MEDPAC Medicare Payment Advisory Commission

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Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1625-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled: Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements. We appreciate your staff's efforts to administer and improve the Medicare payment system for home health agencies (HHAs), particularly given the competing demands on the agency.

This rule proposes a payment update for HHAs in payment year 2016, and details a number of additional proposals. We focus our comments on the rebasing reduction for 2016, the coding adjustment to account for nominal case-mix change, revisions to the home health payment system to address issues identified in a recent CMS report, the value-based purchasing program, and new quality measures.

Rebasing adjustments and proposed CY 2016 home health rate update

The Patient Protection and Affordable Care Act (PPACA) included a provision to rebase home health payments. Under this provision, CMS is required to adjust the home health payment rate based on its analysis of the adequacy of the rate compared to the average cost per episode. PPACA required that the payment reduction from rebasing be phased in annually over four years; limited the annual reduction to no more than 3.5 percent of the base payment rate in effect in 2010 (or $80.95); and specified that any reduction be offset by the statutorily required annual payment update (indexed to the home health market basket).

In the CY 2014 home health PPS final rule, CMS estimated (based on 2011 cost report data and 2012 claims data) that home health payments in 2013 were 13.6 percent in excess of costs,

indicating a need for a rebasing adjustment to the 60-day home health episode payment rate of 3.45 percent per year over four years. However, this adjustment would have resulted in an annual payment reduction that exceeded the $80.95 limit specified in statute. Therefore, CMS implemented the maximum allowed payment rate reduction of $80.95—an amount equal to 2.8 percent of the 2013 60-day episode rate—in each year from 2014 to 2017.

In the current proposed rule, CMS has updated its analysis of the cost of an episode in 2013, using 2013 cost report and claims data, and reports an even wider discrepancy between episode payment and cost than previously estimated. CMS's most recent analysis suggests that a 60-day episode rate reduction of 5.02 percent in each year from 2014 to 2017 would have been needed to align payments with costs. Nevertheless, CMS is statutorily limited to an annual rebasing reduction of $80.95. The $80.95 reduction in CY 2016 (the third year of rebasing) will reduce the 60-day episode payment rate by 2.73 percent. This rebasing adjustment will be offset by the statutorily required 2.3 percent increase in the payment update, for a net decrease in the 60-day episode payment rate of approximately 0.43 percent. (CMS proposes additional adjustments to the 60-day episode rate to reflect changes in both the wage index and the case-mix weights, and to account for nominal case-mix growth (discussed below). These adjustments would further reduce the 60-day episode payment rate, for a total CY 2016 update of –0.78 percent.)

Comment

The Commission recognizes that CMS has implemented the maximum reduction for 60-day episodes permissible by PPACA, but we continue to be concerned that the reductions are too small. In our December 2014 report on the impact of rebasing, the Commission concluded that quality of care and access to care were unlikely to be significantly negatively impacted, and that home health margins were likely to remain high.[1] The Commission recently estimated that home health agencies will have margins of 10.3 percent in 2015.[2] CMS's finding in this proposed rule that the base rate rebasing adjustment should have been set at –5.02 percent—about 50 percent greater than the current adjustment—provides additional evidence that the existing reductions are not sufficient to bring Medicare payments in line with agencies' actual costs of providing care.

In this proposed rule, CMS reports on an analysis of home health claims data from the first year of the four-year phase-in of the rebasing adjustments (CY 2014); the agency's findings support the Commission's conclusion that the impact of rebasing should be modest. The analysis found that the number of agencies billing Medicare dropped by 1.6 percent in 2014, with most of the drop occurring in Florida and Texas. These declines in supply come after many years of rapid expansion and still leave these two states with a substantial number of home health agencies. CMS notes that some cities in Florida and Texas have been subject to moratoria on the enrollment of new home

[1] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Impact of home health payment rebasing on beneficiary access to and quality of care.* Washington, DC: MedPAC.

[2] Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

health agencies because of concerns about fraud; the reduction in supply of agencies in these states may be due in part to this effort.

CMS's analysis also found that the number of home health episodes in 2014 declined by 3.8 percent, with much of the decline occurring in six states with high rates of use (Texas, Florida, Oklahoma, Mississippi, Louisiana, and Illinois). Excluding these states, the number of episodes dropped by 2.6 percent. CMS notes that admissions of Medicare beneficiaries to hospitals and skilled nursing facilities—two common sources of home health patients—declined in 2014, which may have contributed to the reduction in the use of home health services. Another factor may have been new requirements that physicians must examine beneficiaries in person ("face-to-face visit") when ordering home health care.

In the Commission's view, the declines in the number of Medicare-participating home health agencies and in the use of home health services in 2014 do not reflect an access problem attributable to current rebasing. Indeed, home health agencies' Medicare margins suggest an opportunity to rebase further. The Commission recognizes that statute limits CMS's ability to increase the payment reduction, but we reiterate our recommendation that further reductions would be appropriate and would not imperil access or quality.

Proposed reduction to the national standardized 60-day episode payment rate to account for nominal case-mix growth

In the past, CMS has made numerous adjustments to the home health prospective payment system (PPS) to account for coding increases unrelated to patient severity, but the agency has not made such adjustments in recent years. In the proposed rule, CMS notes that total case mix increased by 2.76 percent in 2013 and by 1.41 percent in 2014. Past CMS analysis of home health case-mix change has led the agency to conclude that only 16 percent of total case-mix change is "real" (that is, related to changes in patient severity), while 84 percent is nominal. Therefore, CMS estimates that nominal case-mix change was 2.32 percent in 2013 and 1.18 in 2014. CMS proposes a payment reduction of 3.41 percent to offset this nominal case-mix growth.[3] CMS would spread this reduction over two years, reducing the episode payment rate by 1.72 percent in 2016 and in 2017.

Comment

Both the Commission and CMS have found that case-mix changes unrelated to patient severity occur frequently in Medicare PPSs. This nominal case-mix change results in increased payments even though patients' levels of illness and resource needs remain the same. The Commission has long held that it is necessary for CMS to make adjustments to account for nominal case-mix change to prevent additional overpayments. While the Commission has not independently reviewed the nominal case-mix change in the home health PPS, CMS's proposed reduction is consistent with the agency's past findings on trends in case-mix change in the payment system and thus is warranted to ensure the accuracy of payments under the home health PPS.

[3] The two factors are multiplicative: $1 - 1/(1.0232 \times 1.0118) = 0.0341$.

Report to the Congress on the home health study required by section 3131(d) of the Affordable Care Act and update on subsequent research and analysis

The home health PPS bases the payment for a 60-day episode on a combination of the patient's clinical and functional status, the amount of therapy provided, and the episode's timing in a sequence of episodes. The Commission has long been concerned that basing payment in part on the use of therapy creates incentives for agencies to favor patients to whom therapy services can be provided and to avoid patients who predominantly need nursing and aide services. As noted in the proposed rule, other researchers have also concluded that the current home health payment model drives agency resource allocation and practice decisions, with some researchers finding further that the home health PPS may underpay for certain categories of clinically complex patients who do not require therapy.

PPACA included a requirement that CMS review the costs and payments for certain categories of patients, including low-income beneficiaries and those with high levels of clinical severity. CMS contracted with a research firm to conduct a survey of access to care for home health beneficiaries and a payment-to-cost analysis for beneficiaries with selected characteristics. The survey found that most beneficiaries had good or excellent access to care, and that the most common reasons a beneficiary could not receive home health care was that the beneficiary did not meet coverage requirements or had issues with caregiver support. The quantitative analysis of episode payments and costs suggested that margins may differ substantially across the home health case-mix groups. Further, particular beneficiary characteristics appeared to be strongly associated with margin, which may create incentives for agencies to select certain types of patients over others. Margins were estimated to be lower in 2010 for patients who:

- Required parenteral nutrition,
- Had traumatic wounds or ulcers,
- Needed substantial assistance in bathing,
- Had high Hierarchical Condition Category (HCC) scores (indicating a higher burden of illness),
- Had certain poorly controlled clinical conditions (such as poorly controlled pulmonary disorders), and
- Had lower socio-economic status, such as dual eligibility for Medicare and Medicaid.

Based on these findings, CMS has begun research into new case-mix models for the home health PPS. The three alternative models discussed in the proposed rule are fully prospective in design; unlike the current PPS, they do not use the amount of therapy visits provided as a payment determinant. Two of the models test different clinical classification schemes as an approach to setting payment. The third model retains the current case-mix system but does not include the actual amount of therapy as a payment factor, instead using patient characteristics in a two-step regression to predict the amount of therapy provided.

Comment

The Commission has long-recommended that Medicare eliminate the use of therapy services as a payment factor in the home health PPS, and the consideration of alternative models that are fully prospective is an important step towards realizing this recommendation.[4] Many analysts have concluded that the therapy thresholds in the current system have distorted patterns of care and have been exploited for financial gain. Previous Commission analysis has suggested that removing the therapy thresholds in the current system would increase payments for dual-eligible Medicare beneficiaries and would improve the accuracy of payments for high-cost beneficiaries who have significant nursing and home health needs. Thus, in the near-term, CMS might be able to address at least some of the purported payment inequities found in the mandated report by implementing the alternative model that uses the two-step regression to predict therapy. Modifying the current system to eliminate the payment thresholds would be the least disruptive option for quickly modifying the PPS to address some of CMS's findings. The work on new clinical classification systems to support payment could continue and be included in future revisions to the PPS as it becomes available.

Proposed home health value-based purchasing model

PPACA directed the Secretary of the Department of Health and Human Services to develop a plan to implement a home health value-based purchasing program (HHVBP), and in March 2012 the Secretary issued a report to the Congress outlining such a plan. In this proposed rule, CMS proposes a HHVBP model that would be tested in a demonstration conducted by CMS's Center for Medicare and Medicaid Innovation (CMMI). The model would test whether home health agencies subjected to significant adjustments to the Medicare payment amounts would correspondingly improve quality of care. CMS proposes to use its waiver authority under section 1115A(d)(1) of the Social Security Act to apply a withhold from home health payments made to agencies delivering care in selected states. Agencies with higher quality performance scores would receive bonuses under the demonstration, while those with lower scores would receive lower payments relative to current levels. The demonstration would be budget neutral within the home health PPS; the dollars recovered in penalties would fund the bonuses.

Under section 1115A(d)(1), CMMI/CMS may elect to limit testing of innovative payment models such as a HHVBP to certain geographic areas. CMS proposes to use state borders as boundaries for demarcating which home health agencies will be included in the model. Under the proposed model, participating states would be selected randomly from each of nine regional groups. The groups reflect regional variations, with each group comprising states that are located in close proximity to one another and are similar in at least one important characteristic (such as average utilization rate, average agency size, or predominance of for-profit agencies). This design is intended to ensure that findings are robust and generalizable. CMS proposes a state selection method based on a randomized sampling of states within each of the nine regional groups. Based on this methodology, the nine participating states would be Massachusetts, Maryland, North

[4] Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare payment policy.* Washington DC: MedPAC.

Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. All agencies in these nine states would be required to participate in the model to ensure sufficient participation and to guard against self-selection bias.

CMS proposes that performance in the first year of the model would be computed based on a starter set of 25 currently used measures and four new measures. CMS's starter set would include 10 currently used process measures, assessing rates of:

- Timely initiation of care,
- Types and sources of assistance,
- Use of pressure ulcer prevention and care interventions,
- Assessment of fall risk,
- Depression assessment,
- Influenza vaccine status assessment,
- Influenza vaccine appropriately received,
- Pneumococcal vaccine status assessment (and, if not administered, the reason pneumococcal vaccine was not received), and
- Drug education.

The starter set would also include 15 currently used outcome measures, including specified results from patient and caregiver surveys, and rates of:

- Improvement in locomotion,
- Improvement in bed transferring,
- Improvement in bathing,
- Improvement in dyspnea,
- Discharge to community,
- Hospitalization,
- Emergency department use,
- Improvement in pain interfering with activity,
- Improvement in management of oral medications, and
- Improvement in function.

The four new measures used in the HHVBP model would be reporting of:

- Influenza vaccine coverage for agency personnel,
- Herpes zoster (shingles) vaccine status assessment,
- Advanced care planning, and
- Adverse events for improper medication administration and/or side effects.

CMS proposes to use CY 2015 as the baseline year for performance, with CY 2016 as the first year for performance measurement. The first payment adjustment would begin January 1, 2018, applied to that calendar year based on 2016 performance data. The payment withhold would increase from

5 percent in 2018 to 8 percent in 2021. Agencies that do not have the number of episodes (20) required to produce data for at least five measures would not be subject to the payment adjustment.

CMS's HHVBP model would adopt a scoring approach similar to that used in the hospital VBP program, including allocating points based on achievement or improvement, and calculating those points based on industry benchmarks and thresholds. For each measure, agencies would receive points along an achievement range, a scale between the achievement threshold and a benchmark. CMS proposes to calculate the achievement threshold as the median of all agencies' performance on the specified quality measure during the baseline period, and to calculate the benchmark as the mean of the top decile of all agencies' performance on the specified quality measure during the baseline period. In a departure from the hospital VBP Program approach, in which CMS uses a national sample to calculate the achievement thresholds and benchmarks, CMS proposes for the HHVBP model to calculate the achievement thresholds and benchmarks separately for each selected state and for agency size cohorts. Similarly, under the HHVBP model, CMS would calculate improvement points for each measure by assigning points along an improvement range, a scale indicating change between an agency's performance during the performance period and the baseline period. As in the HHVBP achievement calculation, the improvement benchmark and threshold would be calculated separately for each state and for agency size cohorts. CMS proposes this approach to ensure that agencies would be competing only with similar-sized agencies in their state.

An agency would be rated on a scale of 1-10 in both improvement and achievement for the 25 measures in the starter set that are already in use. The improvement or achievement result for each of the 25 measures—whichever is highest—would be summed; that sum would constitute 90 percent of the agency's Total Performance Score (TPS) under the HHVBP program. The remaining 10 percent of the TPS would be based on whether the agency reports some or all of the four new measures proposed for the starter set.

Comment

The Commission believes that Medicare needs to advance payment reforms that reward the quality of care provided in a setting. The proposed HHVBP model would begin this change for the home health PPS. While the Commission has not recommended a VBP program for home health care, it has recommended a penalty for agencies with high rates of hospitalization. The proposed model includes hospitalization among the starter set of performance measures, and could be an effective interim measure until a hospitalization penalty is implemented. The proposed VBP approach has many desirable features, and could be improved with several refinements.

The compulsory nature of the model addresses a major limitation of past demonstrations. The experience of the past indicates that agencies avoid demonstrations that present financial risk, resulting in relatively low provider participation. A compulsory approach allows for a more robust financial incentive that includes reduced payments for lower performers as well as bonus payments for higher performers. By selecting a large cross section of agencies for inclusion, the proposed

model will test the impact of a design that includes bonuses and penalties on a range of agencies that reflect the variety of agencies operating in the program.

Under CMS's proposed approach, 8 percent—a significant share—of agencies' payments would eventually be at risk for quality, which should create a meaningful incentive for agencies to improve or maintain the quality of care they provide, even if agencies already have better than average performance. In future years, it will be important to maintain the payment withhold at a level that continues to motivate agencies to improve or maintain quality of care. Lowering the payment withhold would dampen agencies' response to the incentive, particularly if agency margins remain relatively high, as the Commission expects under current payment policy.

Several refinements would improve the design of the proposed HHVBP model. First, CMS should make the model more focused and simpler to administer by refining the number of measures and focusing on those that are important to beneficiaries. Second, CMS should focus on rewarding the achievement of specified quality scores, and put a declining emphasis on improvement as a factor. Third, CMS should establish benchmarks for performance in advance of the performance year to clarify the level of achievement necessary for agencies to avoid penalties.

Measures should focus on a limited set of outcome measures that are important to beneficiaries. The proposed model includes too many quality measures, diluting its focus and increasing the burden of operation. As much as possible, the model should rely on a parsimonious set of outcome measures, such as the measures related to preventable adverse events (emergency department use, hospitalizations or re-hospitalizations) and changes in beneficiary functional status. Including fewer measures would decrease the administrative burden of operating the HHVBP program. While the Commission prefers clinical outcome measures over process measures as a general principle, we do recognize the importance of ensuring that all health care personnel—especially those dealing with immunologically vulnerable patients—are immunized annually against influenza (unless the worker has a medical contraindication to the vaccine).

The proposal also would award agencies credit simply for reporting four measures, a feature that will not advance the goal of improving quality. Credit should be received only for performance on a measure, and an agency's incentive payment should not be tied to reporting data.

The Commission is also concerned about the hospitalization and re-hospitalization measures proposed for inclusion in the model. As proposed, these measures track hospitalization events only for a fixed window of time. For example, the hospitalization measure includes only those hospitalizations that occur within 60 days of initiation of home health care, while the re-hospitalization measure includes only those events that occur within 30 days of initiation of home health care. Many home health stays last longer than 30 or 60 days, so under the proposed model, some hospitalizations and re-hospitalizations would not be reflected in the measures. The hospitalization and re-hospitalization measures included in the HHVBP model should be modified to capture all of these events that occur while a beneficiary is in home health care. CMS may also want to consider including hospitalizations that occur in the 30 days after home health care ends, as the Commission considers this a measure of successful transition to the community.

Measuring performance on the basis of improvement. Under the proposed model, agencies' performance on each measure would be measured by their achievement or improvement score, whichever is higher. The Commission is concerned that this methodology is not sufficiently beneficiary-focused, since what matters most to the beneficiary is an agency's actual level of performance. Further, this methodology could create potential inequities in that agencies with equal or better levels of achievement might receive lower payments than agencies with lower achievement scores but high improvement scores. Some allowance for improvement may help agencies adjust to a new HHVBP incentive, but the program should limit the use of improvement measures to the initial three years of operation.

Benchmarks for performance should be established prospectively. As with the Hospital VBP, the proposed HHVBP model would rely on annual relative rankings in performance to determine the Total Performance Score (and the resulting bonuses and penalties). For each measure, an agency's performance will be compared to that of all other agencies of its size in its state. This approach is problematic because agencies will not know in advance the level of performance or achievement that is necessary to avoid a penalty or earn a bonus; this may discourage some quality improvement activities because the financial returns for a given investment in quality may be difficult to determine.

Instead, CMS should establish prospective benchmarks for each quality measure based on historical performance. Agencies would be scored based on their performance relative to the known benchmarks; those with higher scores could have their payment withhold returned, while those below the benchmark could have all or some of it withheld based on the magnitude by which they miss the benchmark. Benchmarks for measures should be set at levels that allow most providers a reasonable expectation of achieving them. The budget neutrality of the program could be maintained by redistributing withheld payments to agencies above the benchmark based on the degree to which they exceeded the benchmarks.

Quality measures under consideration for future years

The proposed rule solicits comment on new measures for implementation in future years. Four of the proposed measures would meet the requirements for cross-sector post-acute care quality measures required by the Improving Medicare Post-acute Transformation Act: all-condition potentially preventable readmission rates, Medicare spending per beneficiary, share of patients discharged to community, and percent of patients for whom medication reconciliation actions were completed. These four measures would be used in the home health and other post-acute care settings as cross-sector measures of quality, beginning in 2017.

CMS also solicits comment on seven potential home health care measures for future development. The measures were identified by CMS through a review of existing measures, comments from stakeholders, and a review of related clinical and academic literature. The additional measures would cover falls, nutrition, pain management, and activities of daily living.

Comment

The Commission is concerned about the proliferation of quality measures in the Medicare program.[5] There are currently 79 CMS-sanctioned home health quality measures: 12 adverse event measures, 38 outcome measures, and 29 process measures. Before expanding the current set of measures any further, CMS should consider whether any of the current measures could be consolidated or eliminated. We recognize that four of the proposed measures are in response to a legislative mandate, but CMS should consider whether any of the existing 79 home health measures would be redundant or unnecessary once the IMPACT Act measures are operational.

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director, at 202/220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman

FJC/ewc

[5] Medicare Payment Advisory Commission. 2015. Comment letter to CMS on *List of measures under consideration for December 1, 2014*. January 5.