IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

NATIONAL ASSOCIATION FOR
HOME CARE & HOSPICE,
228 7th Street, S.E.
Washington, D.C. 20003

Plaintiff,

v.

XAVIER BECERRA,
In His Official Capacity as Secretary of Health and Human Services,
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Defendant.

Civil Action No.

COMPLAINT

Plaintiff National Association for Home Care & Hospice ("NAHC") brings this lawsuit against the Secretary of the United States Department of Health and Human Services ("Secretary") to challenge a final rule purporting to implement revisions to the Home Health Prospective Payment System ("Home Health PPS") contained in the Bipartisan Budget Act of 2018 ("BBA"), Pub. L. No. 115-123, § 51001, 132 Stat. 64, 289–92 (2018). *See Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update*, 87 Fed. Reg. 66,790 (Nov. 4, 2022). The Secretary's final rule violates Congress's statutory directives and is contrary to the requirements of reasoned decision-making. On behalf of itself and its members, NAHC seeks declaratory and injunctive relief requiring the Secretary to comply with the statutory requirements and setting aside the final rule's unlawful provisions.

As grounds for this complaint, NAHC states as follows:

PRELIMINARY STATEMENT

1. Home health agencies are a critical component of our Nation's healthcare system. They provide essential skilled medical care to patients in their personal residences, and the cost of providing that care is significantly lower than the cost of providing care in hospitals and other institutional settings. Home health services are covered under Medicare. The Centers for Medicare & Medicaid Services ("CMS"), which administers the Medicare program, is the Nation's single largest purchaser of home health services.

2. The Secretary's final rule threatens to undermine this integral feature of our healthcare system in violation of express statutory requirements and his obligation to engage in reasoned decision-making. Instead of complying with Congress's directives, the Secretary has unlawfully slashed the payments provided for home health services. And he has done so by effectively applying the same methodology for calculating payments—connecting payments to the amount of therapy provided—that Congress expressly sought to eliminate.

3. The Medicare statute sets forth the methodology that governs how Medicare must pay for home health services. *See* 42 U.S. Code § 1395fff *et seq*. In the past, the amount of therapy sessions provided during an episode of home health care played a major role in determining the amount Medicare paid. Concerned that the Secretary's therapy-focused approach created the wrong incentives, Congress directed the Secretary to change the payment methodology by eliminating therapy as a factor in setting payment rates as of 2020. *See* 42 U.S.C. § 1395fff(b)(4)(B)(ii). Congress made clear, however, that, while it wanted the Secretary to change the payment methodology, it did not want to change the total amount of expenditures provided for home health services. In other words, Congress wanted the Secretary to redistribute its current level of expenditures away from therapy to other important health care services. Congress thus directed the Secretary to ensure that the change to the payment methodology would

remain budget neutral, ensuring that the adoption of the new payment system would result in neither a net increase *nor* a net decrease in total Medicare payments.

4. Acknowledging that a new payment system would lead to changes in behavior, Congress also instructed the Secretary to predict behavior changes and to account for how those changes would influence payments when calculating its budget-neutral expenditure number. Congress then directed that each year the Secretary must check his predicted behavior changes and their effect on expenditures, measure them against actual behavior changes and their effect on expenditures, and make any necessary upward or downward payment adjustments.

5. The Secretary's final rule violates Congress's statutory commands and substitutes the Secretary's own policy preferences for those of Congress. *First*, although the rule purports to implement Congress's instruction to measure the difference on aggregate expenditures of assumed and actual behavior changes, the rule does not measure either assumed or actual behavior changes at all, and it certainly does not calculate the difference of their impact on aggregate expenditures. *Second*, although Congress instructed the Secretary to redistribute aggregate expenditures and hold its change budget neutral, the final rule unlawfully rebases home health payment rates to reduce overall expenditures. *Third*, although Congress commanded the Secretary to remove therapy as a factor in determining payment rates, the final rule ties the payment adjustment to the amount of therapy actually provided.

6. Instead of ensuring budget neutrality and accepting Congress's constraints on the new payment methodology to redistribute expenditures away from therapy and to ensure an approach to care that focuses on all of the patient's clinical needs, the Secretary's final rule cuts payments because home health agencies have predictably provided fewer therapy sessions. In taking this approach, the final rule violates the Medicare statute's plain language and arbitrarily

and capriciously sets payment rates at a level that will result in substantial financial harm to numerous home health agencies across the country.

7. If the Secretary's unlawful actions are not corrected, the final rule will leave numerous Medicare beneficiaries with limited or no access to vital home health services, directly contrary to Congress's intent. Instead of reforming Medicare reimbursement rates to be more patient-centric and less therapy-centric, as Congress directed, the Secretary's final rule will disrupt the market, penalize home health agencies that relied on Congress's statutory reforms, and prevent beneficiaries from accessing the essential home health services they need. Some home health agencies will be forced to stop providing essential services, especially in remote rural areas, and many home health providers could be forced out of business.

8. NAHC member Home Health Services of Mary Lanning Healthcare in Hastings, Nebraska has faced shrinking revenue. In 2023, Medicare revenues are projected to be only $559,736, down from $877,533 in 2019 under the previous payment model. As a result of these falling revenues, the agency has decreased its service area twice already in 2023, leading to the rejection of prospective patients. If further Medicare cuts occur in 2024, the agency is expected to close.

9. Similarly, NAHC member Androscoggin Home Healthcare + Hospice, which is the only provider serving certain rural areas in Maine, has reduced its service area and eliminated most of its remote patient monitoring supports that are used to avoid unnecessary hospital admissions. If Medicare payments are not corrected to be in line with statutory requirements, Androscoggin expects to make further service area reductions, including eliminating other home care programs, reducing the number of staff it employs, and reducing overall home health service availability by more than 50%. Androscoggin has experienced a 34% decline in Medicare revenues, from

$9,797,468 in 2019 under the previous payment model to a projected $6,564,259 under the current payment model at issue herein.

10. Because the Secretary's final rule violates the statute's plain text, reflects an impermissible and unreasonable interpretation, and is arbitrary and capricious and contrary to the requirements of reasoned decision-making, it should be struck down and vacated.

PARTIES

11. The National Association for Home Care & Hospice ("NAHC") is a not-for-profit association that is organized to advance, promote, and protect access to the highest quality care at home, including home health care, hospice, and palliative care. NAHC's membership consists, in part, of home health agencies that provide care to Medicare beneficiaries and receive payment from the Medicare program for those services. NAHC's members are negatively impacted by the Secretary's decision to reduce home health payment rates contrary to Congress's direction.

12. Defendant Xavier Becerra is Secretary of the Department of Health and Human Services and is sued in his official capacity. The Department of Health and Human Services is the federal agency that administers CMS. CMS is the federal agency to which the Secretary has delegated administrative authority over the Medicare program. References to the Secretary herein are meant to refer to him, his subordinate agencies and officials, and to his official predecessors or successors as the context requires. The Secretary oversees regulation of home health agencies under the Medicare program, including those actions complained of herein.

JURISDICTION AND VENUE

13. This Court has subject matter jurisdiction under 28 U.S.C. § 1331 to review the Secretary's final payment rule because NAHC's causes of action arise under the laws of the United States, including the Medicare statute, 42 U.S.C. § 1395 *et seq*., and the Administrative Procedure Act, 5 U.S.C. § 702 *et seq*.

14. This Court also has jurisdiction under 42 U.S.C. § 405(g). NAHC's members have presented their claims to the Secretary in the form of a concrete claim for payment and a Request for Redetermination of the amount of Medicare payment for those services, citing the Secretary's unlawful establishment of home health payment rates.

15. NAHC member Androscoggin Home Healthcare + Hospice has submitted a Request for Redetermination for claim number 22309300281 regarding service dates of 3/1/2023 to 3/31/2023, alleging that the Secretary violated 42 U.S.C. § 1395fff by applying its invalid methodology to determine payment. NAHC member Mary Lanning Healthcare also has submitted a Request for Redetermination for claim number 22315300215607 regarding service dates of 4/40/2023 to 5/29/2023, alleging that the Secretary violated 42 U.S.C. § 1395fff for the same reasons. No administrative body has authority to rule in the members' favor, even though the members are correct on the law. *See* 42 C.F.R. § 405.1063. Further exhaustion of the Secretary's administrative review process is therefore futile.

16. NAHC and its members commented on the Secretary's proposed rule, objecting that it impermissibly and unreasonably violated the statutory requirements by cutting payment rates and without complying with Congress's budget neutrality requirements. In response, the Secretary refused to make meaningful revisions to his proposed rule. The only recourse for NAHC and its members is judicial review of the Secretary's final rule.

17. Venue is proper under 28 U.S.C. § 1391(b), because the defendant, in his official capacity as Secretary of the Department of Health and Human Services, resides in or performs his official duties in this judicial district, and because a substantial part of the events giving rise to this action occurred in this judicial district. Venue is also proper under 42 U.S.C. § 405(g) because NAHC resides in and has its principal place of business in the District of Columbia.

18. NAHC has standing to bring this lawsuit. NAHC actively participated in the rulemaking proceedings and has a substantial interest in ensuring that the Secretary's final rule—and the payment rates set forth in that rule—comply with statutory mandates. At least one of NAHC's members has been injured by the final rule and has standing to sue in its own right. The interests NAHC seeks to protect are germane with its purpose, and NAHC's members are not required to participate in this lawsuit in order to obtain relief against the Secretary.

GENERAL ALLEGATIONS

A. The Relevant Statutory Requirements

19. The Medicare program provides federally funded health insurance for certain elderly and disabled persons under title XVIII of the Social Security Act. 42 U.S.C. § 1395.

20. Part A of the Medicare program covers payment for inpatient hospital services, post-hospital skilled nursing care and home health services. Part B also covers payment for home health services along with payment for physician, medical, and other health services.

1. The Home Health PPS System — the Secretary Set Payments Based, in Part, on the Amount of Therapy Provided.

21. Before 2000, Medicare generally reimbursed home health agencies for the health services they provided to beneficiaries based on the reasonable cost of those services. Beginning in federal fiscal year 2001 (Oct. 1, 2000), Congress directed the Secretary to implement a prospective payment system for home health services, commonly referred to as Home Health PPS. *See* 42 U.S.C. § 1395fff(a).

22. As with other Medicare prospective payment systems, Home Health PPS is designed to control costs by reimbursing home health providers a predetermined fix payment rate for an episode of home health care regardless of the costs the provider incurred to furnish that care.

23. To implement Home Health PPS, Congress instructed the Secretary to define an appropriate unit of service, including the number, type, and duration of clinical visits provided within that unit. *Id*. § 1395fff(b)(2)(A). (The Secretary later identified the unit as a 60-day episode of care.)

24. Congress also instructed the Secretary to compute a "standard prospective payment amount" for the unit of service to be based on aggregate home health agency costs as reflected in their most recently audited home health costs reports at that time. *Id.* § 1395fff(b)(3)(A)(i).

25. Congress directed the Secretary to make the standard payment amount "budget neutral"—that is, to compute the standard rate so that the aggregate amount of Medicare payments made under the new prospective system would equal the aggregate amount Medicare would pay for the same set of services under the previous, reasonable-cost system. *Id*.

26. By statute, the Home Health PPS standard payment rate is updated annually to adjust for factors such as the increase in the cost of goods and services, and for productivity adjustments, and to account for other adjustments Congress has made from time to time. *Id*. § 1395fff(b)(3)(B).

27. The amount of payment for an actual unit of home health services under the Home Health PPS is computed as the standard payment amount applicable for that year adjusted by (1) a "case mix adjustment factor" and (2) a further adjustment to account for the geographic differences in wages and wage-related costs in the area of the country in which the home health agency is located. *Id*. § 1395fff(b)(4)(A).

28. Case mix adjustment factors are the clinical characteristics that explain the variation in costs between different episodes of care. Until 2020, the Secretary had broad discretion to establish case mix adjustment factors for home health services.

29. In exercising that discretion, the Secretary identified as one such factor the amount of therapy that was provided during the 60-day home health episode of care.

2. The Bipartisan Budget Act of 2018 — Congress Directs the Secretary Not to Base Payments on the Amount of Therapy Provided.

30. Congress grew concerned that using therapy as a case mix adjustment factor created the wrong incentives. By taking account of therapy visit volume, the Secretary's payment system encouraged home health agencies to provide more therapy and to avoid high-cost, non-therapy cases (such as patients requiring wound care).

31. Seeking a more patient-focused approach, Congress adopted several changes to the Home Health PPS in the Bipartisan Budget Act of 2018. Those changes took effect for calendar year ("CY") 2020.

32. First, Congress directed the Secretary to replace the 60-day episode of care with a 30-day episode of care as the unit of service for payment under Home Health PPS. *See* 42 U.S.C. § 1395fff(b)(2)(B).

33. Second, Congress directed the Secretary to eliminate the use of "therapy thresholds (established by the Secretary)" as a case mix adjustment factor for calculating reimbursement for services. 42 U.S.C. § 1395fff(b)(4)(B)(ii).

34. Third, Congress directed the Secretary to calculate a new standard prospective payment base rate for a 30-day episode of care.

35. In making these changes, Congress modified the incentives created by the adjustment factors previously applied by the Secretary, while maintaining overall expenditures on home health services. In other words, by keeping overall expenditures the same, Congress revised the program to incentivize home health agencies to provide less therapy when appropriate and to

adopt a more patient-focused approach to care, requiring that making those adjustments in the mix of care would not result in a change in aggregate payments.

36. Accordingly, just as Congress did when it first established the Home Health PPS in 2000, it instructed the Secretary to calculate a new standard payment amount in a budget neutral manner "such that the estimated aggregate amount of expenditures" after these statutory changes "is equal to the estimated aggregate amount of expenditures that otherwise would have been made" without these changes. *Id*. § 1395fff(b)(3)(A)(iv).

37. Congress also directed the Secretary to ensure that adjustments were made to account for changes in behavior that might result by both eliminating the incentives under a therapy-based payment system and moving to a 30-day episode of care as the standard unit of service for payment under the Home Health PPS. As a result, when making his budget-neutrality calculation, the Secretary was required to do more than just divide the 60-day unit of payment amount in half. Congress mandated that the Secretary "make assumptions about behavior changes that could occur as a result of" the unit change and the switch from therapy-based payment and incorporate those assumptions into the payment calculation to ensure budget neutrality. *Id*. Making these assumptions would ensure budget neutrality: that total Medicare expenditures under the new system would be the same as under the former system.

38. As an equation, Congress directed the Secretary to make the following calculation:

Estimated aggregate expenditures under old payment model that would have occurred without any change in payment model or change in behaviors induced by the new payment model	=	Estimated aggregate expenditures with new payment model * Predicted effect on aggregate expenditures of assumed behavior changes prompted by new payment model

39. Congress was aware that predicting behavior is difficult and the Secretary's assumptions could later prove to be inaccurate. To account for that risk, Congress required the Secretary, for calendar years 2020 through 2026, to determine the difference between the effect on estimated aggregate expenditures of assumed behavior changes as predicted and the effect on aggregate expenditures of *actual* behavior changes. *See* 42 U.S.C. § 1395fff(b)(3)(D)(i).

40. Congress then instructed the Secretary to make both forward and backward-looking adjustments to the standard payment amount to account for that difference. *See* 42 U.S.C. § 1395fff(b)(3)(D)(ii)–(iii). The forward-looking adjustment must take the form of "one or more permanent increases or decreases" to the standard payment amount to be applied in future years to offset the *increase or decrease* in estimated aggregate expenditures caused by the Secretary's failure to accurately predict behavior changes when setting the payment amount in 2020. *Id.* The backward-looking adjustment must provide for a temporary *increase or decrease* in the payment rate to offset underpayments or overpayments made in prior calendar years should the Secretary's assumptions about behavior change prove to be inaccurate. *Id.*

B. The Secretary's 2018 and 2019 Rulemakings

41. Over two separate rulemakings in 2018 and 2019, the Secretary implemented the changes to Home Health PPS mandated by Congress in the Bipartisan Budget Act of 2018.

42. The Secretary finalized a new case-mix classification—named the Patient-Driven Groupings Model ("PDGM")—that relies on clinical characteristics and other patient information to determine categories of cases for payment and eliminates the use of therapy service thresholds.

43. The Secretary also calculated a new standard payment amount for a 30-day episode of care and implemented the budget neutrality requirements in 42 U.S.C. § 1395fff(b)(3)(A)(iv) both with and without assumed behavior changes. Accounting for the first variable (the 30-day episode of care) and using home health claims information from 2018, CMS calculated the aggregate expenditures that would occur under the pre-BBA methodology at $16.6 billion. 84 Fed. Reg. 60,478, 60,516 (Nov. 8, 2019). CMS then calculated what the 30-day payment amount would need to be to achieve that aggregate amount without adjusting for behavior assumptions, reaching a 30-day budget neutral standard amount of $1,908.18 per 30-day unit of service. *Id.* at 60,513.

44. The Secretary next made three assumptions about behavior changes and modified the 30-day budget neutral amount to account for those changes. *Id.*; *See* 83 Fed Reg 56,406, 56,461 (Nov. 13, 2018). *First*, the Secretary predicted that home health agencies would change their documentation and coding practices under the new PDGM model to place the highest paying diagnosis code as the principal diagnosis code, leading to higher payment. *Second*, the Secretary assumed that home health agencies would identify more comorbidities in their diagnoses, which could also increase payment. *Third*, the Secretary assumed that home health agencies would provide 1 to 2 extra visits to receive a full 30-day payment, rather than receiving a lower payment for a shorter period of care (also known as a "low-utilization payment adjustment" or "LUPA").

45. The Secretary made no assumptions about how any decline in the provision of therapy services would affect aggregate expenditures. That was for a good reason. Whether therapy increased or decreased moving forward could have no impact on expenditures going forward because Congress had directed the Secretary to eliminate the use of therapy thresholds in setting payment rates under the new system.

46. To offset the consequences of his three assumptions, the Secretary further reduced the standard payment amount in order to keep estimated aggregate expenditures budget neutral—that is, at the $16.6 billion mark. *See* 84 Fed. Reg. at 60,512 & n.17.

47. The Secretary ultimately calculated the final standard payment amount for home health services in calendar year 2020 under the new PDGM to be $1,824.99. *Id*. at 60,518–19.

48. As an equation, the Secretary's rule followed Congress's instructions:

Estimated aggregate expenditures under old payment model that would have occurred without any change in payment model or behaviors induced by the new payment model **16.6 b**	=	Unit of payment such that estimated aggregate expenditures with new payment model equal aggregate expenditures that otherwise would have made without the change **($1,908.18 * estimated units = 16.6b)** * Predicted effect on aggregate expenditures of assumed behavior changes prompted by new payment model **(assumed three identified behavior changes will result in increased cost so reduce unit of payment by 4.36% to $1,824.99)**

C. The Secretary's Unlawful CY 2023 Rulemaking

49. On June 23, 2022, the Secretary issued a proposed rule to update the Medicare Home Health PPS rates for calendar year 2023. *See* 87 Fed. Reg. 37,600 (June 23, 2022).

50. The proposed rule effectively penalized home health agencies for distributing their resources based on a wider range of patient clinical needs beyond therapy (as Congress intended they would). The proposed rule disregarded the Secretary's statutory obligation, set forth at § 1395fff(b)(3)(D)(i), to determine the difference between his assumed behavior changes and actual behavior and the effect of that difference on aggregate expenditures. 87 Fed. Reg. at 37,603. The proposed rule also proposed to reduce total expenditures, failing to comply with Congress's budget neutral requirements.

51. The Secretary disregarded the many comments opposing his proposal, issuing a final rule on November 4, 2022, that mirrored, in large part, the proposed rule. *See* 87 Fed. Reg. 66,790 (Nov. 4, 2022).

52. The final rule suffers from three main statutory defects. *First*, the final rule ignores the statutory requirement to measure the difference on aggregate expenditures of assumed behavior changes and actual behavior changes because it measures neither. *Second*, the final rule violates Congress's instruction to keep the Secretary's payment model change budget neutral and redistribute aggregate expenditures by rebasing home health payment rates to reduce overall expenditures. *Third*, the final rule expressly ties the Secretary's payment to the amount of therapy provided, which Congress expressly prohibited.

1. The Final Rule Fails to Measure the Difference of the Impact on Aggregate Expenditures of Assumed Behavior Changes and Actual Behavior Changes.

53. The Secretary's responsibility in making payment adjustments under § 1395fff(b)(3)(D) is clear: For calendar years 2020 through 2026, the agency is to "determine the impact of differences between assumed behavior changes . . . and actual behavior changes on estimated aggregate expenditures." 42 U.S.C. § 1395fff(b)(3)(D)(i). In the final rulemaking, the Secretary understood as much, noting that he was required under the statute to consider the impact of behavior "changes related to provider behavior in response to the 30-day unit of payment and case-mix changes." 87 Fed. Reg. at 66,801.

54. Emphasizing that this duty is to make adjustments to correct for inaccurate assumptions concerning behavior changes made during the Secretary's initial budget-neutrality calculation, the statute refers back to the "assumed behavior changes (as described in paragraph (3)(A)(iv))." 42 U.S.C. § 1395fff(b)(3)(D)(i). Paragraph (3)(A)(iv) is entitled "[b]udget neutrality for 2020." The Secretary is thus required to use that calculated corrective amount to make

adjustments to the standard prospective payment amount going forward to offset for such increases or decreases in estimated aggregate expenditures, 42 U.S.C. § 1395fff(b)(3)(D)(ii), and to make temporary adjustments retrospectively, *id.* § 1395fff(b)(3)(D)(iii).

55. The Secretary had previously assumed three behavior changes would occur and would increase expenditures under the new payment system, so the Secretary's statutory obligation was to determine whether actual behavior changes increased expenditures under the new PDGM model *beyond* what the Secretary predicted (which would result in a negative adjustment) or whether the changes under the new model resulted in expenditures *below* what the Secretary had predicted (which would warrant a positive adjustment).

56. As an equation, the statute's mandate looks like this:

Impact of assumed behavior changes on estimated aggregate expenditures **(predicted they would increase expenditures by 4.36%)**	-	Impact of actual behavior changes on estimated expenditures **(?)**

57. Rather than measure how accurately the Secretary had predicted that home health agencies would alter their primary diagnosis and comorbidity coding practices or add visits to hit the 30-day episode of care mark—his original set of behavior assumptions—the final rule's methodology disregards both actual behavior changes and assumed behavior changes altogether.

58. Instead, the Secretary's final rule determines the amount of aggregate home health payments made under the new PDGM model and then compares that number to the aggregate amount Medicare would have paid for those same services if they were paid under the pre-PDGM model, a figure he calculated by combining 30-day episodes of care for services provided after the PDGM model was adopted to simulate 60-day units that were then repriced under the pre-PDGM payment model.

59. The Secretary's equation effectively re-runs the budget neutrality calculation with brand new variables, utilizing a measurement that ignores assumed behavior and the changes between assumed and actual behavior. Instead, the final rule *controls for behavior,* taking actual claims information for episodes of care *after* the Bipartisan Budget Act of 2018 changes were put into place and repricing those same services under the pre-BBA system to determine what Medicare would have paid in the aggregate. So while the statutory language instructs the Secretary to equal expenditures to the "estimated aggregate amount of expenditures that otherwise would have been made under the system during such period if [the new payment model] had not been enacted," 42 U.S.C. § 1395fff(b)(3)(A)(iv), the Secretary equalized expenditures to the amount calculated by the old payment system based on actual behavior that occurred *because* the new payment model was enacted.

2. The Final Rule Violates Congress's Budget Neutrality Requirement, Which Was Designed to Redistribute, Not Rebase, Payments.

60. Congress directed the Secretary to ensure that any reforms implemented in response to the statutory changes brought about by the Balanced Budget Act of 2018 are budget neutral. 42 U.S.C. § 1395fff(b)(3)(A)(iv). Congress thus directed the Secretary to redistribute the then-current level of expenditures but not to reduce expenditures as a result of using a new payment methodology.

61. The Secretary's final rule does not comply with the statute. Instead, the final rule substantially and unlawfully decreases aggregate expenditures.

62. The Secretary's final rule acknowledges that he previously estimated a budget neutral number of $16.6 billion and calculated the home health standard payment amount under the 30-day episode of care so that future expenditures would equal that amount. *See* 87 Fed. Reg. at 66,798. The final rule also acknowledges that the Secretary previously assumed that behavior

changes would result in greater expenditures than allowed and, in response, cut the standard payment rate by 4.36 percent to keep future expenditures at $16.6 billion. *Id*. at 66,796.

63. In calculating a payment adjustment, the Secretary was required to revisit his prediction that assumed behavior changes would raise estimated expenditures by 4.36 percent by comparing that estimate to the impact on expenditures of actual behavior changes. The difference between the two should result in an adjustment to the standard payment rate that would bring future estimated expenditures back in line with aggregate estimated expenditures prior to the payment model change. This adjustment is necessary to implement the statutory command to keep the "estimated aggregate amount of expenditures under the [new] system . . . equal to the estimated aggregate amount of expenditures that otherwise would have been made under the system . . . if [Congress's changes to the payment model] had not been enacted." 42 U.S.C. § 1395fff(b)(3)(A)(iv); 87 Fed. Reg. at 66,799.

64. Instead of ensuring budget neutrality, however, the Secretary's final rule imposes a further cut to the standard payment rates, ensuring that estimated aggregated expenditures for 2023 will total just $14.3 billion. 87 Fed. Reg. at 66,805.

65. The Secretary has provided no reasoned explanation for his approach. Instead, the Secretary's final rule justifies his decision to cut payment rates as a reasonable response to the decline in the provision of therapy. He contends that "[i]t would be inappropriate for CMS to continue to pay for therapy as if [Home Health Agencies] were still inflating therapy provision based on the former therapy thresholds, when the number of therapy visits after the implementation of the PDGM has actually declined." *Id.* at 66,799. According to the Secretary, the statute "do[es] not require CMS to pay for therapy that never actually occurred." *Id*.

66. The Secretary cannot trim what he considers to be unnecessary cost of care (otherwise known as rebasing) without explicit statutory authority. When Congress has instructed the Secretary to rebase payment systems, it uses specific language that references a reassessment of the costs of those services. For example, in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3131, 124 Stat. 119, 427 (2010), Congress expressly instructed the Secretary to adjust payment amounts to reflect, among other things, "the average cost of providing care per episode." *Id*.

67. Lacking authority to rebase the home health payment rate, the Secretary's final rule seeks refuge under 42 U.S.C. §§ 1395fff(b)(3)(A)(iv) and 1395fff(b)(3)(D)(iii). "These provisions authorize CMS to account for how behavior changes, like therapy utilization, *would have affected payments under the old 60-day system* . . . ." 87 Fed. Reg. at 66,799 (emphasis added). But that gets the statute backwards. Section 1395fff(b)(3)(D)(i) directs the Secretary to revisit his prediction as to how behavior changes would affect the "estimated aggregate amount of expenditures under" subsection (b)(3)(A)(iv) which, in turn, requires the Secretary to set a payment rate that keeps estimated aggregate expenditures between the old and new payment models budget neutral. That subsection does not ask the Secretary to consider what Medicare would have paid in prior years under a post-PDGM payment model. Contrary to what Congress instructed, the Secretary is applying the pre-PDGM model to a period where behaviors have changed because the new payment system has been enacted.

68. Confirming that the final rule's methodology is not budget neutral and improperly rebases payments, the Secretary has rejected applying this same methodology in a similar context. The Secretary recently revamped the prospective payment system for skilled nursing facilities. *See* 86 Fed. Reg. 19,954, 19,985 (Apr. 15, 2021). Many of the changes resemble those made to

the prospective payment system here. The old system relied heavily on therapy utilization, whereas the new system relies more on patient characteristics, and the Secretary planned to implement the new model for skilled nursing facilities "in a budget neutral manner." *Id.*

69. After an initial analysis, the Secretary proposed a 46 percent adjustment. *See id.* (noting that the "analysis resulted in an adjustment factor of 1.46"). Later, however, the Secretary proposed to make payment adjustments based on the difference between assumed behavior and actual behavior. Noting that the new payment model "is impacting certain aspects of [skilled nursing facility] patient classification and care provision," 86 Fed. Reg. at 19,986, the Secretary recalibrated his adjustments to account for, among other things, "changes in therapy provision." *Id.* at 19,987. Although the Secretary "would typically utilize claims and assessment data from a given period under the new payment system, classify patients under both the current and prior payment model using the same set of data, compare aggregate payments under each payment model, and calculate an appropriate adjustment factor to achieve budget neutrality," the "significant changes in therapy provision" since implementation of the new model meant that this budget-neutrality calculation would no longer work and would instead lead to "a drastic underestimation" of what aggregate payments would have been under the previous system. *Id.*

70. These same behavioral changes are present here and likewise render the Secretary's methodology unsound. The shift of payment incentives away from therapy visits, as well as the impact of COVID-19, "drove a 29.7% reduction in CY 2020 therapy visits." Al Dobson et al., Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2022 HH PPS Proposed Rule, at 3 (Aug. 26, 2021). But instead of accounting for this change in behavior or applying a different methodology focused on measuring actual and assumed behavior changes,

as ordinary rules of fairness and the statute's plain text requires, the Secretary has adopted a model that he has acknowledged elsewhere is inaccurate.

3. The Secretary's Final Rule Violates Congress's Command to Remove Therapy Thresholds as a Factor that Influences Payment.

71. Congress directed the Secretary to eliminate the use of "therapy thresholds (established by the Secretary)" as a factor for calculating reimbursement for services. 42 U.S.C. § 1395fff(b)(4)(B)(ii).

72. The final rule does exactly the opposite. It uses the amount of therapy actually provided after implementing Congress's payment model changes to establish a payment rate to be applied to home health services in 2023.

73. The Secretary was explicit in tying the calculated payment rate to the amount of therapy provided. The final rule states that "[i]t would be inappropriate for [the Secretary] to continue to pay for therapy as if [home health agencies] were still inflating therapy provision based on the former therapy thresholds, when the number of therapy visits after the implementation of the PDGM has actually declined." 87 Fed. Reg. at 66,799. In other words, because therapy has been reduced, the rule reduces expenditures. That flies in the face of the statute.

D. Current and Ongoing Harm

74. NAHC and its membership have been substantially harmed, and will continue to incur substantial future harm, as a direct result of the Secretary's impermissible and unreasonable interpretation of Section 51001 as codified at 42 U.S.C. § 1395fff(b)(3)(A).

75. Two NAHC members illustrate the nature of the harm that the Secretary's invalid "budget neutrality" has already inflicted. Home Health Services of Mary Lanning Healthcare, a non-profit entity in Hastings, Nebraska has experienced a reduction of Medicare revenues under the PDGM payment rates from $877,533 in 2019 to a projected $559,736 that has resulted in forced

reductions in service area, elimination of on-call availability after 4:30 p.m. on weekends and holidays, staff reductions triggered by fear of closure of the agency, and the actual anticipated closure of the agency (which has operated for 51 years), if further Medicare rate cuts occur in 2024. Because of CMS's misapplication of the statute, Mary Lanning has been unable to serve the same number of patients. Its average daily census of patients plummeted from 88 in 2020 to 45 through June 2023 because of its inability to continue the level of service availability it previously provided under the pre-PDGM payment model. There is no other provider of home health services available in much of its former and current service area.

76. Similarly, Androscoggin Homehealthcare + Hospice, a nonprofit provider of Medicare home health services residents in Maine since 1966, has reduced its service area, particularly in the rural regions of the state leaving residents without home health services as a care option. In addition to eliminating service areas, Androscoggin has been forced to reduce in-person patient visits, reduce its workforce, cap patient admissions, and eliminate wound management services, telehealth services, and Medicaid long term home health to chronic care patients. Androscoggin is and was the only home health agency serving many of the rural Maine communities. For 2023, Androscoggin projects a financial deficit of $2,648,000 in Medicare home health services despite having well-below average overhead costs. The consequences of CMS's payment rate reduction are severe and multidimensional with negative impacts on Medicare, Medicare Advantage, and Medicaid patients in the state.

77. Moreover, the Secretary shows no sign of reversing course. In a draft proposed rule for Calendar Year 2024, the Secretary has applied the same flawed methodology to propose yet another decrease in payments for home health agencies. *See* HHS, *Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update* at tbl. A1,

Part II(C)(1)(a) (June 28, 2023), https://public-inspection.federalregister.gov/2023-14044.pdf. Specifically, the Secretary estimates that the proposal would reduce payments to providers of home health services by an additional $870 million in 2024 alone through a 5.653% rate reduction pursuant to the budget neutrality permanent adjustment authority at issue herein, along with proposing an added $1.355 billion in temporary adjustments to be applied at a later, undesignated time. *Id.* at tbls. A1, B14.

SPECIFIC ALLEGATIONS

COUNT I
Agency Action Not in Accordance with Law, in Excess of Statutory Authority
(42 U.S.C. § 1395fff(b)(3)(D); 42 U.S.C. § 1395fff(b)(3)(A); 5 U.S.C. §§ 706(2)(A), 706(2)(C))

78. Paragraphs 1–77 are incorporated herein in their entirety.

79. The Administrative Procedure Act permits judicial review of agency actions, findings, and conclusions that are "not in accordance with law" or are "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706(2)(A), (2)(C).

80. When "Congress has directly spoken to the precise question at issue," this Court must give effect to Congress's unambiguously stated intent. *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984). It is a "core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014).

81. Congress directed the Secretary to ensure that the BBA's statutory reforms are budget neutral. *See* 42 U.S.C. § 1395fff(b)(3)(A)(iv).

82. The Secretary's responsibility in making payment adjustments under § 1395fff(b)(3)(D) is clear: Each year, the agency is to "determine the impact of differences between assumed behavior changes . . . and actual behavior changes on estimated aggregate

expenditures." 42 U.S.C. § 1395fff(b)(3)(D)(i). The Secretary is thus obligated to make adjustments to the prospective payment amounts to correct for inaccurate behavior change assumptions made during the budget-neutrality calculation and to ensure that those adjustments offset any increases or decreases in estimated aggregate expenditures, *see* 42 U.S.C. § 1395fff(b)(3)(D)(ii), and to make temporary adjustments retrospectively, *see* § 1395fff(b)(3)(D)(iii).

83. The Secretary's final rule disregards this clear and express statutory command because it does not compare his assumed behaviors to actual behaviors and because his final rule is not budget neutral. The final rule should therefore be set aside.

COUNT II
Unreasonable Construction of Statute
(42 U.S.C. § 1395fff(b)(4)(B))

84. Paragraphs 1–77 are incorporated herein in their entirety.

85. Congress removed therapy thresholds when it directed the Secretary to ensure that aggregate payments under the PDGM are no more or less than what they would have been under the previous payment system. *See* 42 U.S.C. § 1395fff(b)(4)(B)(ii) ("the Secretary shall eliminate the use of therapy thresholds . . . in case mix adjustment factors established under clause (i) for calculating payments under the prospective payment system").

86. The behavior adjustment that the Secretary's final rule adopts is predicated on the difference between actual PDGM expenditures in 2020 and the Secretary's forecast of what it would have paid for the same claims under the old payment system. But the Secretary's forecast was wrong because the 2020 claims data had significantly lower therapy utilization, which was a driving force for payments before the therapy thresholds were removed. Accordingly, much of

the adjustment that the Secretary's final rule has adopted is attributable to the expenditures that Medicare would not have paid under the old system if the therapy thresholds had never existed.

87. The Secretary concedes that the final rule cuts legacy costs associated with the therapy thresholds out of the payment rate. The final rule states that "[i]t would be inappropriate for [the Secretary] to continue to pay for therapy as if [home health agencies] were still inflating therapy provision based on the former therapy thresholds, when the number of therapy visits after the implementation of the PDGM has actually declined." 87 Fed. Reg. at 66,799. Separately, the final rule asserts that the statute "do[es] not require [the Secretary] to pay for therapy that never actually occurred." *Id*. But no one is asking the Secretary to pay for therapy that never occurred. The problem is that rather than redistributing payments, the Secretary is seeking to rebase them without explicit statutory authority.

88. Under any permissible reading of the statute, it is clear that Congress has prohibited the Secretary from rebasing payments to remove expenditures attributable to the therapy thresholds. *See* 42 U.S.C. § 1395fff(b)(4)(B)(ii).

89. Because any "unsupported agency action normally warrants vacatur," *Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin.*, 429 F.3d 1136, 1151 (D.C. Cir. 2005), and because the Secretary's final rule is manifestly contrary to BBA's requirement of removing therapy thresholds, it should be set aside.

COUNT III
Violation of the Administrative Procedure Act
Arbitrary and Capricious Action
(5 U.S.C. § 706(2)(A))

90. Paragraphs 1–77 are incorporated herein in their entirety.

91. The Administrative Procedure Act permits judicial review of agency actions, findings and conclusions that are "arbitrary, capricious" or "an abuse of discretion." 5 U.S.C. § 706(2)(A).

92. Agency action is arbitrary and capricious and an abuse of discretion when the agency "relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983).

93. The agency must provide a "rational connection between the facts found and the choice made" so as to afford a reviewing court the opportunity to evaluate the agency's decision-making process. *Id*. (quoting *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962)); *see also FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (noting "the requirement that an agency provide reasoned explanation for its action").

94. The Secretary's final rule considers factors not permitted by the statute and fails to consider factors that were required. Instead of analyzing the accuracy of its behavioral assumptions, the Secretary considered other factors in developing the new rates, namely the amount that would have been paid had the Secretary continued to apply the old pricing system with the behavior changes induced only by the new payment model. The Secretary failed to consider how the departure from a therapy-driven pricing model (and the COVID-19 pandemic and other factors) caused home health agencies to change behavior. *See* 87 Fed. Reg. at 37,651, 37,656.

95. The Bipartisan Budget Act, the Administrative Procedure Act, and general principles of reasoned decision-making all demand more. The Secretary was to consider the impact of the difference between the previously calculated assumed behavior changes on estimated aggregate expenditures and the impact of actual behavior changes on estimated aggregate expenditures and adjust for that difference. 42 U.S.C. § 1395fff(b)(3)(D).

96. When Congress has given an agency "strict instructions, clear criteria, and a duty," failure to follow those instructions and to use "extraneous factors" is arbitrary and capricious action. *Cayuga Nation v. United States*, 594 F. Supp. 3d 64, 75 (D.D.C. 2022); *see also Kakar v. U.S. Citizenship & Immigr. Servs.*, 29 F. 4th 129, 135 (2d Cir. 2022) (When, as here, "'an administrative record is insufficient to permit [the court] to . . . conclude that the agency has considered all relevant factors,' remand is appropriate." (quoting *Brodsky v. U.S. Nuclear Regul. Comm'n*, 704 F.3d 113, 119 (2d Cir. 2013)).

97. The explanation given in the final rule runs counter to the record evidence presented to the agency. Take the change in the provision of therapy services. Commenters explained "that there has been a large decrease in therapy utilization since the implementation of" the Bipartisan Budget Act payment system. 87 Fed. Reg. at 37,615. The Secretary's final rule does not dispute that, as a factual matter, this behavior might have changed and that this would throw a wrench in its methodology. Instead, the final rule contends that, regardless of what is actually happening, the decrease in therapy utilization should not be happening because CMS "stated in the CY 2019 HH PPPs final rule . . . that the [new payment system] is not limiting or prohibiting the provision of therapy services" and thus home health agencies "should continue to provide the most appropriate care to Medicare home health beneficiaries." *Id.*

98. In other words, the Secretary's response is that home health agencies are not changing their behaviors in response to the incentives provided by the new payment system. But if that were true, then the Secretary's job should have been easy: the Secretary calculated that changed behavior would require a 4.36% decrease in payment rates; if there has been no change in behavior, the Secretary should have eliminated that 4.36% decrease.

99. The Secretary's methodology simply cannot be supported as a difference in view or the product of agency experience. Here, the Secretary has left behind the words of the statute, the statutory scheme, and available methodologies to create a new payment scheme. The final rule is arbitrary and capricious and should be vacated. *See* 5 U.S.C. § 706(2).

COUNT IV
Violation of the Administrative Procedure Act
Injunctive and Declaratory Relief
(5 U.S.C. § 706)

100. Paragraphs 1–77 are incorporated herein in their entirety.

101. The Administrative Procedure Act requires a court to "hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious . . . or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

102. The Administrative Procedure Act allows a reviewing court to "issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of review proceedings." *Id.* at § 705.

103. For the reasons discussed above, the Secretary's decision to adopt a regulatory scheme implementing reforms to the Home Health PPS that differs from that required under BBA Section 51001 is arbitrary, capricious, and contrary to law.

104. This Court should therefore declare that the Secretary is enjoined from enforcing the Home Health PPS rate cuts found in the Secretary's *Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update*, 87 Fed. Reg. 66,790, and require the Secretary to maintain current Home Health PPS payment rates.

PRAYER FOR RELIEF

WHEREFORE, NAHC requests that this Court enter judgment in its favor:

A. Vacating any agency action found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law, and remand any matters herein to the Secretary for further proceedings in accord with any legal instructions the Court may deem proper and just.

B. Requiring the Secretary to change his regulations to comply with the statutory requirements, including faithfully implementing the applicable provisions of the BBA.

C. Entering an injunction that (1) directs the Secretary to withdraw or suspend his Final Rule until such time as it can be brought into compliance with the statute, and (2) directs the Secretary to withhold applying the new Home Health PPS until such time as the Secretary has made appropriate revisions to his Final Rule.

D. Ordering such other and further relief as the Court deems just and proper, including the award of costs and disbursements of this action and reasonable attorneys' fees.

Respectfully submitted,

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