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HCHB RESPONDS TO CMS ON THE 2024 PROPOSED RULE ON BEHALF OF THE HOME-BASED CARE INDUSTRY

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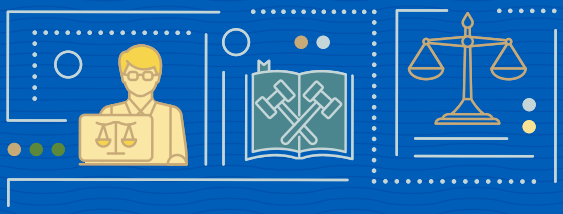


August 24, 2023

Electronic Submission via Regulations.gov

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

Re: CMS-1780-P, CY 2024 Home Health Prospective Payment System (PPS) Proposed Rule

Dear Administrator Brooks-LaSure,

Homecare Homebase ("HCHB") is submitting this comment letter to provide CMS with a uniquely powerful set of data and data-driven arguments that can provide new understanding of the impact of the CY 2024 Home Health PPS Proposed Rule ("Proposed Rule"). Due to HCHB's unique position as the foundational home health platform that serves 44% of all Medicare home health visits, we possess significant detail about patient access, clinical care activities, and agency administrative activities not available to CMS. These data points tell a story of rising home health costs and worsening patient access issues for Medicare beneficiaries, at a level CMS may not even be aware. These access to care issues are driving poor health outcomes, increasing cost to Medicare, and denying beneficiary home health services.

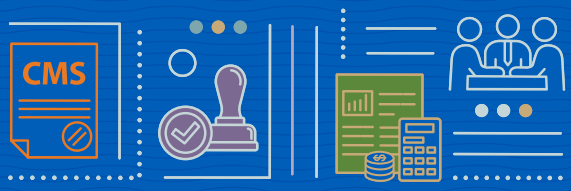
Access to care has been a growing issue in home health. We have now reached a point where nearly half of all patients referred to home health are being turned away from service (Figure 1). This group of 6.2 million Americans who are deprived of service to home health every year either end up in higher cost care settings (such as acute care or skilled nursing facilities) or return home without further care, where studies suggest they have higher readmission and mortality rates and cost the health system more money.

The data demonstrates (as we will outline in this letter) that decreased Medicare beneficiary access to home health services are directly attributable to clinical staffing challenges that have been exacerbated by Medicare payment rate cuts and adjustments that significantly lag inflation (Figure 4). The Proposed Rule includes further payment rate reductions that CMS estimates will be 2.2% for 2024. HCHB models are showing an even higher payment reduction of 2.66% (Figure 5), and several notable discrepancies from CMS models that will be detailed later in this letter. These Proposed Rule payment cuts are being applied inconsistently across (and within) states and even at the individual provider level, with some providers receiving payment reductions as high as 7.7%, further risking access to care by destabilizing the provider landscape. As a result, **HCHB joins the home health provider community to ask that CMS not finalize the payment reductions in the Proposed Rule, and work with the broader home health community to implement the PDGM payment model in a manner that aligns with the goal to increase access to care for those patients that need home health services.**

We will further detail our analysis and arguments in the following pages and elaborate on the statements above. We thank you for your consideration of our comments.

HCHB's Uniquely Powerful Data Set

HCHB is the foundational home health platform for almost half (44%) of the home health industry by visit volume. Agencies utilizing HCHB as their Electronic Health Record and Agency Management platform include all 10 of the largest home health providers in the nation and hundreds of other large-scale home health providers. HCHB's providers represent the most patient-focused home health agencies in the Medi-



care program, with an average star rating of 3.9, significantly above the 3.3 national star rating average. HCHB is utilized as the care and logistics platform for the patient from the moment they are referred to home health, to the moment of discharge and final billing, providing a rich and comprehensive data set to study the various impacts of the Proposed Rule.

As a result of this market position, HCHB possesses detailed data about patient referrals, referral acceptances, care planning, care deployment, visit activities, supply management, administrative activities, reimbursement, patient outcomes, and everything in between. HCHB's data is at a much more detailed level than the data available to CMS and is a more current reflection of case mix and visit profiles, since HCHB is using actual 2023 data and CMS is projecting 2024 patients based on 2022 claims data. As a result, HCHB's data paints a strong and representative picture of how high-quality home health agencies are caring for patients and what is happening when patients are being turned away from care.

HCHB has performed extensive analysis on this data and has modeled the Proposed Rule in detail as we do with precision accuracy every year. We have spent significant time testing and validating our model with customer data and have detailed our methodology in the appendix. Contrary to the CMS calculation which forecasts 2024 payments predicated on Medicare claims data for home health periods from 2022 and does not account for any future changes in number of visits or case mix (88 Fed. Reg. 43796 (July 10, 2023)), HCHB's model looks at all patients, visits, diagnosis codes, and claims to date and shows their actual reimbursement in 2023 versus what the reimbursement on those exact same patients and activities would be in CY 2024 if the Proposed Rule is finalized.

When looking at this analysis and modeling holistically, the data paints a dire picture of growing patient access challenges that are directly driven by the rising cost of care delivery combined with steep reductions to reimbursement driven by annual CMS payment adjustments. This is directly resulting in harm to the Medicare patient community.

HCHB also continues to measure provider behaviors against the CMS assumptions from when the PDGM model was implemented in 2020. CMS made key behavior assumptions that were one of the components of meeting the PDGM budget-neutrality requirements of the Bipartisan Budget Act of 2018 when transitioning from the previous home health payment model. HCHB's data continues to show a very large gap between actual provider behavior versus what CMS stated as assumed behavioral changes. The application of flawed behavioral assumptions is central to the reimbursement challenges that have fueled the major spike in patient non-admissions since PDGM was implemented. These data points will be detailed later in this letter.

Access to Care

The access to care issue, which is already a major concern in home health, has become more problematic as CMS has made annual payment rate adjustments. As of July 2023, patient referral conversions (a measure of the number of patients that were referred to home health and subsequently admitted) have now plummeted to 55% (see Figure 1). This means that 45% of all patients seeking home health are being turned away from service, which extrapolates to 6.2 million patients being turned away annually.

Access to care issues are extremely frustrating for these 6.2 million annual patients denied home health services, and they may ultimately experience worse health outcomes and overall spending in the Medicare program. Home health is a low-cost, high-value service option when compared to alternatives, such as longer acute stays or placement at skilled nursing facilities or other long-term care facilities. A portion of these 6.2 million patients turned away from care end up in those higher cost alternatives, where, in addition to increasing Medicare spending, they also occupy beds and utilize clinical resources that are in short supply. Another portion of these patients end up returning home without any additional care ser-

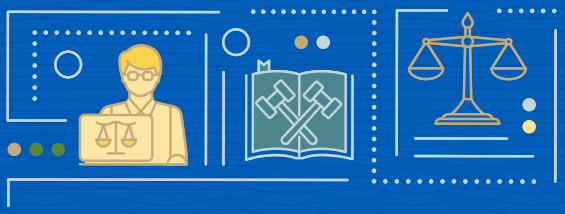
vices. While HCHB, by nature, does not directly possess data about patients that do not come onto home health service, it is very reasonable to hypothesize that these patients sent home without needed care ultimately experience worse outcomes and readmit to acute facilities at a higher rate, thereby increasing overall Medicare spending in addition to the human cost.

The decade-long trend around access to home health care is also very alarming. A decade ago, referral conversions (patients accepted into service after being referred to home health) stood at 79% (see Figure 1) according to data in HCHB. This number declined to 69% in 2019, which was the last full year before PDGM, and before the public health emergency started due to the COVID pandemic. Since the start of 2020, referral conversions have fallen from 69% to 55%, a staggering drop in less than four years.

The timing of this access to care trend correlates with the CMS payment rate adjustments. The cause of this correlation is a shortage of home health clinicians, creating a situation where home health agencies simply do not have the clinical capacity to admit millions of patients needing home health services (Figures 1 and 2). A significant factor in this deficit of home health clinicians is the Medicare annual payment updates that have not kept up with inflation. When considering inflation, it shows the CMS home health spending per patient (PPS per patient) has lagged inflation by 22% (Figure 4) over this same period, before even factoring in the additional payment rate reductions in the Proposed Rule. Some of the additional cost inflation specific to home health agencies is further detailed below. Simply stated, these CMS payment rate deficiencies have created an imbalance that has made it tremendously difficult for home health agencies to recruit and retain clinicians.

Home health agencies have compensated for the clinician shortage by stretching each clinician to see more and more patients. In fact, the average home health clinician is seeing 1.5 more patients per day than they were prior to 2020, a 25% increase in patient load per clinician (Figure 3). However, even with clinicians covering more patients, this still does not provide enough home health capacity to meet the demand. It also places a greater strain on home health clinicians, who are already working in very challenging conditions inside patient homes where they do not have the benefit of other nurses that they can tap on the shoulder and ask for help, like they might in other healthcare settings. The Medicare payment rate reductions during times of extreme rising costs of care (as we will detail in the next paragraph) has made it nearly impossible to pay a fair and competitive wage to these clinicians, creating a dynamic where there is simply not enough clinical capacity to meet home health demand.

Meanwhile, the cost of care is rapidly rising at the same time that Medicare home health payment rates are falling. Home health is facing exceptional expense challenges due to the unique nature of providing care in the home. We have observed rising home health costs in three primary areas. First, agencies have seen significant wage inflation and are having to bear higher salaries. Clinician wages have increased significantly, and we don't expect this to be just an inflationary phenomenon, especially for home health. Agency administrative workers have also seen wage inflation like the rest of the market. Second, home health agencies are also responsible for providing medical supplies which have seen significant cost inflation over the past 4 years. And third, home health agencies must bear the cost of reimbursing travel for their clinicians who are driving between patient homes every day. In considering fuel alone, HCHB data shows that agencies will spend an estimated $203 million in 2023 (Figure 10). While down from the peak of 2022, this is still a 23% increase in fuel costs alone over the average industry fuel costs between 2018-2021 (Figure 10) and represents a total industry fuel expense increase of over $38 million during that time. With the rising costs of clinician wages and the increased cost for supplies and fuel, the industry would expect to see corresponding increases in reimbursement rates, like what CMS provided to hospices, noting the increasing costs of care. Instead, home health has seen Medicare payment cuts and adjustments that simply do not keep up with the true rising costs of care. The result is now 45% of patients are being turned away from care, risking patient outcomes and potentially shifting them into higher cost care settings and increasing overall costs to the Medicare program.



In 2024, CMS is proposing an additional cut to home health reimbursement. CMS estimates this latest cut to be 2.2% based on the CY 2022 claims data. HCHB has modeled the Proposed Rule in detail and is showing a 2.66% cut (Figure 5) year over year, which we will detail further in the next section. The proposed additional home health rate cuts from CMS in 2024, if finalized, are almost certain to worsen the access to care challenges detailed above, just as CMS rate adjustments have done in the past several years, as shown by the data.

Unintended Consequences and Potential Technical Flaws in Rule

HCHB annually produces a model for agencies to measure the impact of the Proposed Rule and Final Rule against their unique agency attributes. Agencies can model all their patient activity year-to-date and compare the current year's rule against the new Proposed and Final Rules. The model essentially shows the differences in 2023 and 2024 reimbursement if the agency saw the exact same patients, performed the exact same care activities, and billed the same claims. This allows an agency to assess the true impact of the rule on their unique set of patients. HCHB can also apply these models in aggregate across our customer base (representing 44% of all Medicare home health visits).

There are several important observations that have come out of this year's modeling. First, HCHB models show a total 2.66% cut to reimbursement, which is even more substantial than the 2.2% cut estimated by CMS (Figure 5). Figure 5 in the appendix goes into greater detail about the HCHB methodology versus the CMS methodology, but in short, CMS' payment calculations for CY 2024 utilize a static analysis by moving forward the claims data and patient population from CY 2022 and applying the 2024 payment rules, whereas HCHB looks at all patients, visits, diagnosis codes, and claims from the first half of 2023, and shows their actual reimbursement in 2023 versus what the reimbursement on those exact same patients and activities would be in CY 2024 is the Proposed Rule finalized, allowing HCHB's model to account for the realities of changing patient landscape. A 2.66% cut would have even stronger impacts on patient access and patient care than those being modeled by industry advocates based on a 2.2% cut. Second, the proposed reimbursement cuts have an inconsistent impact across geographies and agencies (Figures 7 & 8). Our data shows that 49 out of 50 states will see a cut in reimbursement, with some states impacted as high as -5.5% (Figure 8). While most states are seeing cuts in line with the 2.66% average, a handful of states are showing almost no cuts and one state is showing an actual increase in reimbursement of 3.8% under the new proposal (Figure 8). Furthermore, we have individual agencies modeling cuts as high as 7.7%, with other agencies seeing an increase in revenue of 7.0% (Figure 9). The inconsistency of these impacts from the Proposed Rule are likely to further destabilize the home health industry during a time when almost half of all home health patients are already being turned away from service (Figure 1).

When CMS changed to the PDGM payment model in 2020, CMS also outlined several assumed behavior changes that agencies would undergo in the new model. These assumptions were foundational to the CMS argument that the shift to PDGM would be budget neutral, as required by the Bipartisan Budget Act of 2018. These behavior assumptions continue to be a key component in CMS annual updates. HCHB's data continues to show a very large gap between how providers have actually behaved versus the assumptions made by CMS. This discrepancy in the data versus assumptions are a key ongoing reason for the declining payment rates that have contributed to the major spike in patient non-admissions since PDGM was implemented. The two most notable examples are as follows:

1. Diagnosis Coding Behaviors: CMS assumed that home health providers would change coding to achieve higher paying clinical groupings for patients in 100% of cases. HCHB data analysis shows that providers are only shifting coding to higher paying clinical groupings in a net of 6.4% of cases (Figure 6). A closer look at the data reveals that providers are modifying diagnoses to higher paying clinical groupings 16.7% of cases and are actually modifying diagnoses to lower paying clinical grouping in 10.3% of cases, for a net impact of 6.4% of cases. This tells a story of providers work-

ing to achieve accurate coding, rather than working to achieve maximum reimbursement as CMS assumed.

2. LUPA Management: CMS assumed that home health providers would modify behaviors to eliminate LUPAs (Low Utilization Payment Adjustments) in 33% of cases. CMS assumed that providers would add visits to ensure that a larger revenue per patient was achieved in at least 33% of cases. The HCHB data shows that LUPA care plans are being adjusted to Standard care plans in only 15% of cases (Figure 7). It should be noted that there are many clinically appropriate reasons where visits should be added for a patient in order to achieve patient outcomes. This data tells a story of appropriate care planning and conflicts with the CMS assumption that 33% of these cases would be modified from LUPA to Standard.
3. With such a significant contrast between CMS behavioral assumptions and actual provider behaviors (for at least 44% of CMS provider base), it is clear that more collaboration is needed between CMS and the provider community. HCHB would be eager to engage with CMS and work further in collaboration with the provider community to align and study model behaviors to ensure the implications of these changes are being fully considered by CMS.

Recommendations

To summarize, Homecare Homebase respectfully recommends that CMS:

1. Not finalize the proposed payment reductions in the CY 2024 Proposed Rule.
2. Provide enhanced transparency on the calculation methodology so that service providers and key partners like Homecare Homebase can assist with the analysis of the data and ensure unintended consequences are avoided.
3. Engage with the provider community and other stakeholders to implement a PDGM budget-neutral payment methodology that is consistent with the Bipartisan Budget Act of 2018 and will ensure greater access to high quality home health services for Medicare beneficiaries.

Thank you for your consideration of our comments. Homecare Homebase appreciates the opportunity to collaborate with CMS to reform home health in a way that ensures this cost-effective and patient-preferred means of care continues to serve America's most vulnerable seniors.

Should you have any questions, feel free to contact me at 214-974-0949 or sdecker@hchb.com.

Sincerely,

Scott Decker, CEO
Homecare Homebase

Appendix

Figure 1 – Global Access to Care Issues

The Fig. 1 chart is based on 35.6M home health referrals captured in HCHB between 2012 and 2023 (through July). Since the declaration of the PHE in March 2020, the number of patients turned away from service has increased by 15%. Patients admitted now stands at 55%, with patients rejected now standing at 45%. Extrapolating out, this represents 6.2 million patients being turned away from service in 2023.

Referral Conversion percentage is calculated as follows:

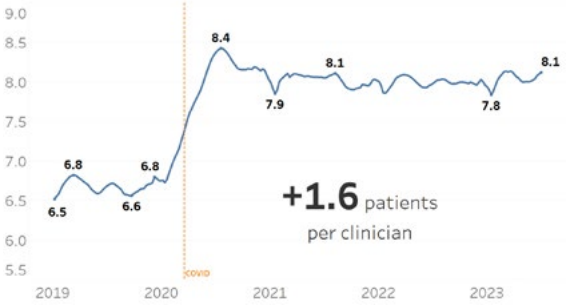
- Numerator: The total # of patients that are admitted into home health service
- Denominator: The total # of patients that are entered into HCHB as a referral

The metric is a relevant but imperfect estimation of access to care issues. A patient is entered into HCHB when an agency intends to bring that patient onto service. The metric does not capture patients that were rejected from care before the patient was entered into HCHB. We know this happens in regions that are challenged with caregiver shortages and is especially prevalent in lower-income urban areas. However, by definition, the data does not exist in HCHB to study this trend. Hospital referral systems, who do have visibility into these patients, have reported much higher access to care issues. On the opposite side of the equation, this metric does not account for potential duplicate referrals. However, given the fact that a patient is not entered into HCHB until an agency intends to bring this patient on, we do not think this is a staggering percentage of cases. We believe that these two factors above largely offset, and that the 45% rejection rate is largely accurate and consistent with our observations of our customers. What is clear is that the metric clearly shows a staggering downward trend in access to care for Medicare patients that is reflective of customer and patient experiences that we directly observe.

Figure 2 – Rejections due to lack of Clinical Staffing

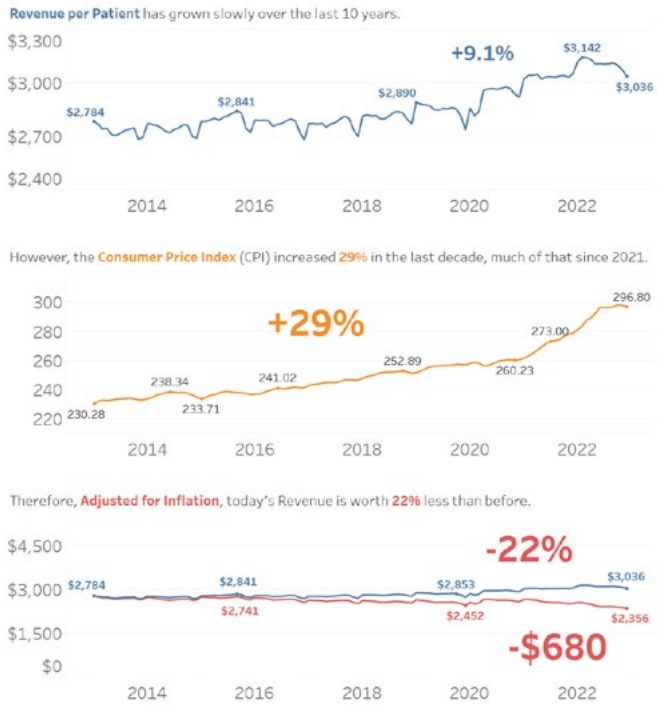
HCHB allows agencies to enter the reason that patients were turned away for clinical staffing shortages. Sometimes the categorization is "other" leaving the reason inconclusive. However, when reasons are well documented, there is a clear trend showing an increase in patients turned away due to staffing, which has seen a 6x increase over the last 5 years. This conclusively shows that the unavailability of clinical staff is a significant driver to the corresponding trend in patient access to care issues over the same period.

Figure 3 – Patients per Clinician



The Fig. 3 chart divides ADC (Average Daily Census) by the number of active clinicians on a weekly basis across all HCHB agencies from 2019 through June 2023.

Figure 4 – Revenue per Patient



The Fig. 4 chart is based on 22.3M Medicare home health patients in HCHB from 2013 through 2022. When adjusted for inflation, based on the CPI from www.bls.gov, it shows a declining trend in average revenue per patient admission.

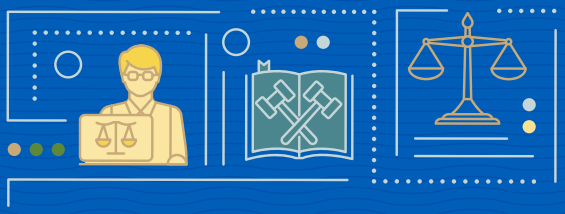


Figure 5 – Total Reimbursement Impact across all HCHB Providers (44% of total Medicare market)

$1,902	$1,851	-2.66%
'23 Actual	'24 Modeled	Change

The Fig. 5 chart is based on 2M PDGM periods ended in the first half of 2023 in HCHB which were individually modeled into 2024 periods based on proposed updates in the Proposed Rule, including changes in the standard payment amount, per-visit rates, case-mix weights, LUPA add-on rates, wage index, FDL ratio, loss-sharing ratio, and HIPPS attributes. The model intentionally does not account for the impacts of adjustments like sequestration and VBP, which we believe allows the model to tell the cleanest story of the impact year-over-year. The model shows that the aggregate revenue impact of the 2024 Proposed Rule for HCHB providers is -2.66%, which is worse than the CMS projected impact of -2.2%.

HCHB models all provider data (44% of all Medicare visits) into this model. The model looks at all patients, visits, diagnosis codes, and claims to date, and shows their actual reimbursement in 2023 versus what the reimbursement on those exact same patients and activities would be under the Proposed Rule. When performing this calculation, the impact across our entire customer base is -2.66%.

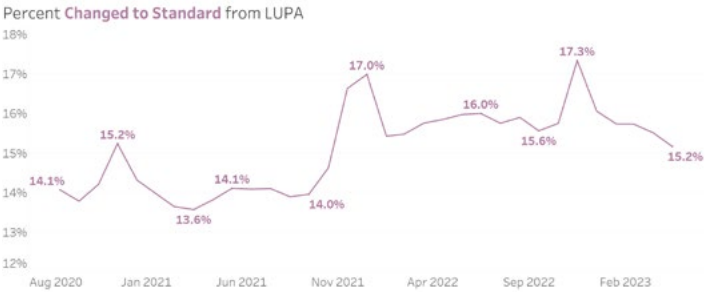
A key question is why HCHB's model shows a larger payment reduction to home health providers than the CMS estimate. CMS utilized 2022 claims data to forecast 2024 payment impact of the Proposed Rule. This CMS methodology does not account for year over year changes in case mix, patient acuity, and visit dynamics. HCHB's model looks at all patients, visits, diagnosis codes, and claims to date and shows their actual reimbursement in 2023 versus what the reimbursement on those exact same patients and activities would be in CY 2024 if the Proposed Rule is finalized. This allows HCHB to account for more recent patient encounters and case mixes that are most reflective of the current state of the industry. Patient complexity captured in the year-over-year change in case mix is the strongest driver in this -2.66% calculation.

HCHB also ran analysis to ensure that the 44% sample was representative of the home health market as a whole, and not skewed by the fact that HCHB has a great volume of claims coming from very large agencies. When analyzing model impact by agency size, there was no correlation between model impact and agency size, creating a greater confidence that this model is representative of the home health market as a whole. HCHB does have unanswered questions about how CMS calculates their estimated impact. A greater understanding of the CMS model would allow HCHB greater clarity in also answering the reasons for the differences. However, HCHB remains very confident that our application of the Proposed Rule using actual patients to date yields a -2.66% impact when comparing the 2023 Final Rule versus this Proposed Rule.

Figure 6 – Behavior Discrepancies – Diagnosis Coding

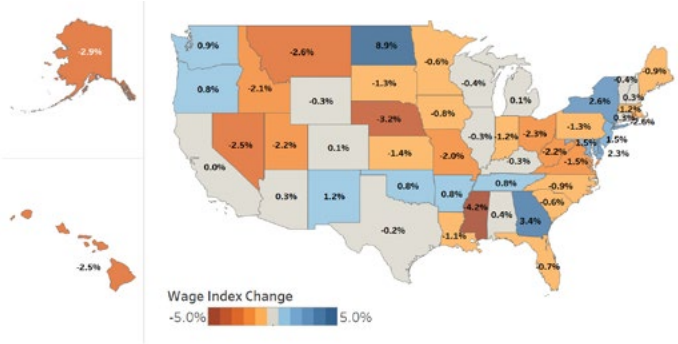
The Fig. 6 chart is based on 17.3M PDGM periods ended in HCHB between March 2020 and May 2023. It shows the percentage of periods that changed to either a higher paying (purple line) or lower paying (teal line) Clinical Grouping based on changes to the primary diagnosis between the beginning and the end of the period. This data set shows that, on average, providers are modifying diagnoses to higher paying Clinical Groupings in only 16.7% of periods while at the same time they are modifying diagnoses to lower paying Clinical Groupings in 10.3% of periods. This net increase in coding in 6.4% of cases stands in stark contrast to the CMS assumption that providers would modify to higher paying clinical groupings in 100% of cases.

Figure 7 – Behavior Discrepancies – LUPA Management



The Fig. 7 chart is based on 690K PDGM periods ended in HCHB between September 2020 and May 2023. It shows the percentage of periods that were initially within 1-2 visits of becoming a Standard, but were modified, increasing payment from LUPA (Low-Utilization Payment Adjustment) to Standard Payments. CMS made a PDGM behavioral assumption that home health providers would modify behaviors to eliminate LUPAs in 33% of cases. The idea is that providers would add visits to ensure that a larger revenue per patient was achieved in at least 33% of cases. The HCHB data shows that LUPA care plans are being adjusted to Standard care plans in only 15% of cases. It should be noted that there are many clinically appropriate reasons where visits should be added for a patient in order to achieve patient outcomes. This data tells a story of appropriate care planning and conflicts with the CMS assumptions that 33% of these cases would be modified from LUPA to Standard.

Figure 8 – Total Miles by Gas Price



The Fig. 8 chart is based on 2M PDGM periods ended in the first half of 2023 in HCHB which were individually modeled into 2024 periods based on proposed updates in the Proposed Rule. This takes the actual wage index received in 2023 for each period and compares it to the wage index it would receive under the Proposed Rule. The resulting change is either positive (blue) or negative (orange). HCHB analysis shows that this wage index change correlates very strongly to overall impact for each state with an R2 of 0.91.

The resulting revenue impact distribution by state is shown below with the typical state being hit with a -2.74% reduction and the worst impacted with a reduction as bad as -5.49%. While most states fall within the green box, there are still a handful with positive impacts with the best resulting in an increase of 3.83%.

Revenue Impact by State

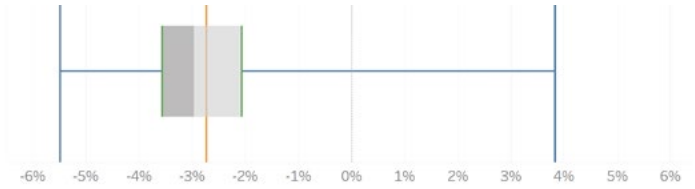
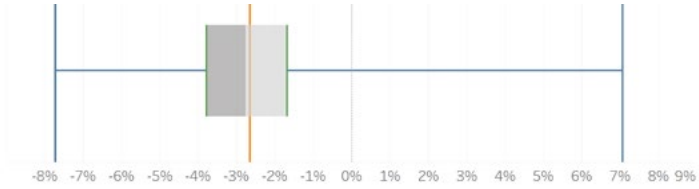


Figure 9 – Inconsistent Impact Across Agencies



The Fig. 9 chart is based on over 2000 providers with at least 100 PDGM periods each. The average provider is at -2.66% and most fall within the green box, however the impact can swing wildly for the rest with impact ranging from plus or minus 7%.

Figure 10 – Industry Fuel Costs

The Fig. 10 chart is based on mileage associated with 291M home health visits in HCHB from 2018 through projected 2023, combined with the average fuel price for each associated year. 2018-2023 fuel prices are from www.eia.gov, while the 2023 fuel price is the average U.S. price per gallon as of the writing of this letter. When extrapolated for HCHB's market share of Medicare patients over the same timeframe, it shows a steady increase in fuel costs year-over-year, with the steepest increase in 2022.