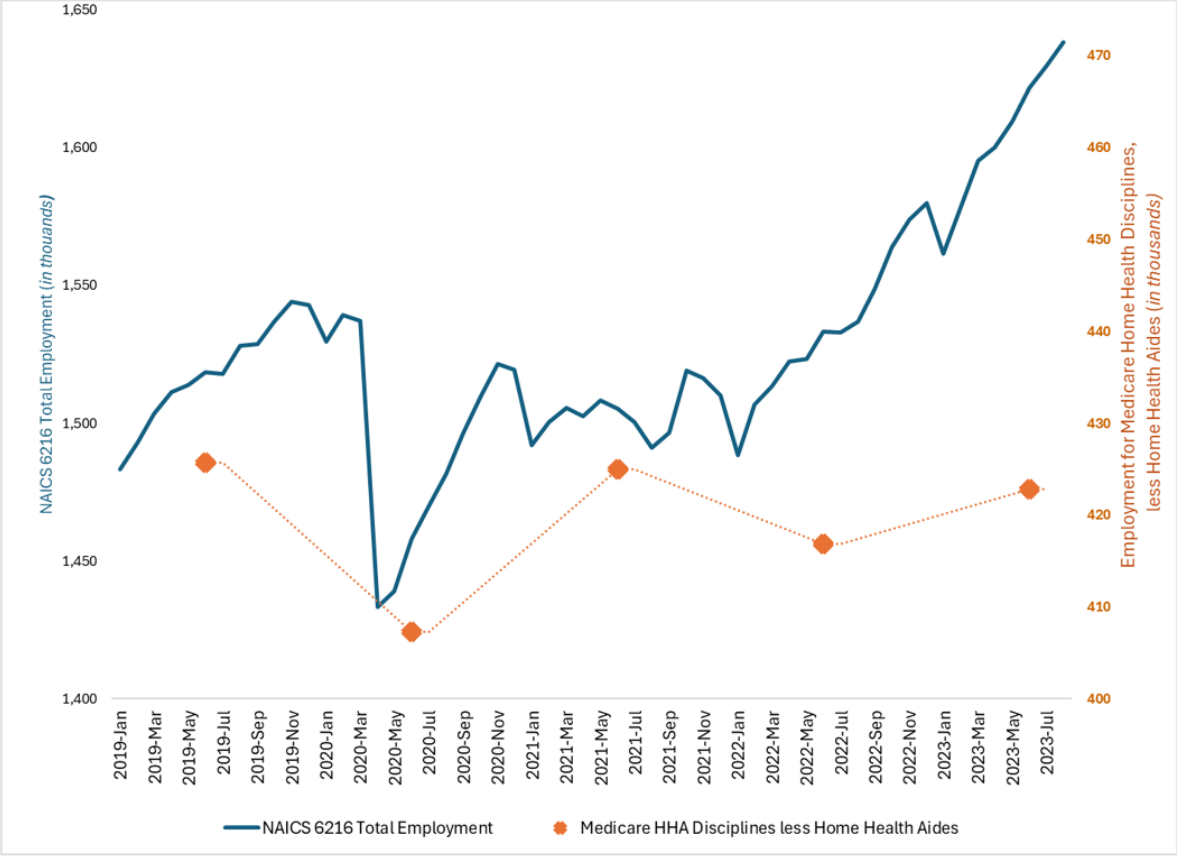
Limiting the analysis to the occupations most relevant to CMS Medicare FFS Home Health disciplines (and excluding the "Home Health and Personal Care Aides" category), the number of employees

[1] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch7_MedPAC_Report_To_Congress_SEC.pdf.

decreases considerably. Table 1 below compares the employment recovery presented by MedPAC (driven by the increase in employment of aides) with the slight decline in employment among other home health agency employees including the workforce critical to delivering skilled care.

**Table 1**

**Employment for Total NAICS 6216 and Medicare HHA Disciplines**




**Source**: MedPAC March 2024 Report to Congress, DD Analysis of BLS Data Series ID CEU6562160001

Home health aides are essential members of the care teams that home health agencies assemble to care for Medicare beneficiaries, but taking a new patient on also requires the availability of skilled care providers, including therapists and nurses, a fundamental aspect of the home health benefit in the statute. We call CMS' attention to the discrepancy between the employment numbers presented by MedPAC and the very different trend for home health agency employees other than aides.

Home health agencies serving the Medicare population have continued to experience labor constraints. With limited staff to meet care needs, agencies are forced to make difficult decisions.

Home health administrators and clinicians report continued recruitment challenges. Home health agencies have lost nurses to other care settings or traveling status, where stress is lower and compensation higher. Hospital discharge planners and home health agency personnel alike report that lack of home health capacity, or lack of capacity to deliver specific nursing or therapy services that a patient needs, means patients stay in the hospital longer than necessary, receive post-acute care in a

more costly facility environment, or are left without a plan to receive the care they need. Patients desperately want to be at home, and home health agencies 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 while others are struggling on the brink of closure. The juxtaposition between the reduced reimbursement and increasing wages is untenable and is causing major financial stress that is impacting care delivery capacity.

2. Fewer Beneficiaries are Accessing Home Health

MedPAC also analyzes the number of home health "users" as a metric to determine access to care and payment rate adequacy. The March 2024 Report to Congress found that "the share of FFS beneficiaries using home health care has been declining as well, falling 3.0 percent in 2022". Dobson | DaVanzo validated the trend MedPAC identified, finding that the percent of fee-for-service Medicare beneficiaries is lower than pre-pandemic levels and has fallen since 2022. Early analysis of 2023 data suggests that the percentage is continuing to fall. These data are presented in Table 2.[2]

**Table 2**

**Comparison of Data on Total Number of FFS Beneficiaries and Number of FFS HH Users**

| | Dobson \| DaVanzo Claims Analysis | | | MedPAC March 2024 Report[3] | |
|---|---|---|---|---|---|
| Time Period | Number of FFS Beneficiaries[4] | Number of HH Users | Percent FFS HH Users | Number of HH Users | Percent FFS HH Users |
| 2019-01-01 to 2019-12-31 | 38,577,012 | 3,310,007 | 8.6% | 3.3 million | 8.5% |
| 2020-01-01 to 2020-12-31 | 37,776,345 | 3,014,721 | 8.0% | 3.1 million | 8.1% |
| 2021-01-01 to 2021-12-31 | 36,356,380 | 3,063,386 | 8.4% | 3.0 million | 8.3% |
| 2022-01-01 to 2022-12-31 | 35,270,914 | 2,863,700 | 8.1% | 2.8 million | 8.0% |
| 2023-01-01 to 2023-12-31 | 34,314,219 | 2,744,472 | 8.0% | | |

Additional data suggest that the reason Medicare FFS beneficiaries are using less home health than in the past is not because they are healthier than they were in the past. Notably, Dobson | Davanzo found that the proportion of Home Health claims with a high comorbidity adjustment has increased from 10.0 percent to 16.7 percent between 2019 and 2023. Additionally, the average DRG weight for home health beneficiaries with a prior hospitalization increased from 1.89 to 1.97 over the same time period. These

[2] Market Saturation data can also be used to observe trends in FFS enrollment and Home Health (HH) utilization. These data show the same trend described in Table 2, with the percent of FFS home health users falling to 6.6 percent in 2023.

[3] MedPAC 2024 Report to Congress: Home Health Chapter https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch7_MedPAC_Report_To_Congress_SEC.pdf#page=8.75, Table 7-2

[4] Obtained from CMS Monthly Medicare Enrollment Data; https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data?query=%7B%22filters%22%3A%7B%22list%22%3A%5B%7B%22conditions%22%3A%5B%7B%22column%22%3A%7B%22value%22%3A%22BENE_GEO_LVL%22%7D%2C%22comparator%22%3A%7B%22value%22%3A%22%3D%22%7D%2C%22filterValue%22%3A%5B%22National%22%5D%7D%2C%7B%22column%22%3A%7B%22value%22%3A%22BENE_STATE_ABRVTN%22%7D%2C%22comparator%22%3A%7B%22value%22%3A%22%3D%22%7D%2C%22filterValue%22%3A%5B%22US%22%5D%7D%2C%7B%22column%22%3A%7B%22value%22%3A%22MONTH%22%7D%2C%22comparator%22%3A%7B%22value%22%3A%22%3D%22%7D%2C%22filterValue%22%3A%5B%22Year%22%5D%7D%5D%7D%5D%2C%22rootConjunction%22%3A%7B%22value%22%3A%22AND%22%7D%7D%2C%22keywords%22%3A%22%22%2C%22offset%22%3A0%2C%22limit%22%3A10%2C%22sort%22%3A%7B%22sortBy%22%3Anull%2C%22sortOrder%22%3Anull%7D%2C%22columns%22%3A%5B%22YEAR%22%2C%22MONTH%22%2C%22BENE_GEO_LVL%22%2C%22BENE_STATE_ABRVTN%22%2C%22ORGNL_MDCR_BENES%22%5D%7D

data are presented in Table 3. The reduction in home health utilization is therefore unlikely to be correlated to beneficiary needs and may be more indicative of supply constraints.[5]

**Table 3**

**Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category, 2019-2023**

| Comorbidity Adjustment | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| None | 52.0% | 49.1% | 49.6% | 37.3% | 30.7% |
| Low | 38.0% | 36.9% | 36.9% | 47.8% | 52.6% |
| High | 10.0% | 14.0% | 13.5% | 14.9% | 16.7% |

**Source:** CY 2025 HH PPS Proposed Rule

**Exhibit 4: Average DRG Weight for Home Health Beneficiaries with prior Hospitalization**

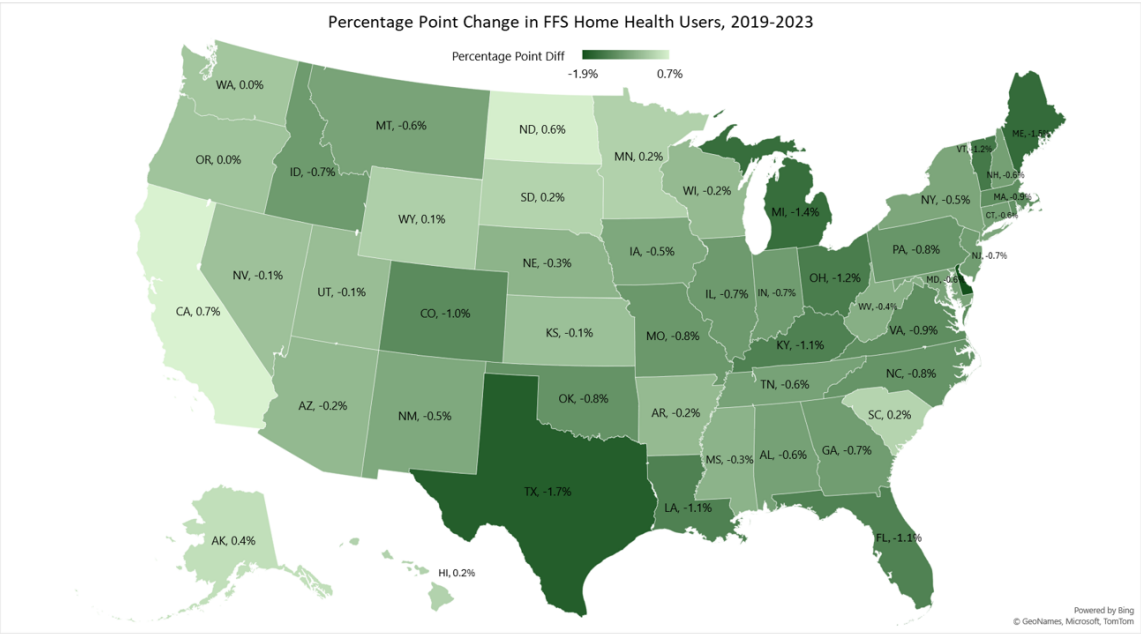
| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| **Average DRG Weight** | 1.89 | 1.95 | 1.95 | 1.97 |

**Source:** DD Analysis of Claims Data under DUA 54757

In some parts of the country, home health use is declining even more than the national average presented in Table 2. Overall, the percentage of FFS Medicare beneficiaries with at least one home health claim is -0.6 percentage points below 2019 levels (and falling in recent years). By state, the percentage point decline in FFS beneficiaries ranged between -1.9 to 0.6 percentage points.

**Table 4**

**Percentage Point Change in Proportion of FFS Beneficiaries with at Least one Home Health Claim 2019-2023, by State**




**Source:** Dobson | DaVanzo Analysis of Claims Data under DUA 54757

[5] While MedPAC suggests that the declining trend in home health utilizations could be explained by lower use of inpatient hospital care among FFS beneficiaries because a hospital stay is a common precursor to HH care, ***Table 3*** shows that the population of home health users with a prior hospitalization are on average sicker in 2022 compared to 2019, meaning those users are likely to have more home health use.

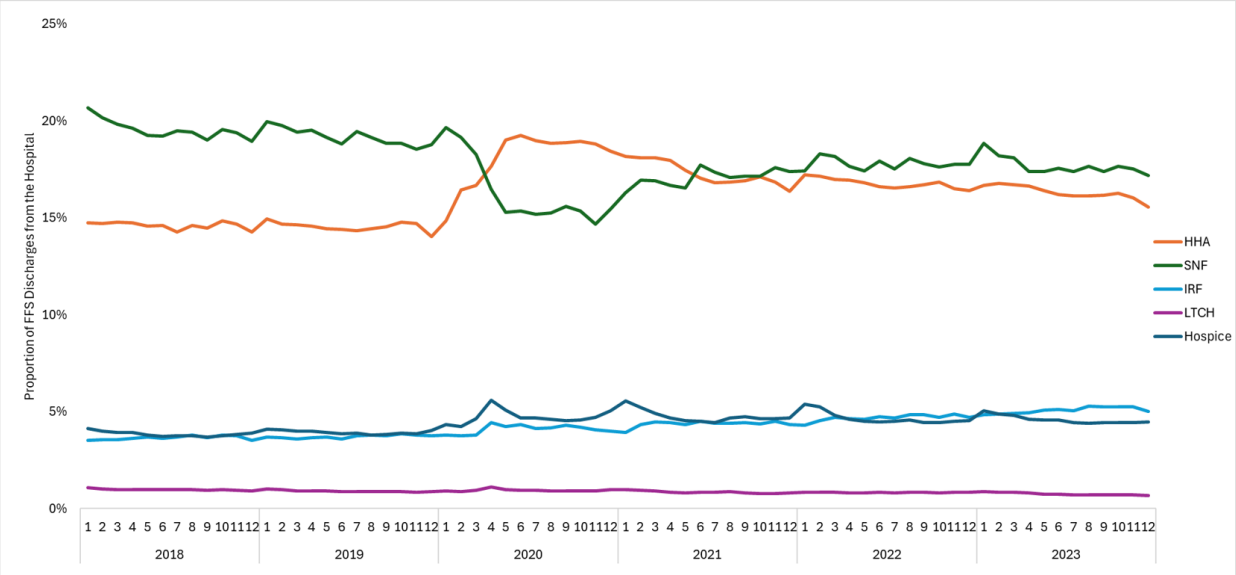
Ten states saw a decline of 1 percent of more: Delaware, Texas, Maine, Michigan, Vermont, Ohio, Kentucky, Louisiana, Florida, Colorado. These declines mean that beneficiaries who would have received home health care in the past are no longer accessing this vital health care.

It is possible some of the beneficiaries who would have received home health before 2020 are receiving care in higher acuity settings, such as skilled nursing facilities (SNFs). It is also possible beneficiaries are going without care. From independent third parties to governmental entities, study after study repeatedly confirm that home health is the most cost-effective site of care for patients.

As shown in Table 5, the proportion of hospital discharges to home health increased between 2019 and 2020 (during the COVID-19 pandemic) and started to decline between 2020 and 2023. Due to the observed substitution effect that occurred during the pandemic months, there was a decline in SNF admissions, but the trends began to reverse between 2021 and 2023.

**Table 5**

**Trends in Hospital Discharges to Post-Acute Care Settings, 2019-2023**




**Source:** Dobson | DaVanzo Analysis of Claims Data under DUA 54757

The pandemic created a rapid shift towards the home as a setting for care, including prompting a shift to home health away from SNFs. Caring for patients in the lowest-cost appropriate setting would be a success for longstanding value-based care goals. Instead of taking steps to preserve the pandemic shift to home health, CMS' implementation of PDGM rate cuts starting in 2020 created an environment in which home health agencies could not compete.

Even when beneficiaries do receive home health, the number of visits they receive has been steadily declining. Overall, the number of visits in 2023 is only 81% of 2019 levels. As shown in Table 6, skilled nursing visits are now 86% of what they were in 2019; physical therapy visits are 83% of what they were in 2019; occupational therapy visits, 71%; speech therapy, 67%; home health aide visits, 61%; and social worker visits, 63%. We fully recognize that advocates call for home health agencies to provide more, not less care, but providers are constrained by labor market forces and Medicare payment rates that are lower today than they were in 2020.

**Table 6**

**TABLE 3: UTILIZATION OF VISITS PER 30-DAY PERIODS OF CARE BY HOME HEALTH DISCIPLINE, CYs 2018-2023**

| Discipline | CY 2018 (Simulated) | CY 2019 (Simulated) | CY 2020 | CY 2021 | CY 2022 | CY 2023 |
|---|---|---|---|---|---|---|
| Skilled Nursing | 4.53 | 4.49 | 4.35 | 4.05 | 3.90 | 3.86 |
| Physical Therapy | 3.30 | 3.33 | 2.70 | 2.74 | 2.77 | 2.78 |
| Occupational Therapy | 1.02 | 1.07 | 0.79 | 0.78 | 0.77 | 0.76 |
| Speech Therapy | 0.21 | 0.21 | 0.16 | 0.15 | 0.14 | 0.14 |
| Home Health Aide | 0.72 | 0.67 | 0.54 | 0.48 | 0.43 | 0.41 |
| Social Worker | 0.08 | 0.08 | 0.06 | 0.05 | 0.05 | 0.05 |
| Total (all disciplines) | **9.86** | **9.85** | **8.59** | **8.25** | **8.06** | **8.00** |

**Source:** CY 2018 and CY 2019 simulated PDGM data with behavior assumptions came from the Home Health LDS. CY 2020 data was accessed from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC) on July 12, 2021. CY 2021 data was accessed from the CCW VRDC on July 14, 2022. CY 2022 data was accessed from the CCW VRDC on July 13, 2023. CY 2023 data was accessed from the CCW VRDC on March 19, 2024.
**Note:** All 30-day periods of care claims were included (for example LUPAs, PEPs, and outliers). There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.

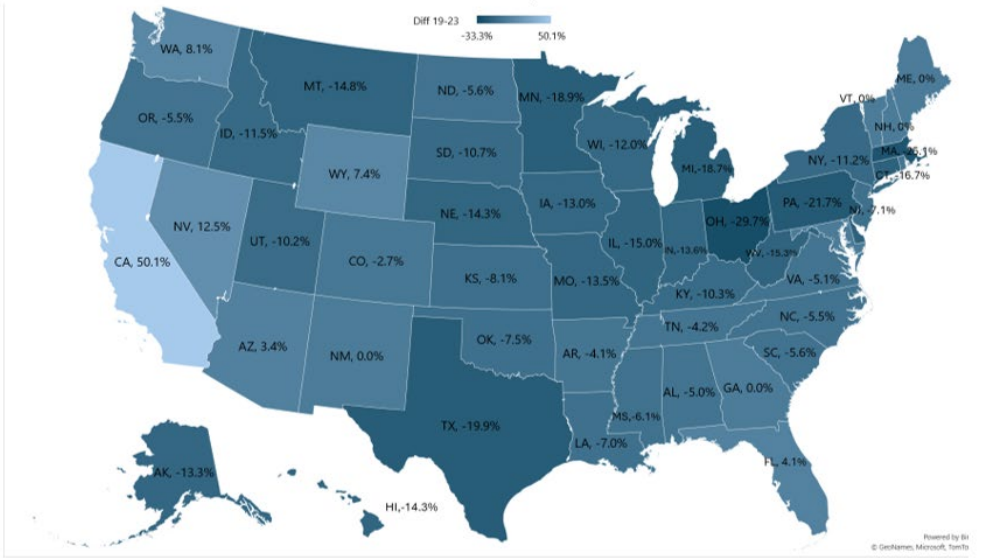
3. Home Health Agencies are Closing

MedPAC also looks at home health agency closures as a factor in assessing access to care. Trends in the number of home health agencies billing Medicare FFS shows significant variability across the country. Most states experienced decreases in the number of Medicare FFS billing home health agencies, pointing to reduced access.

California is a clear outlier in these data, and as a large state, it skews the national average. Dobson | DaVanzo observed more than a 50 percent increase in the number of home health agencies billing Medicare since 2019. The next closest state (Nevada) saw an increase of 12.5. See Table 7. Overall, the change in the number of home health agencies excluding California showed a -12 percent decrease or a reduction of 832 agencies between 2019 and 2023. Agency closures signal declining access to care.

**Table 7**

**Percent Change in Number of FFS Medicare Billing HHAs by State, 2019-2023 (with and without California)**




**Source:** Dobson | DaVanzo Analysis of Claims Data under DUA 54757

4. Rate Reductions Decrease Access to Care

CMS has in the past recognized the clear connection between payment rate cuts and access to care. [6] Given the tenuous state of access to home health based on current rates, CMS should proceed with caution in moving forward with further Medicare payment rate reductions. Year over year cuts to home health have resulted in compromised access to care trends demonstrated in the charts discussed above.

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

Home health is a vital benefit, not a convenience. Not being able to access home health when it is ordered has dire consequences. 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.

## II. Impacts of PDGM Permanent and Temporary Adjustments and Other Payment Changes

Medicare payments should be accurate, predictable, and support access to high quality home healthcare. However, the Partnership is very concerned that CMS' proposal for CY 2025 for a further significant permanent reduction to the 30-day home health payment rate continues a flawed policy is inconsistent with these goals and will continue to erode the home health benefit to the detriment of the Medicare beneficiaries who rely on it. In addition, the cumulative temporary reductions outlined in the CY 2025 Proposed Rule foreshadow further steep cuts in reimbursement and act to further destabilize the home health care delivery system.

As detailed in the section above, the payment reductions applied by CMS for CY 2023 and CY 2024 are having a significant impact on patient access. This combined with the continued growth in labor costs and inaccurate annual payment updates and forecast errors in the market basket are having consequences for both patients and providers who struggle to provide critical home healthcare services to the patients that need it. Given the ongoing cuts in reimbursement imposed by CMS, payments under the home health PPS have effectively been frozen since January 1, 2022, while at the same time the cost of delivering care has skyrocketed. In the interest of ensuring a viable home health benefit for Medicare beneficiaries, the Partnership urges CMS not to finalize the reductions proposed in the CY 2025 rule.

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. CMS has chosen to interpret the Medicare Statute[7] in a way that results in a series of steep cuts in reimbursement that do not maintain budget neutrality.

The Proposed Rule would apply a permanent –4.067 percent downward adjustment to the 30-day payment rate. Combined with the annual payment update, this results in an average estimated -1.7 percent overall payment impact for home health providers in CY 2025. For the third straight year, the rule would apply a reduction that eliminates any benefit of the annual payment update. Tables 8 and 9 below detail the level of permanent adjustments (reductions) both determined and applied by CMS to date (a 10.5 percent reduction).

**Table 8**
**Permanent Adjustments Determined**

| Data Year | Percent Reduction in Rate |
|---|---|
| CY 2020 | -6.52 Percent |
| CY 2021 | -1.42 Percent |
| CY 2022 | -1.767 Percent |
| CY 2023 | -1.125 Percent* |

**Proposed for CY 2025*

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

**Table 9**
**Permanent Adjustments Applied**

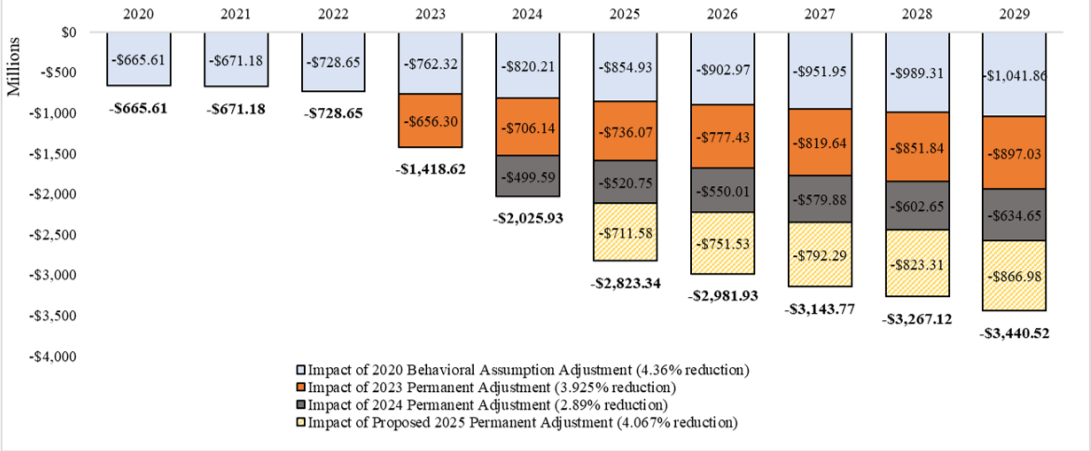
| Data Year | Percent Reduction in Rate |
|---|---|
| CY 2023 | -3.925 Percent |
| CY 2024 | -2.89 Percent |
| CY 2025 | -4.067 Percent* |
| **Total to Date** | -10.5 Percent |

**Proposed for CY 2025*

While CMS did not propose the application of "temporary" retrospective adjustments to recover payments made in prior years (2020 through 2023), CMS increased the amount owed by home health providers in future years by one billion dollars in this Proposed Rule. This amount now totals $4.5 billion and will likely increase as CMS continues to assess budget neutrality for years 2024 through 2026. In the attached report, Dobson|Davanzo estimates an additional $2 billion in temporary adjustments equating to possible reductions totaling $6.5 billion. The Partnership estimates the current permanent adjustments alone will result in aggregate cuts to home health reimbursement of $21 billion through 2029. Table 10 below details the year-by-year cumulative impact of these cuts.

**Table 10**
**Cumulative Impact of Permanent Adjustments**

**Aggregate Modeled Impacts of 2020, 2023, 2023 and Proposed 2025 Reductions on Home Health Medicare Payments, 2020-2029 (In Millions)**




**Notes:** This chart is based on information contained in the CY2025 HH PPS Proposed rule and shows the impact of adjustments calculated based on the first four data years of PDGM (2020-2023). It includes the proposed permanent payment reduction in 2025 but does not reflect any additional permanent and/or temporary reductions in payments.

The significant payment reductions along with future cuts yet to be determined by CMS based on future data years (2024 through 2026) are stripping critical resources away from providers that are needed for patient care. Given the grave impact and flaws in its approach, CMS must act to suspend these cuts in CY 2025 and work to create a sustainable reimbursement framework that supports care delivery.

The Partnership has outlined in previous comment letters associated with the CY 2023 and CY 2024 Proposed Rules[8], the technical flaws and legal insufficiency of the Agency's methodology underlying the permanent and temporary adjustments. As noted in our comments last year, as CMS continues to apply its methodology with each new data year, which relies on a pre-2020 obsolete payment system to set a ceiling on current and future payments, the cumulative permanent adjustment continues to increase. Given CMS is still relying on the pre-PDM home health payment model which has never been updated, the result is not surprising. This has created a downward spiral in reimbursement with devastating consequences for patients at a time when in-home care is an essential and increasingly preferred option for many patients, families, and their physicians.

In addition to the significant reductions in payment applied in this and recent years' rules, other aspects of the proposed changes to the home health PPS for CY 2025 will cause adverse impacts on providers which have the effect of magnifying the -4.067 percent cut to the 30-day payment rate. These include a home health market basket which again 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 combined effects of wage index changes and new Core Based Statistical Area (CBSA) delineations. Finally, CMS' failure to address continued significant projection errors in the market basket forecasts underlying the CY 2021, CY 2022, and now CY 2023 payment rates means that home health providers have effectively incurred an additional payment cut of -5.7 percent creating enormous financial and workforce challenges in the current labor market and health care economy.

In short, the steep cuts and high degree of uncertainty around reimbursement year to year for home health providers makes it extremely difficult to operate in the current environment and effectively care for their patients. Again, the Partnership urges CMS to withdraw its proposal for further permanent adjustments to reduce payments in CY 2025.

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 had on patient care, access, and the viability of the Medicare home health benefit. The agency's approach has resulted in significant cuts in payment for CY 2023, CY 2024, and a new proposal for further steeper cuts in CY 2025 making payment levels far lower than what the law requires and was contemplated by the Congress.

*a. Background*

The Social Security Act (the Act)[9] 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

[8] 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, etc., Submitted August 16, 2022;
Comments of the Partnership for Quality Home Healthcare to CMS-1780-P: Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements, etc; Submitted August 29, 2023.

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

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[10] 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[11] 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 and CY 2024 home health Proposed Rule, 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 CY 2023 and CY 2024 proposed rules, 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, 2022, and now 2023 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 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:

- 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

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

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

assumed and actual behavior changes, the 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 or revise its methodology for determining both permanent and temporary adjustments and develop and propose a new methodology that aligns with statutory requirements.

*c. Technical Concerns with CMS' Methodology*

In addition to the Partnership's fundamental concerns with how CMS interprets the statute related to its proposed methodology for determining permanent and temporary adjustments to home health payments, we continue to have technical concerns with the agency's approach. These comments and concerns were detailed in our previous comments to both the CY 2023 and CY 2024 Proposed Rules (referenced above) and in the report by Dobson|Davanzo attached to the Partnership's comments to the CY 2023 home health proposed rule[12].

In brief, these technical concerns focused on CMS' use of an approach that 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. 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. While CMS acknowledged and corrected for such concerns to avoid what it described as an "overcorrection" in establishing similar adjustments under the Skilled Nursing Facility PPS for fiscal year 2023, the Agency chose not to address this concern and instead incorporate the errors under the home health PPS. In addition, as detailed in the report by Dobson|Davanzo (referenced above), use of partial data, differences in diagnosis coding under PDGM and the pre-PDGM payment models, differences in early versus late discharges, and missing OASIS items all create bias in the data and compound estimation error in CMS' results.

Each time CMS has applied its methodology to a new year of data it results in additional cuts in reimbursement, as shown in Table 8 above. This outcome is not surprising given CMS' methodology

[12] Report by Dobson|Davanzo: "Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2023 HH PPS Proposed Rule/Assessing the Impact of CMS' Interpretation of Budget Neutrality Under PDGM and the Future of Access to Home Health Services", August 16, 2022.

reprices claims based using a flawed simulation and uses the result to apply an artificial ceiling to the payment rate under PDGM . Each passing year, its simulation of the former system reflects less the incentives, coding, and clinical treatment patterns of the present day. It is clear that the payment reductions resulting from this disconnect between PDGM and CMS' simulation of the former pre-PDGM payment model will continue through 2026 as CMS analyzes each new year of data. The result will be further unjustified cuts to home health reimbursement and the deterioration of patient access, care delivery, and a vital Medicare benefit.

Finally, with each new permanent adjustment comes additional temporary adjustments that will be clawed back from home health providers already struggling to provide care. These temporary adjustments already total $4.5 billion as proposed in this year's rule adding to the instability and uncertainty around payments and the future delivery of home health services. The Agency's approach is already eroding 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 -4.067 percent will bring the total permanent adjustment applied to the home health 30-day payment rate to negative -10.5 percent. This, along with future temporary adjustments of $4.5 billion cannot be absorbed by home health providers and will cause further significant disruptions in patient access and care delivery. Medicare beneficiaries need and deserve a viable and sustainable benefit for in-home skilled services for both fee-for-service (FFS) and Medicare Advantage (MA). The unprecedented magnitude of the reductions applied by CMS under PDGM and the uncertainty and instability they create impacts all Medicare beneficiaries and must be addressed by CMS in this year's Final Rule.

The Partnership recommends that CMS withdraw its proposal and not apply the proposed permanent adjustments to the home health payment rates in CY 2025. CMS should review the law and propose a new methodology that aligns with the statutory requirements or work with Congress to establish a sustainable reimbursement structure under the Home Health Benefit. 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 2025

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. Unfortunately, the application of permanent adjustments in CY 2023 and CY 2024 has effectively meant that payment rates have been flat since January 1, 2022. The Proposed Rule would again allow for no effective annual increase in payments but in fact an average reduction of -1.7 percent.

The law[13] 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

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

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 payment update of 2.5 percent which is based on a market basket increase of 3.0 percent minus a 0.5 percent productivity adjustment. As a result, the 30-day period payment rate in CY 2025 would decline to $2,008.12 from its CY 2024 level of $2038.13.

Over the past several years, health care providers, including home health, have experienced staffing shortages and significant increases in the cost of labor and other resources necessary to deliver care to patients. The 2024 Medicare Trustees report[14] acknowledged these challenges and the significant reduction in Medicare expenditures for home health services that result. The report specifically notes:

> "Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed."

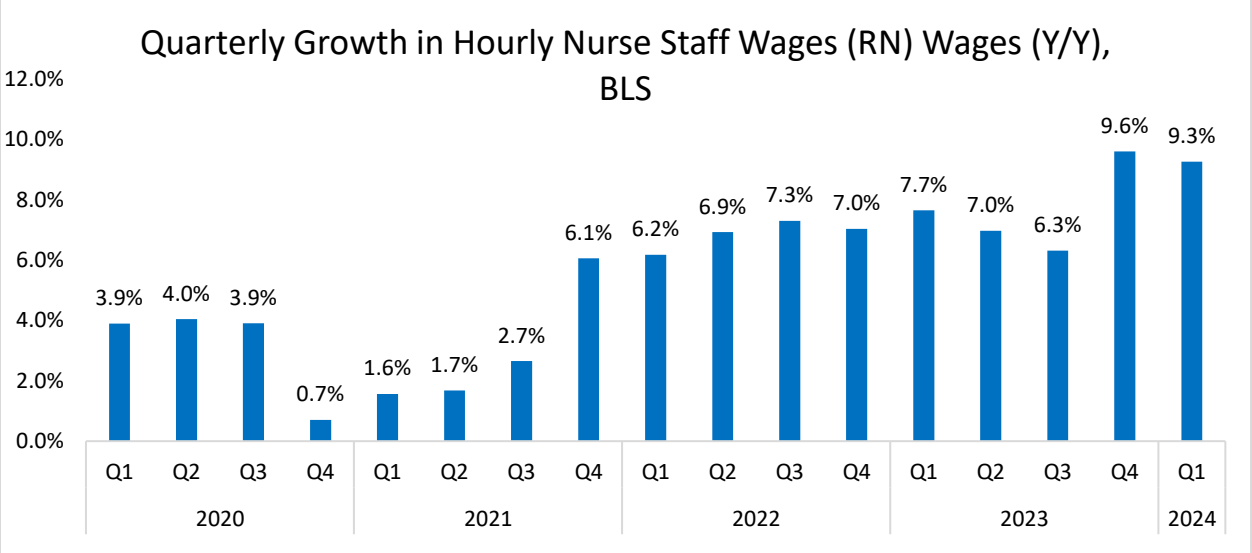
However, annual increases to the home health payment rates in recent years, which are based on the home health market basket, continue to not keep pace with actual cost increases experienced by the home health sector, particularly for staffing. In addition, CMS' forecasts of the market basket which are used to set payment rates have been manifestly inaccurate in the recent past resulting in a negative -5.7 under-forecast over the period 2021 through 2023, as discussed further below. This is effectively another significant cut in reimbursement as dramatic cost increases over this period continue unabated. Finally, we note that the shortfalls created by these inaccurate annual payment updates are cumulative over time, exacerbating the financial instability that home health providers face one year to the next.

The continued increase in providers' costs and the inaccuracy of recent updates continues to exert intense financial pressure on providers which in turn impacts access to care for patients. CMS' proposal to further reduce the 30-day payment amount by -4.067 percent) eliminates any benefit from the proposed annual payment update to address these escalating costs and current workforce and other challenges. Rather it results in a reduction in payments intensifying the challenges they are already facing.

The Partnership continues to question the methodology underlying market basket and associated forecasts when other benchmark indicators show more consistently higher rates of growth, particularly as it relates to staffing costs which are the primary resource in the delivery of home health care. As detailed in Table 11 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 over 9 percent for the first quarter of 2024, more than double the home health market basket forecast determined by the Office of the Actuary and reflected in the CY 2024 annual payment update.

[14] The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 6, 2024.

**Table 11[15]**
**Quarterly Growth (Year-over-Year) in Nursing Staff Hourly Wages, 2020-2024**




Source: Analysis of BLS data by Dobson|Davanzo

Partnership members continue to report significant increases in labor costs over the past year in order to be competitive in their respective labor markets. An annual update factor of 2.5 percent for CY 2025, even if it was not eliminated by the permanent adjustments, does not reflect the higher wage growth which continues to characterize the current labor market, nor does it reflect the federal government's own data on wage growth presented above.

It is critically important that the annual payment update reflects actual price growth. Particularly at a time when home health providers are facing increased demand for services resulting from staffing shortages, staff turnover, and competition from other healthcare provider sectors that have not faced three consecutive years of Medicare payment rate reductions. Partnership members continue to increase hourly rates and offer incentives to employees, however, those programs are unsustainable with continued cuts in reimbursement.

***Recommendation:*** The Partnership recommends that CMS apply the annual update factor based on the market basket for CY 2025, however, we urge CMS to re-examine the market basket and forecast methodology (as discussed further below) to ensure that payment under the home health PPS more accurately reflects price trends and the cost of providing care.

3. Forecast Error in the Home Health Market Basket

The Partnership considers the accuracy of the annual payment updates to be critically important to ensuring resources are available to provide patient care. The annual updates to the home health payment rates are based on forecasts of the market basket. Unfortunately, in making these forecasts in recent years, CMS has significantly under-estimated actual price growth. This recent series of forecast

[15] Bureau of Labor Statistics, Wages and salaries, cost per hour worked for civilian workers in registered nurse occupations, https://db.nomics.world/BLS/cm/CMU102000012N000D?tab=chart

errors total -5.7 percent for the period 2021 through 2023. This effectively acts as another large cut in reimbursement for home health providers as the cost of providing care grows dramatically and providers are facing significant payment reductions as a result of the permanent adjustments CMS has applied or proposed to date. The Partnership believes that CMS should correct for this error in home health payments going forward in CY 2025 to ensure accurate rates that reflect the true cost of care.

Public data[16] from the 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 through 2023. It may be that, historically, the market basket forecasts used by CMS to update home health payments relatively accurate over time, however, that has not been the case in recent years. The recent volatility in the economy and persistently large increases in labor costs during the period 2021 through 2023 has not been accounted for in CMS' forecast model.

As shown in Table 12 below, the forecast error in the home health market basket for CYs 2021 through 2023 resulted in a shortfall in the annual payment rate updates for those years of 5.7 percent.

**Table 12**
**Market Basket Forecast Error: CY 2021 through CY 2023**

| MB Forecast Error Impact | CY 2021 | CY 2022 | CY 2023 | Cumulative |
|---|---|---|---|---|
| **Actual Market Basket** | 3.9% | 6.2% | 4.7% | 10.7% |
| **HH PPS Projected Market Basket (Used in Final Rules)** | 2.3% | 3.1% | 4.1% | 5.5% |
| **Difference** | **-1.6%** | **-3.1%** | **-0.6%** | **-5.7%*** |

*Actual cumulative compounded forecast error over the three-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. In addition, we urge CMS to provide greater transparency regarding the forecast methodology it uses. While the technical details regarding structure and composition of the market basket are described fully by CMS, the forecast model that CMS employs is what is used by the Agency to actually establish payment rates each year. This forecast model is not currently available to the public and has not gone through formal rulemaking but may benefit from increased transparency and stakeholder input.

As shown in Table 13 below, the significant forecast errors in the market basket for the period CY 2021 through CY 2023 results in a significant cumulative reduction in aggregate payments over a 10-year period totaling more than $10 billion. The Partnership continues to believe, as detailed in its comment letter to the CY 2024 Proposed Rule, that special consideration is warranted to avoid significant long-term underfunding of the home health benefit. Correcting this significant projection error is appropriate and will help home health providers address current staffing, and other challenges acknowledged by CMS and the Medicare Trustees that have grown more acute as CMS has continues to apply permanent adjustments to the payment rates. We note that CMS applies a forecast error correction under the

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

skilled nursing facility PPS and thus there is precedent for doing so here. We believe application of a one-time adjustment to address this extraordinarily high error over this period is appropriate.

**Table 13**
**Projected Impact of 5.7 Market Basket Forecast Error**
**CY 2021 through CY 2030**

| Total Payments | Impact of CY 2021 and CY 2022 Forecast Error |
|---|---|
| 2021 | -$269,463,659 |
| 2022 | -$864,918,306 |
| 2023 | -$982,479,659 |
| 2024 | -$1,026,548,318 |
| 2025 | -$1,026,459,392 |
| 2026 | -$1,084,160,016 |
| 2027 | -$1,142,996,351 |
| 2028 | -$1,187,801,203 |
| 2029 | -$1,250,809,271 |
| 2030 | -$1,297,909,029 |
| **Total** | **-$10, 133,545,205** |

Source: Dobson | Davanzo

***Recommendation:*** The Partnership recommends that CMS finalize a one-time forecast error correction to account for the underestimates of the market basket for CY 2021through CY 2023. This correction would be applied prospectively to CY 2025 payments. Such a one-time adjustment would account for the significant forecast error, which is unlikely to be meaningfully offset by future over-forecasts over time. As a one-time adjustment, this would not conflict with the prospective nature of the payment rates going forward. We also continue to urge CMS to explore options to improve the accuracy of its forecast model and make it transparent to the public. Finally, if CMS chooses not to make this one-time adjustment, the Agency should acknowledge that the home health payment rates are already significantly under-valued by these recent forecast errors by -5.7 percent and not apply the proposed permanent adjustment.

4. Wage Index / New CBSA Delineations

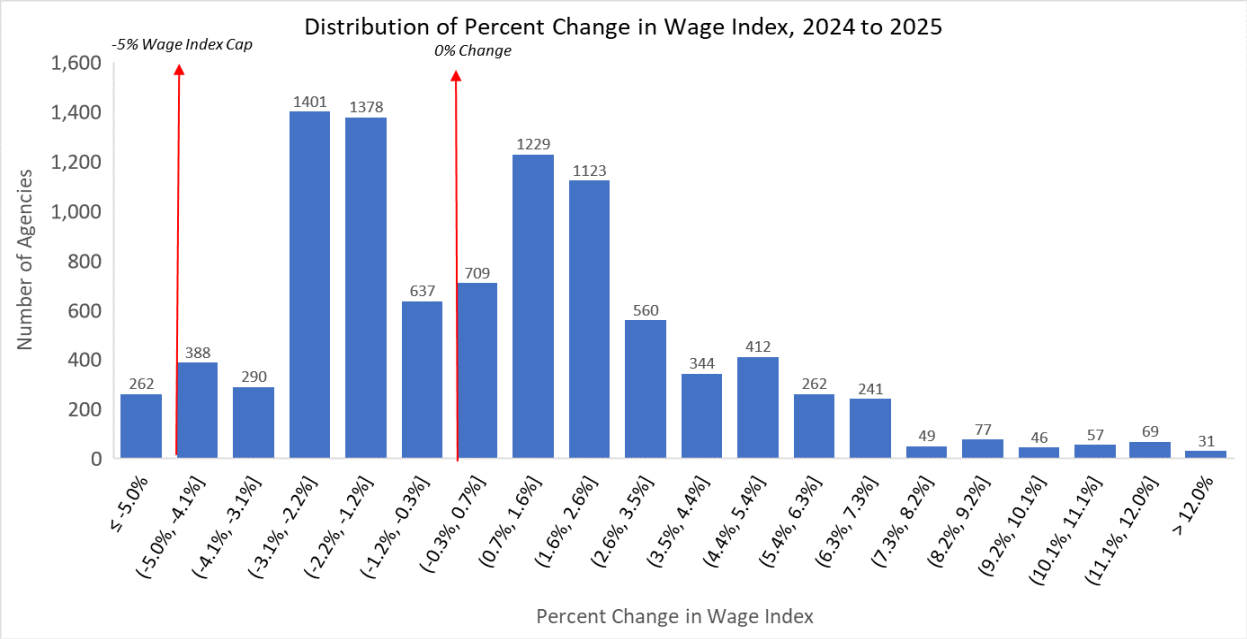
The Partnership supports the annual update to wage index to reflect the most recent data on geographic wage differences across the country. In addition, we understand the need to adopt the new Core Based Statistical Areas (CBSAs) in order to utilize geographic designations that reflect the most current U.S. population data. However, we do have concerns that these two changes in combination result in substantial payment variances for many home health providers. In addition, our analysis shows that the cumulative effect of these proposed changes, other proposed changes impacting the PDGM case mix model, and the proposed permanent adjustment of negative -4.067 percent magnify the impact of the Proposed Rule in a way that is detrimental for many providers and contributes significantly to the ongoing instability in home health payments from year to year. Finally, we are concerned about the significant variability in the wage index from year to year which further contributes to the lack of stability and predictability of Medicare payments.

For CY 2025, CMS proposes to base the Home Health PPS wage index on the FY 2025 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2020, and before October 1, 2021 (FY 2021 cost report data). Based on existing regulations and policy, the proposed CY 2025 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 Home Health PPS Final Rule.

In addition, CMS is proposing to implement revised CBSA geographic delineations as a result of updates by the Office of Management and Budget (OMB) using the latest (2020) census data. This policy is consistent with its proposals for other post-acute payment systems for 2025. The new CBSA designations can impact a provider's wage index resulting in an increase or decrease in payment and CMS notes that its policy applying a permanent 5 percent cap on decreases in an area's wage index value from year to year is sufficient to mitigate any significant adverse payment impacts associated with this change. Accordingly, CMS does not propose a phase-in or other mitigation mechanism related to the new geographic delineations.

The Partnership, working with Dobson|Davanzo, conducted detailed analysis of these proposed changes. We note that the distributional effects of these proposed changes for CY 2025 would be significant and for thousands of providers would result in further payment reduction in CY 2025 exacerbating the adverse effects of the proposed -4.067 permanent adjustment and creating enormous challenges in delivering care. Tables 14 and Table 15 below detail the impact of the proposed geographic wage index for CY 2025.

**Table 14**
**Distribution of Percent Change in Wage Index 2024 to 2025**




Source: Dobson|Davanzo

**Table 15**
**Home Health Providers Significantly Impacted by Wage Index Change in CY 2025**

| Count | Number | Percent |
|---|---|---|
| Number of HH Providers with change >/= -5.0% & < -4.4% | 518 | 5.4% |
| Number of HH Providers with change >/= -5.0% & < -2.0% | 2643 | 27.6% |
| Total Number of Agencies | 9,565 | **** |

Source: Dobson|Davanzo

Similar to CY 2025, Table 16 summarizes the impact of the wage index change finalized in last year's (CY 2024) final rule. As can be seen from the table, the changes to the wage index were similarly impactful to this year's CY 2025 Proposed Rule with thousands of providers facing material decreases in wage index values and payment as a result. 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 similar widespread changes in the wage index and payments last year. This, along with the -4.067 permanent adjustment, pushes payments to unsustainable levels for these providers. In addition, this raises concerns with the year over year variability of the wage index and its impact on the stability and predictability in payments.

**Table 16**
**Home Health Providers Significantly Impacted by Wage Index Change CY 2023 to 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

An analysis of the average wage index values across States shows significant variability from year to year further contributing to the unstable reimbursement environment for home health providers. Examples of this are shown in Table 17 below. As demonstrated in the examples, many States (and the CBSAs within them) experience swings in wage index values from year to year. These are often decreases, followed by increases, and vice versa. This outcome creates added instability for home health providers already struggling with years of rate cuts and increased costs. Home health providers are not able to increase or decrease salaries in the way that aligns with these continual wage index fluctuations creating challenges in staffing and operations. Again, such variability compounds the instability in reimbursement associated with the permanent adjustments making it very difficult to obtain the staffing and other resources necessary to provide effective care.

**Table 17**
**Examples of Wage Index Instability - Percent Change in Statewide Average (CYs 2023 to 2025)**

| State | CY 2023 | CY 2024 | CY 2025 |
|---|---|---|---|
| Hawaii | +2.0 | -2.3 | -4.9 |
| Montana | -4.0 | -2.6 | +6.1 |
| New York | +0.2 | +2.4 | -3.5 |
| Kansas | +0.5 | -1.4 | +1.6 |
| South Carolina | -1.5 | +0.6 | -2.1 |
| Mississippi | -0.9 | -3.7 | +4.3 |

| | | | |
|---|---|---|---|
| North Dakota | -2.2 | +8.0 | -2.0 |
| Pennsylvania | +0.1 | -1.3 | +1.8 |

***Recommendation:*** While the Partnership supports making changes that improve the accuracy of the geographic wage index under the home health PPS, we ask that CMS consider the significant adverse impact of the CY 2025 wage index and new geographic delineations on thousands of home health providers. We recommend that CMS move forward with changes in the wage index and new CBSA delineations, however, we ask the Agency to **not** apply the -4.067 permanent adjustment in CY 2025 to avoid the cumulative effect of multiple reimbursement cuts on many providers that compounds the ongoing instability of home health payments and impairs patient access and care delivery, particularly in areas with large changes in wage index values. CMS should also explore ways to improve the stability of the wage index from year to year.

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

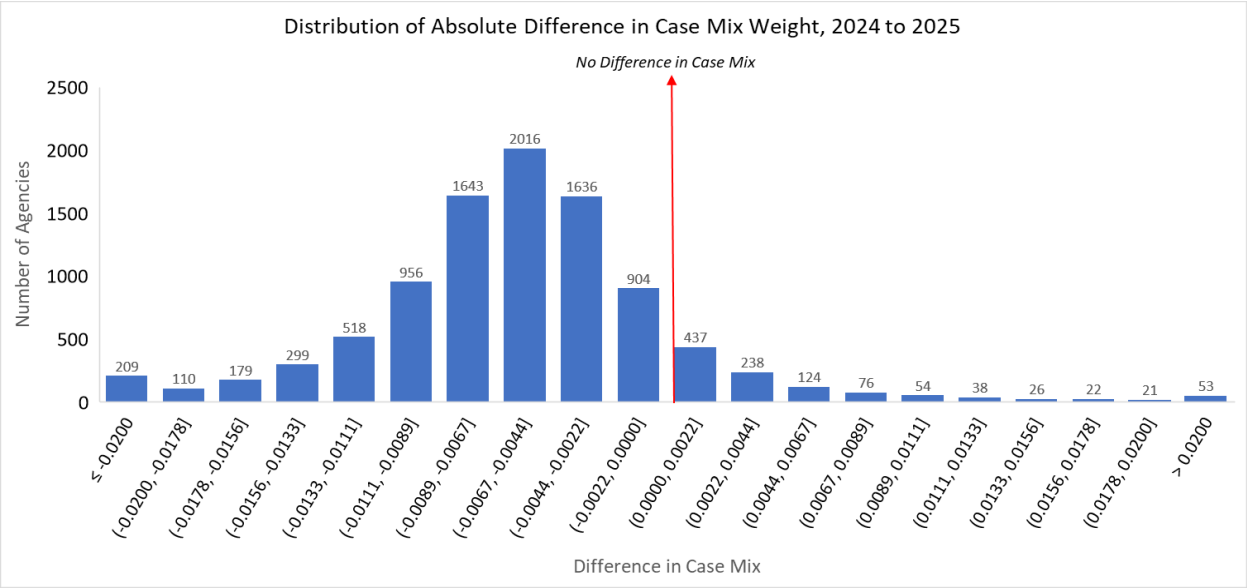
CMS proposes to recalibrate the PDGM case-mix weights, LUPA thresholds, and functional levels for CY 2025 using data from 2023 claims to ensure that PDGM accurately reflects home health resource use. In general, the Partnership supports annual recalibration of the case-mix weights to ensure payments reflect current trends in care delivery and are as accurate as possible.

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 2025 case-mix weights, CMS used CY 2023 home health claims data with linked OASIS data (as of March 19, 2024). 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 2023 claims data for the Final Rule.

Similar to our comments regarding the wage index update above, the Partnership supports use of the most recent available data to update the PPS case-mix adjustment each year. However, we are again concerned that the proposed changes to the case mix weights and functional levels for CY 2025 contribute to substantial year to year payment variances and, while calibrated by CMS to be budget neutral in the aggregate, have a significant financial impact on many providers as weights are driven lower to meet CMS' budget neutrality target.

The cumulative effect of these proposed changes, along with the significant impact resulting from the wage index update and new CBSA delineations, and the proposed permanent adjustment of -4.067 percent will result in very significant adverse payment impacts for many home health providers, significantly greater than the -1.7 percent average impact determined by CMS in the Proposed Rule. Table 18 below shows the significant number (89 percent) of home health providers that would experience decreases in their average case mix weight as a result of these changes.

**Table 18**
**Distribution of Absolute Difference in Average Case Mix Weight, CY 2024 to CY 2025**




***Recommendation:*** The Partnership supports recalibration of the case-mix weights using updated data from 2023 claims, however, the Partnership again recommends that CMS not apply the permanent adjustment of -4.067 in CY 2025 to avoid the cumulative effect of multiple reimbursement changes that have significant negative impacts for thousands of home health providers and will further harm patient access and care delivery.

6. Financial Impact of CY 2024 Payment Changes

CMS' high level impact analysis showing an aggregate -1.7 percent decrease in payments for CY 2025 does not convey the substantial adverse impact that the Proposed Rule will have on the home health provider community, the variability of that impact across 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 below and in the attached report by Dobson|Davanzo.

As discussed above, in addition to the significant reductions in payment advanced in this Proposed Rule and already applied in CY 2023 and CY 2024 by CMS, other aspects of the home health payment system and proposed "routine" changes are causing highly disparate and adverse impacts on thousands of home health providers which have the effect of magnifying the proposed permanent cut to the 30-day payment rate. These include a home health market basket which continues to fail to reflect the rising costs of providing care, particularly for labor as staff shortages continue; changes in case-mix weights and functional levels which penalize providers treating the sickest patients; and the effects of the revised CBSA delineations and wage index changes for CY 2025. Unfortunately, and similar to CY 2024, the impact analysis presented in the Proposed Rule focuses largely on broad averages and classes of providers and does not convey the magnitude of the harm resulting from the proposed policies in the rule.

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 2025 is estimated to be -$280 million (-1.7 percent). CMS notes that the $280 million decrease in estimated payments for CY 2025 reflects the effects of the CY 2025 proposed home health payment update percentage of 2.5 percent ($415 million increase), an estimated 3 .6 percent decrease that reflects the effects of the permanent behavior assumption adjustment ($595 million decrease) and an estimated 0.6 percent decrease that reflects the effects of an updated fixed dollar loss (FDL) ratio associated with the outlier adjustment ($100 million decrease). As a result of the proposed changes, the 30-day period payment rate in CY 2025 declines to $2,008.12 from its CY 2024 level of $2038.13.

CMS' analysis of the broad impact of the Proposed Rule raises concerns for the Partnership because of its sole reliance on 2023 claims data which offers a dated and static view of the factors impacting providers in the current market which continue to evolve quickly. In addition, CMS' impact analysis addresses average payment changes in total and across broad classes of home health providers. This masks the extent of the downward impact on payments and re-distributional effects that will adversely impact thousands of home health providers in CY 2025 under the Proposed Rule policies. Below and in the attached report from Dobson|Davanzo, the Partnership provides analysis detailing the harmful and variable effects of these proposals on home health providers. Tables 19 through 22 show the variability of the Proposed Rule's impact based on analysis of 2023 home health claims.

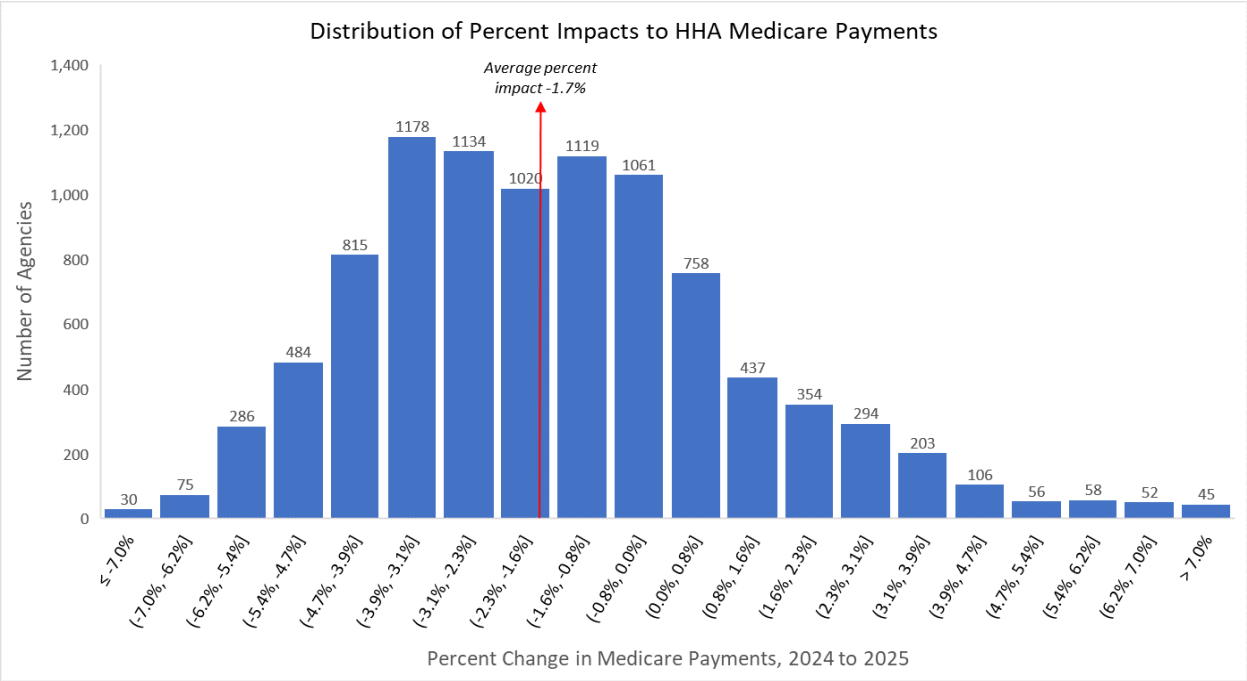
- Table 19 shows the range of payment impacts across home health care providers for CY 2024 resulting from the Proposed Rule.

- Table 20 provides the average Medicare payment impact by state.

- Table 21 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 22 provides a simple count of providers above and below the average Impact of the Proposed Rule.

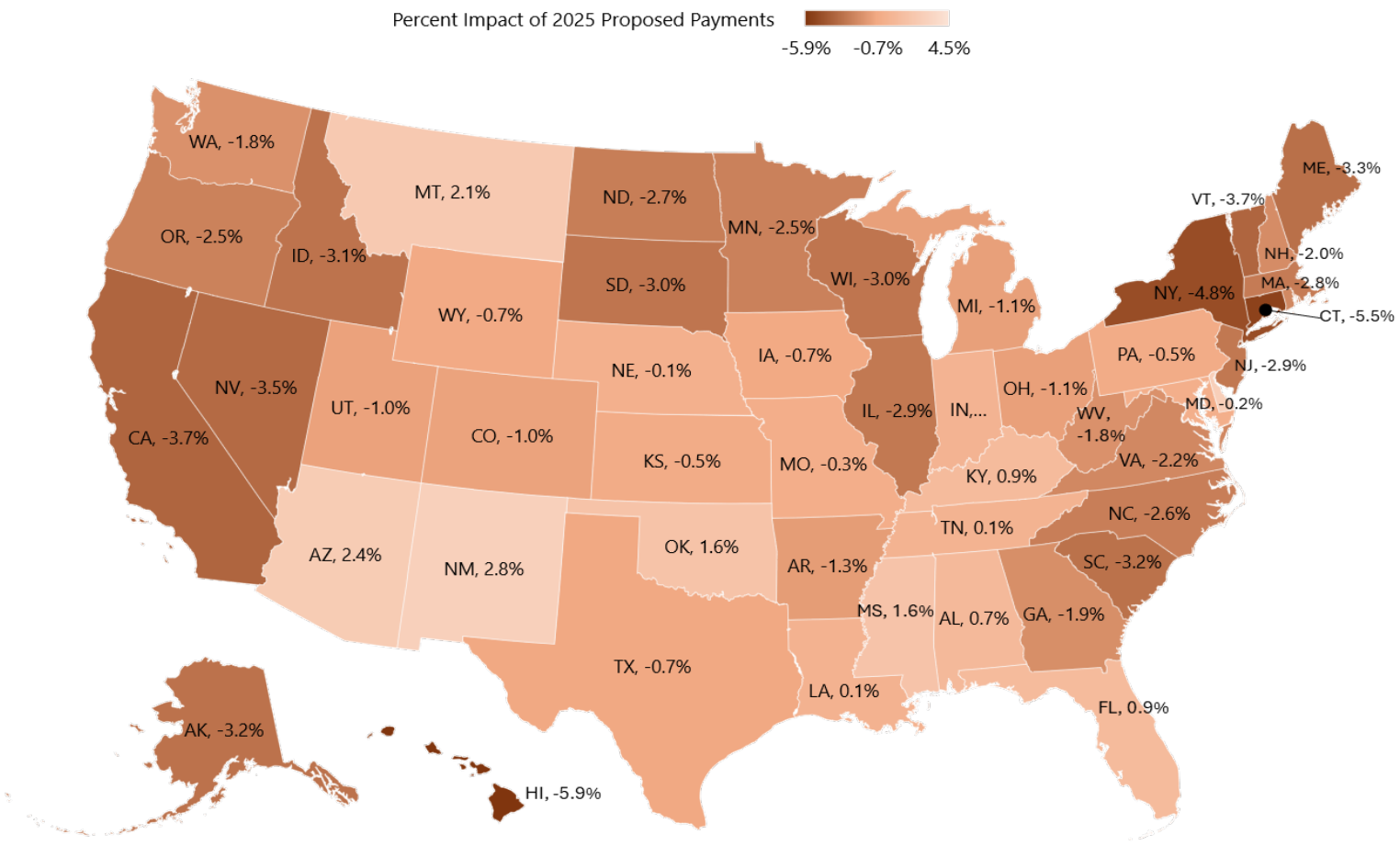
**Table 19**
**Distribution of CY 2025 Proposed Rule Medicare Payment Impact Across Providers**




Source: Dobson|Davanzo

**Table 20**

CY 2025 HH PPS Proposed Rule Projected Impacts to HHA Medicare Payments, by State




Source: Dobson | DaVanzo analysis of OASIS LDS Files for CY 2025 HH PPS Proposed Rule. DUA

**Table 21:**
**Top 10 states by Highest Percent Reduction in CY 2025 Payments**

| State | Number of Home Health Agencies | Percent Impact of 2025 Proposed Payments | Range of Agency Impacts (min-max) | Range of Agency Impacts (5th -95th Percentile) |
|---|---|---|---|---|
| **National** | **9,565** | **-1.7%** | **-29.7% , 13.8%** | **-5.2% , 3.2%** |
| Hawaii | 12 | -5.9% | -12.5% , -5.1% | -9.4% , -5.1% |
| Connecticut | 71 | -5.3% | -6.7% , -0.2% | -6.0% , -4.2% |
| New York | 102 | -4.8% | -6.7% , 4.6% | -6.4% , 0.0% |
| California | 2029 | -3.7% | -9.3% , 11.5% | -5.9% , -0.4% |
| Vermont | 10 | -3.7% | -4.3% , -3.0% | -4.3% , -3.2% |
| Nevada | 160 | -3.5% | -6.6% , -1.0% | -5.0% , -2.3% |
| Maine | 20 | -3.3% | -4.8% , -1.7% | -4.8% , -1.7% |
| South Carolina | 75 | -3.2% | -5.1% , 4.6% | -4.7% , -0.2% |
| Alaska | 13 | -3.2% | -5.2% , -2.1% | -5.1% , -2.3% |
| Idaho | 46 | -3.1% | -6.0% , -0.5% | -5.9% , -1.1% |

Source: Dobson|Davanzo

**Table 22**
**Providers Above and Below Average Impact of Proposed Rule**

| | | |
|---|---|---|
| Number of Providers Impact > -1.7% | 4,830 | 54.8% |
| Number of Providers Impact < -1.7% | 4,735 | 45.2% |
| Total Number | 9,565 | 100% |

Source: Dobson|Davanzo

These data demonstrate the significant number of providers with substantial negative payment impacts far exceeding the average aggregate payment impact of -1.7 percent determined by CMS or impacts by broad classes of providers identified in the agency's impact analysis. As shown in Table 21 and 22, a majority of providers face payment decreases greater than CMS' average impact. They also show how the broader redistribution of payments between CY 2024 and CY 2025 combined with the -4.067 permanent adjustment significantly impacts home health providers, including those in rural states. In addition, the analysis showing declines in Medicare payments needs to be considered in light of the concurrent rise in the costs of care, particularly for staffing. It is clear that the financial challenges faced by providers are severe and getting worse.

Under the Proposed Rule, CY 2025 would be the third consecutive year CMS has applied significant reductions in payments to home health providers. The proposed permanent adjustment of -4.067 to the 30-day payment rate payments on top of the adjustments for 2023 and 2024 are not sustainable. Given rising costs and annual updates that have failed to reflect these cost increases, an average net -1.7

percent decrease in payments cannot be absorbed, and as we have shown the decrease in payments is significantly larger for thousands of providers and many areas of the country.

As presented earlier in this comment letter all data trends on access to care for home health point downward and indicate care delivery under the Medicare Home Health Benefit is already being compromised by these reductions. Without a viable Home Health Benefit and provider community, the impact on access to care will be broader than just Medicare fee-for-service but also adversely impact 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 2025 and take action to address this continuing crisis.

Finally, while CMS is not proposing to implement temporary adjustments in CY 2025, we wish to note our deep concern that CMS may apply these adjustments in future years. The Proposed Rule indicates that the current total for temporary adjustments that are required to be recouped by CMS are $4.5 billion. On top of the steep permanent adjustments already proposed or applied since 2023, these temporary adjustments would result in further severe reductions in payments to home health providers establishing payments far below the reduced payment rates that CMS asserts are budget neutral. The result would be further harm to patient care and access and a fundamental dissolution of the Home Health Benefit that beneficiaries rely on. The application of temporary adjustments would clearly result in outsized reductions that would have extreme adverse effect on home health providers and patients.

***Recommendation:*** The Partnership urges CMS to carefully consider the data presented on the ongoing deterioration of patient access presented in Section I of this letter and the payment impact analysis in this section detailing the wide-ranging cumulative and variable effects of the proposed -4.068 percent permanent adjustment combined with other routine payment changes impacting the wage index and case-mix adjustment. We reiterate our recommendation above that CMS withdraw its proposal and not apply the proposed permanent adjustments to the home health payment rates in CY 2025. CMS should review the law and propose a new methodology that aligns with the statutory requirements or work with Congress to establish a sustainable reimbursement structure under the Home Health Benefit

## III. Home Health CoP (Conditions of Participation) Changes

In section VI.A. of the Proposed Rule, CMS proposes to add a new standard at § 484.105(d) that would require home health agencies to develop, implement, and maintain an acceptance to service policy that is applied consistently to each prospective patient referred for home health care. CMS also proposes that the policy must address, at minimum, the following criteria related to the home health agency's capacity to provide patient care: the anticipated needs of the referred prospective patient, the home health agency's case load and case mix, the home health agency's staffing levels, and the skills and competencies of the home health agency's staff. CMS also proposes that home health agencies would be required to make specified information available to the public that is reviewed at least annually.

According to CMS in Table 1 (Summary of Costs, Transfers and Benefits), the projected cost to develop, implement and maintain through an annual review the acceptance to service policy is expected to total $3,078,400 for all home health agencies and $65,999 for an annual review. To make specified information publicly available, CMS estimates a onetime cost of $99,763 for all home health agencies and $33,286 for an annual update.

The Partnership appreciates CMS' goal of improving the referral process and reducing avoidable care delays by helping ensure that referring entities and patients can select the most appropriate home health agency based on their care needs and to make this information more broadly accessible.

However, the Partnership feels strongly that the overlay of yet another costly, uncompensated, CoP compliance requirement is exactly the wrong approach to ameliorating concerns and questions about the availability and appropriateness of one home health agency's ability to provide timely services over another's. While we are sensitive to the complex and unique care needs of patients presented to us for admission, including those confronting challenging social determinants of health or other obstacles, we assert that our agencies already meet the "reasonable expectation" that a specific home health agency can meet the patient's needs in his or her place of residence, on a timely basis.

We acknowledge that referral practices, arising from hospital discharge planers, beneficiaries themselves or from their caregivers, can sometime offer an incomplete picture of a home health agency's real-time ability to assume multiple clinical responsibilities in a timely manner. But Partnership member organizations deploy nurse and social worker navigators already to support these important care transitions.

Constrained by timing demands and labor shortages, hospital and other institutionally-directed discharge planning processes often provide useful, but generic, information about home health agency transfer options in a specific service area, sometimes providing beneficiaries with a number of choices that lack the specificity CMS seeks in its proposal. Home health agencies typically see patient transfer opportunities online in real time along with local competitors and often need to make service acceptance decisions promptly. Home health agencies accept new patients only when their own internal systems can confirm that the needs of the patient, however complex, can be met expeditiously. While coordination with institutional discharge planners occurs and can streamline care transitions, such coordination is not the norm.

Recognizing the significant burdens faced by institutional discharge planners and social workers, Partnership home health agencies retain dedicated staff prepared to answer patient-specific concerns about care needs, clinical availability and care planning already as standard operating procedure. As home health agencies face their own labor shortages and financial shortfalls detailed elsewhere in this letter, the proposed solution to improving the information flow between discharging entities and home health agencies is not a new and costly CoP on home health agencies. CMS should instead provide appropriate resources at every stage of the process to support seamless care transitions by more fully supporting institutional discharge professionals and home health agency onboarding specialists.

CMS' proposed, costly new CoP on home health agencies would do absolutely nothing to change the realities and complexities of patient transfers and would instead shoulder home health agencies with still more compliance obligations that will fail to change or improve the patient experience.

The Partnership appreciates the concern that some home health agencies may be taking on beneficiaries they can't serve quickly or with the right care disciplines, or that some new beneficiaries may face start of care delays or wait times to be seen by appropriate clinical professionals. Partnership member organizations acknowledge that these dynamics can and do occur, but the answer or solution to the problem does not lie in the requirement of a new CoP that will require still further home health

agency staff resources amid significant labor constraints that CMS itself acknowledges "may be related to workforce shortages." [17]

As discussed elsewhere in this letter, the home health agency workforce attraction and retention problem is real and shows no signs of abating. Home health agencies compete for clinical and administrative labor in the same competitive markets as higher-paying hospital systems, skilled nursing facilities and other health care facilities that do not require nurses and therapists to travel to patient homes, and that have not been subjected to systematic and paralyzing across-the-board payment rate reductions that have exacerbated the home health agency staffing crisis since 2020.

The Partnership also notes that current home health agency CoPs at § 484.55(a)(1) require home health agencies to conduct an initial assessment visit to determine the immediate care and support needs of the patient within 48 hours of the referral, within 48 hours of the patient's return home, or on the physician-ordered start or care date. Moreover, §484.55(b) requires that the comprehensive assessment must be completed in a timely manner, by a registered nurse, but no later than 5 calendar days after the start of care.

Accordingly, the Partnership finds the proposed new CoP to overlap with, or be duplicative of, existing CoPs that home health agencies fully comply with under current law and policy. Adding yet another layer of reporting obligation, recordkeeping and annual review to a CoP process that already ensures timely care initiation is overly burdensome, bureaucratic and unnecessarily expensive for home health agencies that have continued to absorb deleterious year-over-year rate reductions that make implementation of the new proposed CoP impracticable, if not impossible.

The Partnership also shares the concern that implementation of any CoP CMS finalizes is likely to be inconsistent and uneven. We are especially concerned that the array of requirements proposed in the CoP will be difficult for surveyors to interpret and will likely lead to divergent outcomes and standards for home health agencies, depending on where the survey took place and which state and/or federal officials conducted the surveys themselves. The proposed CoP is vague with respect to how surveyors should identify, document and cite alleged deficiencies, and CMS' interpretative guidance, especially in its early stages, is likely to cause more confusion that will only create more home health agency staff distraction and time commitment that it does not have to resolve. Surveyors are primarily trained to focus on care quality and patient safety, not more broadly on access to care, which this CoP, if finalized, would require them to do.

***Recommendation:*** For all the above reasons – its impracticalness, its burdensomeness, its duplicative nature in the context of existing CoPs, its complexity in implementation with surveyors, and, most importantly, in its unrealistic assessment of clinical and operational time and labor costs associated with it in an unyielding era of dramatic CMS payment reductions for home health agencies, the Partnership strongly opposes finalizing the proposed service acceptance CoP in the Proposed Rule.

## IV. 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

[17] 89 *Fed. Reg*. 128 (July 31, 2024) at 55399.

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 home health agencies and finalize a 2025 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 2025. 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 2025.**

Sincerely,

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

# Appendix 1

# Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2025 HH PPS Proposed Rule

## *Assessing the Impact of CMS' Proposed Payments and the Future of Access to Home Health Services*

Submitted to: Partnership for Quality Home Healthcare (PQHH)

Submitted by:

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Monday, August 26, 2024

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## Executive Summary

Dobson DaVanzo & Associates, LLC (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 2025 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 2025 HH PPS Proposed Rule. We also draw from our work in prior rule making cycles.

Outlined below are key conclusions from our analysis.

1. **Insufficient Data Made Available by CMS**
   **CMS' CY 2025 HH PPS Proposed Rule data are not sufficient for a precise replication of CMS' impact analysis of the CY 2025 proposed payments.** Unlike in the CY 2020 rule making cycle, CMS did not make available the "current law" (CY 2024) payments to allow precise modelling of CY 2025 proposed payment impacts at different levels of aggregation. Yet, these case-level data are critical for a complete and accurate assessment of the agency-level distributional impact of the CY 2025 HH PPS proposed policies.

2. **Impact of the CY 2025 HH PPS Proposed Rule on HHA Medicare Payments**
   **CMS projects that CY 2025 payments will result in aggregate payment reductions of 1.7 percent across all agencies, however significant variation in agency-level impacts exist, with percent impacts ranging between -5.2% (95$^{th}$ percentile) to 3.2% (5$^{th}$ percentile).** This variation in agency-level impacts is largely driven by the fluctuation in the wage index between CY 2024 and CY 2025. The observed variation in agency-level impacts is also driven in part by the proposed CY 2025 case-mix recalibration.

3. **Analysis of HH PPS Market Baskets**
   **The HH PPS market basket updates are not reflective of actual price and labor supply 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.** Analysis of the projected and actual market basket for CY 2021 through CY 2023 indicates a cumulative forecast error of 5.7 percent, which if uncorrected could result in -$10.1 billion in reduced payments for HHAs over a 10-year period. While CMS proposes a market basket increase of 3.0 percent in CY 2025, data from the Bureau of Labor and Statistics (BLS) indicates that hourly nurse wages grew by 9.3 percent in Q1 of 2024 compared to the Q1 of 2023. Additionally, analysis of home health-specific labor supply shows much slower growth in employment for the staff most relevant to delivering home health services, suggesting continued labor supply constraints. We also observe a reduction in the number of home health agencies billing Medicare between 2019 and 2023.

4. **Trends in Medicare FFS Home Health Utilization**

[1] CMS DUA 54747.

**Our analysis of claims data show declines in the percent of Medicare FFS beneficiaries are home health services between 2019 and 2023, yet patient severity appears to be increasing.** Despite a continued decrease trend in the number of Medicare FFS beneficiaries (-11.1 percent reduction between 2019-2023), there is a much larger reduction in the number of FFS beneficiaries using home health within the same period (-17.1 percent).

5. **Impact of the Existing and Proposed Permanent Reductions and Future Temporary Reductions**

   **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 $28 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 $28 billion reduction reflects the cumulative impact of the 4.36 percent reduction due to assumed provider behaviors implemented in CY 2020, the cumulative impact of the permanent adjustment for CY 2023, CY 2024, and CY 2025, and a modeled $6.5 billion reduction due to the temporary reductions to reconcile CY 2020 through CY 2026 aggregate payments.[2]

The extensive scale of the proposed CY 2025 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 may widen healthcare disparities for underserved populations. 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 and serving vulnerable, hard to reach, complex populations.

[2] Note that CMS states in the CY 2025 HH PPS proposed rule that a $4.5 billion reduction is required to reconcile CY 2020 through CY 2023 payments. We (Dobson | DaVanzo) further estimate that an additional $2.0 billion would be required to reconcile CY 2024 through CY 2026 payments.

## Introduction

Dobson DaVanzo & Associates (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to analyze available Medicare home health claims data reflecting the implementation of the Patient-Driven Groupings Model (PDGM) in support of PQHH development of comments for the CY 2025 Home Health Prospective Payment System (HH PPS) Proposed rule. Dobson | DaVanzo previously supported PQHH in the review of PDGM as included in Calendar Year (CY) 2018 through CY 2024 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, CMS 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. Using the same methodology, CMS finalized a -2.89 percent cut (half of the initially proposed -5.653 percent) in CY 2024. In the CY 2025 HH PPS Proposed rule, CMS is proposing a permanent adjustment of -4.067 percent in CY 2025, which includes the remaining permanent adjustments not applied in prior final rules. CMS also calculated additional temporary adjustments of approximately $4.5 billion to reconcile retrospective overpayments from CY 2020 through 2023.

For CY 2025, CMS is projecting that home health will experience an aggregate reduction of $280 million in payments, or a -1.7 percent reduction. This aggregate reduction includes a -3.6 percent overall payment reduction due to the permanent adjustment, a 0.6 percent reduction due to the effects of the fixed-dollar loss ratio (FDL) updates, and a 2.5 percent payment update reflecting the market basket update of 3 percent reduced by a productivity adjustment of 0.5 percent.

## Detailed Findings

### 1. Insufficient Data Made Available by CMS

We commend CMS for making case-level data available through the CY 2025 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 2024 CLAIMS-LEVEL PAYMENTS THAT CMS USED TO CREATE THE IMPACT TABLE IN THE PROPOSED RULE ARE NOT PROVIDED

In the CY 2025 Proposed Rule CMS OASIS-LDS PDGM impact file, CMS provided projected case-level CY 2025 payments based on CY 2023 home health claims data adjusted to reflect the CY 2025 payment update, permanent behavioral adjustment and FDL update.

Additionally, we determined total CY 2025 payments of $15.2 billion from CMS' OASIS-LDS dataset. We note that the code that CMS used to create the LDS file shows that total payments in the impact file are $15.2 as well. Yet, from the proposed rule, we calculated that projected CY 2025 payments would have had to be $16.19 billion and CY 2024 payments of $16.47 billion to equate to a $280 million (or a 1.7 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 2025 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.

To model the impacts of the proposed payments on home health revenues, the specific adjustments that the agency applied to the CY 2023 data to project the CY 2024 payments are needed. The complete CY 2024 data are currently not available as the year is not complete and we would require another 2 to 5 months for run out after year end.

### 2. Impact of the CY 2025 HH PPS Proposed Rule on HHA Medicare Payments

#### IMPACT OF CY 2025 HH PPS PROPOSED PAYMENT RATES ON HHA MEDICARE PAYMENTS

CMS projects in the CY 2025 HH PPS that home health agencies will experience an aggregate reduction of $280 million, or a 1.7 percent reduction, in payments between CY 2024 and CY 2025. This aggregate reduction includes an overall 3.6 percent reduction[3] due to the permanent behavioral adjustment, a 0.6 percent decrease for the FDL, and a 2.5 percent increase for payment update, inclusive of the market basket update for the multifactor productivity adjustment (MPF).

[3] As CMS notes in the CY 2025 HH PPS proposed rule, the -4.067 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 3.6 percent overall payment reduction.

### *METHODOLOGY*

We examined the impacts of the CY 2025 HH PPS proposed payment rates on HHA Medicare payments by comparing current law (Dobson | DaVanzo estimated CY 2024) payments to the projected CY 2025 payments provided by CMS in the OASIS LDS files through the following steps.

*Step 1*: We obtained CY 2025 projected case-level payments from the CY 2025 CMS OASIS-LDS impact file dataset. We then aggregated the cases for each agency using the provider CCN and determined the CY 2025 payments for each agency.

*Step 2:* We modeled CY 2024 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 2024 claim-level payments by adjusting the CY 2024 standard base payment rate by case mix and the labor portion by wage index.
- Partial Episode Payment (PEP) Cases: We proportionally adjusted the CY 2024 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 CY 2024 outlier threshold. We also implemented a 5 percent cap to each agency's aggregate outlier payments.
- Low Utilization Payment Adjustment (LUPA) Cases: We estimated episode payments by applying the CY 2024 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 modeled CY 2024 payments and the projected CY 2025 payments for each agency.

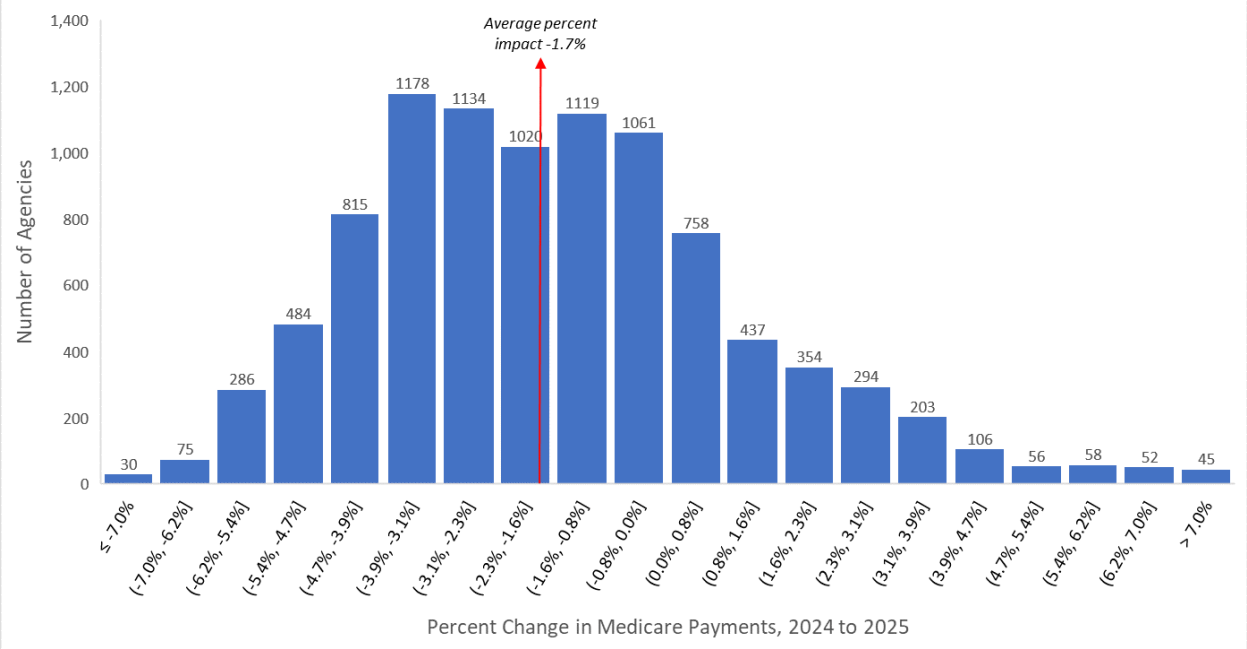
We note that the total CY 2025 payments determined from the CY 2025 CMS OASIS-LDS impact dataset were short of the projected CY 2025 payments that would have resulted in a -$280 million reduction in payments, or a -1.7 percent reduction. We calculated that CY 2025 payments of $15.24 billion and CY 2024 payments of $15.60 billion equate to a -$365 million (or a -2.3 percent) reduction in payments over the two years. We therefore applied adjustments at the agency level such that the CY 2024 and CY 2025 payments differences for each agency summed up to a $280 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 $280 million to determine the adjusted payment reduction. We used the same method to adjust the CY 2024 and CY 2025 payments for each agency.

## *RESULTS*

### Agency Impacts

When comparing the percent impact (i.e., the percent change between modeled CY 2024 and projected CY 2025 payments) at the agency level, we find that home health agencies have impacts that are approximately normally distributed around the average impact of -1.7 percent. The percent impact ranges between -29.7 percent to 13.8 percent with a 5th and 95th percentile range of -5.2 percent and 3.2 percent. We also estimate that roughly 50.5 percent of HHAs in 2025 will have larger negative payment reductions than -1.7 percent. The full distribution of projected agency percentage impacts is shown in **Exhibit 1** below**.**

**Exhibit 1: Distribution of Agencies by Percent Change in Medicare Payments between CY 2024 and CY 2025**




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

### Rural vs. Urban Impacts

We also examined the distribution of the percent projected change in Medicare payments for agencies in rural versus urban areas. We found that 15 percent of agencies are located in rural areas, serve approximately 15 percent of Home Health cases, and will experience a smaller negative percent reduction compared to agencies in urban areas. These results are shown in **Exhibit 2**.

**Exhibit 2: Percent Impact between CY 2024 and CY 2025 for Agencies in Rural vs. Urban Areas**

| Location | Percent of Agencies | Percent of Cases | Projected 2025 Payment Impact | Per Capita Payment Impact | Percent Impact |
|---|---|---|---|---|---|
| Rural | 15% | 15% | -$8,663,498 | -$7.57 | -0.43% |
| Urban | 85% | 85% | -$269,878,434 | -$39.96 | -1.87% |

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

Despite the trends at the national level, rural HHAs will experience a larger negative reduction in Medicare payments compared to urban HHAs in sixteen states. These states are identified in **Table 1** in the Appendix.

## State Impacts

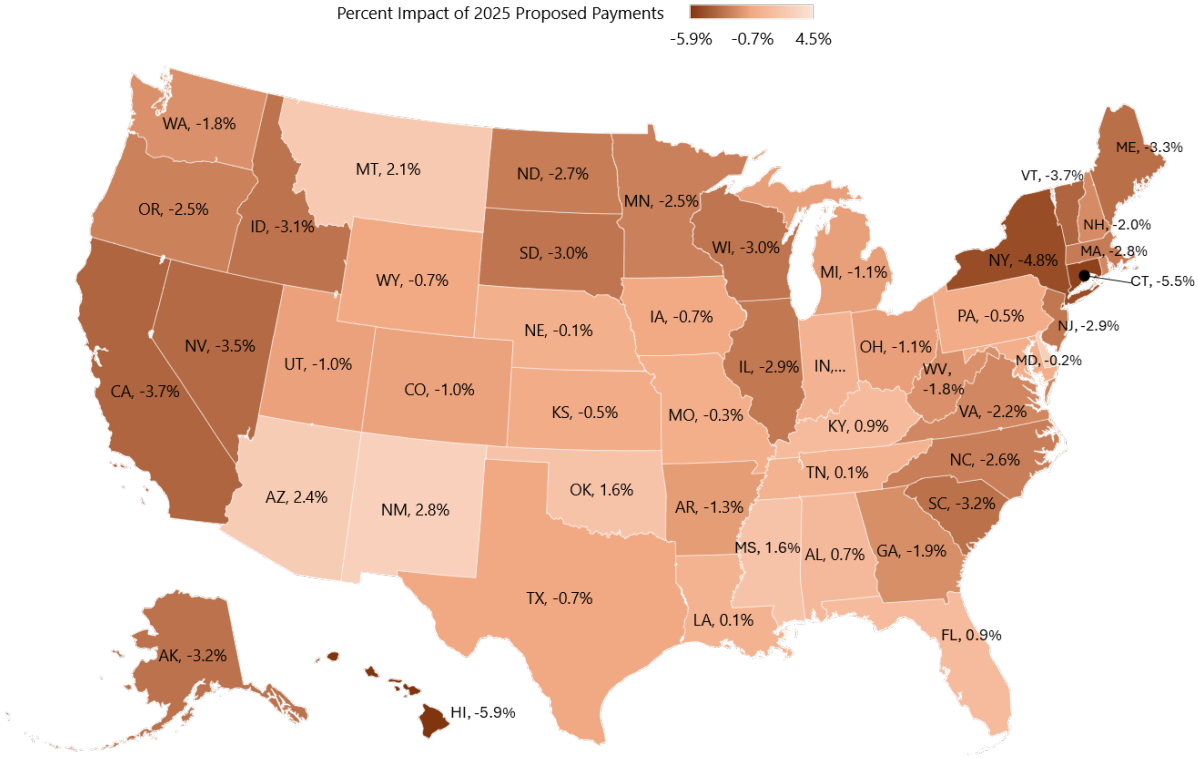
In **Exhibits 3** and **4** below, we show the projected changes in Medicare payments for HHAs in each state. Results show that while CMS estimates an aggregate reduction of -1.7 percent, the top 10 states with the highest percent reduction in payments are projected to experience average percent reductions ranging from -5.9 percent to -3.1 percent—reductions that are nearly double than the overall percent impact of -1.7 percent.

**Exhibit 3: Top 10 States with Highest Projected Revenue Changes between CY 2024 and CY 2025[4]**

| State | Number of HHAs | Case Count | 2024 Simulated Total Case Payments | 2025 Total Case Payments | Impact of 2025 Proposed Payments | Percent Impact | Range of Agency Impacts (Min – Max) | Range of Agency Impacts (5th -95th percentile) |
|---|---|---|---|---|---|---|---|---|
| HI | 12 | 9,187 | $21,664,273 | $20,389,953 | ($1,274,321) | -5.90% | -12.5%, -5.1% | -9.4%, -5.1% |
| CT | 71 | 38,318 | $207,230,089 | $196,262,486 | ($10,967,604) | -5.30% | -6.7%, -0.2% | -6.0%, -4.2% |
| NY | 102 | 8,038 | $808,820,546 | $769,918,143 | ($38,902,403) | -4.80% | -6.7%, 4.6% | -6.4%, 0.0% |
| CA | 2,029 | 189,412 | $3,168,732,723 | $3,050,110,017 | ($118,622,707) | -3.70% | -9.3%, 11.5% | -5.9%, -0.4% |
| VT | 10 | 108,134 | $48,501,730 | $46,690,802 | ($1,810,928) | -3.70% | -4.3%, -3.0% | -4.3%, -3.2% |
| NV | 160 | 25,601 | $219,481,338 | $211,769,500 | ($7,711,838) | -3.50% | -6.6%, -1.0% | -5.0%, -2.3% |
| ME | 20 | 12,588 | $49,370,851 | $47,749,522 | ($1,621,329) | -3.30% | -4.8%, -1.7% | -4.8%, -1.7% |
| SC | 75 | 60,083 | $297,442,808 | $287,963,953 | ($9,478,854) | -3.20% | -5.1%, 4.6% | -4.7%, -0.2% |
| AK | 13 | 254,118 | $18,651,920 | $18,063,009 | ($588,912) | -3.20% | -5.2%, -2.1% | -5.1%, -2.3% |
| ID | 46 | 36,829 | $65,902,921 | $63,846,388 | ($2,056,533) | -3.10% | -6.0%, -0.5% | -5.9%, -1.1% |
| **All States** | **9,565** | **7,923,651** | **$16,470,588,235** | **$16,190,588,235** | **($280,000,000)** | **-1.70%** | **-29.7%, 13.8%** | **-5.2%, 3.2%** |

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

**Exhibit 4: Distribution of Projected Revenue Changes by State, between CY 2024 and CY 2025**




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

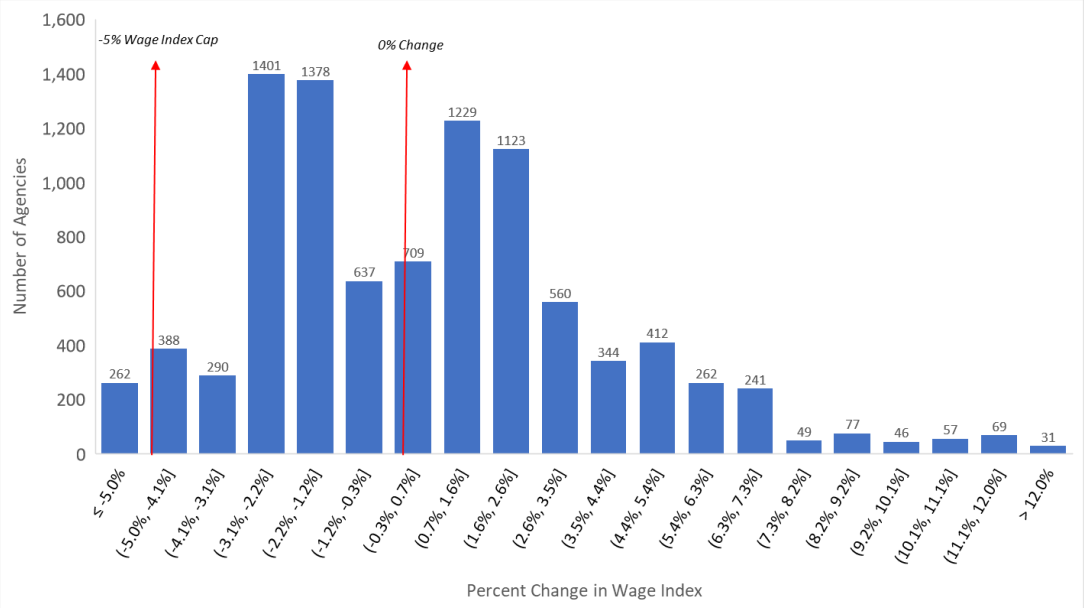
[4] Numbers may not add up due to the effects of rounding.

## IMPACT OF THE CY 2025 HH PPS PROPOSED WAGE INDEX

We examined the changes in the average wage index for each home health agency using the data on CY 2023, CY 2024, and CY 2025 wage indices for each case available in the CMS OASIS LDS dataset.

In **Exhibits 5** and **6** below, we show the percent change in average wage index between CY 2023 and CY 2024 and CY 2024 and CY 2025 for each agency. As illustrated in the exhibits, there is significant volatility in the wage index, despite the -5 percent cap. For instance, between CY 2024 and CY 2025, nearly one third of the agencies are projected to have a larger negative percent reduction than -2.0 percent and less than -5.0 percent. In comparison, based on data from the CY 2024 HH PPS Proposed and Final Rule, 50.4 percent of agencies were projected to have a larger negative percent reduction than -2.0 percent and less than -5.0 percent reduction in wage index between CY 2023 and 2024.

**Exhibit 5: Distribution of Percent Change in Wage Index, CY 2024 to CY 2025**




| Threshold* | Number of HHAs | Percentage |
|---|---|---|
| Agencies with >= -5.0% & < -4.4% change | 518 | 5.4% |
| Agencies with >= -5.0% & < -2.0% change | 2,643 | 27.6% |

**Not included in chart*

**Exhibit 6: Distribution of Percent Change in Wage Index, CY 2023 to CY 2024 (CY 2024 HH PPS LDS File)**

| 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% |

*Source: Dobson | DaVanzo analysis of OASIS LDS Files for CY 2025 HH PPS Proposed Rule, DUA 58177, Dobson | DaVanzo analysis of OASIS LDS Files for CY 2024 HH PPS Proposed Rule, DUA 59233, *Not included in chart*

## 3. Analysis of HH PPS Market Baskets

### ANALYSIS OF MARKET BASKET FORECAST ERROR AND IMPACT ON FUTURE PAYMENTS

We identified a market basket forecast error of 5.7 percent for the CY 2021 to CY 2023 HH PPS finalized market basket updates. We also estimated that, if uncorrected, the forecast error would result in -$10.1 billion in lost payments for HHAs between 2021 and 2030. The methodology for our analysis is outlined below.

#### *METHODOLOGY*

*Step 1:* We obtained the projected market basket rates used by CMS in the CY 2021 HH PPS[5] and CY 2023 HH PPS[6] Final Rules and compared them to the actual market basket rates subsequently published by CMS for the respective years.[7] We then calculated actual and projected market basket cumulative rates for CY 2021 and CY 2023 as described below.

- *Actual market basket cumulative rate* – We determined the cumulative actual market basket rate by multiplying the actual market basket increase of 3.9 percent in CY 2021 (103.9% of CY 2020) by the actual market basket increase of 6.2 percent in CY 2022 (106.2% of CY 2021) and 4.7 percent in CY 2023 (104.7% of CY 2022), yielding a 15.5 percent cumulative market basket rate ((103.9% * 106.2%*104.7%) - 1 = 15.5%); 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 percent used in the CY 2021 NPRM (102.3% of CY 2020) by the projected market basket increase of 3.1 percent used in the CY 2022 NPRM (103.1% of CY 2021) and the projected market basket of 4.1 percent in CY 2023 (104.1% of CY 2022), yielding a 9.8 percent cumulative market basket rate ((102.3% * 103.1%*104.1%) - 1 = 9.8%).

As illustrated in ***Exhibit 8***, the forecast error of 5.7 percent is the difference between the actual cumulative market basket rates and the projected cumulative market basket rates as identified in Final Rules.

**Exhibit 8: Market Basket Forecast Error in CY 2021 through CY 2023**

| MB Forecast Error Impact | CY 2021 | CY 2022 | CY 2023 | Cumulative Impact |
|---|---|---|---|---|
| Actual Market Basket | 3.9% | 6.2% | 4.7% | 15.5% |
| HH PPS Projected Market Basket (Used in Final Rules) | 2.3% | 3.1% | 4.1% | 9.8% |
| **Difference** | **1.6%** | **3.1%** | **0.6%** | **5.7%** |

*Source: Dobson | DaVanzo Analysis of CMS HH PPS Final Rule Market Baskets and CMS Published Market Basket Data*

[5] 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.

[6] 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.

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

*Step 2*: We 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 2024 from Final Rules and applied the projected market basket update rates, less assumed productivity adjustments, to obtain payment rates for CY 2026 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 2025.** We obtained base payment rates for CY 2021 through CY 2025 from the published Proposed and Final Rules for each respective year.
- **Base Payment Rates for CY 2026 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.[8]

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

- **Volume of Home Health Cases for CY 2021 through CY 2030.** We obtained the volume of home health episodes in CY 2020 through CY 2023 from 100% Medicare FFS claims data and estimated the volume of home health episodes in CY 2024 and beyond by inflating the CY 2022 volume using the CBO baseline projected changes in Medicare part A enrollment.[9]

***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[10], 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[11], we determined that 91 percent of payments in CY 2021 are fully paid cases, therefore total payments for all cases can be obtained by dividing the payments for fully paid cases by 91 percent.

*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 2023 and keeping all other inputs constant. We then followed the same steps in *Step 1* to determine the alternative total payments.

[8] 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.

[9] CBO Baseline Medicare, May 2024. https://www.cbo.gov/system/files/2024-05/51302-2024-05-medicare.pdf.

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

[11]

*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 $10.1 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, CY 2022 and CY 2023. Results are summarized in ***Exhibit 9***, below.

**Exhibit 9: Projected Impact of 5.7 Percent Forecast Market Basket Error in CY 2021 through CY 2030**

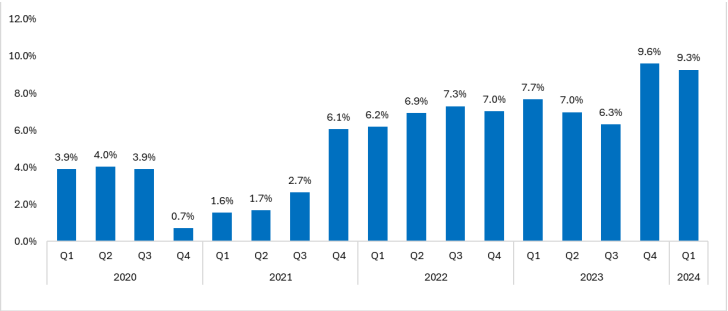
| Year | Impact of Forecast Error |
|---|---|
| 2021 | 269,463,659 |
| 2022 | 864,918,306 |
| 2023 | 982,479,659 |
| 2024 | 1,026,548,318 |
| 2025 | 1,026,459,392 |
| 2026 | 1,084,160,016 |
| 2027 | 1,142,996,351 |
| 2028 | 1,187,801,203 |
| 2029 | 1,250,809,271 |
| 2030 | 1,297,909,029 |
| **10-year Impact** | **$10,133,545,205** |

*Source: Dobson | DaVanzo Analysis*

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

In the CY 2025 HH PPS proposed rule, CMS proposes a 3.0 percent market basket update. However, this update 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. For example, while CMS proposes a 3.0 percent market basket update for CY 2025, BLS data shows that nursing staff wages will grow by 9.3 percent in Q1 2024 compared to Q1 2023. These results are illustrated in **Exhibit 7**.

**Exhibit 7: Quarterly Growth (Year-over-Year) in Nursing Staff Hourly Wages, 2020-2024**




*Source: Analysis of Data on BLS Wages and salaries, cost per hour worked for civilian workers in Registered Nurse Occupations*[12]

[12] https://db.nomics.world/BLS/cm/CMU102000012N000D?tab=chart

## TRENDS IN LABOR SUPPLY FOR RELEVANT HHA STAFFING DISCIPLINES

Despite reports of strong growth in employment of staff available for home health, our analysis shows a slight decline in employment of the staff most relevant to delivering home health services between 2019 and 2023.

In the March 2024 Report to Congress[13], MedPAC presented monthly data from the Bureau of Labor Statistics (BLS) on employment for establishments classified by the North American Industry Classification System (NAICS) as home health care services (NAICS 6216). MedPAC concluded that the "broader medical home care sector[14] indicate that total employment was about 5 percent higher in July 2023 than it was in February 2020, prior to the pandemic." MedPAC further stated that the reported staffing shortages may reflect local labor conditions or other factors not observed in national labor force measures.

We conducted additional analyses of annual BLS data under NAICS 6216 to understand these trends through the following steps.

### *METHODOLOGY*

*Step 1:* We obtained annual employment data for all categories under NAICS 6216 from the BLS website. Our review of the BLS data revealed that NAICS 6216 includes not only Medicare Home Health Agencies but also other services in the segment, "such as personal care services, homemaker and companion services, medical equipment and supplies, counseling, 24-hour some care, dietary and nutrition services, audiology, and other specialized care."

*Step 2:* We replicated the MedPAC analysis by aggregating the total NAICS 6216 employment data for each year and separately identified and aggregated the employment data for categories relevant to the six home health disciplines (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Language Therapy, Medical Social Worker and Home Health Aide).

### *RESULTS*

Within BLS' NAICS 6216, employees in the "Home Health and Personal Care Aides" occupation category represent more than half (approximately 60 percent) of all employees for years 2019-2023 yet the "Home Health Aide" discipline represents less than seven percent of visits per 30-day periods of care provided to Medicare FFS enrollees.

MedPAC's reported growth in total employment for the broader home health sector is largely driven by growth in "Home Health and Personal Care Aides". Within BLS NAIC 6216, the total number employees increased from 1,498,620 in 2019 to 1,601,940 in 2023. More than 80 percent of this growth is within the "Home Health and Personal Care Aides" category.

Our analysis constrained occupations to those most relevant to CMS Medicare FFS Home Health disciplines and excluded the "Home Health and Personal Care Aides" category. With this analysis, we observed that the number of employees decreased from 425,680 in 2019 to 422,820 in 2023 (or 0.2 percent).

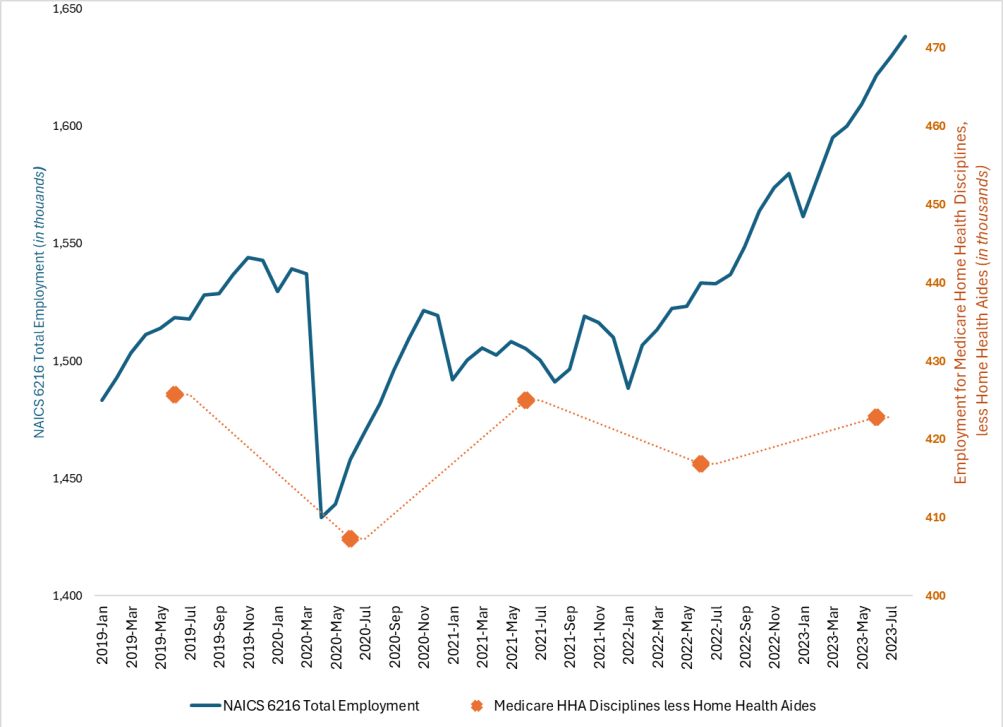
***Exhibit 10*** below shows the changes in employment for all occupations with in NAIC 6216 (as modeled in the MedPAC March 2024 report to congress) compared to changes in employment for the Medicare FFS HH disciplines less home health aides. As shown, we observed decreases in

[13] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch7_MedPAC_Report_To_Congress_SEC.pdf.

[14] Using a definition that includes Medicare HHAs, hospice, private duty, pediatric agencies, and other home care providers.

employment after excluding Home Health aides and limiting the data to just Medicare FFS HH disciplines (orange line).

**Exhibit 10: Employment for Total NAICS 6216 and Medicare HHA Disciplines**




*Source: MedPAC March 2024 Report to Congress, Dobson | DaVanzo Analysis of BLS Data Series ID CEU6562160001*

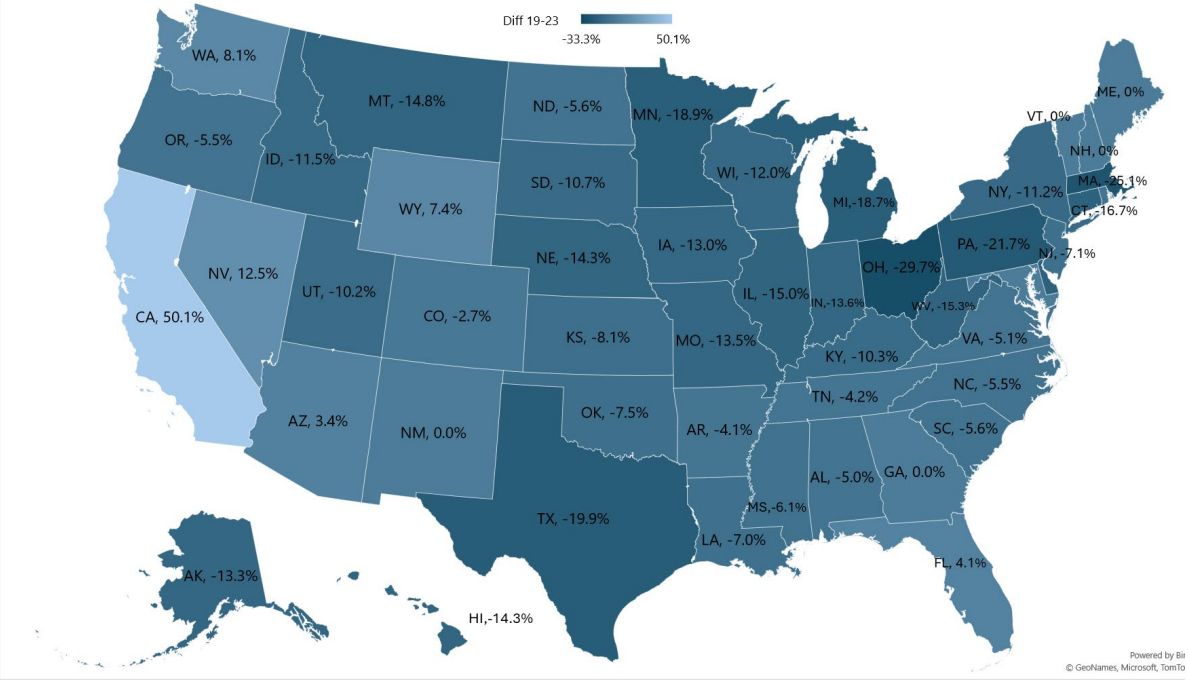
## TRENDS IN THE NUMBER OF MEDICARE FFS BILLING HOME HEALTH AGENCIES

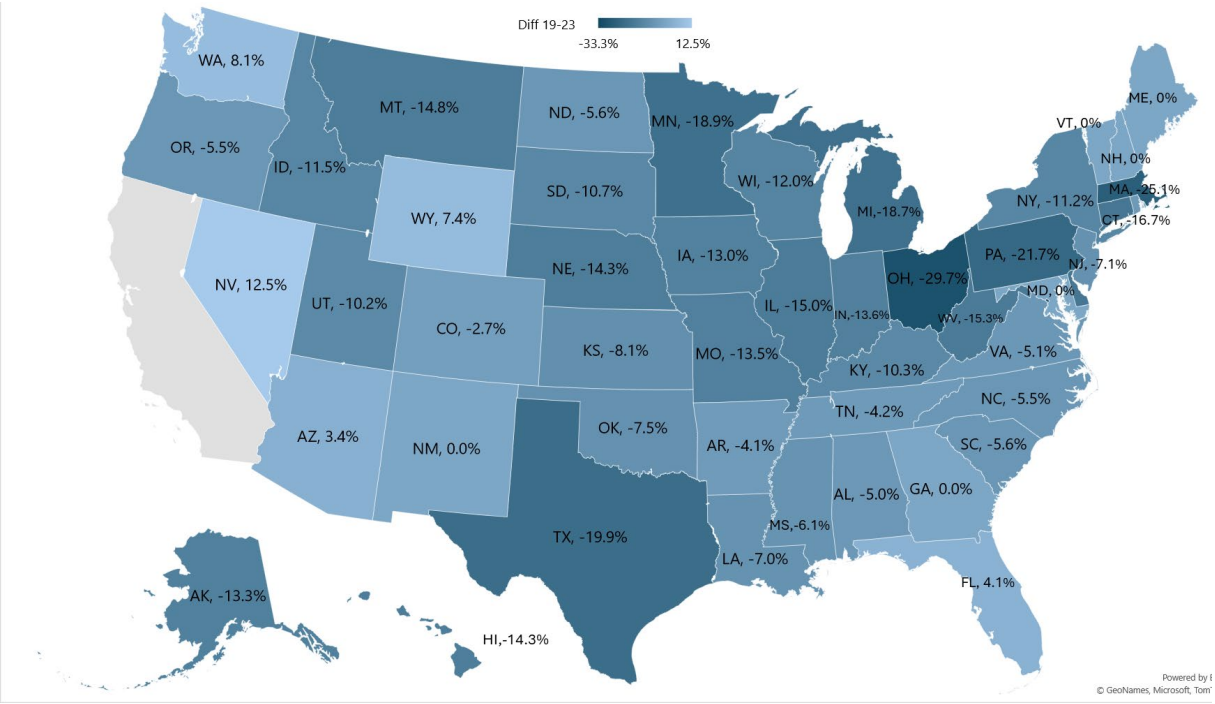
We also conducted analyses to examine trends in the number of HHAs billing Medicare by year between 2019 and 2023.

Results showed that overall, the number of HHAs billing Medicare for FFS beneficiaries reduced by 3 percent, or 293 agencies, between 2019 and 2023. Given the larger than average increases in the number of HHAs observed in California, we also computed the overall change in the number of HHAs excluding California and results showed a 12 percent decrease, or a reduction of 832 agencies, between 2019 and 2023. ***Exhibit 11*** maps the state-level analysis.

However, we observed great variability in the percent change of the number of home health agencies billing Medicare between 2019 and 2023. While some states experienced decreases in the number of Medicare FFS billing HHAs, others experienced increases, with the percent change ranging from -33 percent to 50 percent as shown in ***Exhibit 11 and 12***.

**Exhibit 11: Percent Change in Number of FFS Medicare Billing HHAs by State, 2019-2023 (with and without California)**




***Source:*** *Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

**Exhibit 12: Top 10 States with Largest Reductions in the Number of Medicare Billing HHAs**

| State | 2019 | 2023 | Difference | Percent Change |
|---|---|---|---|---|
| **All States** | **9,971** | **9,675** | **(318)** | **-3.0%** |
| **All States (Excluding California)** | **8,518** | **7,494** | **(832)** | **-12.0%** |
| District of Columbia | 21 | 14 | (7) | -33.3% |
| Ohio | 462 | 325 | (137) | -29.7% |
| Massachusetts | 207 | 156 | (51) | -24.6% |
| Pennsylvania | 304 | 238 | (66) | -21.7% |
| Texas | 1,885 | 1,510 | (375) | -19.9% |
| Minnesota | 143 | 116 | (27) | -18.9% |
| Michigan | 427 | 347 | (80) | -18.7% |
| Connecticut | 84 | 70 | (14) | -16.7% |
| Delaware | 18 | 15 | (3) | -16.7% |

*Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

## 4. Trends in Medicare FFS Home Health Utilization

### NATIONAL TRENDS IN HOME HEALTH UTILIZATION

We examined data on the utilization of home health services among Medicare FFS to explore longitudinal trends between 2019 and 2023.

#### *METHODOLOGY*

We identified the number of unique beneficiaries with at least one home health episode from the 100% Medicare claims data between 2019 and 2023. We also obtained the number of Medicare FFS enrolled beneficiaries between 2019 and 2023 from the publicly available Medicare enrollment files.

#### *RESULTS*

As shown in **Exhibit 13**, Medicare FFS beneficiaries received fewer home health services in 2023 compared to 2019. While there is a decreasing trend in the number of Medicare FFS beneficiaries, an overall 11.1 percent reduction between 2019-2023, there is a much larger reduction in the number of FFS beneficiaries using home health within the same period, a reduction of 17.1 percent. The percent of FFS beneficiaries receiving home health services declined from 8.6 percent in 2019 to 8.0 percent in 2023.

**Exhibit 13: Trends in Percent of FFS Home Health Beneficiaries with at Least One HH Episode**

| Year | 2019 | 2020 | 2021 | 2022 | 2023[15] | Percent difference 2019-2023 |
|---|---|---|---|---|---|---|
| Total Number of FFS Benes | 38,577,012 | 37,776,345 | 36,356,380 | 35,270,914 | 34,314,219 | -11.1% |
| Total Number of Medicare (FFS + MA) Benes | 61,514,510 | 62,840,267 | 63,892,626 | 65,100,546 | 66,476,533 | 8.1% |
| Unique FFS Benes with at least one HH Claim | 3,310,007 | 3,014,721 | 3,063,386 | 2,863,700 | 2,744,472 | -17.1% |
| Percent of FFS Benes with at least one HH Claim | 8.6% | 8.0% | 8.4% | 8.1% | 8.0% | |

*Sources: Dobson | DaVanzo Analysis of Claims Data under DUA 54757, CMS Medicare Monthly Enrollment PUF*

We reviewed additional data to explore whether the observed reductions in home health service utilization were accompanied by changes in patient severity during the period during 2019 and 2023.

[15] Claims data subject to runout

As shown in **Exhibit 14**, CMS' analysis of home health claims shows that the proportion of Home Health claims with a high comorbidity adjustment has increased from 10.0 percent to 16.7 percent between 2019 and 2023. Similarly, our analysis of inpatient claims for home health users with a prior hospitalization shows that the average DRG weight for those home health beneficiaries with a prior hospitalization increased from 1.89 to 1.97 between 2019 and 2022 (**Exhibit 15**).

In summary, the reduction in home health utilization does not appear to be accompanied by a decline in patient severity, suggesting that the utilization trends could be indicative of lack of access to home health services.[16]

**Exhibit 14: Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category, 2019-2023**

| Comorbidity Adjustment | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| None | 52.0% | 49.1% | 49.6% | 37.3% | 30.7% |
| Low | 38.0% | 36.9% | 36.9% | 47.8% | 52.6% |
| High | 10.0% | 14.0% | 13.5% | 14.9% | 16.7% |

*Source: CY 2025 HH PPS Proposed Rule*

**Exhibit 15: Average DRG Weight for Home Health Beneficiaries with Prior Hospitalization**

| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| **Average DRG Weight** | 1.89 | 1.95 | 1.95 | 1.97 |

*Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

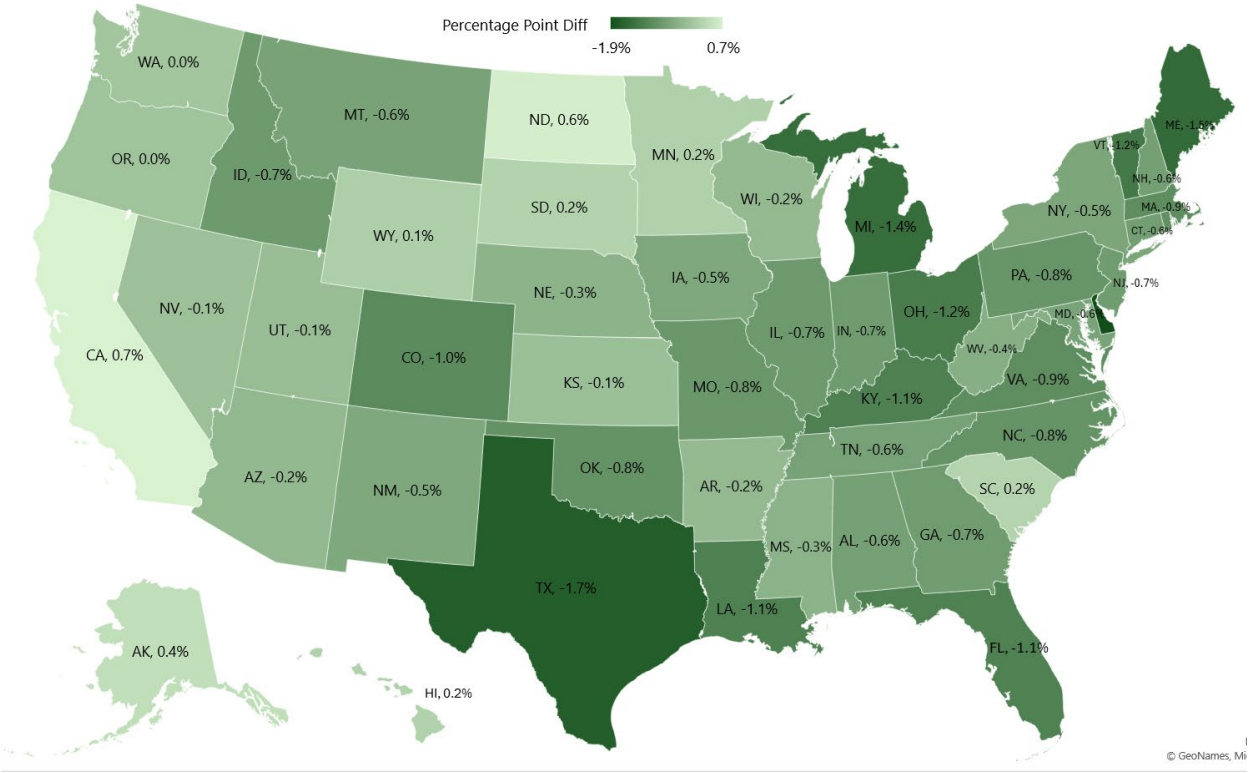
### STATE-LEVEL TRENDS IN HOME HEALTH UTILIZATION

Overall, there was a 0.6 percentage point decline in the percent of FFS beneficiaries with at least one home health claim. By state, the percentage point decline in FFS beneficiaries ranged between -1.9 to 0.6 percentage points.

The top 10 states with the largest reductions in FFS home health utilization is shown in **Exhibit 16**.

[16] While MedPAC suggests that the declining trend in home health utilizations could be explained by lower use of inpatient hospital care among FFS beneficiaries because a hospital stay is a common precursor to HH care, **Exhibit 4** shows that the population of home health users with a prior hospitalization are on average sicker in 2022 compared to 2019, meaning those users are likely to have more home health use.

**Exhibit 16: Percentage Point Change in Proportion of FFS Beneficiaries with at Least One Home Health Claim 2019-2023, by State (excluding California)**




*Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

**Exhibit 17: Top 10 States with Largest Reductions in the Proportion of FFS Beneficiaries with at Least One Home Health Claim**

| STATE | 2019 | 2020 | 2021 | 2022 | 2023 | Percentage Point Difference (2019-2023) |
|---|---|---|---|---|---|---|
| **All States** | **8.6%** | **8.0%** | **8.4%** | **8.1%** | **8.0%** | **-0.6%** |
| Delaware | 8.7% | 7.8% | 8.2% | 7.9% | 6.8% | -1.9% |
| Texas | 10.8% | 9.8% | 10.0% | 9.5% | 9.2% | -1.7% |
| Maine | 8.1% | 7.2% | 7.5% | 6.8% | 6.7% | -1.5% |
| Michigan | 9.6% | 8.4% | 8.8% | 8.4% | 8.1% | -1.4% |
| Vermont | 9.4% | 8.6% | 9.3% | 8.7% | 8.2% | -1.2% |
| Ohio | 8.6% | 7.8% | 8.1% | 7.7% | 7.4% | -1.2% |
| Kentucky | 9.0% | 8.3% | 8.6% | 8.2% | 7.9% | -1.1% |
| Louisiana | 11.2% | 10.7% | 10.9% | 10.4% | 10.1% | -1.1% |
| Florida | 12.7% | 11.8% | 12.2% | 11.7% | 11.6% | -1.1% |
| Colorado | 6.4% | 5.8% | 6.0% | 5.7% | 5.4% | -1.0% |

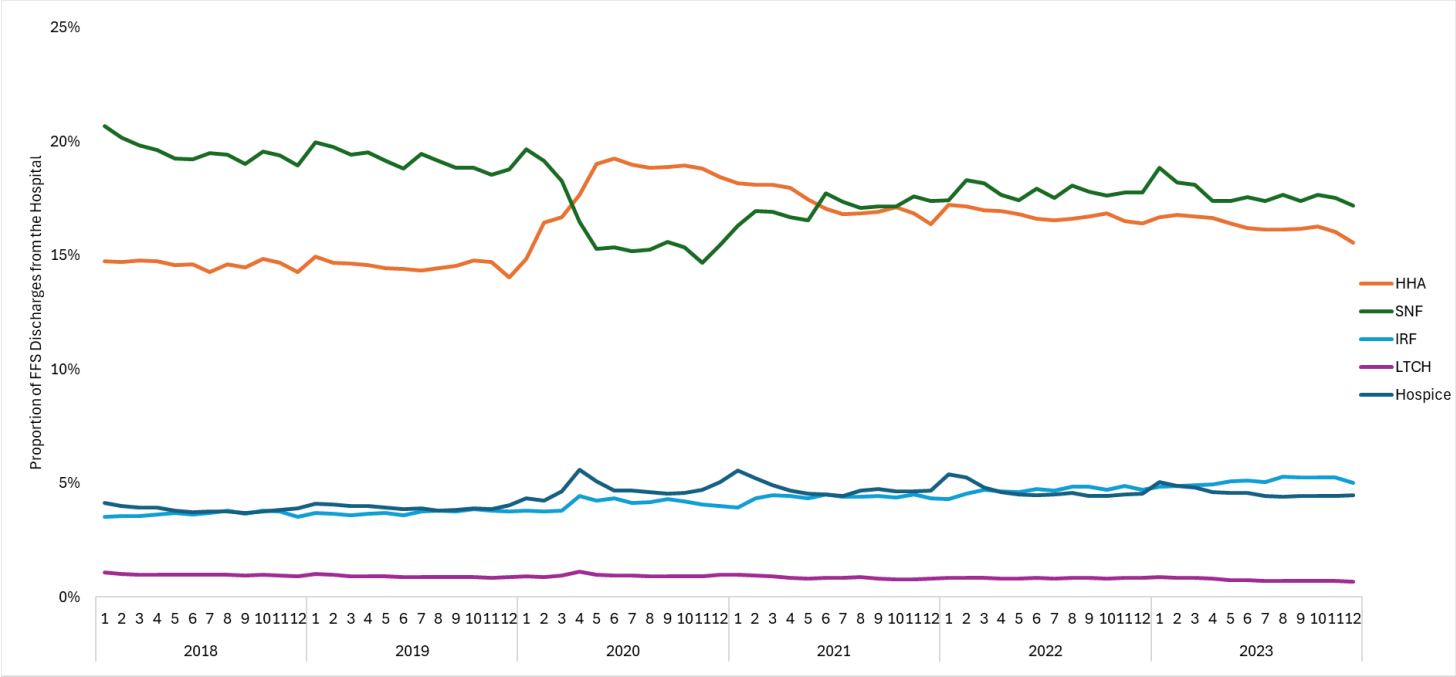
*Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

## TRENDS IN HOME HEALTH UTILIZATION FOLLOWING A HOSPITALIZATION

As shown in ***Exhibit 18***, the proportion of hospital discharges to home health increased between 2019 and 2020 and started to decline between 2020 and 2023, although remained above pre-pandemic levels. This

corresponds to the observed substitution effect that occurred during the pandemic months where there was a decline in SNF admissions, but the trends began to reverse between 2021 and 2023.

**Exhibit 18: Trends in Hospital Discharges to Post-Acute Care Settings, 2019-2023**




***Source:*** *Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

## 5. Impact of the Existing and Proposed and Future Permanent and 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 $4.5 billion that would be required to reconcile CY 2020, CY 2021, CY 2022, and CY 2023 aggregate payments to budget neutral levels. CMS further indicates in the CY 2025 HH PPS Proposed Rule that they are not applying the temporary reduction to the CY 2025 payments and instead will propose a temporary adjustment factor in future rulemaking.

Given that CMS is required by law to annually analyze data from CY 2020 through CY 2026 and offset any increases or decreases in estimated aggregate expenditures through permanent and/or temporary adjustments, we estimated the temporary adjustments that would be required to offset for such increases in the aggregate expenditures for CY 2024 through CY 2026.

### *METHODOLOGY*

We estimated the temporary adjustment dollar amount for CY 2024 through CY 2026 using the methodology CMS uses to determine overpayments for CYs 2020 through CY 2023 in the CY 2025 Proposed Rule, as described below.

*Step 1*: We calculated the budget-neutral 30-day payment rate with assumed and actual behaviors for CY 2024 through CY 2026 as described below.

Budget-neutral rate with assumed behavioral changes: We determined the budget-neutral rates with assumed behavioral changes by inflating the prior year's recalculated budget-neutral rate with actual behaviors using the CY's update factors. For example, we determined the CY 2024 budget neutral rate with assumed behavioral changes using the recalculated CY 2023 base payment rate, multiplied by the CY 2024 case-mix weights recalibration neutrality factor, the CY 2024 wage index budget neutrality factor, and the CY 2024 home health payment update factor.

Budget-neutral rate with actual behavioral changes: We assumed that for CY 2024 through CY 2026, CMS would determine permanent adjustments equal to the average of the permanent adjustments calculated for CY 2022 and CY 2023. That is, we estimate that CMS will calculate permanent adjustments of 1.45 percent, an average of 1.77 and 1.13 percent. We then determined what the budget-neutral rate with actual behavioral changes needed to be to result in a permanent adjustment of 1.45 percent. The estimated budget neutral rate with assumed, and actual rates are summarized in **Exhibit 18** below.

**Exhibit 18: Budget-Neutral 30-Day Payment Rates with Assumed and Actual Behavior Changes**

| | Budget-neutral 30-day Payment Rate with Assumed Behavior Changes | Budget-neutral 30-day Payment Rate with Actual Behavior Changes | Permanent Adjustment |
|---|---|---|---|
| CY 2020 | $1,864.03 | $1,742.52 | -6.52% |
| CY 2021 | $1,777.19 | $1,751.90 | -1.42% |
| CY 2022 | $1,872.18 | $1,839.10 | -1.77% |
| CY 2023 | $1,894.49 | $1873.17 | -1.13% |
| CY 2024 | $1,955.25 | $1,926.98 | -1.45% |
| CY 2025 | $1,979.09 | $1,950.48 | -1.45% |
| CY 2026 | $2,001.19 | $1,972.26 | -1.45% |

We determined the overpayment rate as the difference between the budget neutral rates for each year and the CMS finalized 30-day standardized payment rate.

*Step 2*: We estimated the volume of home health episodes in CY 2024 through CY 2026 by adjusting the CY 2022 volume using the CBO baseline projected changes in Medicare part A enrollment.[17]

*Step 3*: We then calculated the total CY 2024 payments with assumed and actual behavior changes by multiplying the *Step 1* overpayment rate by the *Step 2* projected volume. We estimated CY 2024

[17] CBO Baseline Medicare, May 2024. https://www.cbo.gov/system/files/2024-05/51302-2024-05-medicare.pdf.

overpayments of $1.0 billion, CY 2025 overpayments of $0.5 billion and CY 2026 overpayments of $0.5 billion from the difference between total payments with assumed and actual behavior changes.

#### *RESULTS*

In total, we estimated temporary reductions of $6.5 billion would be required to reconcile CY 2020 through CY 2026 aggregate payments to budget neutral levels. This represents a reduction of 40.4 percent ($6.5 billion/ $16.2 billion—the projected CY 2025 HH PPS payments).

**Exhibit 19: HH PPS Proposed, Final and Estimated Aggregate Payments**

| Year | Overpayments | Source |
|---|---|---|
| 2020 | ($873,073,121) | *CY 2024 HH PPS Final Rule* |
| 2021 | ($1,211,002,953) | *CY 2024 HH PPS Final Rule* |
| 2022 | ($1,405,447,290) | *CY 2024 HH PPS Final Rule* |
| 2023 | ($965,883,723) | *CY 2025 HH PPS Proposed Rule* |
| 2024 | ($1,005,948,418) | *Dobson \| DaVanzo Estimate* |
| 2025 | ($529,449,243) | *Dobson \| DaVanzo Estimate* |
| 2026 | ($554,193,231) | *Dobson \| DaVanzo Estimate* |
| **TOTAL** | **($6,544,997,979)** | |

### OVERALL IMPACT OF CY 2025 HH PPS PROPOSED RULE REDUCTIONS AND FUTURE REDUCTIONS: IMPACT TO HHA PAYMENTS

In aggregate, we estimate that the payment reductions due to behavioral adjustments will lead to an approximate reduction of $27.7 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 2024 and CY 2025 permanent adjustments, and a $6.5 billion reduction due to temporary adjustments for CY 2020, CY 2021, CY 2022, and CY 2024.

#### *METHODOLOGY*

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

*Step 1*: We obtained the volume of home health episodes in CY 2020 through CY 2023 from 100% Medicare FFS claims data and estimated the volume of home health episodes in CY 2024 and beyond by adjusting the CY 2022[18] volume using the CBO baseline projected changes in Medicare part A enrollment.

*Step 2*: Next, we obtained the CY 2020 through CY 2025 base payment rates from the respective Final Rules and projected payment rates for CY 2026 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.

[18] Given that CY 2023 HH PPS claims are subject to changes due to runout, we used the CY 2022 claims to develop our projections.

*Step 3*: We 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, CY 2024, and CY 2025.

*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 *Step 1* projected volume by the *Step 2* base payment rates with behavioral adjustments. Total payments without behavioral adjustments for CY 2020 through CY 2029 were calculated by multiplying the *Step 1* projected volume by the *Step 3* base payment rates without behavioral adjustments.

### *RESULTS*

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

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

| Total Payments | Impact of BA |
|---|---|
| 2020 | ($665,606,700) |
| 2021 | ($671,184,874) |
| 2022 | ($728,647,653) |
| 2024 | ($1,418,622,546) |
| 2025 | ($2,025,933,052) |
| 2025 | ($2,823,337,689) |
| 2026 | ($2,981,925,516) |
| 2027 | ($3,143,768,345) |
| 2028 | ($3,267,115,376) |
| 2029 | ($3,440,520,339) |
| **Total Impact of Permanent Adjustments (CY 2020-CY 2029)** | **($21,166,662,090)** |
| **Total Impact of Temporary Adjustments (If applied between CY 2020-CY 2029)** | **($6,544,997,979)** |
| **Total Impact of Permanent and Temporary Adjustments (CY 2020-CY 2029)** | **($27,711,660,069)** |

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

## Appendix

**Table 1: Percent Impact Between CY 2024 and CY 2025 for Agencies in Rural vs. Urban Areas by State**

| STATE | Location | Percent of HHAs | Case Count | Percent Impact 2025 Proposed Payments |
|---|---|---|---|---|
| AK | rural | 36% | 1,878 | -4.7% |
| | urban | 64% | 5,458 | -2.6% |
| AL | rural | 36% | 33,522 | -1.2% |
| | urban | 64% | 119,140 | 1.2% |
| AR | rural | 61% | 43,656 | -2.2% |
| | urban | 39% | 43,236 | -0.5% |
| AZ | rural | 7% | 3,683 | 3.2% |
| | urban | 93% | 106,276 | 2.4% |
| CA | rural | 1% | 19,355 | -3.3% |
| | urban | 99% | 1,183,160 | -3.7% |
| CO | rural | 16% | 6,869 | -3.0% |
| | urban | 84% | 56,943 | -0.8% |
| CT | rural | 3% | 3,511 | -5.6% |
| | urban | 97% | 82,049 | -5.3% |
| DC | urban | 100% | 7,859 | 4.5% |
| DE | urban | 100% | 28,619 | 2.6% |
| FL | rural | 2% | 19,679 | 0.6% |
| | urban | 98% | 718,583 | 0.9% |
| GA | rural | 22% | 35,815 | -2.7% |
| | urban | 78% | 149,574 | -1.7% |
| HI | rural | 27% | 1,347 | -6.3% |
| | urban | 73% | 6,983 | -5.8% |
| IA | rural | 55% | 11,377 | 0.0% |
| | urban | 45% | 30,109 | -0.9% |
| ID | rural | 39% | 13,828 | -3.1% |
| | urban | 61% | 21,115 | -3.1% |
| IL | rural | 7% | 27,911 | -2.7% |
| | urban | 93% | 313,227 | -2.9% |
| IN | rural | 12% | 17,404 | 1.1% |
| | urban | 88% | 99,663 | 0.0% |
| KS | rural | 41% | 25,786 | 0.8% |
| | urban | 59% | 50,347 | -1.0% |
| KY | rural | 48% | 36,530 | 0.7% |
| | urban | 52% | 67,281 | 0.9% |
| LA | rural | 26% | 54,521 | 0.5% |
| | urban | 74% | 116,228 | -0.1% |
| MA | urban | 100% | 239,213 | -2.8% |
| MD | rural | 10% | 10,285 | 0.5% |
| | urban | 90% | 136,439 | -0.3% |
| ME | rural | 30% | 2,461 | -2.7% |
| | urban | 70% | 22,215 | -3.3% |
| MI | rural | 8% | 13,347 | -1.1% |
| | urban | 92% | 171,790 | -1.2% |
| MN | rural | 41% | 11,350 | -2.4% |
| | urban | 59% | 61,087 | -2.5% |
| MO | rural | 33% | 20,477 | 0.8% |
| | urban | 67% | 71,684 | -0.6% |

| | | | | |
|---|---|---|---|---|
| MS | rural | 62% | 114,529 | 1.7% |
| | urban | 38% | 57,763 | 1.4% |
| MT | rural | 57% | 4,319 | 3.0% |
| | urban | 43% | 7,225 | 1.5% |
| NC | rural | 33% | 50,548 | -2.8% |
| | urban | 67% | 151,059 | -2.6% |
| ND | rural | 53% | 1,732 | -5.1% |
| | urban | 47% | 7,738 | -2.1% |
| NE | rural | 41% | 6,346 | -1.1% |
| | urban | 59% | 29,329 | 0.1% |
| NH | rural | 33% | 15,627 | -1.0% |
| | urban | 67% | 21,260 | -2.7% |
| NJ | rural | 3% | 2,758 | -2.0% |
| | urban | 97% | 153,705 | -2.9% |
| NM | rural | 44% | 17,097 | 6.1% |
| | urban | 56% | 25,923 | 0.8% |
| NV | rural | 3% | 1,717 | -4.7% |
| | urban | 97% | 99,994 | -3.5% |
| NY | rural | 21% | 21,531 | -2.9% |
| | urban | 79% | 275,804 | -4.9% |
| OH | rural | 37% | 68,087 | -0.8% |
| | urban | 63% | 146,764 | -1.3% |
| OK | rural | 44% | 104,271 | 2.6% |
| | urban | 56% | 131,106 | 0.8% |
| OR | rural | 29% | 9,878 | 0.2% |
| | urban | 71% | 44,291 | -3.0% |
| PA | rural | 14% | 26,874 | 3.4% |
| | urban | 86% | 235,683 | -0.9% |
| PR | rural | 3% | 54 | -3.4% |
| | urban | 97% | 9,028 | -2.6% |
| RI | urban | 100% | 21,648 | -2.1% |
| SC | rural | 16% | 19,619 | -3.2% |
| | urban | 84% | 139,028 | -3.2% |
| SD | rural | 52% | 5,310 | -4.0% |
| | urban | 48% | 5,417 | -2.1% |
| TN | rural | 28% | 53,419 | -0.4% |
| | urban | 72% | 144,990 | 0.3% |
| TX | rural | 11% | 119,962 | -0.2% |
| | urban | 89% | 697,793 | -0.8% |
| UT | rural | 10% | 1,698 | -0.1% |
| | urban | 90% | 56,392 | -1.1% |
| VA | rural | 18% | 23,030 | -1.8% |
| | urban | 82% | 176,004 | -2.2% |
| VT | rural | 70% | 13,434 | -3.8% |
| | urban | 30% | 10,772 | -3.7% |
| WA | rural | 10% | 9,095 | -4.7% |
| | urban | 90% | 102,657 | -1.6% |
| WI | rural | 31% | 12,614 | -2.6% |
| | urban | 69% | 57,490 | -3.1% |
| WV | rural | 37% | 16,424 | -2.5% |
| | urban | 63% | 33,060 | -1.5% |
| WY | rural | 71% | 7,545 | 0.2% |
| | urban | 29% | 3,049 | -2.8% |