Home Health Care News

Andrew Donlan, November 02, 2023

After the U.S. Centers for Medicare & Medicaid Services (CMS) released its CY 2024 final payment rule Wednesday, home health providers found themselves in a position they know all too well.

Is a 0.8% aggregate payment increase better than the 2.2% decrease that was proposed? Of course. Was the rule, in its totality, effective in easing the payment concerns of providers moving forward? Of course not.

The home health industry's last few years have been filled with long, hard advocacy battles between the proposed rule and final rule. Like the early 90s Buffalo Bills, those advocacy seasons have been successful, but none of them have ended up with the ultimate goal achieved: a Super Bowl win, or a total nixing of present and future home health cuts.

Both last year's final rule – a 0.7% increase – and this year's final rule offered providers a breather. It's a breather that doesn't last long.

CMS stands by its methodologies for evaluating the budget neutrality of the Patient-Driven Groupings Model (PDGM), and also believes it overpaid providers to the tune of $3.4 billion from 2020-2022. That means providers will likely be back in the same position from June to October 2024 as they were from June to October of this year.

It's an arduous process for everyone that calls the industry home, and it reminds me of something Amedisys Inc. (Nasdaq: AMED) Chairman Paul Kusserow told me in January.

"My concern is the game that we play with CMS," Kusserow said. "It's a long, exhausting game. They come up with a proposed significant cut. The whole industry gets all worked up about it and runs to Washington. I've done this, and everybody in our business has. We lobby, lobby lobby, they get a lot of pressure, and then they come back with something that is just mediocre. It's not enough for us to get Congress all worked up about it to pass legislation. But it's enough to keep us in purgatory. We have to get through this dribbling sense of inadequate reimbursement."

In 2024, CMS and the home health industry will continue to play that game. CMS has not to this point gotten what it wants, and nor has the home health industry.

This week's exclusive, members-only HHCN+ Update addresses Wednesday's final rule, but also addresses what it could mean for the home health industry moving forward.

Short-term wins

Immediately after the rule dropped, trade associations rushed to make sure those paying attention didn't miss the forest for the trees.

Some of the trees, for instance: the final rule's difference from the proposed rule will amount to a revenue boost of $26 million for Amedisys and a $18 million boost for Enhabit Inc. (NYSE: EHAB), according to the Jefferies Group.

Smaller agencies will see similar relief from projections stemming from the 2024 proposed rule, relative to their overall revenue. But that shouldn't satisfy them, the Partnership for Quality Home Healthcare CEO Joanne Cunningham argued.

"To put these numbers into context, the rule finalizes a base rate year-over-year increase of less than $1 per day to care for Medicare's sickest patients," she said in a statement. "And while CMS is slightly delaying implementation of the permanent cut for next year, those dollars will be cut from home health in future years."

In its statement, the National Association for Home Care & Hospice (NAHC) reiterated that it would need continued support from its lawmaker allies in Congress if there was any hope to put an end to future cuts.

The New York-based home health provider VNS Health called CMS' current path "not good policy, not a good use of taxpayer dollars and not good for patients."

Its CEO, Dan Savitt, argued that the continued cuts would further reduce patient access, which, in turn, would end up costing the Medicare program more.

“Faced with longer stays, patients with more complex medical needs, and fewer available beds, hospitals are trying to discharge more and sicker patients to home health care agencies,” he said in a statement shared with Home Health Care News. “But amidst a severe and persistent workforce crisis, VNS Health and home care agencies across the country are not able to keep up with this rising demand. Last year, agencies had to turn away about 75% of hospital referrals to home health care. The situation is worse in ‘home health deserts’ – areas already suffering from disparate levels of care where the workforce crisis is even more challenging.”

That’s nearly the exact same tone that Carrie Edwards – the director of home care services at Mary Lanning Healthcare – struck at an aging-in-place hearing held by the Senate Finance Committee’s Subcommittee on Health Care in September.

Edwards painted a more specific picture. As a result of CMS policy, Mary Lanning’s home health arm had reduced its coverage from a 60-mile radius to a 25-mile radius in just two years, undoubtedly leaving home health-needy patients behind.

But CMS either does not seem to buy these claims. That much was evident in the agency’s 531-page final rule.

“In any event, CMS looked closely at our data to ensure the payment rate adequately covers the costs reported by HHAs, without creating unnecessary hardship to providers and maintaining access to quality services for all beneficiaries,” the agency wrote. “Maintaining access is one of CMS’s priorities when making policy decisions. We do not intend to obstruct the provision of home health services to any beneficiary who qualifies for this benefit.”

What’s more, CMS reminded home health stakeholders that even if it did buy the access argument, its hands are tied by law. Congress mandates that PDGM must be budget neutral, and the agency won’t budge from its stance that the model has not been

CMS rebuttals

While CMS backed off more severe cuts, it did not back off its reasoning for proposing those cuts, nor its reasons for implementing the cuts it did.

It even fought back against analyses and comments submitted by providers during the public comment period in its final rule.

On taking into account Medicare Advantage (MA) home health rates, CMS said – more or less – “not our problem.”

“We have never endorsed the view that Medicare funds should be used to subsidize reimbursement rates from other payers – a policy that would be inconsistent with our obligation to be responsible stewards of the Medicare Trust Funds and would ultimately increase costs to Medicare beneficiaries, taxpayers, or both,” CMS wrote. “As we noted in the CY 2023 HH PPS final rule, we responded to this assertion stating: ‘Medicare has never set payments to [cross-subsidize] other payers.’”

Even if that's the case, though, CMS should refrain from claiming home health providers have sky-high margins. The agency is at least aware that Medicare fee-for-service payments are not home health providers' singular revenue stream.

And, if home health providers were to ignore those MA patients to chase after the higher margin, over 50% of the Medicare population would be left without access to home health care.

"We observed many methodological weaknesses in the analyses submitted by commenters," CMS continued. "It is unclear whether the proprietary data on which commenters base their analyses includes referrals from only Medicare FFS beneficiaries or also includes referrals from patients covered by other payers, which means the entire analysis may be inapt for Medicare FFS policy."

CMS also took issue with the referral rejection rate numbers, insinuating that more referrals being rejected did not ultimately mean fewer patients were receiving care.

"In addition, the proportion of hospital referrals rejected by HHAs does not equate to the

proportion of qualifying beneficiaries who are denied care," the agency wrote. "The data fails to capture why the beneficiary was rejected – for example, because the analysis focuses on numbers of referrals denied rather than numbers of beneficiaries denied care, the rejection referral proportion could be inflated by a small number of beneficiaries rejected from multiple HHAs, or by beneficiaries rejected from one HHA but who ultimately received care from another HHA."

All of this is to say, CMS is unconvinced by messaging from the provider community. What matters now is whether Congress is convinced, and willing and able to act on the issue.

If not, home health providers will remain in payment purgatory.