

August 24, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1747-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements," *Federal Register*, vol. 86, no. 127, p. 35874 (July 7, 2021). We appreciate your staff's efforts to administer and improve the Medicare program for beneficiaries and providers, particularly given the considerable demands on the agency.

Our comments address proposals in the rule related to Medicare payment policies for home health agencies (HHAs), including:

- Calendar year (CY) 2022 national standardized 30-day period payment rates
- Analysis of cost report data for 30-day periods of care
- Adjusting the home health base payment rate to account for unexpected changes in spending under the Patient-Driven Groupings Model (PDGM)
- Calendar year 2022 PDGM case-mix weights
- Expanding the Home Health Value-based Purchasing Program (HH VBP) model nationwide
- Revisions to the Home Health Quality Reporting Program (QRP)

Calendar year 2022 national standardized 30-day period payment rate

The proposed rule would implement a 1.8 percent update to the base payment rate for HHA services. This increase reflects payment adjustments mandated by statute: a 2.4 percent home health market basket update for 2022 reduced by the multifactor productivity adjustment of 0.6 percent.

Comment

The Commission recognizes that CMS must provide the statutorily mandated payment update, but we note that this increase is not warranted based on our analysis of payment adequacy. In our March 2021 report to the Congress, the Commission found positive access, quality, and financial indicators for the sector, with margins of 15.8 percent for freestanding HHAs in 2019.¹ Though consistent with statute, a payment update of 1.8 percent will keep payments higher than necessary for adequate access to quality care. Indeed, the Commission recommended that the Congress reduce the 2021 Medicare base payment rate for HHAs by 5 percent for the 2021 payment year.

Analysis of cost report data for 30-day periods of care

Pursuant to the Bipartisan Budget Act of 2018 (BBA 2018), Medicare implemented a new case-mix system, the Patient-Driven Groupings Model (PDGM) and a new 30-day unit of payment in 2020. Each 30-day payment period qualifies for a full case-mix-adjusted payment if the number of visits in a period exceeds the low-utilization payment adjustment (LUPA) threshold.² As part of the agency's review of the impact of the first year of the new payment system, CMS compares the cost of an average non-LUPA episode in 2020 (which account for about 92 percent of periods) to the base rate in effect for that year. CMS estimates that the average 30-day non-LUPA period of care cost \$1,394.68 in 2020, while the base rate for 2020 was \$1,864.03.³ As a result, Medicare's base rate for 2020 was \$469.32, or 34 percent, greater than the estimated cost of care. CMS's finding of high payments in 2020 reflects the payment levels set by statute; the agency has no authority to adjust payments based on its analysis of cost reports.

Comment

CMS's analysis indicates that payment substantially exceeds the cost of care for the average period in 2020. The 34 percent overage is notable because the base payment rate for 2020 already reflected a reduction of 4.36 percent, implemented by CMS to offset HHAs' anticipated responses to the new payment system. Despite this adjustment, payments under the PDGM continue to be excessive, as they were under the previous home health case-mix system. The high payments for

¹ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

² Each of the 432 payment groups in the PDGM has a unique LUPA threshold, and the thresholds range from 2 to 6 visits.

³ The analysis utilized 2019 cost reports and 2020 claims data to estimate the cost of a 30-day non-LUPA period. Costs per visit were assumed to increase by 2.6 percent in 2020, the amount indicated by the home health market basket index.

non-LUPA periods weaken the incentive for efficiency under the prospective payment system (PPS). Though CMS lacks the authority under the BBA 2018 statute to re-base payments to bring them closer to the cost of care, this excess should be considered when the agency reviews the budget-neutrality requirements under BBA 2018 (the following section provides the Commission's view on this policy).

Adjusting the home health base payment rate to account for unexpected changes in spending under the PDGM

BBA 2018 requires CMS to analyze data for CYs 2020 through 2026, the period after implementation of the 30-day unit of payment and a new case-mix adjustment methodology, to determine how actual aggregate home health expenditures differed from the expenditures that would have occurred in the absence of the payment system changes. This analysis considers aggregate home health PPS payments for all periods (LUPA and non-LUPA), and it is separate from the payment-to-cost analysis of non-LUPA periods discussed in the previous section of this letter.

The statute requires CMS to increase or decrease the home health base rate to account for the difference in spending if the aggregate actual expenditures deviated from the expenditures expected under CMS's estimate. CMS has the authority to make permanent adjustments when it determines that an observed deviation from expected behavior will continue in future years. The statute provides the authority for temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year.

In this proposed rule, CMS presents an analysis that estimates the aggregate expenditures that would have occurred under the prior case-mix system if it had been in effect for 2020. To do this, CMS applied the 153-group payment system that was in effect in 2019 to the claims that were paid under the PDGM in 2020. The estimated aggregate expenditures under the 153-group system were lower than actual expenditures, indicating that Medicare would have spent less on home health care in 2020 had the prior case-mix system still been in effect.

Next, CMS computed how much lower the base rate for the 30-day PDGM system would need to be to bring expenditures under this system in 2020 equal to the amount it estimated would have been spent if the 153-group system had still been in effect. The analysis found that the PDGM base rate for 2020 was 6 percent higher than it should have been.

Based on this finding, CMS concludes that a temporary retrospective adjustment for CY 2020 and subsequent years is needed until a permanent prospective adjustment can be implemented. However, CMS notes that the statute provides for flexibility in the timing and amount of these adjustments. CMS also notes that stakeholders may have alternative methods for estimating the aggregate expenditures that would have occurred in the absence of the PDGM. Therefore, CMS does not propose to reduce the base payment amount for 2022 and solicits comments on the methods used in the agency's analysis.

Comment

The Commission strongly supports immediate implementation of the 6 percent reduction to lower home health spending to the budgetary target set by BBA 2018. As noted in our March 2021 report to Congress, Medicare has long overpaid for home health care, and lower payments would better align payments with costs. The method used by CMS for computing the budget-neutral amount is reasonable, as applying the case-mix system in effect prior to 2020 reflects how Medicare would have paid in the absence of the BBA 2018 changes. In applying the prior case-mix system to the claims for 2020, the method also incorporates the utilization and coding changes that occurred in this year. As the effect of the coronavirus public health emergency (PHE) is included in the estimated budget-neutral amount and actual home health expenditures, the method ensures that any difference between the two calculated spending amounts is not attributable to the PHE. This method results in an estimated spending level that is consistent with the statutory mandate to calculate the home health spending that would have occurred in the absence of the implementation of the PDGM.

A 6 percent reduction to the base payment should not raise payment adequacy concerns for HHAs; even with this reduction, payments for 2022 would still be slightly higher than the level recommended by the Commission. As mentioned earlier, in our March 2021 report to the Congress, we recommended that the 2022 base payment rate be reduced by 5 percent. We note that this recommendation was made before CMS released its analysis indicating that the base rate should be lowered by 6 percent. This suggests that per-period home health payments were higher in 2020 than the Commission anticipated. If CMS implemented the 6 percent reduction, the net change to home health payments under the proposed rule would be –4.3 percent, less than the reduction recommended by the Commission for 2022.⁴ In making our recommendation for the 2022 payment update, we concluded that a 5 percent reduction would not compromise beneficiary access to care or the quality of home health care they receive. Therefore, a smaller decrease of 4.3 percent should be sustainable.

In the proposed rule, CMS notes that, by delaying the reduction to the base payment rate, the agency may have to make larger adjustments in future years. We agree that delaying the reduction required by BBA 2018 could necessitate future reductions of a larger magnitude. CMS does not provide a justification for delaying the payment rate reduction, though the agency does indicate that it is seeking comment on its methodology for calculating excess payments. However, waiting to take action may be disruptive, as it will create uncertainty for HHAs about how CMS is enforcing the BBA 2018 budgetary limit and about the level of future home health payments. By implementing the reduction in 2022, CMS will forestall the need for larger reductions in future years, provide certainty about how the agency will enforce the budgetary requirements of BBA 2018, and ensure that Medicare spending for home health remains within the budgetary limits Congress intended.

⁴ The 4.3 percent would be the cumulative effect of the 1.8 percent payment update and the 6 percent reduction under the budget-neutrality requirement.

Calendar year 2022 PDGM case-mix weights

Under the PDGM, patients are assigned to a case-mix group based on clinical indications, functional status, timing of the home health period, and whether the patient used inpatient hospital or institutional post-acute care prior to the period. The standard 30-day period payment for a case-mix group is the product of multiplying the case-mix weight by the home health base payment rate.

CMS proposes to update the case-mix weights in the PDGM using data from 2020. CMS acknowledges that care in 2020 was disrupted by the PHE but asserts that it is appropriate to use data from this year because the incumbent weights were set using data from 2018, before the new system was in effect.

The functional status payment groups for the PDGM were set so that one-third of periods would be categorized into each of the low, medium, and high payment groups. In its review of coding for 2020, CMS notes that the share of periods coded with the highest level of functional severity (level of disability with walking, transferring, and other activities of daily living) increased from 33 percent of periods in 2019 to 42 percent in 2020. In contrast, many other measures of case mix in the payment system were unchanged, including the share of periods that were preceded by a hospital or institutional post-acute care stay and the share of periods that were preceded by a home health period.

Comment

The Commission concurs with CMS's proposal to use 2020 claims data to recalibrate the payment weights for the 2022 payment year. However, we note that the increase in the periods coded for the highest level of functional severity may reflect changes in home health agency coding practices. While functional severity of patients may change over time, and patients may not always be evenly split among the three functional categories, the 9 percentage point increase in the high category observed in 2020 is significant. In the past, the Commission has been concerned that assessment of functional severity may be susceptible to provider coding practices and thus may be a less reliable indicator of case-mix severity.⁵ The increase in 2020 may reflect some impacts from COVID-19, but it is notable that many other measures of case mix in the payment system were unchanged.

The re-weighting CMS has proposed for 2022 would reset the payment categories based on 2020 data, so that periods will again be evenly distributed across the three functional payment categories. Maintaining this distribution helps to ensure the accuracy of Medicare payments. We urge CMS to continue to update the functional categories in this manner in future payment years.

⁵ Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Expanding the Home Health Value-based Purchasing Program (HH VBP) model nationwide

The HH VBP model, currently operating in nine states, aims to improve the delivery of home health care services to Medicare beneficiaries by giving HHAs incentives to provide better quality care with greater efficiency. Beginning in CY 2018, HHAs in each of the nine states have their Medicare payments adjusted upward or downward based on their performance on a set of quality measures relative to other HHAs in their state. HHAs can earn points on whether they *achieve* certain performance or whether they *improve* performance compared to a baseline year. The pool of HH VBP dollars is funded by a payment withhold that has increased from 5 percent in 2018 to 8 percent in 2021. The initial rules of the program defined a starter set of measures including outcome measures collected in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies, patient experience survey measures from the Home Health Consumer Assessment of Health Providers and Systems (HH CAHPS), claims-calculated measures (e.g., *Acute Care Hospitalization: Unplanned Hospitalization during First 60 Days of Home Health*), and agency-submitted process measures.

In this proposed rule, CMS proposes to expand the HH VBP model, beginning January 1, 2022, to the 50 states, territories, and the District of Columbia, funded by a 5 percent payment withhold. Section 1115A(c) of the Social Security Act provides the Secretary with the authority to expand models on a nationwide basis if they meet certain criteria, including if the Secretary determines that the expansion is expected to either reduce spending without reducing quality of care or improve the quality of patient care without increasing spending. The third evaluation report of the program stated that the HH VBP model resulted in improved quality of care (i.e., consistently increasing total performance scores) and a reduction in Medicare expenditures through three performance years of the model (CYs 2016 to 2018).⁶

Due to the potentially destabilizing effects of the PHE on quality measure data in CY 2020, CMS proposes CY 2019 as the HH VBP baseline year (comparison year for scoring improvement) for the CY 2022 performance year/CY 2024 payment year and subsequent years. CMS may propose to update the baseline year for subsequent years of the HH VBP through future rulemaking.

Comment

The Commission has recommended that Medicare link payment to quality of care to reward accountable entities and providers for offering high-quality care to beneficiaries. Therefore, the Commission supports implementing the HH VBP nationwide. However, we support using national comparisons as opposed to state cohorts in the scoring methodology. Medicare is a national program. HHAs should thus be scored on how they perform compared to all other HHAs; the program's beneficiaries should have the expectation of uniform standards of care and outcomes, irrespective of the state in which they live.

⁶ Pozniak, A., M. Turenne, E. Lammers, et al. 2020. *Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model: Third evaluation report*. Prepared for the Centers for Medicare & Medicaid Services. Ann Arbor, MI: Arbor Research Collaborative for Health and L&M Policy Research.

In addition, we urge CMS to make two changes to the HH VBP based on the Commission's set of principles for how Medicare quality incentive programs should be designed.⁷ Our proposed changes are consistent with the design of our skilled nursing facility value incentive program (SNF VIP), which the Commission recently recommended to the Congress to replace the existing SNF VBP.⁸

First, the HH VBP should score a small set of outcome, patient experience, and value (e.g., resource use) measures that are not unduly burdensome for providers to report. As in our SNF VIP model, the HH VBP could score three claims-based measures of quality and resource use: all-condition hospitalizations within the HH stay, successful discharge to the community, and Medicare spending per beneficiary. Given that patient experience is a key measure of a provider's quality, the HH VBP should continue to score HH CAHPS measures. The measure set should be revised as other measures become available. In addition, agencies record and report functional assessment data through OASIS. Because this information affects payments for HHAs and the calculation of certain quality metrics, providers have an incentive to report the information in ways that raise payments and appear to improve performance. In a recent report to the Congress, we cite numerous examples of providers responding to financial incentives in how they report patients' function, so the assessment data becomes of questionable value for payment, quality measurement, and care planning.⁹ Therefore, though the Commission agrees that improving a patient's functional ability is a goal of home health care, we urge CMS not to include these OASIS-based measures of function (e.g., *Composite Change in Self-Care* and *Composite Change in Mobility*) in the HH VBP until their accuracy is improved.

Second, the HH VBP should use a scoring approach that awards points for achieved performance with minimal use of thresholds, or cliffs. We encourage CMS to move away from scoring improvement in the HH VBP, to only scoring achievement. Because using one continuous performance scale results in every HHA having an incentive to improve, the program does not need to score HHAs separately on whether they improved over time. Also, the HH VBP should have uniform beneficiary expectations for standards of care and outcomes.

If the HH VBP is implemented with the current model's measure set, CMS should consider how recent changes to the payment system affect scoring some of the measures. Two claims-based measures, *Acute Care Hospitalizations (ACH)* and *Emergency Department (ED) Use without Hospitalization*, are measured during the first 60 days of home health use in the baseline year and performance year (CY 2022 and future years). While we understand the rationale for not using 2020 as the baseline year, we encourage CMS to consider how the changes to the home health payment system from the 60-day unit under the previous case-mix system (in CY 2019) to the 30-

⁷ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁸ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁹ Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

day unit under PDGM (in CY 2020 and later) could affect home health agencies' scores on the ACH and ED use measures between the baseline and performance years. As described in the following section, we support moving to a *Home Health Within Stay Potentially Preventable Hospitalization* measure, which reflects the changes in the payment unit.

Revisions to the Home Health Quality Reporting Program (QRP)

CMS proposes to remove the *Drug Education on all Medications Provided to Patient/Caregiver* measure beginning with the CY 2023 HH QRP. CMS explains that HHAs' performance on this measure is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

CMS also proposes to replace the *Acute Care Hospitalization During the First 60 Days of Home Health* measure and *Emergency Department Use Without Hospitalization During the First 60 Days of Home Health* measure with the *Home Health Within Stay Potentially Preventable Hospitalization* (PPH) measure beginning with CY 2023. CMS's rationale is that the proposed PPH measure will better provide an assessment on HH quality by focusing on observation stays and acute hospitalizations that could be prevented by HHA intervention.

Comment

As noted above, the Commission asserts that Medicare quality incentive programs should use a small set of outcome, patient experience, and value measures that are not unduly burdensome to assess the quality of care. Process measures are burdensome on providers to report, while yielding limited information to support clinical improvement. Therefore, the Commission supports removing the "topped out" process *Drug Education on all Medications Provided to Patient/Caregiver* measure from the QRP.

We also support CMS including the PPH measure in the QRP for three reasons. First, it is a claims-based outcome measure consistent with the Commission's principles for quality measurement. Second, it is a more complete measure of hospital events because it counts observation stays along with acute hospitalizations. From the beneficiary's perspective, observation stays may be indistinguishable from an inpatient admission. The Commission has recently begun reporting hospitalization within-stay measure rates across post-acute settings, which also capture observation stays along with acute hospitalizations. Third, the measure captures hospital use during the stay, as opposed to the first 60 days, which reflects the change to the home health payment system from a 60-day unit of payment to a 30-day unit of payment.

Conclusion

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

Chiquita Brooks-LaSure

Administrator

Page 9

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

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Chernew", with a horizontal line extending to the right from the end of the signature.

Michael Chernew, Ph.D.
Chair

MC/ec