MEDPAC Medicare Payment Advisory Commission

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August 30, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1711-P

Dear Ms. Verma:

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 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements," *Federal Register*, vol. 84, no. 138, p. 34598 (July 18, 2019). 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 comment addresses proposals in the rule related to Medicare payment policies for home health agencies (HHAs), including:

- Calendar year (CY) 2020 national standardized 60-day episode payment rates;
- Rural add-on payments for CYs 2019 through 2022;
- Changes to payment for therapy and the unit of payment mandated by the Bipartisan Budget Act of 2018;
- Implementation of the Patient-Driven Groupings Model (PDGM) in 2020;
- Determination of the base rate for the 30-day unit of payment; and
- Revisions to the discharge-to-community quality measure used in the home health quality reporting program.

We also comment on proposed changes to Medicare's payments for home infusion therapy services.

Proposed CY 2020 national standardized 60-day episode payment rate

The proposed rule would implement a 1.5 percent update to the base payment rate for HHA services, as required by the Bipartisan Budget Act of 2018.

Comment

The Commission recognizes that CMS must provide the statutorily mandated payment update but notes that this increase is not warranted based on our analysis of payment adequacy. The Commission reported margins of 15.2 percent in 2017 for freestanding HHAs. The increase in payments under this rule will raise agency margins even higher, widening the gap between Medicare's payments for home health care and the actual cost of care. These additional expenditures will further strain the finances of Medicare beneficiaries and the program.

In our March 2019 report to Congress, the Commission recommended that, for the 2020 payment year, the Congress should reduce the calendar year 2019 Medicare base payment rate for home health agencies by 5 percent.[1] We believe this reduction is necessary to better align Medicare's payments with the actual costs of HHAs. The Commission recognizes the 1.5 percent increase proposed by CMS is required by law but notes that it will widen the gap between Medicare's payment for home health care and the average costs of providers.

Proposed rural add-on payments for CYs 2019 through 2022

The proposed rule would implement the second year of the home health rural payment add-on required by the Bipartisan Budget Act of 2018 (BBA of 2018). The Act established three categories of rural counties and ties the duration and size of the payment add-on for each category to the population density and utilization levels within these areas. CMS used Medicare data on patient location and service utilization from 2015 for the computation and established the following categories:

- ***High-utilization counties***. Rural counties in the top quartile of per capita utilization for all (urban and rural) counties in 2015, or those with 17.8 episodes or more per 100 beneficiaries, were classified as high-utilization areas. Services furnished in these counties will receive a payment add-on of one-half percent in 2020.
- ***Low-population counties.*** Episodes provided in areas with a population density of six individuals or fewer per square mile and that are not high-utilization counties will receive a 3 percent add-on in 2020.
- ***All other counties.*** Rural counties that are not categorized in either of the above categories would receive a 2 percent add-on in 2020

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These designations remain in effect until 2022.

[1] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Comment

The rural payment add-on policy for 2020 is an improvement over prior policies because it better targets Medicare's scarce resources. In general, MedPAC has not found systemic issues with rural access to care, and margins of rural home health agencies are generally above 10 percent per year, comparable to urban agencies. Average utilization is not significantly different between urban and rural areas, but there is some variation around this average, with high- and low-use areas found in both urban and rural counties. The proposed policy targets payments to areas with lower population density and limits payments to rural areas with higher utilization. This is consistent with the findings in our June 2012 report to the Congress, which noted that Medicare should target rural payment adjustments to areas that may have access challenges.

Changes to payment for therapy and the unit of payment mandated by the Bipartisan Budget Act of 2018

The rule proposes to implement two policies the BBA of 2018 requires in 2020: (1) the elimination of the number of therapy visits provided in a home health episode as a payment factor in the home health prospective payment system (PPS) and (2) a 30-day unit of payment. Both policies were proposed by CMS in last year's home health payment rule.

The statutory requirement to eliminate therapy visits will give a greater role to patient characteristics in setting payment for home health services. The number of therapy visits per episode has increased significantly since the home health PPS was implemented, raising concerns that financial incentives to provide more therapy were influencing patient care. CMS has made several attempts to reduce the incentives to provide more therapy under the current system, such as reducing payments for episodes with greater numbers of therapy visits. However, the share of episodes qualifying for additional payment has continued to increase.

In last year's notice of proposed rulemaking, CMS proposed the 30-day unit of payment period to better align the unit of payment with utilization trends, noting that most episodes last fewer than 60 days, with 25 percent of episodes in 2016 complete by 30 days. CMS found that, in general, the number of visits declines with time, with the first 30-day period of the episode having a higher average number of visits than the second 30-day period. In addition, CMS found that the predictive ability of case-mix factors was higher for 30-day periods than for the current 60-day episodes.

Comment

We support the elimination of therapy as a payment factor. For many years, MedPAC has been concerned about the incentives created by the use of therapy as a payment adjuster, a concern that has been echoed by other federal oversight agencies. Including therapy as a payment factor in the PPS creates a financial incentive that can distort the care delivered to beneficiaries, causing HHAs to favor these services because of the higher payments. We recommended eliminating the therapy

adjustments in our March 2018 report to the Congress and in several prior reports.[2] Consistent with the Commission's recommendation, the alternative system proposed by CMS would increase the role of patient characteristics in setting payment, thereby reducing a significant vulnerability in the current system.

CMS should closely monitor the impact of moving to the 30-day unit of payment. As CMS notes, many episodes end before the 30th day. HHAs would now have an incentive to, when feasible, extend services past the 30th day to trigger an additional 30-day period and the resulting payment. Though CMS requires that agencies provide a certain number of visits to receive the full case-mix-adjusted episode payment, agencies might need to provide only a few additional visits to surpass the threshold.

Implementation of the Patient-Driven Groupings Model (PDGM) in 2020

CMS proposes to implement the PDGM in the home health PPS for CY 2020, consistent with the policy it proposed last year. The PDGM categorizes 30-day episodes into 432 payment groups based on the following characteristics:

- ***Episode timing.*** Services in the first 30 days of a spell of home health would be classified as "early," while services in the subsequent 30-day periods would be classified as "late." For example, if a beneficiary had two consecutive 60-day payment episodes under the current system, the first 30-day period would be classified as early, while the three subsequent 30-day periods would be classified as later 30-day periods under the proposed system.

- ***Referral source.*** Cases would be categorized based on the services received prior to the beginning of the episode: prior hospitalization or institutional post-acute care (PAC), or admission from the community. Episodes with a prior hospitalization or institutional PAC stay receive higher payments, reflecting the higher average service use of these patients.

- ***Clinical category.*** The new system would create 12 clinical categories based on patients' reported conditions: need for musculoskeletal rehabilitation; neuro/stroke rehabilitation; wound care; behavioral health care; complex care; and seven clinical subcategories for medication management, teaching, and assessment (surgical care, cardiac and circulatory, endocrine, gastroenterology/genitourinary, infectious disease, respiratory, and other).

- ***Functional/cognitive level.*** Similar to the existing system, the PDGM would classify patients' cognitive and physical functioning using information from the Outcome and Assessment Information Set (OASIS) home health patient assessment.

[2] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

- ***Presence of comorbidities.*** CMS proposes to adjust payment for commonly occurring comorbidities in home health care. There would be a three-tiered adjustment for all selected comorbidities.

Comment

The PDGM and the 30-day unit of payment will be the most significant changes to the home health PPS since the system was implemented in 2001. The new case-mix system is intended to be less complex than the current system, while accurately describing a beneficiary's primary need for home health care.

The PDGM would use hospital or institutional PAC use in the 14-day window before admission to home health care to set payment; Medicare would pay more for cases with prior use of these services than for cases without them. CMS notes that this adjustment is consistent with patterns of service in home health care, as patients discharged from the hospital or institutional post-acute care average more visits than those admitted from the community. The adjustment would better align payments to costs, and without such an adjustment Medicare would relatively underpay post-hospital cases and relatively overpay for community-admitted episodes.

However, adjusting payment to reflect prior hospitalization also creates an incentive that would need to be carefully balanced. Though the higher payments compensate for the additional visits required for a post-hospital home health episode, they also may dilute incentives for HHAs to avoid readmissions for patients while they are in home health care. The payment adjustment for post-hospital episodes will increase payment by hundreds of dollars per episode (though the exact amount will vary by episode type). If a beneficiary is hospitalized while under an HHA's care, Medicare's payment for subsequent home health episodes—likely provided by the same agency—will be substantially higher. In contrast, in CMS's value-based purchasing (VBP) demonstration, only a fraction of the incentive is tied to hospitalization rates; six percent of an agency's total Medicare payments will be tied to quality, and the rate of hospitalization is only 1 of the 16 quality measures that influence a provider's payment under VBP (CMS has proposed to remove one measure, discussed below). Though agencies will generally seek to minimize hospitalizations, CMS should be attentive to the magnitude of the relatively large positive payment adjustment in the PDGM for post-hospital cases, compared to the relatively small penalty the current VBP ties to HHA hospitalization rates. Assigning more weight to the hospitalization measure in the VBP demonstration would reduce the magnitude of the disparity between these two payment adjustments and encourage better care.

Determination of the base rate for the 30-day unit of payment

The BBA of 2018 requires Medicare to set the base rate for 30-day home health episodes in a budget-neutral manner. The statute requires CMS to account for expected changes in coding or other HHA practices when setting the base rate for 2020. CMS details three behavioral responses by HHAs that it estimates could result in an 8.01 percent increase in case mix unrelated to patient severity in 2020:

- CMS assumes that HHAs will slightly increase the number of visits in an episode to qualify for a full-episode payment. Medicare currently makes a low-utilization payment adjustment (LUPA) for episodes with four or fewer visits. LUPA payments in 2016 averaged $408 per episode, compared with $2,998 for a full episode. In the new system, the LUPA threshold would vary based on payment group, from two to six visits. CMS assumes that visits will increase for about one-third of episodes that are one or two visits below the new thresholds. More episodes would qualify for the higher-paying full episode payment as a result of this behavioral change, and CMS estimates this would increase average payment per episode by 1.86 percent.

- CMS assumes that more frequent reporting of secondary diagnoses will result in additional episodes qualifying for the comorbidity payment adjustment in the PDGM. The OASIS patient assessment instrument, which allows HHAs to report up to five secondary diagnoses, was the data source for constructing the new case-mix system. Medicare will make payments based on administrative claims HHAs submit, and claims allow providers to report up to 24 secondary diagnoses. CMS estimates that the average payment per episode will increase by 0.37 percent because of the additional secondary diagnoses that HHAs can report on the claim.

- CMS assumes that HHAs will change coding practices to more frequently report primary diagnoses that result in assignment to higher-paying clinical categories, and this will raise payments by 5.91 percent per episode.

Accounting for the behavioral adjustment above, CMS estimates that in 2020 the 30-day base rate would equal $1,791.73. CMS estimates that the average 30-day episode will cost $1,577.52 in 2020, resulting in payments that exceed costs by 14 percent.

The BBA of 2018 requires CMS to analyze data for CYs 2020 through 2026, the period after implementation of the 30-day unit of payment and new case-mix adjustment methodology, to determine how actual aggregate home health expenditures differ from the expenditures expected under the assumed behavior changes. 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 deviate from the expenditures expected under CMS's assumptions. 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. For example, if CMS identified an overpayment or underpayment in 2020 during a review in a later year, it would adjust payments in a future year to recover or repay any amounts due.

Comment

The significant changes to the unit of payment and the case-mix system proposed for 2020 will likely lead to extensive changes in agency practices. The past experiences of the home health PPS

demonstrated that HHAs change coding, utilization, and the mix of services provided in reaction to new payment incentives. For example, when CMS implemented revisions to the home health case-mix system in 2008, subsequent analysis found that behavioral responses unrelated to patient severity caused payments to increase by 4 percent in that year—despite having increased only 1 percent per year, on average, between 2001 and 2007. CMS continued to find nominal increases in case mix unrelated to patient severity in later years and reduced payments by an average of 1.8 percent a year from 2008 through 2017 to account for this trend. The proposed episode payment reduction of 8.01 percent appears to be consistent with past trends in coding that CMS has reported.

The analysis of payments and costs in the proposed rule suggests that payments will be more than adequate in 2020. CMS estimates that even with the reduction proposed for 2020, aggregate payments will be 14 percent greater than costs; the excess above costs would be even greater without the reduction proposed by CMS. MedPAC reported margins of 15.2 percent in 2017 for freestanding home health agencies and projected margins of 16 percent for 2019. These substantial margins suggest that, even if the coding behaviors CMS expects do not occur, many HHAs will be able to absorb the 8.01 percent payment reduction and still have adequate margins.

In addition, the proposed adjustment may not represent all of the behavioral changes that could occur. Agencies could respond to the new 30-day unit of payment by providing additional visits after an initial 30-day episode, which would trigger an additional 30-day payment. Additional episodes in response to the shorter unit of payment would result in higher aggregate payments. CMS should therefore examine volume trends under the new system. If episode volume attributable to the incentives of the new system increases spending above the amount that CMS expects would have occurred in the absence of the system, CMS should reduce payments to reflect this excess.

Revisions to the discharge-to-community quality measure

As part of the Home Health Quality Reporting Program (QRP), CMS calculates a risk-adjusted rate of fee-for-service beneficiaries discharged to the community from a home health stay who do not have a subsequent hospital readmission and who remain alive during the following 31 days. It is a measure of whether a provider keeps its patients and—in the case of nursing facilities, its residents—out of the hospital and alive after returning from a preceding hospitalization. CMS proposes to exclude patients who were nursing facility residents before a home health stay from the measure calculation because they are not expected to return to the community following their stay.

Comment

The Commission maintains that Medicare quality measures should be patient oriented, encourage coordination across providers and time, and promote improvement in the delivery system. Medicare quality programs should include population-based outcome measures that are not unduly burdensome for providers. For example, measures that can be calculated by CMS using claims data represent a low level of provider burden. In principle, therefore, the Commission supports the inclusion of a discharge-to-community measure in the QRP. The Commission also supports CMS implementing uniform quality measures across PAC settings. However, the Commission does not

support CMS's proposal to remove baseline nursing home residents from the measure sample for this uniform PAC quality measure. Rather, the Commission supports expanding the definition of "return to the community" to include nursing home residents returning to their residence—that is, the nursing home where they live. Further, providers should be held accountable for the quality of care they provide for as much of their Medicare patient population as feasible.

Payment for home infusion therapy services

Beginning in 2019, Medicare added coverage of home infusion therapy services for certain drugs. Through the durable medical equipment (DME) benefit, Medicare Part B has historically covered a small group of drugs administered in the home with a DME-covered infusion pump. In these circumstances, the DME benefit covers the drug, infusion pump, and supplies associated with home infusion. The DME benefit does not cover nursing or other professional services. In 2019, Congress expanded Medicare coverage to include home infusion therapy services, which are defined as professional services including nursing services, training and education (not otherwise paid for under the DME benefit), and monitoring services. Coverage of home infusion therapy services is limited to the small group of drugs administered with a DME-covered infusion pump.

Transitional system (2019–2020)

The Bipartisan Budget Act of 2018 established transitional payments for home infusion therapy services in 2019 and 2020. The statute grouped home infusion drugs into three categories:

- ***Category 1:*** mix of different types of medicines (e.g., cardiovascular, anti-infectives, pain medications, and certain other products)
- ***Category 2:*** immune globulin
- ***Category 3****:* chemotherapy

The statute crosswalks each of these three categories to different drug administration Current Procedural Terminology (CPT) codes and sets the payment rate for home infusion therapy services equal to the rates that would be paid for 4 hours of infusion under the physician fee schedule (PFS). Payment is made for each infusion drug administration calendar day, which CMS defines as a day when home infusion therapy services are furnished by a skilled professional in the individual's home on the day of an infusion.

Home infusion therapy payment system (2021 onward)

The 21st Century Cures Act establishes a payment system for home infusion therapy services beginning 2021. The unit of payment remains the same as the transitional system: an infusion drug administration calendar day. This means that payment for home infusion therapy will be made only when a nurse or other skilled professional is in the patient's home on the day of an infusion.

Different from the transitional system, the statute gives CMS some flexibility on how the payment rates are established. The statute specifies that the payment amount cannot exceed the amount that would have been paid if the infusion had been furnished in a physician's office and cannot exceed the PFS payment for 5 hours of infusion. The statute permits CMS to adjust the payment amount to reflect patient acuity and complexity of drug administration.

For 2021, CMS proposes to continue using the three payment categories and CPT code crosswalk established under the transitional system. CMS proposes to increase payment rates, pegging them at levels equivalent to 5 hours of infusion under the PFS (instead of 4 hours under the transitional system). CMS also proposes to pay a higher rate for the first home infusion therapy visit and a lower rate for subsequent visits to reflect the higher first-visit costs associated with patient education and training. CMS would increase the payment rate for the first visit using the ratio of the PFS payment for physician evaluation and management services for a new patient versus an established patient.

Comment

We are concerned that CMS is proposing to increase the payment rates for home infusion therapy—from the equivalent of a 4-hour infusion to a 5-hour infusion under the PFS—without evidence that the current rates are inadequate. In support of its proposal, CMS states that home care does not benefit from the same economies of scale as a physician's office. CMS also notes that the home infusion payment reflects a bundle, covering an in-home visit as well as services furnished between visits. However, these points are also true under the current transitional system, and they do not establish why 5 hours is a more appropriate payment benchmark than the current 4 hours. In addition, CMS states that "some patients require more care coordination or longer visits and paying the maximum amount allowed by statute acknowledges the varying care needs of each individual patient within each category." We do not believe that increasing the aggregate level of payment to the maximum level permitted by statute is an appropriate approach for addressing variation in costs across patients.

We urge CMS to reconsider its proposal to use 5 hours as the basis of payment for home infusion therapy services, unless it can provide evidence that the current rates are inadequate. We encourage CMS to consider other approaches to address variation in costs such as developing a payment adjuster for patient acuity or complexity of drug administration. Alternatively, the statute gives CMS the option of establishing a system of outlier payments. Although in our view it may be premature to develop a system of outliers, developing such a system would be preferable to increasing aggregate payments for the purpose of addressing cost variation.

With respect to CMS's proposal to maintain the three payment categories, we encourage the agency to do further analysis to consider whether modifications to these categories would be appropriate. The statute requires that CMS establish single payment amounts for types of infusion therapy, taking into account variation in utilization of nursing services by therapy type. CMS's rationale for continuing use of the three categories is that doing so would maintain consistency with an already established system and make for a smooth transition. CMS states that because the

three categories have different payment amounts, they reflect variation in nursing for the different types of therapy. However, according to a CMS contractor report, members of CMS's Home Infusion Technical Expert Panel indicated that the three categories do not always group products with similar complexity together. [3] Data will soon be available that could permit CMS to evaluate the three categories. In 2019, home infusion therapy providers are required to report on claims the length of nurse visits furnished, and we would expect that data would be available for next year's rulemaking. We urge CMS to use that information in next year's proposed rule to consider whether modifications to the three categories are appropriate for 2021.

We support CMS's proposal to pay a higher rate for the first home infusion therapy visit and a lower rate for subsequent visits. We believe it is reasonable to expect that the first home infusion therapy visit will have higher costs associated with patient education and training on the infusion process and self-monitoring. As noted above, claims data are expected to be available on the visit time associated with furnishing home infusion therapy for next year's rulemaking. We encourage CMS to examine these data as it considers setting an appropriate payment rate for the first visit versus subsequent visits.

Finally, we reiterate our comment from last year supporting CMS's definition of an "infusion drug administration calendar day" as: a day when home infusion therapy services are provided by skilled professionals in the individual's home on a day of an infusion drug administration. Given that the level of payment for an "infusion drug administration calendar day" is generally similar to or higher than the payment rate for a home health nurse visit, we believe it is reasonable to conclude that this level of payment requires an in-home nurse visit.

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 James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

Francis J. Crosson M.D.

Francis J. Crosson, M.D.
Chairman

[3] Abt Associates. 2018. Summary of the Home Infusion Technical Expert Panel meeting and recommendations. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Downloads/2018-10-10-TEP-Slides-Summary.pdf.