Medicare Home Health Prospective Payment System (HH PPS) Calendar Year (CY) 2023 Behavior Change Recap, 60-day Episode Construction Overview, and Payment Rate Development Webinar

Presented by Centers for Medicare and Medicare Services and Abt Associates
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Link to audio recording of the meeting: https://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/hh-pdgm

Introduction

Brian Slater: Okay. So, it sounds like others can hear me now. All right.

All right, I think we have about half of those that originally signed up, so in the interest of time since we're pushing five minutes here, I think I'm just going to go ahead and get started.

So, like I said, good afternoon and good morning to those of you joining us from the West Coast. My name is Brian Slater, I'm the director of the Division of Home Health and Hospice here in the Chronic Care Policy Group at CMS. We appreciate you guys joining us for today's webinar, the Medicare Home Health Prospective Payment System Calendar Year 2023 Behavior Change Recap 60-day episode construction overview and payment rate development webinar. I know that's a lot but hopefully we will simplify things as we go through these slides. So, during the next 90 minutes or so myself, my deputy director, Kelly Vontran, as well as T.J. Christian and Mike Plotzke from Abt Associates will provide an overview. Since releasing the slide deck about a month ago we received a number of questions. Because we are appreciative of the questions, and we received those in advance we'll try and focus our presentation on covering those questions and the related material to those questions. So therefore, we won't be covering every single slide in the slide deck but at the end of the presentation when we have the live Q&A session, you know, that will provide the opportunity for us to circle back if need be on any certain questions or input that you have on specific materials that are in the slide deck. Then if there are any slides that you'd like to -- for us to cover in more detail during the Q&A we can certainly do that at that time.

A few housekeeping items. If you prefer to submit your question not via the live chat feature that we have here, you can do it in the question-and-answer function on the Zoom call. Please do so. We'll try and get to those questions as best we can, but we are going to try and focus on the live questions that we receive. So, during the live Q&A, please use the raise hand icon. As soon as you do that, you'll enter into queue that we can then ask you to answer your question live. Our goal here is just to get to everyone as humanly possible but in the time constraints hopefully we get to everyone but if not, you know, any interested parties that either have questions that we didn't get to or questions that arise after the webinar, I mean feel free to email our home health policy mailbox and we'll try and get back to you as soon as possible. Also please note that sometime during this meeting there will be an audio recording and transcript of the meeting that we're going to post on our CMS website. That will most likely be the home health center web page.

Finally, this webinar is an overview of the calendar year 2023 home health PPS rate development. As such we will focus on responses on the calendar year 2023 and will not be answering any questions related to calendar year 2024 rulemaking. So, thank you for your participation in this public engagement. We'll get started.

So, on the second slide you see here we're going to be referring to a lot of acronyms throughout the webinar. Please consult this chart if any are unfamiliar to you. As a reminder, the slide deck is also available if you want it after the fact on the CMS home health agency center web page. There's various links and resources mentioned in the slide deck at the very end. So, for the agenda, we're going to be going through like I said before the majority of the material but not all of it. We will circle back if and when we need to but, we're trying to leave as much time available for the live Q&A portion and to address any and as many questions as humanly possible in the Q&A function in the Zoom chat. So, we have a lot of

material to cover. It's important to note that except for the new supplemental data files everything that we cover is a recap of the material that's already been presented through rulemaking. But during the Q&A session we can answer your questions and explore any other topics in more detail that you would like. So having said that I will turn the presentation over to Kelly Vontran, my deputy director, who will walk you through this webinar, and she will provide the legal context pursuant to Section 4142 of the CAA, 2023.

Purpose of Webinar and Overview of Section 4142 of the Consolidated Appropriations Act, 2023

Kelly Vontran: Thanks, Brian. Section 4142 of the Consolidated Appropriations Act of 2023, set forth the requirements as they relate to materials posted on our PDGM web page and also described in this presentation. Next slide.

So, we are holding this webinar to increase transparency for how health home payments were set under the Medicare program for Calendar Year 2023. Specifically, we posted materials on February 28th and are conducting this webinar to increase transparency for home health payments under the Medicare program, as required by law.

The next several slides in the power point presentation include the provisions of the CAA of 2023. Since the language on these slides is verbatim from the law, I will not read all of the language but I will summarize at the end. Specifically, these provisions set forth the requirements related to data transparency, stakeholder engagement, and timing for such engagement. Next slide. Slide 10.

So, to summarize, the CAA of 2023 requires CMS to:

- Present, to the extent practicable, a description of actual behavior changes that occurred under the home health PPS from 2018 through 2021,
- Describe the creation of the simulated 60-day episodes and the corresponding datasets,
- Discuss payment rate development for 2023, and,
- Provide time for stakeholders to provide input and ask questions on the data provided.

So, for the remainder of the presentation that is the information that we will cover.

Next slide. So, in addition to the material we are reviewing today, I want to highlight that in accordance with the requirements of the CAA of 2023, CMS has recently begun offering two new sources of data that provide information on the home health claims used to construct the permanent adjustment and payment rate for calendar year 2023.

First, CMS has provided a spreadsheet with descriptive statistics on the simulated 153-group 60-day episodes and 30-day periods from calendar year 2021 that were used to construct the permanent adjustment to the payment rate.

Second, CMS has provided new Supplemental Limited Datasets, also called LDS files, containing claim-level and OASIS-level information on the simulated 153-group 60-day episodes and 30-day periods from calendar year 2021 used to construct the permanent adjustment to the CY 2023 payment rate.

Those files are available at the links shown on this slide and we will also describe them in further detail later in the presentation.

And finally, this presentation provides a description of the actual behavior changes occurring under the Home Health PPS from calendar years 2018 through 2021. I will now turn the presentation over to T.J. Christian from Abt Associates to walk through information related to behavior changes and adjustments that were made to payments.

Description of Actual Behavior Changes that Occurred Under the Home Health Prospective Payment System from 2018 – 2021

T.J. Christian: Hi great. So, Hi! My name is T.J. Christian and I'm a health economist at Abt Associates and my organization has been working with CMS to help set the payment rates for the Home Health Prospective Payment System.

So now, I would like to review with you the information on actual behavior change and how they affect the permanent payment adjustment and related questions. Next slide.

So, to show these behavioral changes, this slide deck presents a series of tables and figures from the calendar year 2023 Proposed Rule that show changes in utilization from simulated and actual 30-day periods for 2018 through 2021. We will address a question we received regarding this section and then can also discuss these exhibits later during the Q&A if there are questions.

So, we'll talk more about the calculation of the permanent adjustment in a later part of this presentation, but we wanted to provide some context for how these behavior changes fit in with the permanent adjustment.

Just to reiterate what CMS has stated previously, we refer to the term "actual behavioral changes," as encompassing the three assumed behavioral changes that were previously identified by CMS when the PDGM was implemented and any additional behavioral changes that were not identified when the PDGM was established.

Alright, so when the calendar year 2020 national, standardized 30-day period PDGM payment rate was established, Section 1895 of the Act required CMS to make assumptions about behavioral change – CMS made three assumptions regarding clinical groupings, comorbidities, and LUPA episodes to establish the PDGM payment rate.

So, it is important to examine all behavioral changes, not just the ones previously identified, because, as we will discuss later, the entirety of those behavioral changes is what impacts the payment adjustments, both the permanent and temporary. So, we note that we only applied a permanent adjustment to the calendar year 2023 home health 30-day payment rate. While we calculated the temporary payment adjustment, we did not apply the adjustment to the calendar year 2023 rate, but rather solicited comments on how best to apply the temporary adjustment in the future. So, for the purposes of this webinar, we are focusing on the permanent payment adjustment applied to the calendar year 2023 payment rate. The permanent adjustment is used to set the home health payment rate and make payments budget neutral between the PDGM and the prior 153-payment system, for the same underlying

set of data as required by law. Although the slide deck has information on individual behavioral changes in the monitoring section, since CMS looks at the combined effect of behavioral changes for rate setting, it is not necessary to link any part of the permanent adjustment to a particular or single behavioral change.

So, just to recap – CMS is required to determine whether the payment rate we implemented in calendar year 2020, based on those assumed behaviors, was accurate in ensuring that the aggregate expenditures between the PDGM and the 153-group payment system for the same set of data were equal. So next, we will have Mike Plotzke present some questions that were asked that are relevant to the material I just presented.

Hi everybody, I'm Mike Plotzke from Abt Associates. Like T.J. said, we received several questions sent to the home health policy mailbox regarding what CMS is required to do regarding the permanent payment adjustment, and we would like to spend a little time here reviewing those questions. I'll summarize the questions and then provide a response.

Alright, so the first question is given that reduction in therapy was an intent of the PDGM, why did CMS simulate the non-PDGM counterfactual by applying pre-PDGM grouper logic to post-PDGM claims affected by PDGM's intended decrease in therapy?

So as a response to that question, and also as described on the slides that are in the slide deck for 13 – 17, CMS is required to determine whether the payment rate we implemented in calendar year 2020, based on those assumed behaviors, was accurate in ensuring the aggregate expenditures between the PDGM and the 153-group payment system for the same set of data were equal. Therefore, we are required to account for the reduction in therapy visits when setting the budget neutral payment rate. As stated in the 2023 final rule, "the law did not mandate a reduction in the provision of therapy or even decrease the payment rates for therapy disciplines. It simply removed a payment incentive structured around the quantity of therapy visits, which had resulted in provider behavior to maximize payment, exactly the type of actual behavior change that CMS is tasked to consider when setting the base payment rate."

A separate question we received was as follows: The goals of the PDGM payment system included improving access to home health services for low-income beneficiaries or beneficiaries in underserved areas. The question asker asked how do the cuts developed in connection with the 2023 payment rate connect to goals around low-income and underserved access?

In the calendar year 2020 final rule which implemented the new case-mix system we stated thatthe PDGM relies more heavily on clinical characteristics and other patient information to place patients into meaningful payment categories. The PDGM uses timing, admission source, principal and other diagnoses, and functional impairment to case-mix adjust payments. Relying more heavily on clinical and other characteristics, rather than primarily on the volume of services provided more accurately aligns with Congressional goals to ensure that patients with complex and chronic conditions (including those that may be underserved or in low-income areas) would receive the home health services most tailored to their needs.

Furthermore, the law is explicit that any permanent or temporary adjustment is made to the national, standardized 30-day payment rate and, as such, CMS does not have the discretion to vary this adjustment based on underserved areas or other factors. The purpose of any adjustment is not to create an access issue nor penalize the population of beneficiaries. The provisions in the BBA of 2018 were clear in that the

permanent and temporary adjustments are made to account for the difference in aggregate payments based on actual behavior change resulting from implementation of the PDGM and the 30-day unit of payment.

In the March, 2023 MedPAC report, it states that the share of FFS beneficiaries using home health care increased to 8.3 percent in 2021 and that access is more than adequate in most areas. Separately, CMS continues to monitor utilization of the home health benefit to better understand how the benefit is being used and CMS has solicited comments on ways to better address health equity.

CMS is committed to its' strategic pillars to advance health equity, expand access to coverage and care, and drive high-quality, person-centered care, while promoting affordability and sustainability. As we continue to analyze the effects of actual behavior change in response to the PDGM, we will be mindful of these pillars to ensure continued access of quality home health care and beneficiaries receive the services to which they are entitled.

And a final question we received on this topic was, how can CMS conclude that PDGM achieves budget neutrality as intended when the number of HHAs and beneficiaries served has fallen between 2019 and 2021?

So, in response to that question, CMS controls for the number of home health agencies and beneficiaries by using the *same year of data* in the permanent adjustment calculation to ensure aggregate expenditures across the PDGM and 153-group payment system are equivalent. For example, for the payment adjustment for calendar year 2023, we used data from calendar year 2021. That included actual 30-day periods from 2021 and simulated 60-day episodes from 2021. Declines in volume across years are not relevant in determining budget neutrality since we use the same set of claims in a single year to determine budget neutrality for the payment rate.

So, we can certainly talk more about topics related to these questions when we get to the Q&A at the end, but first we are going to move on to cover other material that people asked about. We received one question about the monitoring that T.J. will cover, but otherwise, since the monitoring information has already been described in rulemaking and posted with this PowerPoint presentation, we will skip over it for now, but can return to this section during the Q&A or if we have more time at the end.

Brian Slater: We're going to pause real quick and take 30 seconds to try to adjust audio here. Apologies for that. Since I saw the comments coming in, we wanted to ensure that everyone heard everything. We will get back to it.

T.J. Christian: Alright, well thanks Mike. So, another one of the questions we received was related to the case-mix weights analysis shown on the next few slides. Let me describe this analysis briefly. With this analysis we decomposed the change in case-mix weights for the 153-group payment system using actual 60-day episodes in 2018 and 2019 and simulated 60-day episodes in 2020 and 2021. We aimed to determine which components of the old case-mix system may have changed the most after the introduction of the PDGM. To do that, we either held or changed the clinical level, functional level, or therapy level of the 60-day episodes so it would look like the data from 2018 (before the PDGM) or 2021 (after the PDGM implementation) with respect to each of these three HIPPS components under the 153-group payment system.

T.J. Christian: So, for example, the first character of the HIPPS code is the grouping step which represents the timing and broad therapy groups of the episode. To simulate the case-mix weight when using the calendar year 2021 therapy levels but using the calendar year 2018 clinical and functional levels, we first looked at the distribution of simulated 60-day episodes in 2021 using the first character of the HIPPS. We found that 52.3% of the simulated 60-day episodes in 2021 had a first HIPPS character equal to "1" which represents 60-day episodes that are early and have 0-13 therapy visits. We then reassigned the first character of the HIPPS code for the 2018 data so that also 52.3% of the actual 60-day episodes had a first HIPPS character code equal to "1" and then changed the remaining 2018 actual 60-day episodes so the percentage of episodes by the first HIPPS character matched what we saw in 2021. Since we made those changes to the 2018 data, this new data set already had the same distribution of episodes by HIPPS codes for the 2nd and 3rd character (which respectively represent the clinical and functional levels) as is seen in the 2018 data. Once we made the change to the first HIPPS character to the 2018 data, every 60-day episode was in a particular HIPPS group, and we could determine the average case-mix weight for the new set of episodes. Again, that average case-mix represents the average case-mix we would see with the first character of the HIPPS looking like data from 2021 and the second and third character of the HIPPS looking like data from 2018.

T.J. Christian: So, we continued the approach we just described, to create the four scenarios shown in the table on this slide and in the CY 2023 rules. These scenarios allowed us to calculate the average case-mix weight at the specified distribution levels across the HIPPS characters. Using this approach, we were able to determine the decline in the average 60-day episode case-mix weights between 2018 and 2021 was driven largely by therapy utilization. For example, the average case-mix for the actual 60-day episodes in 2018, without changing the HIPPS codes, was equal to 1.0176. However, when we changed the 2018 data to the distribution of therapy visits in 2021 but kept the clinical and functional levels at the 2018 distribution, the average case-mix weight decreased to 0.9383.

When we kept the therapy distribution at the 2018 level but changed the clinical and functional levels to the 2021 distribution, the average case-mix weight increased to 1.038. Therefore, if therapy utilization of the simulated 60-day episodes in 2021 looked like they did in 2018, the average case-mix, as well as aggregate expenditures, for 2021 would have been much larger than we had found.

So, we received a question that asked whether CMS could identify what the 0.9682 case-mix cited in the Final Rule represents versus what the same number represented on Slide 34?

So, Slide 34 has a typo. Scenario 3 should indicate all HIPPS characters are at the 2021 distribution, instead of 2018 under the clinical column. The average case-mix weight for simulated 2021 60-day episodes is equal to 0.9368. However, looking at non-LUPA 60-day episodes shows the average case-mix weight is 0.9682.

So, at this point I'm going to hand the presentation back to Mike, who is now going to review how we constructed the permanent adjustment.

Construction of CY 2021 Simulated 60-Day Episodes

Michael Plotzke: Alright, hope everyone can hear me okay if people can not hear me okay use the thing in the Q&A so we can try to fix the audio a little bit more. So, we are going to move to Slide 37, and I am now

briefly going to discuss the construction of the simulated 60-day episodes and answer some questions we received about the methodology. An important part of the permanent adjustment and rate setting process includes the creation of simulated 60-day episodes from actual 30-day periods because it allows us to estimate what aggregate payments would have been with the same levels of utilization and behaviors seen under the PDGM but grouped and paid out under the 153-group payment system. So, in order to evaluate if the national, standardized 30-day payment rate we set for calendar year 2021 and the resulting estimated aggregate expenditures after the implementation of the PDGM was correct, we used actual 30-day period claims data from 2021 to simulate 60-day episodes and calculated what aggregate expenditures would have been under the 153-group case-mix system and 60-day unit of payment.

The approach we used to construct the simulated 60-day episodes was previously described in calendar year 2023 rulemaking. Simply, to make the simulated 60-day episodes, we combined two 30-day periods of care together to form a single 60-day episode.

Instead of spending time reviewing those steps in more detail, I will instead focus on the questions we have received regarding the construction of the 60-day episodes. During the Q&A if anyone has questions about the process, I will try to answer them. But again, I refer you back to the 2023 final rule which includes a detailed methodology of the creation of the simulated 60-day episodes. There is also summary information on those simulated 60-day episodes available on the CMS PDGM website, as well as the supplemental LDS files.

Alright, so I didn't cover it, but the last few slides in the slide deck reviewed exclusions that were made in creating the 60-day episodes. We received a couple of questions on the exclusions. The first one we received was as follows: "slide 41 indicates the exclusion of 14,302 30-day periods, but in the rule it refers to those as 60-day episodes – please clarify."

So, the question writer is correct in the discrepancy. The slide should have said 60-day episodes instead of 30-day periods (just like it was listed in the final rule).

Another question we received asked about the claims that were excluded and whether those claims could be made available in the future on a datafile of some sort.

The response is this information is already available. The LDS file released with the 2023 final rule has additional 30-day periods that were excluded as part of the creation of the simulated 60-day episodes. Between the LDS file and the supplemental file, we have already provided information on 99.7 percent of the 30-day periods that we begin our rulemaking analyses with.

The data transparency requirements meant that we needed to provide the data used in calculating the permanent adjustment. We wanted to provide the most cleaned-up version of the file possible that had the information used to calculate the permanent adjustment. We will continue to make the most recent and complete data available in future rulemaking. It is important to note though that exclusions for the permanent adjustment are necessary. This was described in the 2023 final rule as follows, "Without these exclusions, we would not be confident we were appropriately grouping 30-day periods into simulated 60-day episodes. We do not expect the small portion of excluded claims significantly biased our results."

Alright, so another question we received regarding the creation of the 60-day episodes was as follows. So, the question asked, "when CMS combined actual 30-day billing periods into simulated 60-day episodes, how did they address cases in which the second 30 days in a simulated 60-day episode contained no visits, and was therefore not paid under the PDGM?"

In response to that, there are no 30-day periods without visits – so no 60-day episode would have a 30-day period without visits. Alright, next slide please.

We also received two other questions regarding combining 30-day periods into a 60-day episode. One question we received was, "How does CMS determine the final assignment of the clinical domain in their simulation of the 60-day system when there are two 30-day periods referencing different OASIS assessment. What is the percentage of claims where the primary diagnosis differs between the OASIS assessments?"

So, the answer to this question is that we use the OASIS diagnosis to determine the clinical domain, so in most cases each 30-day period in a 60-day episode will point to the same OASIS assessment. There are some cases where a 60-day episode has different OASIS assessments across the two 30-day periods. In those cases, we always use the first OASIS chronologically. Roughly 2.9 percent of the simulated 60-day episodes in 2021 that were formed from two 30-day periods had different primary diagnoses on their OASIS assessments across those two 30-day periods.

Another question we received related to the construction of the 60-day episodes. This question was, **"**the logic used by CMS to group two billing periods with 0-14 days between the end date of the first period and the start date of the second period can result in simulated episodes of more than 60 days. How did CMS account for this discrepancy in their budget neutrality analysis?"

So, that description of how two 30-day periods are combined is accurate and is shown on Slides 43 and 44 in the slide deck. The length of the simulated 60-day episode is equal to the sum of the length of the two 30-day periods that make up the simulated 60-day episode. Since we are only using the days within the underlying 30-day periods, the simulated 60-day episode would not include information on more than 60 days in total. As described in the CY 2023 final rule, "Our simulated 60-day episodes of care produced a distribution of two 30-day periods of care where 70.6 percent of the 60-day episodes were made up of two 30-day periods of care and 29.4 percent of the 60-day episodes were made up of a single 30-day period of care. This distribution is like what we found when we simulated 30-day periods of care for implementation of the PDGM."

Alright. So now, after the 60-day episodes are created, we ran them through the October 2019 grouper that assigns a HIPPS code for the 153-group payment system. So next, I want to review several questions regarding that particular grouper and how data changed between the old and the new payment system. Let me review those questions now.

So, the first question we received was, "How did CMS account for diagnosis code changes between 2019 and 2020 that resulted in excluded simulated episodes in the budget neutrality calculation?"

So, the answer is that episodes would not be excluded based on having a particular diagnosis – they were only excluded from the creation of the 60-day episode if the diagnosis was missing entirely. This question was addressed in the 2023 final rule as it related to a diagnosis of COVID-19 – which was not a code that

existed prior to 2020. The rule stated, “simulated 60-day episodes with a primary diagnosis of COVID–19 would still be assigned a HIPPS under the V8219 Home Health Grouper from 3M and would not have been excluded from the repricing analysis unless there was another unrelated issue with the claim that prevented grouping.” Simply put, a new diagnosis that did not exist under the 153-group system would not affect the clinical domain under the 153-group system because that new diagnosis would not contribute to the clinical score.

Next, we received a question that asked the following, “The OASIS questions considered for HIPPS calculation changed under the PDGM. For example, several OASIS questions became optional on recertification and were therefore presumably no longer answered by all providers. How did CMS account for these data inconsistencies between 2019 and 2020 assessments?”

So, in response, as stated in the CY2023 final rule, “If a particular OASIS item did not have a response, then that item would not contribute to the functional or clinical score under the 153-group payment system. If there were certain OASIS items missing on claims, those items may not have affected the overall functional or clinical score and corresponding level.”

So, for the OASIS items that were optional, they were still filled out for more than 98% of the simulated 60-day episodes in 2021.

We also received a question about how the definition of “early” and “late” changed between 2019 and 2020 and how did CMS account for this difference in the budget neutrality calculation?

So, in response, for the simulated 60-day episodes, the first two episodes are early and for the actual 30-day periods only the first period is early. Since the payments are calculated separately, that is, we calculated 60-day payments with 60-day episodes and calculate 30-day payments with 30-day periods, this difference causes no impact on the budget neutrality calculation.

One final question we received on this topic was, in cases where a HIPPS group cannot be assigned with the grouper – how does CMS assign case-mix groups?

So, for purposes of the permanent adjustment and the 30-day periods, we use the HIPPS code that is on the first 30-day period claim instead of using the PDGM grouper to generate the HIPPS code. We use the 153-group grouper to generate the HIPPS code for the simulated 60-day episode. However, if periods were dropped because we could not generate a HIPPS code for the simulated 60-day episode then the simulated 60-day episode and its 30-day period components would not be included in the permanent adjustment calculation.

Alright, so now were going to skip to Slide 51. So, we covered the construction of the 60-day episodes and the questions we received. Those 60-day episodes are very important because we used them to establish the permanent adjustment. We received several questions regarding the permanent adjustment, so I’m going to review those questions now.

Probably the most important question we received on this topic was how did CMS determine the $1,751.90 30-day budget neutral rate?

So, as described on Slide 51 and also in the calendar year 2023 final rule in the section titled, “Calculating Permanent and Temporary Payment Adjustment”, the permanent adjustment is calculated by determining the reduction required to go from the actual base payment rate to the budget neutral base payment rate. We did this by first determining the total aggregate expenditures of the simulated 60-day episodes, which equaled $13.2 billion. Next, we determined the total aggregate expenditures for the 30-day periods that were made up the simulated 60-day episodes using the actual 2021 payment rate of $1,901.12. That equaled aggregate expenditures of $14.2 billion. Given the difference between $13.2 billion and $14.2 billion, we concluded that the base payment rate we set for 2021 was too high. We therefore reduced the payment rate until the total aggregate expenditures of the actual 30-day periods which constructed the simulated 60-day episodes was the same aggregate expenditures as the 153-group system. In other words, we used an iterative process to determine that the payment rate of $1,751.90 produces aggregate expenditures that matched the 153-group aggregate expenditures. Again, that amount was $13.2 billion. For calendar year 2021 data, this represented a decrease of the payment rate from $1,901.12 to $1,751.90, which is a 7.85% reduction.

The LDS file can be used to confirm the payment rates described equal the aggregate expenditures described. We also received a question asking us to provide a formula for how the rate was determined, like was done with the PDPM. However, because the PDGM and PDPM use different methods to set the payment rate, there is not a comparable formula that we can provide other than what I just explained a moment ago. However, the data needed to replicate the results has been made available.

Alright, moving on, a second question that was asked was “How can home health agencies absorb the permanent adjustment without a negative impact on the patient population intended to be served by home health agencies? What further beneficiary and patient impacts would CMS project with such a cut? Is CMS taking the real-world impacts into consideration as it considers the timing of future cuts?”
So, in response, as described on Slides 13 – 17, CMS is required to determine whether the payment rate we implemented in 2020, based on those assumed behaviors, was accurate in ensuring the aggregate expenditures between the PDGM and the 153-group payment system for the same set of data were equal. These adjustments are required to be made through 2026. CMS will monitor the impacts of these cuts. Moreover, even since the implementation of the PDGM, MedPAC has repeatedly recommended payment reductions to the home health payment rate and in its March 2023 report, MedPAC recommended that the Congress should reduce the 2023 base payment rate by 7 percent. Additionally, in the calendar year 2023 proposed rule, we provided analysis of the costs of providing care (using 2021 data) and this analysis showed that payment exceeded the costs of providing care by approximately 34 percent. We also note that the overall aggregate impact in calendar year 2023 is estimated to be an increase of 0.7 percent. Finally, we were asked, is CMS planning to apply a “true-up” calculation based on 2026 claims for the permanent adjustment?

And in response, as required by law, CMS will analyze data for years 2020-2026 and if needed through notice and comment rulemaking, will make permanent adjustments at a time and in a manner determined appropriate.

Alright, so the remainder of the slides in this section explain other parts of the rate setting process for 2023. Those slides just repeat the information provided in the 2023 final rule, so we will skip this section for now. I’m going to hand it over to T.J. again and he will discuss the new data files that have been made available.

Description of Supplemental Data Files

T.J. Christian: Alright, thanks Mike. So, the next set of questions we received dealt with the supplemental data files that were released as part of Section 4142 of the CAA of 2023. Let me discuss the supplemental LDS files briefly and then answer the questions we received regarding those files.

In accordance with Section 4142 of the CAA, 2023, CMS released an additional LDS file showing the simulated 60-day episodes under the home health prospective payment system in effect prior to implementation of the PDGM, using data from 30-day periods paid under such Model, used to determine the payment adjustment to the calendar year 2023 rates.

CMS also released an additional LDS data file showing the 30-day periods used to carry out the permanent adjustment methodology described in the calendar year 2023 home health prospective payment rate update.

If you are not familiar with the files I was just discussing, let me describe them briefly. These supplemental LDS files include information at the claim level with items like:

- Indicators for which 30-day periods were used to construct 60-day episodes,
- OASIS items relevant for grouping 60-day episodes,
- Information on visits and minutes of care by discipline during the 60-day episodes and 30-day periods, and
- Information on payments and payment adjustments such as LUPA, PEP, and Outliers periods or episodes

A user of the supplemental LDS files can determine which 30-day periods were used to create simulated 60-day episodes and verify the calendar year 2021 budget neutral PDGM rate of $1,751.90 produces aggregate expenditures for 30-day periods equal to those estimated when using 60-day episodes and a payment rate equal to $3,284.88.

The data that is provided covered the data used for the calendar 2023 home health prospective payment system rate, which used data from calendar year 2021. We received a question on why was data from 2020 not provided?

So, the answer is that only data from calendar year 2021 was released because that is the only year of data that was used to determine the permanent adjustment and used in other parts of the rate setting process. 2020 data was not used in rate setting for 2023. Since, no temporary adjustment was proposed or finalized in the calendar year 2023 rule it was not necessary to release the calendar year 2020 simulated 60-day episodes. Any interested parties can use the LDS file from calendar year 2020 and use the actual payment rate and the budget neutral payment rate to better understand the temporary adjustment.

We also received a question, “Why did CMS provide an LDS file as opposed to the same type of impact file it provided in advance of the 2020 final rule? Can CMS release a provider-level impact file?”

So, similar to what was done for the 2020 final rule, we have released an LDS file with information on 30-day periods used in impacts. Additionally, we have now released supplemental LDS files with information

on the 30-day periods and simulated 60-day episodes for 2021 used in constructing the permanent adjustment. The impacts conducted for the 2023 rule use the same type of methodology that was used in the 2020 rule. In 2020 we released provider-level impacts because of the switch to the new payment system. However, now in 2023 we are not changing the payment system, we are only reducing the base payment rate, and the permanent adjustment will impact all home health agencies equally. Provider-level impacts are not needed to evaluate the permanent adjustment. Therefore, we felt it was unnecessary to include those provider level impacts for calendar year 2023.

Alright, so anyone who previously purchased the calendar year 2023 final LDS file should already have been sent the new supplemental files. Anyone who does not have access to the file already will need to submit a data use agreement to request access and to purchase the LDS file.

So, we received a few comments requesting more clarity on the process for obtaining the supplemental data in the future.

Just to note, we will ensure clear instructions are posted in advance of rulemaking and will work to make sure the data can be released as quickly as possible.

Go to Slide 60. Yep, thank you. One final question we received regarding the LDS file was whether CMS can make available current law payments for future LDS files? Also, will CMS consider feedback and discussion from this stakeholder meeting in deciding what data to release along with future rulemaking? So just to say, we appreciate the feedback and will consider whether we will release this type of information in the future. We will be transparent as possible in the data we use to calculate the permanent adjustment and other payment changes. We will consider feedback on what data would be best to provide and encourage interested parties to email the CMS home health policy address with ideas. We are planning to release the supplemental LDS files in future years where we make any permanent or temporary adjustment.

In addition to the LDS file, CMS has also provided a publicly available excel spreadsheet that contains descriptive statistics from the supplemental LDS file we've just been discussing. That publicly available file contains several descriptive statistics by HIPPS for the 30-day periods and simulated 60-day episodes. These descriptive statistics include the number of 30-day periods and simulated 60-day episodes, information on payment adjustments such as rural add-on, outlier, LUPAs, and PEPs, and the average payments per claim, the average number of visits per claim, and the average length of visits per claim.

So, the supplemental file will allow users to verify the 2021 budget neutral PDGM rate of $1,751.90 produces aggregate expenditures for 30-day periods equal to those estimated when using 60-day episodes and a payment rate of $3,284.88. It also allows the user to observe the number and percentage of simulated 60-day episodes and 30-day periods by HIPPS.

Question and Answer Session

T.J. Christian: Alright, so now that I've reviewed the new data files, I'm going to turn it back to Mike to kick off the Q&A session.

Mike Plotzke: Alright, thanks T.J., before we open up the Q&A session to everyone, I want to review a few last questions we received that didn't fit into the previous slides.

The first of those remaining questions is "Was the actual average payment for a 30-day period in 2020 and 2021 greater or lower than the amount CMS established as the PDGM base rate for a 30-day period for calendar year 2020?"

So, in response to that, the actual average case-mix adjusted payment prior to other adjustments are higher than the PDGM base rate. So, using the CY2023 rulemaking LDS file (with data from 2021), we find the average case-mix weight for non-LUPA 30-day periods is equal to 1.0387. And using the calendar year 2022 rulemaking LDS file (with data from CY2020), we find the average case-mix weight for non-LUPA 30-day periods is equal to 1.0394. Since the average case-mix weight is larger than one, this means the average payment for those years is higher than the base payment rate.

We also received a question, "Does CMS believe it can rely on data from 2020 – the height of the COVID public health emergency – as the basis for determining long-ranging policy decisions in its formulation of both the permanent and temporary cuts for all providers?"

So, in response to that, CMS is required to annually determine differences in aggregate expenditures using data from 2020 – 2026. The permanent adjustments used for CY2023 rulemaking however used data from 2021, not 2020. Further, the permanent adjustment will be updated yearly with data through 2026. Therefore, the permanent adjustment taken in later years will rely on data several years past the height of the COVID PHE. The temporary adjustment is also accounted for with each year of data, as required by law. As stated in the 2023 final rule, the permanent adjustment "methodology controls for changes in utilization as a result of exogenous factors such as the COVID–19 PHE by using the same claims dataset, that is the same basket of services, under both payment systems. This ensures any difference in aggregate expenditures is not related to the COVID–19 PHE or other exogenous factors."

In another question, someone stated "CMS is required to annually determine the *impact* of differences between assumed and actual behavior changes on estimated aggregate expenditures. How do the behavior changes previously identified relate to estimated aggregated spending? Why didn't CMS provide new data showing how the identified behaviors impacted aggregate expenditures under PDGM? Does CMS have any data or analysis related to this determination?"

So, in response, the Permanent Adjustment was developed by considering all behavior change collectively, as opposed to individually. That means that while CMS included in this presentation, to the extent practicable, identified behavior changes, it need not link every dollar of decreased estimated aggregate expenditures to a particular behavior change. The assumed behaviors were important in establishing the initial rate as we "assumed" these behaviors for the purposes of satisfying the law in establishing the 2020 rate, the law now requires us to examine whether such rate is accurate based on "actual" behavior change. The law did not require that we get the behaviors themselves right but rather whether or not we are paying more under the PDGM than otherwise would have been paid under the 153-group model. The comparison is not assumed versus actual behaviors, but the initial rate established versus each year's rate to ensure expenditures within each year are budget neutral.

We can certainly quantify: 1) the impact of the behaviors identified; and 2) the observed changes in expenditures that CMS is not able to link to described behavior changes. But even if we show the assumed

behavior changes happened to a different extent than what we originally anticipated, it would not impact the permanent adjustment because we are required to ensure aggregate payments between the PDGM payments, and the 153-group system are the same using data from 2020 through 2026.

Alright, so, the final question I want to review is this, "Did CMS examine other inputs to care (such as labor and other costs, and clinical and nursing services) to see how these inputs changed, whether they had an upward or downward effect on payments and costs, and the impact of reducing payments on care resources more broadly?"

So, in response, besides what is already accounted for within the permanent adjustment, changes in labor and other costs, clinical and nursing services, and other inputs are outside the scope of what CMS can account for via a payment rate change under Section 1895 of the Act. However, these are items that we have monitored and reported during rulemaking, and we will continue to monitor those items. We would include these items in adjustments if we had the authority to rebase, but again, the payment adjustment under Section 1895 does not permit CMS to rebase the payment rate.

Okay. So that should conclude all the questions that we had covered. So, I think at this point we want to open up the floor to questions. As Brian discussed, please use the raise hand functionality and we will call on you.

Jackie Ryan: Christie, I unmuted you. Just unmute on your side to speak. Christie, are you there? Okay. Dr. Steven, you are able to talk now.

Dr. Steven Landers: Thanks so much. Thank you for the update and all your work here. I'm a physician leader and CEO of a non-profit visiting nurse association. I'm very concerned about access issues that we're seeing and also just our overall sustainability as a community agency. The concerns are most heavily weighted towards high poverty urban areas and more diverse communities but also more broadly because it doesn't seem like the rate update addressed all the massive cost increases that have been occurring since 2021 and even since 2022. For example, the IRS mileage rate that we used to reimburse our clinicians, home health agencies drive tens of millions of miles if not more than that a year. The IRS rate, you know, that went up by 12% from last year to this year. Labor costs for nurses, home health aides are up, and in some places, you can't even find folks. One of the reasons you can't find them is because we are competing with the hospitals and the hospitals have differential treatment by CMS under wage index policy. So, for example, the hospitals might be using an imputed rural floor on their wage index calculation. They might reclassify their wage index. And then also with the transition policy from the old wage index system to the new one, hospitals were given a longer runway. So, we're often missing out on talent. So, that's hurting care in the community and more favoring care to move into facility-based settings which probably will increase the overall cost. So, my two questions are, how did you determine the market basket update? It seemed like there was a big bump from the incredibly low number in the proposed rule to the final rule. It just seems like you're not getting all the input costs right especially with those IRS mileage increases and labor cost increases. And then also, why are you not evening the wage index modelling along with hospitals and other facilities so you don't create this disparity? I didn't understand those aspects of how you set the rate for this year. It's hurting folks.

Brian Slater: Hey Dr. Landers. This is Brian Slater. Appreciate your question. This is something I think we have addressed before to specifically address your comments and not to go on a long diatribe but since we have a bunch of people with their hands up. So, question one, that is not my area. That is the Office of

the Actuary that comes up with the market basket. It should reflect similar costs you had mentioned and alluded to. However, that's kind of outside of our purview. We just adopt what number that they push forward to us. I agree, they at least reflected the -- or relooked at it from the proposed to the final and as you know in instances in other years they can fluctuate from the proposed to the final. Your second question as far as hospitals, unfortunately hospitals have specific statutory authority like you mentioned reclassification, that's under 1886(d)(10) I think it is. So, we don't have that authority. That's specific to inpatient hospitals. So, things of that nature we just don't have the authority to go about. It would take a home health specific wage index to do something of that nature. That comes with other hurdles as I'm sure you're aware like auditing of the cost reports. It's not as simple as just, you know, saying, hey, we're going to now use the home health data. So, I appreciate the suggestion. I think it's something that, you know, is always a source of topic but it's also statutorily driven.

Jackie Ryan: It looks like Wendy, you have a question. You're able to unmute yourself now. Wendy, your line is unmuted so you're able to speak now.

Wendy: That was an error. I'm sorry.

Jackie Ryan: Okay. No problem. We'll go to the next person. Okay. It looks like James, you are able to speak now. James, you're unmuted. You're able to speak now. We'll go to the next person. Jaime, your line is unmuted. You are able to speak now.

Jamie O'Brien: Hi. I also am a vice president of a non-profit home health and hospice agency. And really, Doctor Landry I think his name was kind of asked my question, because these payment model comparisons are interesting, and I understand how they came about but regardless even if they seem to make sense to accountants to people in the industry who are trying to run a home health agency it's just not viable. I mean, CMS really needs to consider what their priorities are because we're the lowest cost to Medicare, we save Medicare the most money without having hospitalizations and skilled nursing facilities. It's all the talk. I think it was called build it back of the money that was going to be invested in home health, seeing the great service we provided during COVID. And honestly, I don't know how the industry is going to continue if this isn't looked at. We cannot compete with the hospitals. We have nurses and therapists who can make double at least than what we can pay as a home health agency. The doctor gave a great example of mileage. All of the other expenses, paying for PPE… The list goes on and on. And I understand this forum is just about comparing the model before PDGM to this one and how the base rate was taken into account but if people don't seriously look at the big picture, I don't see how home health agencies will remain.

Brian Slater: Understood Jamie. I didn't sense a question there so I'm not going to answer, I guess. I think it was just more of a comment. So, I appreciate your comments and your thoughts and just know and everyone on this call that this is not an us that you heard from the call today to get the industry to just make cuts. We're just trying to follow the letter of the law. Congress puts certain aspects into play like I alluded to before specific to inpatient. This was specific to home health. So, we're trying to do the best that we can with the data that we have available. That's what we're moving forward with from an adjustment standpoint in trying to just set the payment rate to cover the cost of providing care.

Jackie Ryan: All right. So, Stacy you should be unmuted now. You're able to speak now.

Stacy Smith: Hi good afternoon. Thank you. Stacy Smith, I'm vice president of public policy for AccentCare. I had put two questions in the chat box, and I'll summarize those questions. But earlier in the presentation you referenced MedPAC's recommendation to reduce home health payments by 7%. But in their March 2018 report, they specifically noted that removing of the therapy threshold was a budget neutral event and then made a further recommendation to rebase payments by a set amount. So, they clearly separated the two of, you know, removing therapy thresholds for the purposes of payment from a rebasing action that would require a Congressional action. So, I guess my question is, how is CMS justify implementing the removal of the therapy thresholds in a non-budget neutral manner that is inconsistent with MedPAC's analysis of removing the thresholds?

Brian Slater: Thanks for your question, Stacy. I didn't see it in the Q&A so I'm glad you got in the queue. I don't remember the 2018 MedPAC report off the top of my head, I remember reading it I think what they meant was -- I think this is something that we -- it's good that you brought it up because we can clarify it today. The law removed the threshold meaning the extra reimbursement for therapy. It did not remove therapy from the PDGM. We did not expect to see a change in therapy from the old system to the new system. It is behavior in our minds when it for lack of a better term falls off a cliff and it's directly driven, and a proponent of the reimbursement that was derived from the therapy threshold. So, the statutory mandate that we have to account for behavior change, that's how we view the therapy. It's not -- you're 100% right just to be clear. Rebasing authority is separate and distinct from the behavioral assumptions just to be clear on that. We do not have rebasing authority. But we are accounting the change in therapy and the provision of therapy to a behavior change.

Jackie Ryan: All right. Sandra, you should be able to speak now. Sandra? Okay. We'll move on. Joanne, you should be able to speak now.

Joanne Cunningham: Can you guys hear me okay?

Jackie Ryan: Yes.

Joanne Cunningham: Great. Well. thank you very much for providing this presentation. I just want to follow up on a couple of comments that were made. Earlier I think Tyler had indicated or maybe it was Brian that CMS would be monitoring impacts on access. I just wanted to hear a little bit more about how CMS will be monitoring access issues. I would submit that I think the way that MedPAC analyzes access to home healthcare is not robust enough. I would expect to see CMS really dig in to better understanding whether or not there's access issues. What we are seeing with real time data directly from the industry is that access is already being compromised. And it's in the form of essentially referrals to home health not being able to -- referrals for patient care to be served in home health, not being able to be served. So, patients right now, those referral rates, those conversion rates are already showing that because of the compression on the home health community you're already seeing access to home healthcare being compromised. We're seeing and hearing direct accounts, seeing this in the data and also hearing it from home health leaders that relationships with hospital systems are already being affected. I heard one CEO of a large system -- a large home health system who indicated that they were telling two of their large hospital systems that they are no longer able, because of staffing shortages effected by these rate cuts, they're already indicating to those systems that they cannot take any home health referrals from hospitals. So can you just spend a little time talking with a little bit of specificity how CMS is going to be monitoring the impact on access to patient care for the home health community.

Kelly Vontran: Hi, Joanne. This is Kelly Vontran calling in. One of the things that caught my attention in your question was about referrals that are not being accepted by home health agencies. Is that my understanding? I guess she's not able to answer that. Okay, so let me just see. Joanne if you can hear me, you know we have heard this too as well anecdotally. Unfortunately, we don't have data that shows us the proportion of home health referrals that are not accepted. If we could have any, if you have any mechanism of any empirical evidence, I think that might be really helpful for us to understand how prevalent a problem this might actually be. Because, again, right now, we have no mechanism of tracking that. Because unless they're under the home health benefit, we're not aware that they were referred to it. So that might be really helpful for us in understanding any potential access issue.

Joanne Cunningham: Yes, and Kelly, we do have that data. I'd be happy to follow up. We are seeing in real time already impact to -- and those conversion rates being affected, and the trend lines are going in the wrong direction. That will have an impact. We're also seeing length of stay in hospitals being affected by the fact that those referrals are not able to be converted by home health agencies into service. So, love to follow up.

Kelly Vontran: Yeah. That would be really helpful. Because again, we have heard this anecdotally, but we have no way to track that because they're not actually under the benefit. So, if you could send that information or you can reach out to us and we can have a further discussion about that, that would be helpful in informing us about any potential access issues to getting into the Medicare home health benefit.

Joanne Cunningham: Will do.

Jackie Ryan: Sandra, are you still there? I think you're able to speak if you did want to ask your question still. No? Okay. We will move on. Sherry, you should be able to unmute yourself now.

Sherry Teague: Hi, my name is Sherry Teague and I'm one of the owner founders of K and K Healthcare Solutions. We do a lot of consulting in the home health space. And as far as access to care and giving the beneficiary what they need, what we're finding is not only is there a reduction in the number of therapy visits that are being provided but there's also a distinct reduction in the number of aide visits that are being provided. I know that we're at a shortage for caregivers and nurses, but we are hearing more and more every day about agencies that are not providing aide services anymore. I'm wondering if that's being tracked via data and if that will be also lumped in as a behavior change as the therapy visits decreasing has been?

Michael Plotzke: Question, I will say in addition to the monitoring we're doing looking at therapy visits we are also looking at aide visits and how those have changed over time. Any reduction in aide visits wouldn't impact payment or payment adjustments in the same way reductions in therapy visits impact payment adjustments simply because the old payment system didn't pay additional for aide visits outside of just visits that would exceed the LUPA threshold or the outlier payment. In terms of the case-mix adjustment, it didn't have any impact on the old case mix. So, it wouldn't have the same impact as we're seeing with therapy visits.

Jackie Ryan: Okay. It looks like Andrew you have a question. You should be able to unmute yourself now. Andrew are you there?

Andrew Baird: Yes, I'm here. Can you hear me?

Jackie Ryan: Yes, I can. Perfect.

Andrew Baird: Great, thank you. Andrew Baird, VP of Government Affairs and Policy Counsel with Enhabit. Earlier in the presentation you all mentioned that CMS does not need to associate every portion of the behavioral assumption cuts with specific behavioral change assumptions, and I think this was outlined on Slide 16. You also said that CMS does not actually need to be accurate with those behavioral assumptions but just that the payments under PDGM need to not be more than would otherwise be the case. Just a comment and a question here. First of all, it's categorically discomforting to hear that CMS may not need to be concerned with the accuracy of any cuts associated with those assumptions around behavioral changes, particular given the level of cuts that were communicated in the 2023 rule. But as providers who are now subject to these cuts, why can't CMS share additional information that links the entirety of these cuts with specific underlying assumptions? AKA, why can't the full amount of cuts be linked back to specific assumptions, especially if there's the notion that the assumptions need not be accurate?

Mike Plotzke: So, for your question and comment, so I would say first off, I wouldn't say that the adjustment that was made for 2023 was a guess or I'm not -- you know, or inaccurate or we don't care about the accuracy of the adjustment. It was the – the statement was more referring to the initial behavioral assumptions to establish the 2020 payment rate. Those were based on how we thought the providers would react to the payment system. Now that we know how providers react to payment system because we have the actual data from 2020 and 2021 in the PDGM we're able to specifically say this is the level of services that were provided under PDGM, these are the aggregate expenditures that are associated with the services and we can also compare this is what the old payment rate would have -- the old payment system would have paid for that same level of services and compare that aggregate expenditures and then come up with a payment adjustment to make sure they are equivalent which is what CMS is required to do by law. And so, I think the second part to your question was just how can we relate or why don't we relate the adjustments to these particular behaviors that were mentioned when the PDGM rate was initially established. Again, the initial behaviors for the PDGM payment rate that were established were used to primarily set the payment rate. Now we're at the point where those initial assumptions don't have any impact on what the new payment rate is or is not. In the case where there would have been no behavior assumptions or there would be different behavior assumptions, we still would have ended up at the exact same payment rate we did end up with in 2023. So those initial behavior assumptions and the adjustments that were made really are no longer relevant to how the payment rate is set. And again, the goal is now to make sure that data in a particular year looking at the same set of data priced out under the PDGM versus the 153-payment group system that we choose a PDGM payment rate the achieves the same level of aggregate expenditures under both systems.

Jackie Ryan: Alright, perfect. So, Katy you should be able to unmute yourself now.

Katy Barnett: Hi. Can you hear me?

Jackie Ryan: Yes, perfect.

Jackie Ryan: Excellent. I'm Katy Barnett, I'm the director of home care and hospice operations and policy for LeadingAge. We really appreciate this opportunity to hear more about the work that you all have done and put into this, and we really appreciate you targeting the questions that you had already received.

However, it was difficult to follow those questions. We'd like to request that CMS publish the questions that you responded to on this webinar separately from the transcript with the answers so that we can follow along just for transparency sake so that we know exactly what questions you had asked or had answered during this conversation and we don't have to necessarily search through the entire transcript. That would be incredibly helpful. Those questions were incredibly pertinent to this work.

Brian Slater: Yeah, thanks Katy. We appreciate that. I think we recognize in the good faith effort of following the statute and being as transparent as we want to be, I think we're going to come up with some kind of game plan. I think we're generally thinking having kind of a Q&A document on our home health center webpage, where we will take down the Q&A's that are feverishly coming in in the Q&A portion as well as anyone we can't get to in the interest of time, it looks like we are going to have to wrap up in a few, but those that we don't get to please feel free to leverage the home health policy mailbox. We'll also upload those as well to the Q&A document and try and keep that as live as possible because I know that some might come up, you know, during this call or, you know, a week or two from now. So, we'll do our best to ensure the transparency, Katy.

Jackie Ryan: Okay. Carolyn Brickner you should be able to speak now.

Carlin Brickner: Hello. Can you hear me?

Jackie Ryan: Yes. Yes, I can.

Carlin Brickner: This is Carlin Brickner from VNS health. And so, my first a comment on the actual behavioral changes shown on Slides 33, 34 and page 46. I wanted to critique this because the four-equation model that was used by CMS in the former prospective payment system was a model that was fully conditional on the observed therapy thresholds. So therefore, the CMI is conditional on the level of therapy that was previously in the payment system. So, when you go to regroup this with the 2019 data in order to complete the exercise you have to refit the PPS 4-equation model conditional on the 2021 behavior of therapy levels otherwise the scenario that you're showing in Slide 34 is just highlighting that you were successful in changing the therapy behavior changes over this period of time. So, I guess that was my question. Was that the intent to demonstrate that therapy utilization decline? Or because you were making this behavioral change by comparing PPS to the PDGM in 2021 the requirement of the balanced budget act was to make sure that the payment system was fully prospective. Do you think that you've allowed the therapy thresholds to creep back into the payment system in this behavioral change?

Brian Slater: So, I think I'll jump in to start and then I'll let Abt jump in as well. I would argue that the statute does not just say prospective because it says set a prospective rate and then go back and look and see if you got that rate right. So that obviously lends itself to a retrospective look back authority. I'm trying to remember one of the other points that you made in there. I think another point that I'll make that when we went down this route, I think most of you on this call were probably around then when we went forward with a proposal of the HHGM, that did not include behavior assumptions or adjustments. That only transpired once Congress stepped in, and we are now statutorily mandated to do that. So, we did not try to do some, you know, back door rebasing, everything that we've heard it was just to try and reset the payment system to be more patient-centric. In addition to setting the payment most appropriately to the cost of providing care. Once the law came out that's what the requirement was. That's what we've done to the best of our ability. So, I'll kind of leave it at that and let Abt jump in if they had anything else to add.

Mike Plotzke: Yeah, so I'll address the first part of the question that was dealing with the four-equation model. I may not exactly understand what you're asking. But certainly, the approach that we used for repricing was to take that stimulated 60-day episode and with that simulated 60-day episode we had all the components that we needed to form the case mix group for that 60-day episode. So, we needed information on timing and therapy. Then the OASIS assessment information that impacted the clinical and functional and also the NRS. So, yeah, that is how the case mix weight was set. That's, again, the purpose of the permanent adjustment was just to make sure that the aggregate expenditures for the same set of data priced under two different payment systems was equivalent and to ensure that happened we did need to use the old payment system and the grouping and approaches under that old payment system.

Jackie Ryan: Ed Swan, you should be able to speak now.

Ed Swan: Yeah, this is Ed Swan. I'm the Vice President of IT at Amedisys. First off, I wanted to tell you thank you for giving us an opportunity to see your presentation and ask all these questions. I was tasked with trying to replicate the work of going back and creating the 60-day stimulated episodes with our data. One of the questions I asked, I wanted to see if I could get a little further clarification on it to help me understand. It was the question regarding the 14-day gap between billing periods creating the potential of 60-day stimulated episodes that would have been billed as two separate episodes had that body of work occurred in 2019. You seem to indicate in your answer that you did in fact recognize that this was the case, but I didn't really understand what you did about it and whether or not you just went forward with that discrepancy in place and felt that to discrepancy was just too small to be a concern or how it was addressed. Could you elaborate a little bit on that?

Mike Plotzke: Absolutely. So, yeah, thanks for that question. So, yeah, the whole point of putting the two 30-day periods together even if there's a small gap between them was just, again, uncertainty about how that would have been billed under the old or prior payment system when there was a 60-day episode. So, the impact of grouping two 30-day periods that didn't like fall back-to-back with each other are pretty minimal. Again, like we explained in the presentation we just used the information from the two 30-day periods to construct what the 60-day episode was going to be so we could use the therapy visits and the length of therapy visits, just all the visits to create that 60-day episode and also as mentioned before if those two 30-day periods that were separated by that small gap were referred to different OASIS assessments, we used the first OASIS assessment. The only other thing that I can think of that maybe wasn't explained was if there was a PEP in one of two 30-day periods or one of the two 30-day periods in the 60-day episode was billed as a PEP. We assumed that entire 60-day episode was going to be a PEP. We capped the length of the simulated 60-day episode at 60 days. So, if the first 30-day period was 30-days and there was a 10-day gap and then another 30-day period that was 30-days that wouldn't be billed as 70 days and that would impact the PEP calculation by multiplying 70 over 60. Instead, we would cap the length of that 60-day episode by 60 days. Beyond that I don't think the gap should introduce any complications into the creation of the 60-day episodes. But if you do have any follow up questions, we definitely would love to answer them.

Jackie Ryan: Eileen, you should be able to speak now.

Eileen Orel: Hi. My name is Eileen. I'm the Executive Director at Aquinas Home Health and Hospice. I love all the information here and I've been reviewing all the data. What I was wondering for future events is

there any way you can address the managed plans? Because all this is applicable for traditional Medicare, but I think all of us that are out here living this day in, and day out are seeing that we're having just as much of the managed plans and they're between 50 and 70% lower than the Medicare allowable. But it still falls under CMS. And you're trying to -- that in addition to all these cuts are really putting us behind the eight ball. So, I was wondering are there any plans to address the discrepancy and payment from the managed plans from traditional Medicare?

Brian Slater: Hey Eileen, this is Brian. Appreciate your question. This is something that we've actually heard fairly recently, as recent as this Monday. Unfortunately, that's not my area. We just do the Fee For Service here. I don't know if all those on the call want me to be up in that area given the conversation we're having today. But that's definitely something that is outside of our purview but it's definitely on our radar and, you know, we plan to at least bring it to our leadership's attention. But that's where it will at least end from our standpoint. But since it's been brought up as recently as this call but also on Monday like I said that's something that's on our radar and we'll be sure to let leadership know.

Jackie Ryan: All right. And then Mia, you should be able to speak now.

Mia Munoz: Hi. My name is Mia Munoz. I literally just had one quick question. And it was just whether I missed Slide 52, or if that slide was skipped and why? Yes. That one. I was just wondering if there's anything that you could elaborate on this slide?

Mike Plotzke: So, thank you for your question. Yeah, that slide was skipped. That was just part of the rest of the payment rate adjustment discussion. And since we had -- a lot of the material was included in the rule. We skipped over it so we could address more questions. But, you know, just briefly, you know everything on that slide shown on the screen right now CMS did recognize a potential hardship for implementing that full payment reduction. So, because CMS had the discretion to implement as adjustment in a time and manner deemed appropriate, CMS only finalized a 3.925% reduction. And that reduction was just half of the 7.85%.

Brian Slater: So, I think we're right up against 3 o'clock. Again, I apologize for anyone who is in the queue that, you know, wanted to ask a question but couldn't live. I see that the Q&As within the Zoom have continued to increase. So, we will continue to be transparent. We'll follow up with that Q&A document as I said. The transcript I think for this should be out maybe in about a week. Don't hold me specifically to a week but around that. We'll try and get the Q&A up as soon as possible. I think as we have questions available, we might start populating that document and then we'll kind of have it on a flow basis kind of like we did with the PHE FAQ documents. That's kind of the route that we're going to go forward. So, I appreciate everyone's time within the last 30 days to look at the slides. Hopefully you appreciated us, you know, going through and like the approach that we took to address some of the questions within the slides and also, you know, I always appreciate the questions and to hear thoughts and feedback from you guys who are the boots on the ground. So, I think having said that appreciate everyone's time and have a great rest of your afternoon.

[Event concluded]