Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2022 HH PPS Proposed Rule: Summary of Findings from Dobson | DaVanzo reports

PRESENTED TO: OIRA

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PREPARED BY: Al Dobson, Ph.D., Sandra Agik, M.A., Sung Kim, M.A., Kimberly Rhodes, M.A., NaToya Mitchell, M.A., Komi Mati, Ph.D., Joan DaVanzo, Ph.D., M.S.W.

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

The Partnership for Quality Home Healthcare Key Issues

- **Implementation of PDGM was accompanied by the application of a -4.36 percent payment adjustment to account for certain perceived changes in provider behavior related to PDGM to ensure a budget neutral transition from the old case-mix system.**
- **However, based on 12 months of CY 2020 data (9.1 million cases), payments are not budget neutral and CMS' two and most significant behavioral assumptions have failed to materialize.**
  - Average case payments remain lower than CMS' budget neutral projections.
  - Case-mix groups reflect historical trends of primary diagnoses rather than CMS' projections of payment-optimized groupings.
  - Rates of Low Utilization Payment Adjustments (LUPAs) are higher than CMS' projections.
- **CMS' methodology for future annual determinations of budget neutrality fails to draw a reasonable comparison between very different case mix systems resulting in bias and inaccurate results.**
- **HHAs continue to face challenges both financially, with higher labor and other costs that are not reflected in CMS' annual payment updates, but also in care delivery with the ongoing pandemic. The Partnership encourages CMS to remove -4.36 percent adjustment for CY 2022 and adopt a more accurate methodology for its future annual determinations of budget neutrality.**

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Background

- **PDGM implementation in the Home Health Prospective Payment System (HH PPS) began January 1, 2020.**
- **COVID-19 pandemic-related state shut-down orders began in March 2020.**
- **Medicare claims data from 2020 are available to Dobson | DaVanzo under CMS Research Identifiable File (RIF) Data Use Agreement (DUA) 54757.**
- **Dobson | DaVanzo also acquired case-level impact and rate setting files from CY 2020, CY 2021 Final Rules and CY 2022 Proposed Rules for our analyses.**
- **On July 7, 2021, CMS published its Proposed Rule to update the HH PPS for CY 2022 HH PPS.**
  - In the CY 2022 HH PPS Proposed Rule, CMS proposed an approach to assessing budget neutrality and determined that CY 2020 payments were 6% too high. However, CMS proposed to defer any payment reductions reflecting the 6% overpayments in CY 2020.
  - CMS also proposed to recalibrate the PDGM-associated case-mix weights using CY 2020 data.
- **PQHH submitted comments on the 2022 HH PPS proposed rule to CMS on August 26, 2021 with 2 DDA reports attached.**

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Presentation outline: Summary of Conclusions

1. **CMS' conclusion that CY 2020 base payments were set 6% higher than they should have been is not supported by data at hand.**
2. **Based on an alternative approach, we find that the CY 2020 30-day average payments were 1.4% below CMS projections with behavioral assumptions.**
3. **The observed -1.4% difference between average CY 2020 payments and projected payments with behavioral adjustments (-4.36% payment reduction) are likely because two of three behavioral assumptions have not been met.**
4. **In the absence of any corrective action, we estimate that CMS behavioral adjustments could lead to a reduction of approximately $2.43 billion in home health payments between CY 2020 and CY 2022.**
5. **The PQHH Labor Cost Survey results indicate that CY 2020 and CY 2021 HH PPS Market baskets are not reflective of labor and administrative price trends in the home health industry.**
6. **Inadequate reimbursement for and reporting of telehealth utilization will affect future rate-setting as CY 2020 home health payments and claims do not reflect telehealth utilization and related costs that have risen during the pandemic.**
7. **The redistributional effects of CY 2022 recalibrated case-mix weights based on CY 2020 data are likely inappropriate for CY 2022 payments as CY 2020 utilization patterns may not be reflective of future CY 2022 utilization and redistribution results in unjustifiable impacts on some HHAs.**
8. **In conclusion, as with the CY 2022 IPPS proposed rule and CY 2022 SNF PPS final rule, we recommend that CY 2020 data should not be used for CY 2022 rate-setting or case-mix recalibration.**

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Conclusion 1: CMS' assertion that CY 2020 base payments were set 6% higher than they should have been is not supported by data at hand.

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CMS methodology for assessing budget neutrality is inherently flawed

- **CMS' methodology that compares aggregate payments under both PDGM and the prior 60-day system using CY 2020 data is inherently flawed—under the 60-day system case-mix and payments are largely driven by therapy visits, while under PDGM case-mix and payments rely more heavily on clinical characteristics as therapy thresholds are eliminated.**
- **Thus CY 2020 data (and perhaps CY 2021 data) cannot be used to estimate what 60-day payments would have been in CY 2020 in the absence of PDGM implementation.**

CMS BUDGET NEUTRALITY METHODOLOGY IN BRIEF:

- **To evaluate whether the 30-day budget neutral payment amount for CY 2020 maintained budget neutrality, CMS used actual CY 2020 30-day period claims data to simulate 60-day episodes and determined what CY 2020 payments would have been under the 153-group case-mix system and 60-day unit of payment.**
  - *Preliminary results indicated that aggregate payments to HHAs were higher in CY 2020 under the PDGM case-mix adjustment methodology and the 30-day unit of payment compared to what HHAs would have been paid had the PDGM and 30-day unit of payment not been implemented.*
- **Additionally, CMS calculated what the CY 2020 30-day periods of care base payment rate and Fixed Dollar Loss (FDL) ratio should have been, to achieve the estimated aggregate payments for the simulated 60-day episodes in CY 2020. CMS then calculated a percent change between the payment rates by dividing the CY 2020 repriced 30-day base payment rate (reflecting payments under the 60-day system) by the actual CY 2020 base payment (reflecting 30-day payments) rate minus one.**
  - *CMS determined the actual CY 2020 30-day base payment rate was approximately 6 percent higher than it would have been under the 60-day payment system.*

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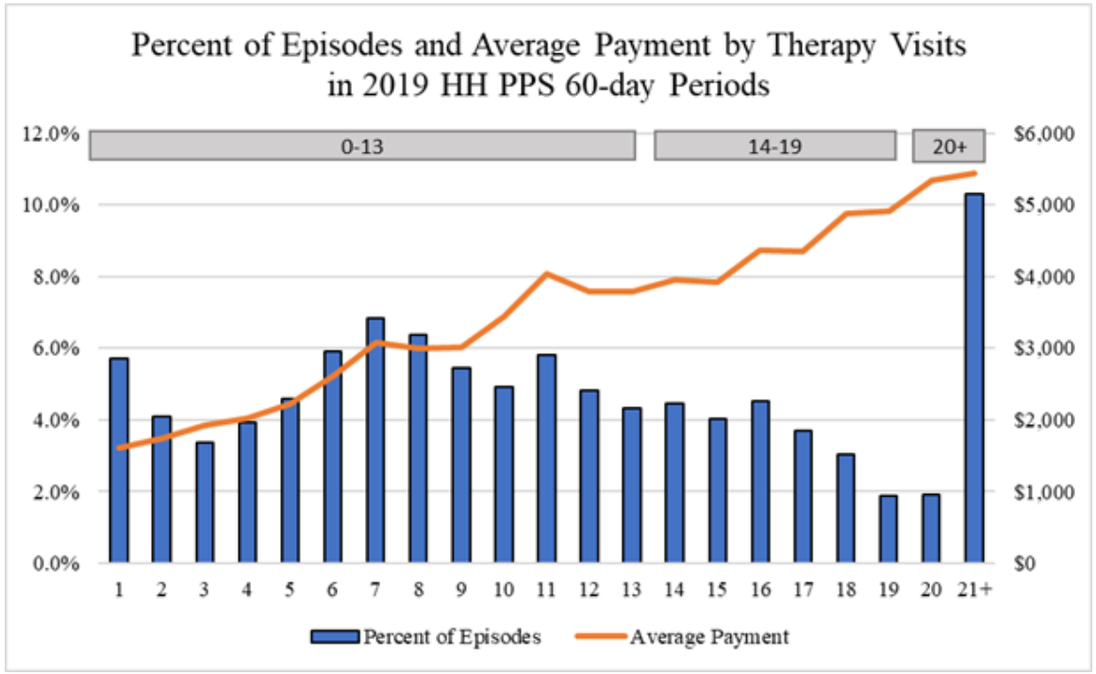
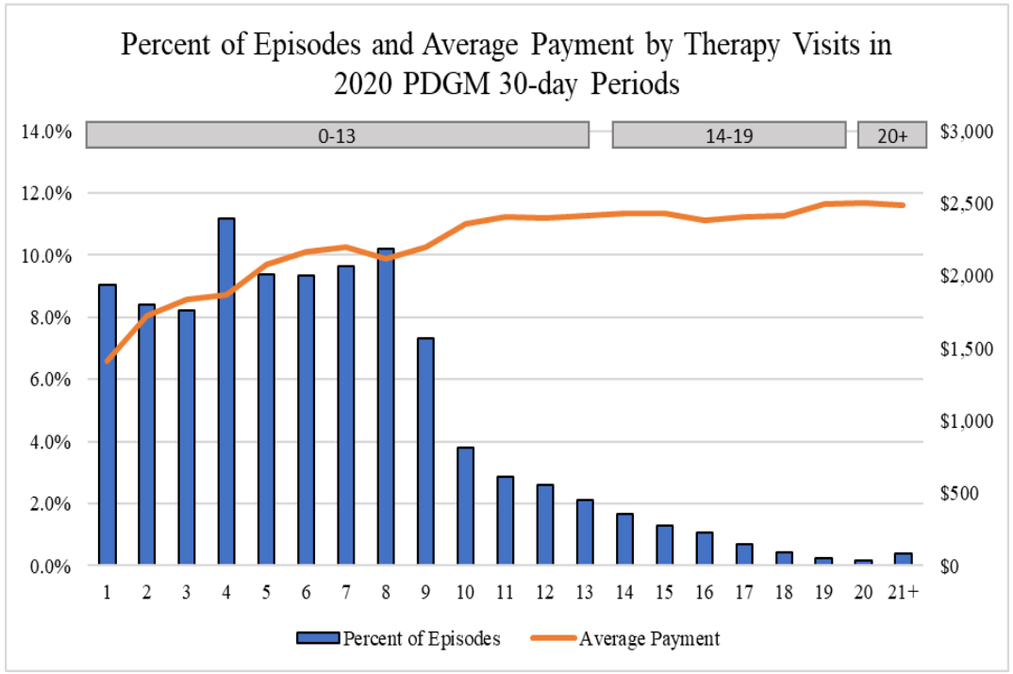
CY 2020 data are distorted by the effects of PDGM implementation

- **The 2019 HH PPS 60-day payments are driven by therapy visit counts while payments under PDGM are not, which makes the repricing of 2020 data using the 2019 payment system flawed. This renders the repriced case mix weights not meaningful for the purpose at hand.**
- **CY 2020 data are distorted by the effects of PDGM implementation and the COVID-19 PHE, as the shift of payment incentives away from therapy visits and the COVID-19 PHE drove a 29.7% reduction in CY 2020 therapy visits. Observed therapy visit clusters at thresholds visible in 2019 are no longer visible in 2020.**
- **This explains the "inaccurate" conclusion by CMS that CY 2020 base payment rates were set 6% higher than they should have been.**





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

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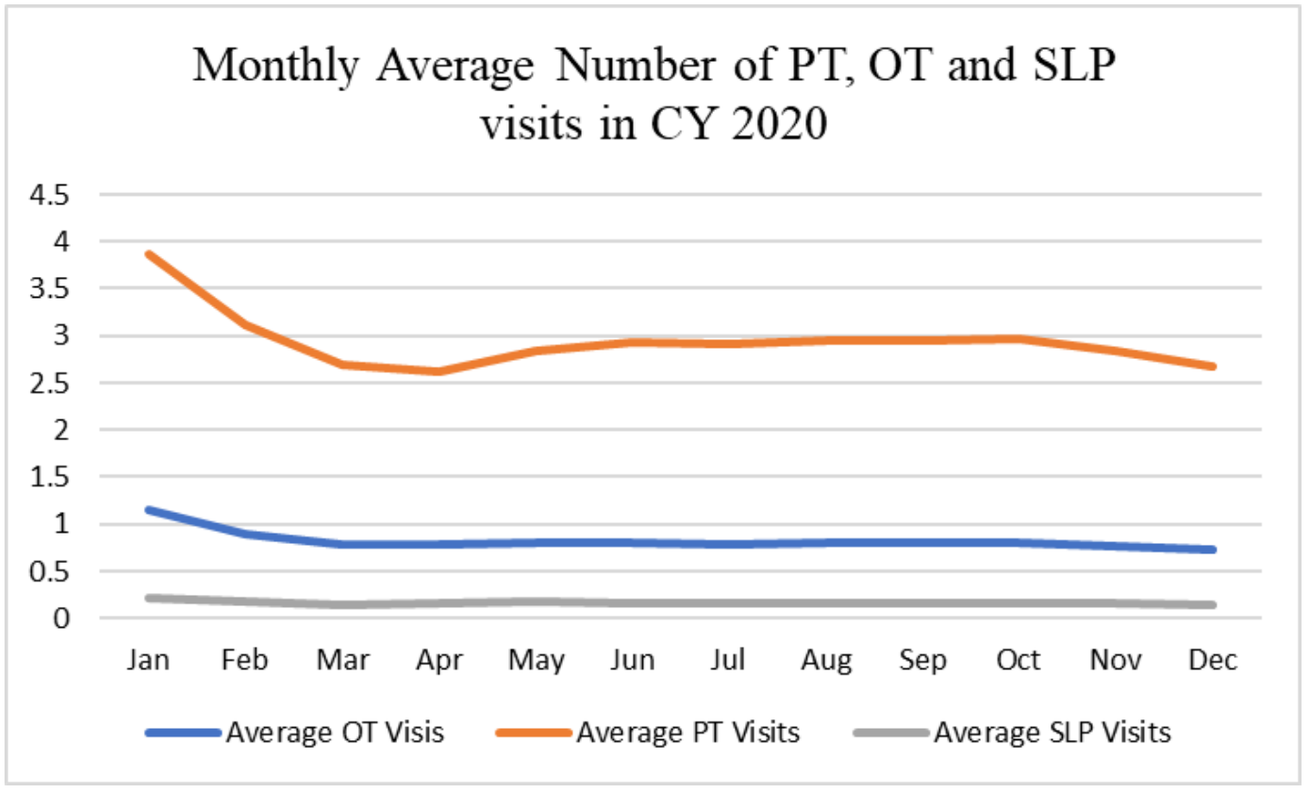
Initial decline in therapy visits occurred before the COVID-19 pandemic in CY 2020

- **When examining the 2020 monthly volume of therapy visits, we note a reduction in average monthly PT and OT visits starting in March 2020 which appeared to recover during the summer months, and once again declined in November and December, perhaps coinciding with the second major wave of outbreaks.[1]**
- **<u>Importantly, the highest reduction in therapy visits occurred before the COVID-19 PHE started in March 2020</u>—indicating that HHA providers were likely already experiencing significant declines in therapy visits as a result of PDGM. PT visits, for example, decline from 3.9 to 2.7 between January and March of 2020.**



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

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1. We also observed minimal but directionally consistent declines in SLP visits starting in March 2020, although volumes appeared to recover throughout the rest of the year.

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

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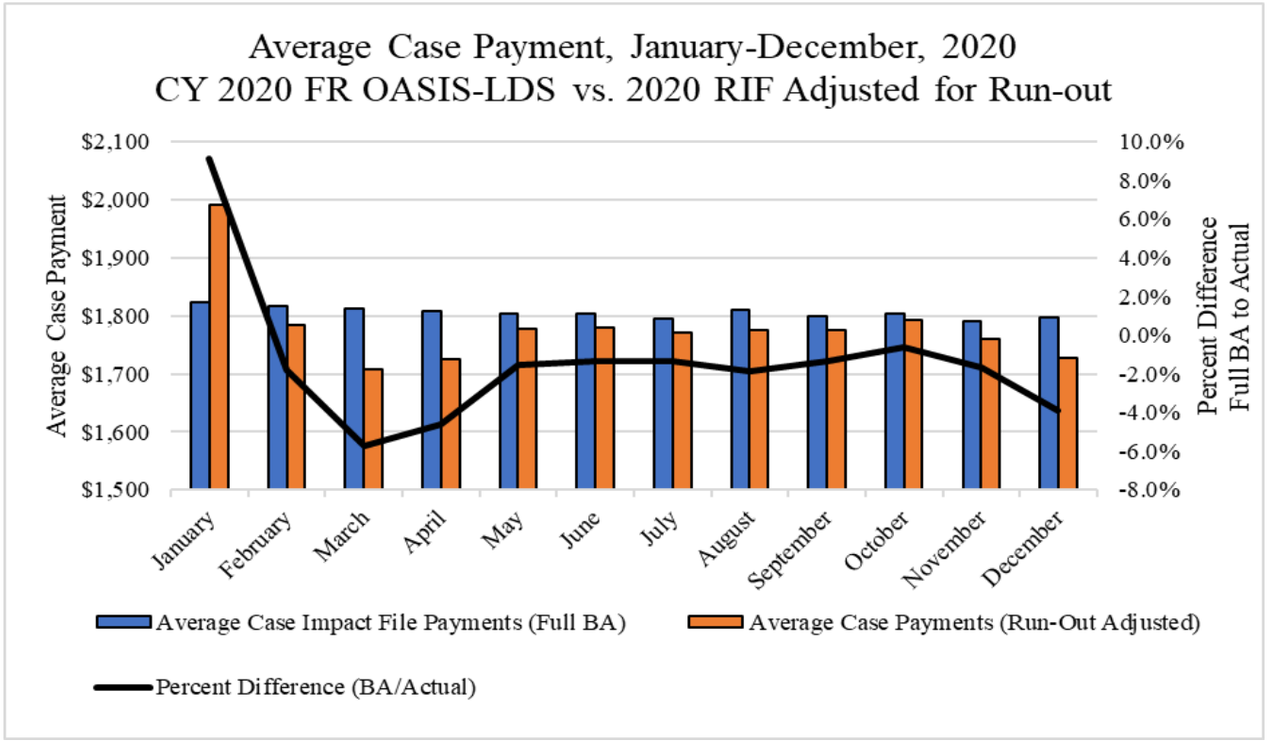
Based on our alternative approach, we found that the CY 2020 average payments were 1.4% below CMS projections with behavioral assumptions

- **DDA compared average payments between actual CY2020 100% RIF Home Health Data and simulated 30-day periods of care (based on CY2018 data produced by CMS).**
  - Updated July data download shows that actual average Case Payment – est. $1,780 is 1.4% below Impact File (Budget Neutral) rate indicating in some part that behavioral assumptions did not hold.

Average payments in CY 2020 compared to average projected payments with BA

	Actual CY 2020 (DDA Calculation)	Impact File (BA)
Average Payments	$1,780.71	$1,805.41



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

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<u>Conclusion 3:</u> The observed -1.4% difference between average CY 2020 30-day episode payments and projected 30- day episode payments with behavioral adjustments (-4.36% payment reduction) are likely because two of three behavioral assumptions have not been met as of July 2021.

In total, this means that CY 2020 payments were 5.76% lower than they would have been in absence of the change to the 30-day payment system (PDGM).

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Behavioral assumptions under PDGM

- **CMS applied behavioral assumptions to about ½ of the cases which resulted in a net -4.36% reduction in the base payment amount.**
- **CMS' behavioral assumptions are summarized below:**
  - 1/3 of LUPAs that were 1 or 2 visits away from the LUPA threshold would have visits added such that they became full 30-day periods.
  - Use highest paying DX code on a claim moving it to a higher paying claim.
  - More cases will have comorbidity adjustments.
- **The observed -1.4% shortfall in CY 2020 average payments is likely because two of three behavioral assumptions have not been met.**
  - LUPA rates remain higher than projected and clinical groupings reflect historical trends without behavioral adjustments.
- **Dobson | DaVanzo will continue to monitor CY 2020 and CY 2021 data as new monthly data become available and as run-out becomes more complete.**

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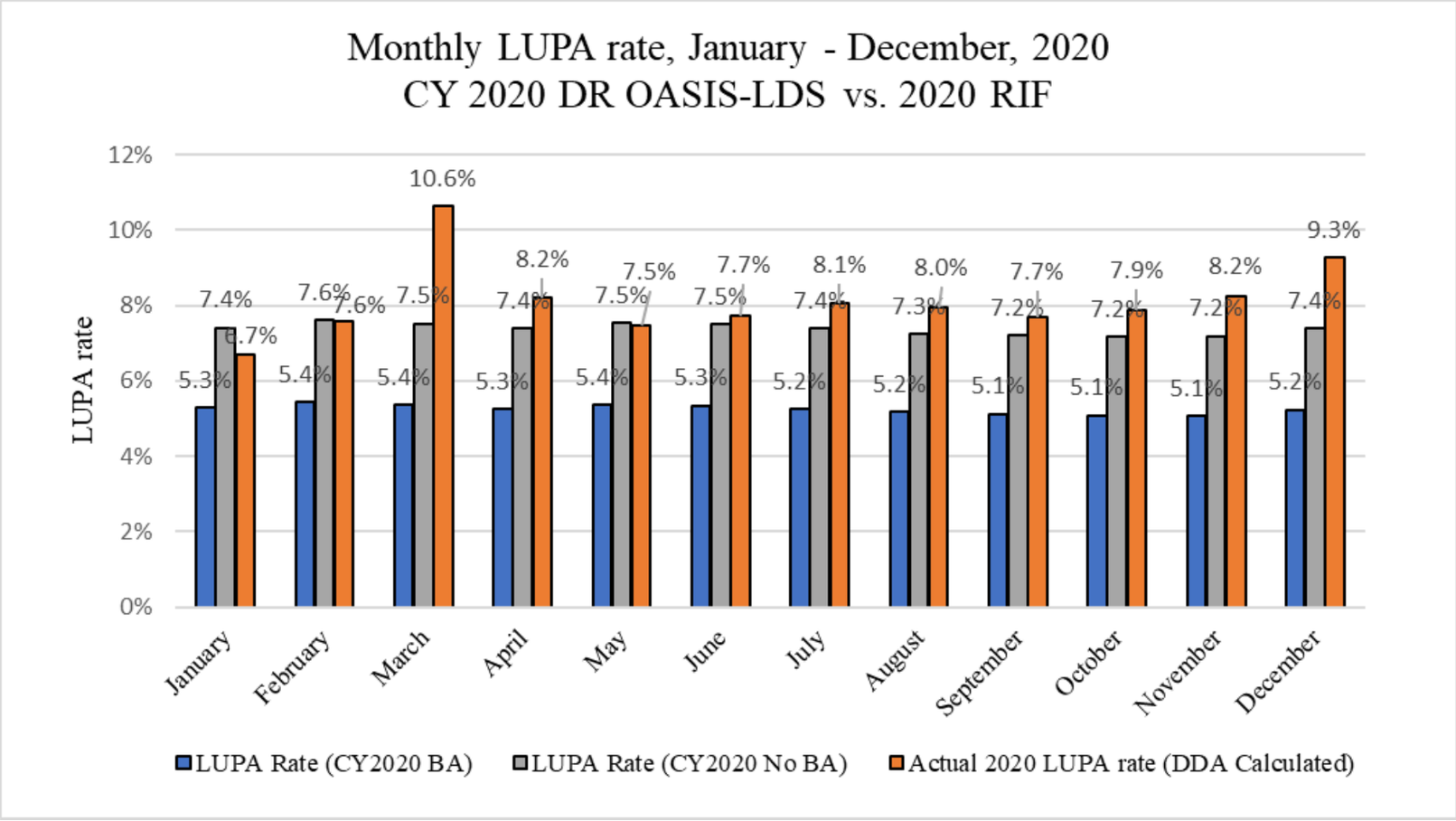
LUPA rates remain much higher than projected: 8.17% through December compared to the predicted 5.3% with behavioral assumptions[1,2]

- **LUPA rates remain much higher than projected throughout 2020.**
  - Average LUPA rate is 8.17% compared to predicted 5.3% with behavioral assumptions in CY 2020.



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

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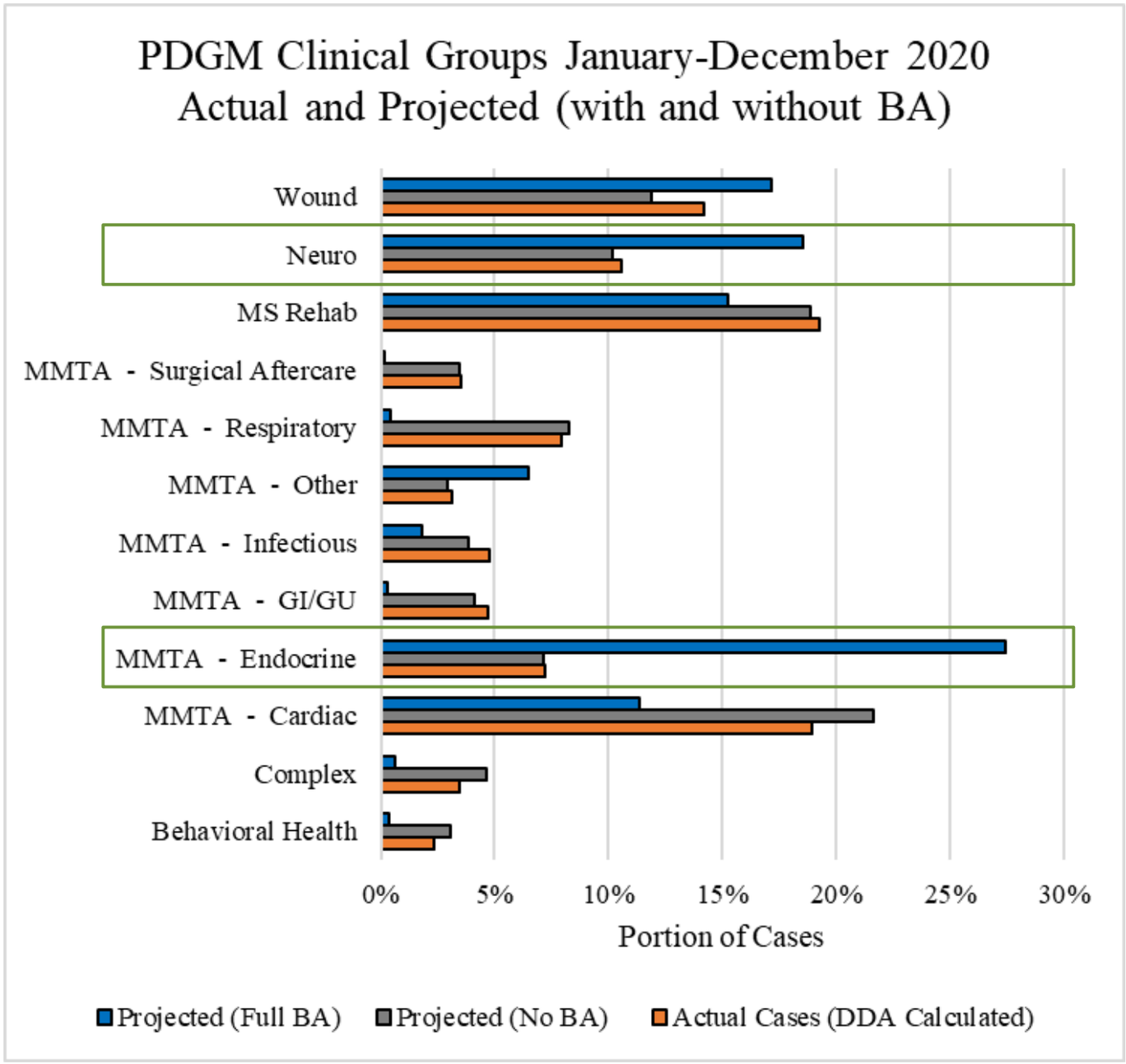
1. Excludes zero payment and zero visit claims
2. 2020 claims data with run-out through July 2021

Clinical groupings reflect CMS predicted trends without behavioral assumptions[1]



- **Generally, clinical groups continue to reflect historical trends of primary diagnoses rather than payment-optimized groupings.**
- **Strikingly, MMTA-Endocrine and Neuro groups stayed close to historical levels, yet CMS predicted providers would change coding behaviors to maximize payments.**

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

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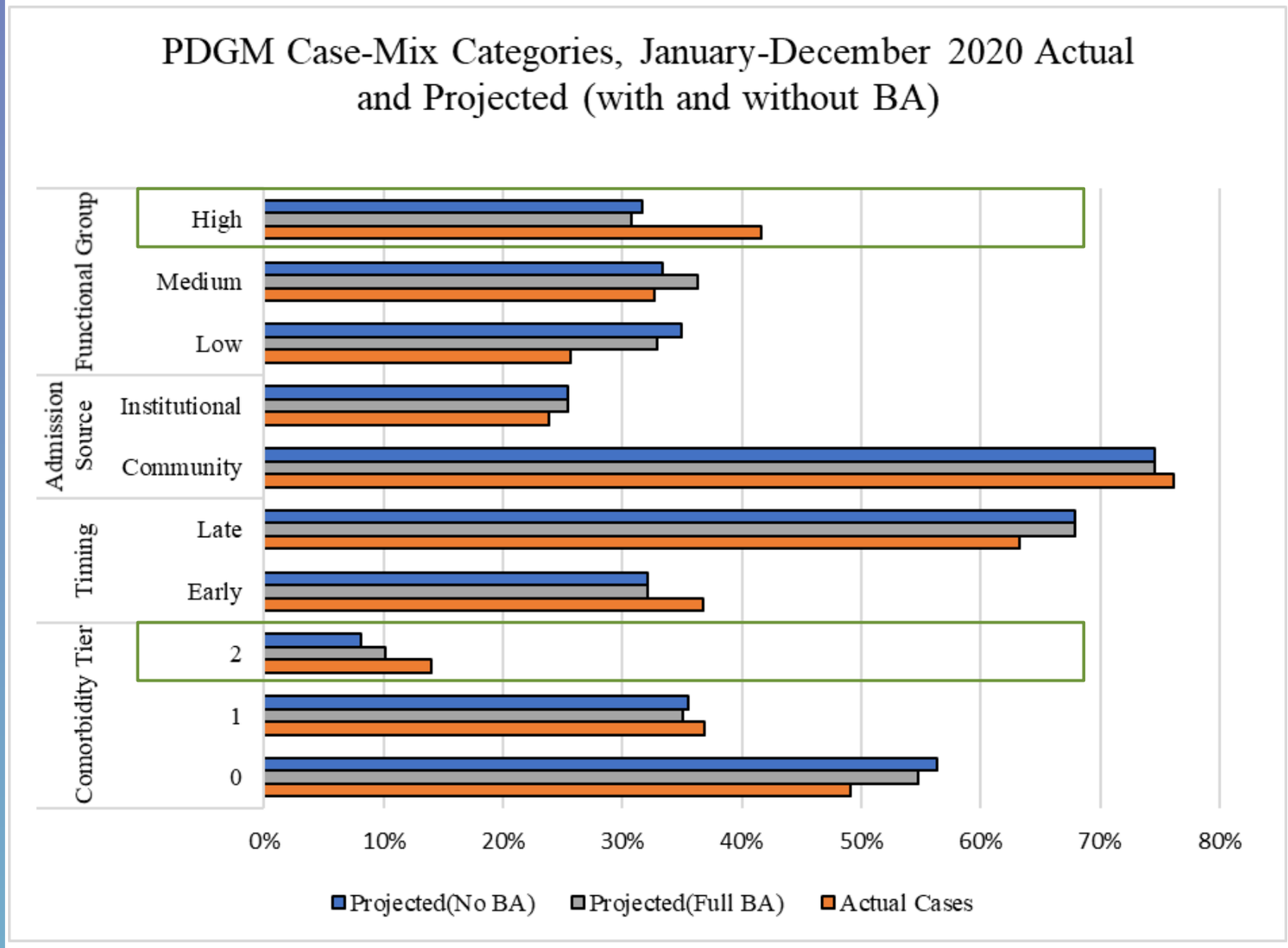
1. 2020 claims data with run-out through July 2021

Comorbidity and functional group scores are much higher than anticipated[1]



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

- **Comorbidity and functional group scores remain consistently higher than anticipated.**
- **This may be some part due to behavioral adjustment but also some part due to patient acuity changes as a result of the pandemic.**

1. 2020 claims data with run-out through July 2021

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

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-4.36% Behavioral adjustment reduction could result in approximately $2.43B reduction in payments from 2020 through 2022

- **Payment reductions due to behavioral assumptions are approximately $2.43B using projected growth rates from the CBO's baseline of March 2020.[1]**

<u>Methodology</u>:

- CY 2020 HH payments from CY 2020 claims data equal $16.86B.
- Based on the Congressional Budget Office's (CBO) baseline of March 2020, home health payments are projected to increase by 5.6% in CY 2021 and 5.3% in CY 2020.[2]
- We determined the projected payments in CY 2021 and CY 2022 by increasing the CY 2020 payments by the projected growth rates determined from the CBO's baseline.
- We applied a +4.36% increase[3] to estimated HH Payments (assumed to have behavioral adjustments) to determine payments without behavioral adjustments.

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

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

1. We conducted a series of sensitivity analyses and found comparable results.
2. Note that these growth rates are reflective of both price and quantity.
3. Note that reverse percentage derivation of payments with no BA require further adjustments to the 4.36% increase. We further adjusted the payments with no BA by 0.2% to account for this.

<u>Conclusion 5:</u> The PQHH Labor Cost Survey results indicate that CY 2020 and CY 2021 HH PPS Market baskets are not reflective of labor and administrative price trends in the Home Health industry.

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Background on HH PPS Market Baskets and the 2021 PQHH Labor Cost Survey

- **The COVID-19 PHE in CY 2020 has affected the supply of and demand for certain inputs, including HH labor leading to a general increase in labor and other input prices.**
- **In April 2020, the Bureau of Labor Statistics (BLS) reported that year-over-year growth in average hourly earnings skyrocketed to about 8%—the highest observed since the series began in 2006.[1]**
- **However, the CMS HH PPS market basket update factor has recently declined from 3.0 in CY 2019 to 2.4 in CY 2022.[2]**
  - This is likely because the market basket price indices do not reflect the pandemic-driven inflation in large part because the market basket composite index is determined on a 4-quarter rolling average basis and reflect general cost changes within the healthcare industry—failing to account for home health specific price changes on a real-time and industry specific basis**.**
- **Dobson | DaVanzo was commissioned by the Partnership for Quality Home Healthcare (PQHH) to investigate the impact of the COVID-19 Public Health Emergency (PHE) on home health labor and other input prices used to derive the HH PPS market basket update factor in the CY 2019 – CY 2022 HH PPS final and proposed rules.**

1. The United States Government. (2021, June 17). The pandemic's effect on measured wage growth. The White House. https://www.whitehouse.gov/cea/blog/2021/04/19/the-pandemics-effect-on-measured-wage-growth/.
2. Market basket data. CMS. (n.d.). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.

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2021 PQHH Labor Cost Survey methodology

- **The PQHH Labor Cost Survey tool was designed to assess the factors impacting HHA labor supply and demand in the home health industry. The questions were developed in an iterative process with feedback from PQHH member representatives.**
- **The survey was administered through Survey Monkey and the survey tool included a mix of questions aimed at collecting real-time and trending data from the PQHH membership on the increasing costs of labor and other inputs (such as benefits and administrative, general and other costs) in the home health industry.**
- **PQHH member organizations are market leaders in their communities. As employers, they have a clear understanding of the wages and labor market dynamics in their areas of operation.**
- **10 out of 13 PQHH member organizations responded to the survey. Responding HHAs operate in 44 of the 50 states and represent 22.1% of home health cases in these states across 3 years (2019- 2021).**
- **Data Analysis:**
  - To ensure that our results reflect the general market distribution of home health agencies, we weighted the responses using the average market share of small, medium, and large providers. First, we categorized each provider as small, medium, or large, based on whether they delivered less than 10,000 episodes, between 10,000-100,000 home health episodes, or greater than 100,000 home health episodes.
  - We then determined the average survey reported growth rates for small, medium, and large HHAs and weighted those averages based on the percent market share. The weights assigned represent the case volume market share for small, medium, and large HHAs in the general home health market. The average values reported therefore reflect the overall home-health market rather than the PQHH membership as whole or any individual members.

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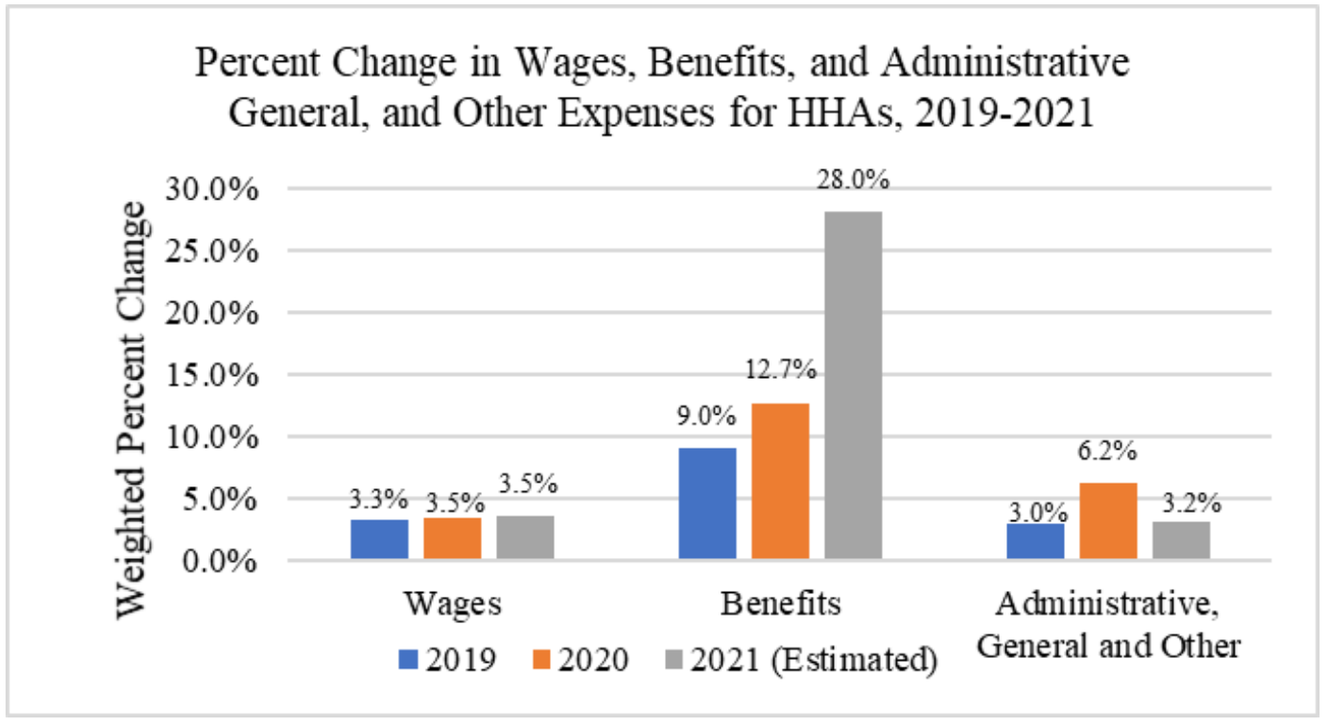
HHA wages, benefits, and administrative costs increased at a higher rate in 2020 than they did in 2019

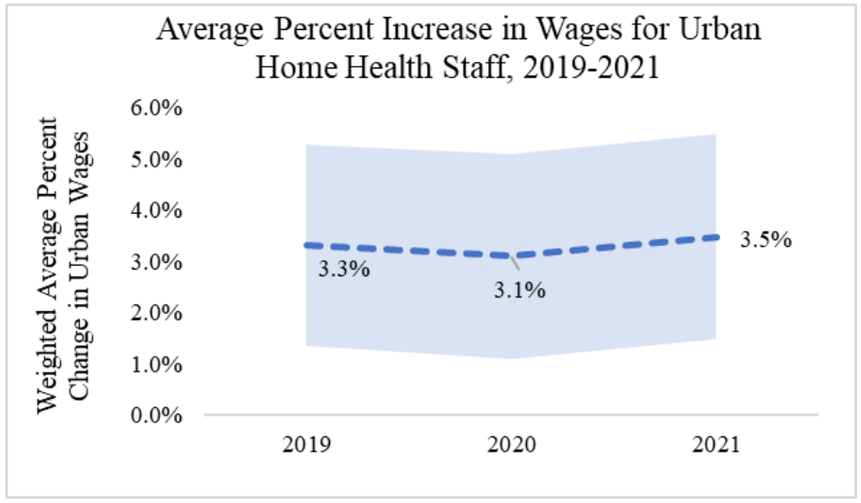
- **Home health labor (wages and benefits) costs as well as costs associated with administrative, general, and other services increased at a higher rate in 2020 than they did in 2019.**
- **Although benefits costs are anticipated to increase at a higher rate in 2021 than in 2020, costs for wages and administrative, general, and other services are anticipated to grow at the same rate or at a slower rate in 2021.[1]**
  - HHA wages are anticipated to grow at the same rate in 2021 as they did in 2020, benefits costs are expected to grow at a rate that is 15.3 percentage points higher in 2021 than in 2020, while administrative, general, and other costs are expected to grow at a rate that is 3.0 percentage points lower in 2021 than in 2020.

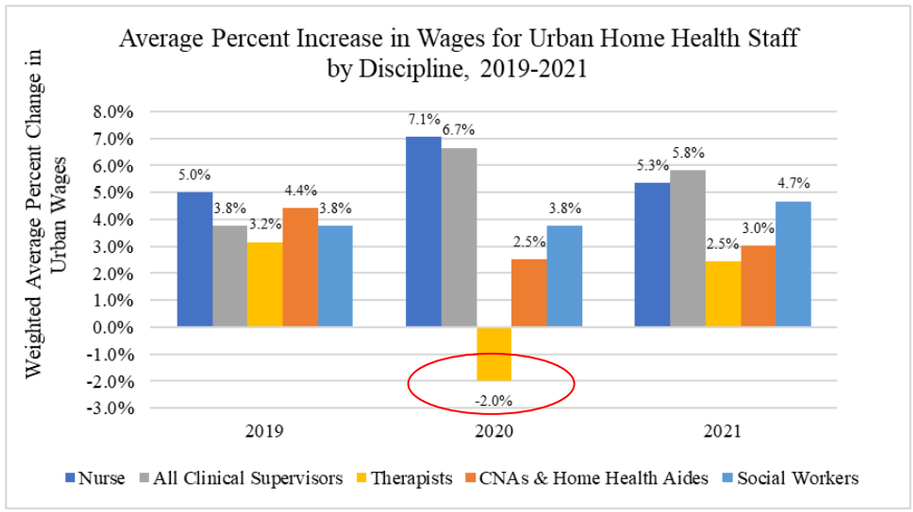


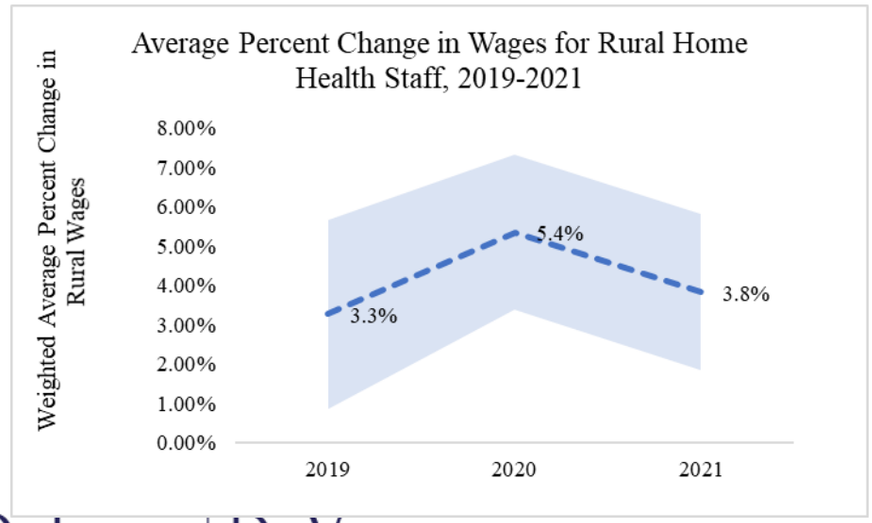
1. Average Percent changes were determined by weighting agency level increases by the proportion of national volumes for each agency and proportion of rural and urban patient population. As such, average weighted percentages reflect the general market results for HHAs.

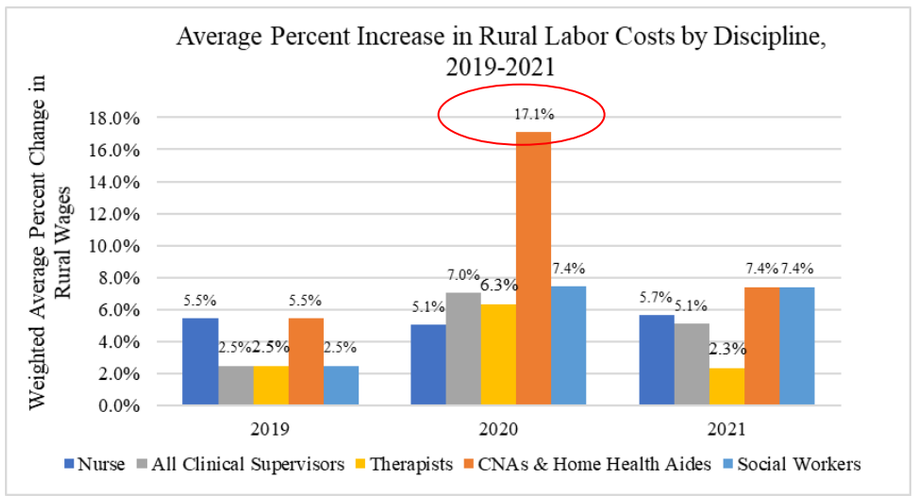
HHA wages in urban areas increased at a slower rate in 2020 while wages in rural areas increased at a much higher rate in 2020 than they did in 2019

- **Wages in urban areas increased at a slightly slower rate in 2020 than they did in 2019, while wages in rural areas increased at a higher rate in 2020 than they did in 2019.**
  - The observed reduction in the average weighted percent increase in wages for home health staff in urban areas in 2020 is likely primarily driven by the decline in wages for therapy professions (which declined by 2.0% from 2019 to 2020).
  - The observed increase in the average weighted percent change in wages for home health staff in rural areas in 2020 is likely primarily driven by the increase in wages of rural certified nursing assistants and home health aides which increased by 17.1% in 2020.









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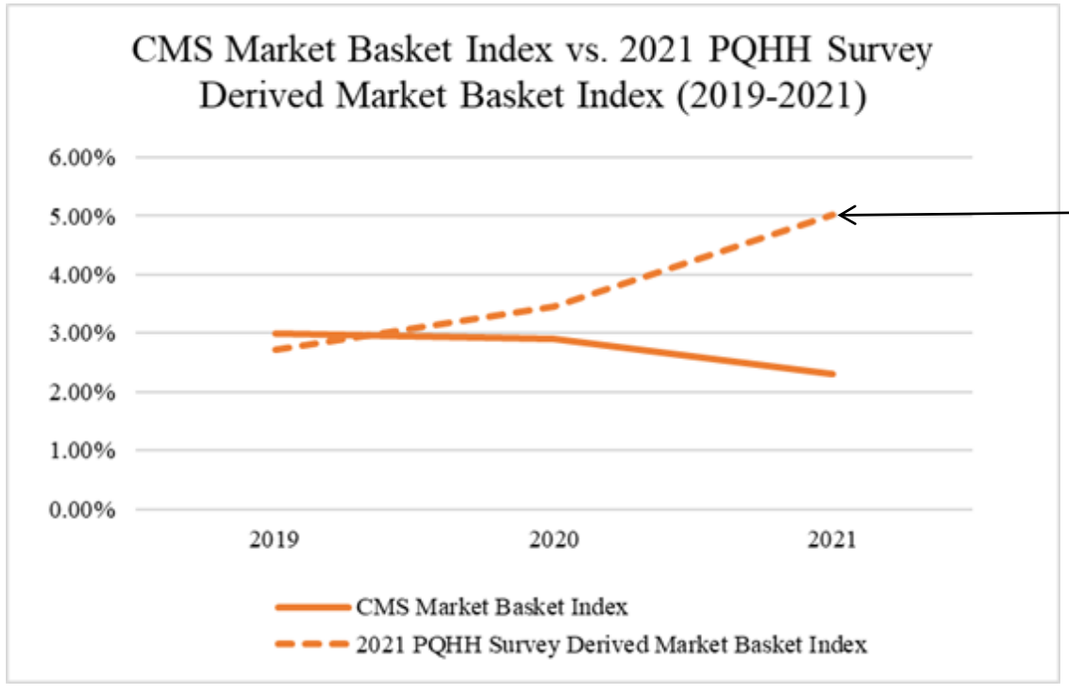
Counterfactual Market Basket from the 2021 PQHH Labor Cost Survey shows increases between 2019 and 2021

- **We derived the counterfactual market basket index using growth rates for the three largest components of the index (wages and salaries, benefits, and administrative, general, and other expenses) obtained from the PQHH Labor Cost Survey. These growth rates were weighted by the respective market basket cost category weights and combined to derive a counterfactual market basket update factor for each year.**
  - Note that the cost category growth rates obtained from the survey represent 93.4% of the HH PPS market basket.
- **Results from the 2021 PQHH Labor Cost survey indicate that HH PPS market basket should have increased by approximately 1.1 percentage points between 2019 and 2020 and 1.2 percentage points between 2020 and 2021.**
  - The observed upward trends across cost categories, and the overall market basket indicate that the market basket should have remained flat or risen between CY 2019 to CY 2021 instead of the observed decline.



Counterfactual market basket from PQHH labor cost survey shows increase between 2019 and 2021

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

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<u>Conclusion 6</u>: Inadequate reimbursement for and reporting of telehealth utilization will affect future rate-setting as CY 2020 home health payments and claims do not reflect telehealth utilization and related costs that have risen during the pandemic.

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<u>Conclusion 7:</u> The redistributional effects of CY 2022 recalibrated case-mix weights based on CY 2020 data are likely inappropriate for CY 2022 payments as CY 2020 utilization patterns may not be reflective of future CY 2022 utilization and redistribution results in unjustifiable impacts on some HHAs.

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The redistributional effects of recalibrated case-mix weights based on CY 2020 data are inappropriate for CY 2022 payments

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

CY 2022 National, Standardized Payment Amount

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

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

- **The CY 2020 data that CMS relies upon to set rates and recalibrate case-mix weights are likely not representative of utilization patterns in CY 2022.**
- **Although CMS implements a budget neutrality factor of 1.039 to offset the aggregate reduction in payments due to the recalibrated case-mix weights, we believe the varying redistributional effects on individual HHAs are unjustifiable for CY 2022 payments if the observed COVID-19 trends do not persist in CY 2022.**
  - CMS impact analyses indicate that small HHAs with less than 1,000 cases and HHAs in the pacific region will experience significant payment reductions due to the case-mix recalibration.

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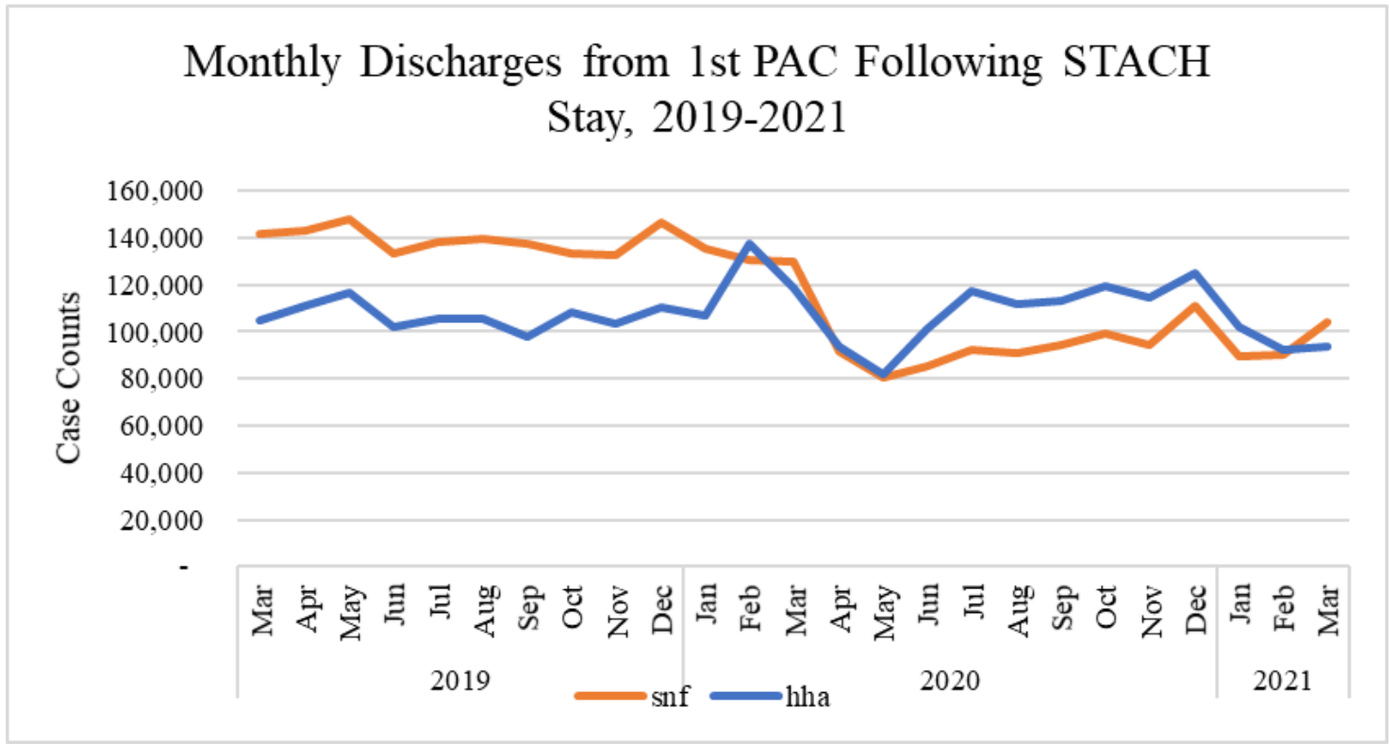
Relative volume of STACH discharges to HHA was higher than STACH discharges to SNF in 2020, indicating that HHAs likely substituted for SNF care

- **In 2019, there were more discharges following STACH stay from SNFs compared to HHAs. However, in 2020, those trends reversed; data shows there were more PAC discharges following STACH stay from HHAs compared to SNFs**
- **Early 2021 data shows that the trends may be reversing yet again but more recent data will be required to determine the magnitude of the reversal.**
- **These data show that HHA volumes in CY 2020 were atypical as HHAs likely substituted for SNF care in CY 2020. Therefore CY 2020 data may not be representative of future utilization in CY 2022.**



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

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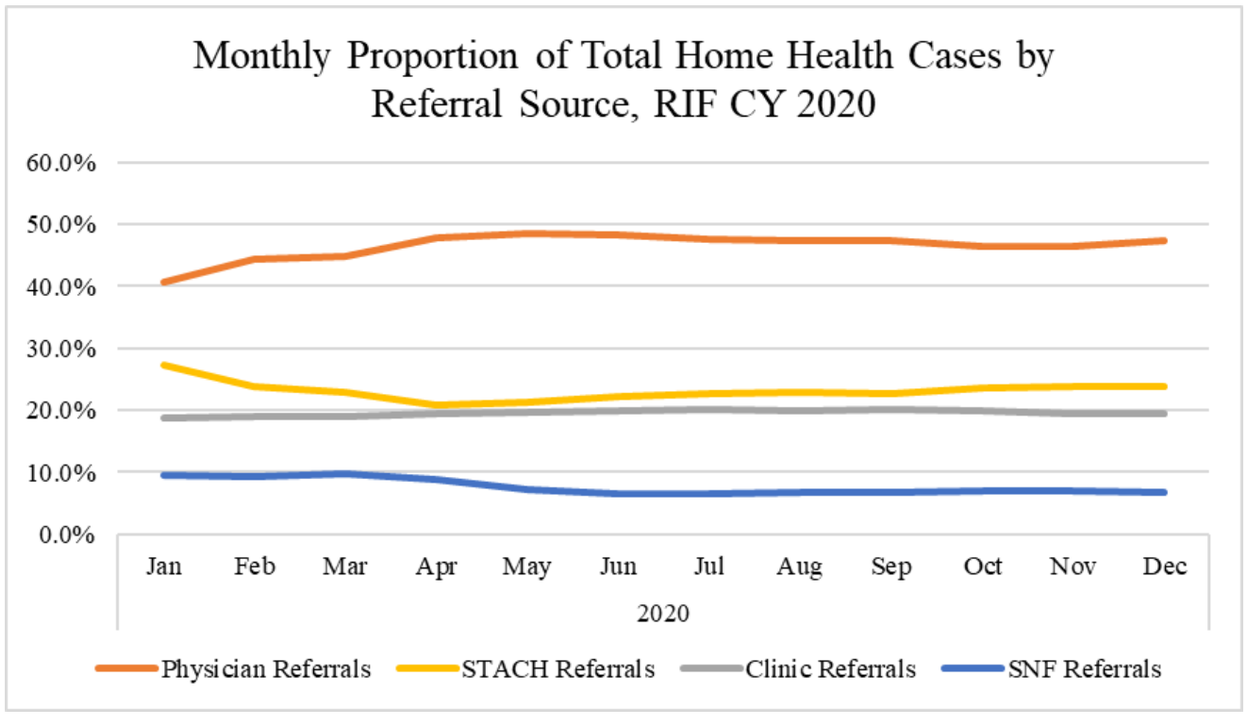
HHAs experienced a reduction in STACH referrals as a total of HHA cases[1] in 2020

- **SNF and Hospital referrals as a proportion of total HHA cases experienced reductions with the onset of the pandemic in March and April of 2020 while Physician referrals increased; Clinic referral remained relatively stable. SNF and Hospital referrals as a proportion of total cases have not returned to pre-pandemic levels.**
- **These findings indicate that referral sources may have been impacted by the pandemic, especially due to the cancellation of elective surgeries and volume reduction in STACH settings—possibly driving the decrease in STACH referrals to HHAs.**
- **Observed utilization in CY 2020 was atypical and further shows that CY 2020 data may not be representative of future utilization in CY 2022.**



- Physician referral: The patient was admitted upon the recommendation of a personal physician.
- Hospital referral: The patient was admitted as an inpatient transfer from an acute care facility.
- Clinic referral: The patient was admitted upon the recommendation of this facility's clinic physician.
- SNF Referral: The patient was admitted as an inpatient transfer from a SNF.

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

1. DDA analysis of referral source in CY 2020 data from RIF

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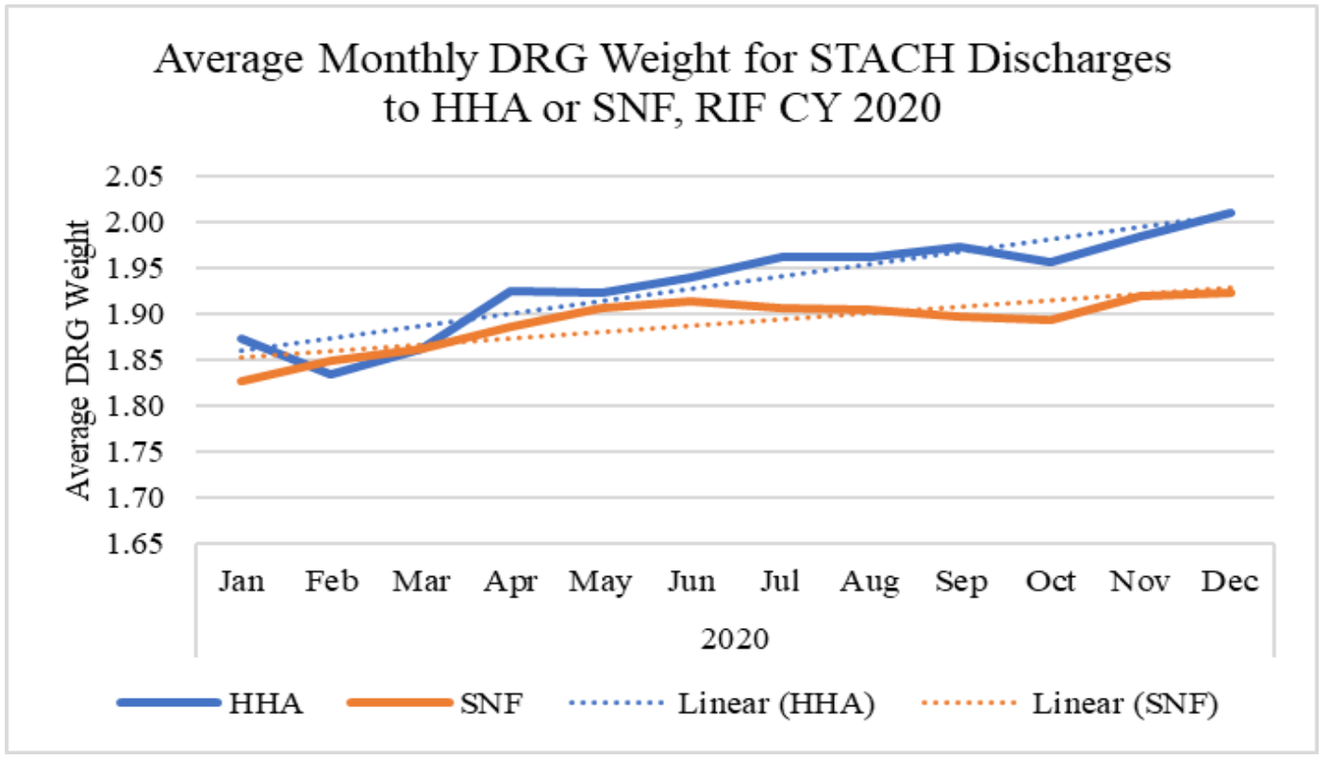
STACH referrals to HHAs appeared to be of higher and increasing severity in 2020 compared to prior years

- **DRG weights[1] for STACH discharges to HHAs are higher and rising faster than DRG weights for STACH patients discharged to SNF in 2020.**
- **These data further illustrate that as HHAs substituted for SNF care in CY 2020, they likely took on cases of higher severity further indicating that CY 2020 data may not be representative of future utilization and severity of cases in CY 2022.**



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

1. Note that DRG weights account for COVID-19 diagnosis severity. Section 3710 of the CARES Act directs the Secretary to increase the IPPS weighting factor of the assigned diagnosis-related group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 public health emergency period. Issued May 2020.

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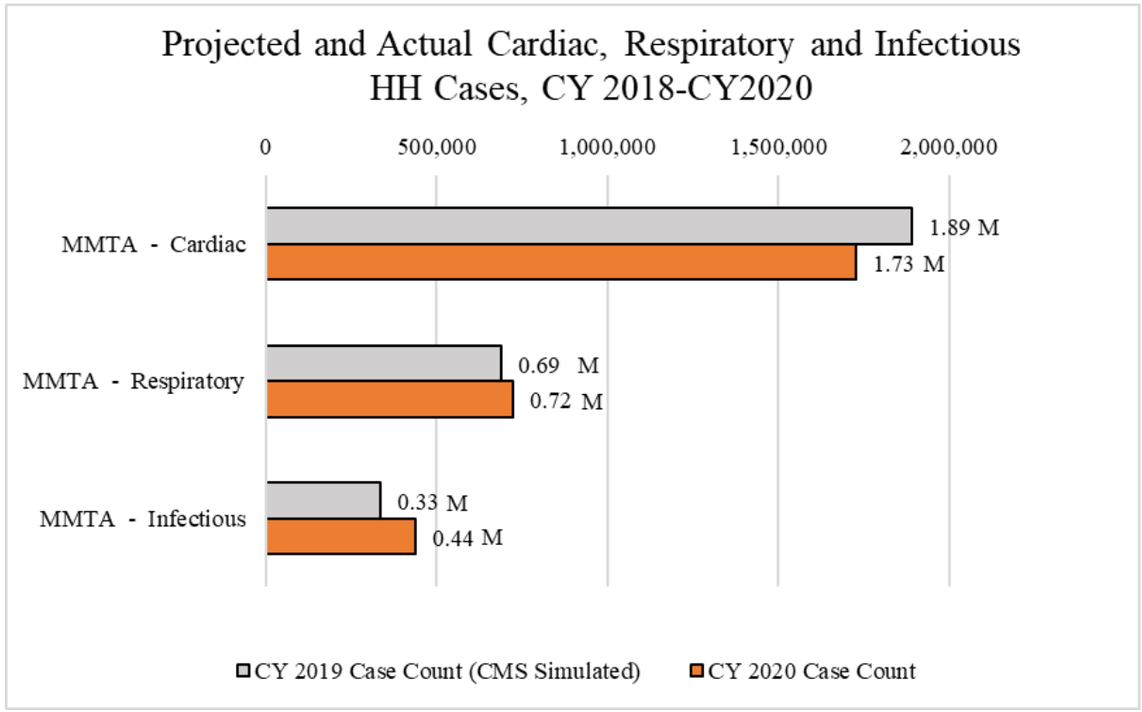
General increase in respiratory and infectious cases while cardiac cases decreased from CY 2018 - CY 2020 reflect atypical utilization

- **Cardiac cases declined by 8.4% from CY 2019 to CY 2020.**
- **Respiratory cases increased by 4.3% while infectious disease cases increased by 33.3% between CY 2019 to CY 2020.**
  - This signifies that HHAs likely took on more severe cases in CY 2020 than they did in prior years possibly influencing the observed increase in comorbidity and functional case-mix groupings.



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

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Significant reductions in average home health visits per episode, average visits across all disciplines, and reduction in overall utilization in CY 2020 reflect atypical utilization

- **In addition to reductions in therapy visits, there were significant reductions in average visits across Skilled Nursing, Home Health Aide and Social Worker disciplines in 2020. We also observed an overall decline in total number of visits across all disciplines and average visits per unique beneficiary.**
- **These trends underscore the significant shifts in home health utilization that occurred as a result of the pandemic. CMS should therefore exercise caution as they use CY 2020 for any purposes such as rate-setting or case-mix recalibration.**
- **The observed reduction in average visits is likely due to the impact of the COVID-19 PHE that resulted in significant visit volume declines and the use of telehealth which are currently not captured in claims data.**

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

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

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

Overall Utilization of Home Health Services, CY 2018 - CY 2020

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

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

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<u>Conclusion 8:</u> In conclusion, as with the CY 2022 IPPS proposed rule and CY 2022 SNF PPS final rule, we recommend that CY 2020 data should not be used for CY 2022 rate-setting or case-mix recalibration.

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Policy recommendations

1. **Similar to CMS conclusions in the CY 2022 SNF PPS final rule and CMS' CY 2022 HH PPS proposed rule, CMS should not consider any temporary or permanent decreases to PDGM 30-day payment amounts reflecting that CY 2020 base payment rates were 6% too high stemming from an inaccurate budget neutrality assessment methodology.**
   - This issue may be addressed using CY 2021 data in the calculation of CY 2023 payment rates, although it is possible that CY 2021 data may also be distorted by recent developing trends related to the surge of COVID-19 delta variant cases.
2. **Instead of the potential proposed 6% reduction, CMS from a budget neutral perspective should consider taking corrective action to increase base payment rates by 5.76% so the HH PPS will be more likely to achieve budget neutrality for CY 2022, as authorized by the Bipartisan Budget Act.**
3. **CMS should continue to track the behavioral assumptions using data for future years not impacted by the COVID-19 PHE to determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures.**
4. **As CMS recognizes and the data shows, any current or future reductions to account for provider behavioral shifts for payment optimization are not appropriate.**
5. **Accordingly, CMS should comprehensively assess all aspects of the home health Market Basket Index derivation to ensure that it reasonably forecasts annual cost increases and that the price proxies accurately reflect trends in the home health industry.**
6. **We urge CMS to institute an appropriate reimbursement methodology for home health telehealth services. This will ensure that telehealth services are well captured in home health claims and Medicare Cost Reports which will subsequently increase the accuracy of future rate-setting and home health reimbursement.**
7. **We recommend against CMS using CY 2020 data for case-mix recalibration in the CY 2022 HH PPS proposed rule.**