MEDPAC | Medicare Payment Advisory Commission

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Michael E. Chernew, Ph.D., Chair
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August 22, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1803-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 Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies," *Federal Register*, vol. 89, no. 128, p. 55312 (July 3, 2024). We appreciate your staff's efforts to administer and improve the Medicare program for beneficiaries, taxpayers, and providers, particularly given the considerable demands on the agency.

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

- Proposed CY 2025 home health payment update
- Proposed CY 2025 permanent and temporary budget-neutrality adjustments
- Plan of care development and scope of services home health patients receive
- Proposed adoption of the core-based statistical area (CBSA) delineations for wage index

Proposed CY 2025 home health payment update

CMS proposes a 2.5 percent update to the base payment rate for HHA services. This increase reflects payment adjustments mandated by statute: a 3.0 percent home health market basket update for 2025 reduced by the multifactor productivity adjustment of 0.5 percent.

Comment

The Commission recognizes that statute requires CMS to update the home health PPS by the market basket minus an adjustment for productivity. But we note that this increase is not warranted based on our most recent assessment of Medicare fee-for-service (FFS) payment adequacy. In our March 2024 report to the Congress, the Commission assessed the adequacy of Medicare's FFS payments under the home health PPS (including beneficiaries' access to care, quality of care, and financial indicators for the sector) and recommended that the Congress reduce the 2024 FFS Medicare base payment rate for HHAs by 7 percent for the 2025 payment year.[1] The Commission found that freestanding HHAs had a historically high aggregate FFS Medicare margin of 22.1 percent in 2022, indicating that payments far exceeded costs.

CMS's proposed payment update would be offset by a budget-neutrality adjustment required by the Bipartisan Budget Act of 2018 (BBA 2018) discussed below. Thus, the net update to the 2025 home health base rate would be –1.5 percent, far less than the reduction recommended by the Commission. We also note that, in this proposed rule, CMS reported that the home health PPS base payment rate for 2023 exceeded the estimated cost of a typical 30-day period by 32 percent.[2] In addition to increasing FFS Medicare expenditures, these excess payments increased the benchmarks used to set payments for Medicare Advantage plans and raised the Part B premium paid by Medicare beneficiaries. In addition, the relatively high payments undermine incentives for HHAs to furnish care efficiently. Given these excess payments, a 1.5 percent reduction to the base rate in 2025 would not compromise beneficiaries' access to care or the quality of home health care they receive; indeed, a reduction of this magnitude will likely leave payments above HHA costs.

Proposed CY 2025 permanent and temporary budget-neutrality adjustments

BBA 2018 required CMS to change the unit of payment in the home health PPS from 60 days to 30 days, and it also mandated the payment system no longer use the number of therapy visits provided during the 30-day period as a payment factor. BBA 2018 required CMS to implement these changes on a budget-neutral basis, such that spending in 2020 through 2026 would be the same as it would have been if the changes had not been made.

The statute required CMS to increase or decrease the home health base payment rate to account for the difference in spending if the aggregate actual expenditures deviated from the agency's estimate of what expenditures would have been under the pre–BBA 2018 payment system. CMS is required to make permanent adjustments to the home health base payment rate when the agency determines that an observed deviation from expected behavior will continue in future years.

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[1] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[2] CMS's estimate excludes "low-use" periods that had relatively low numbers of home health visits.

In the CY 2025 proposed rule, CMS notes the history of the permanent adjustments and updated its analysis with an additional year of home health claims data:

- In the CY 2023 HH PPS final rule, CMS assessed home health claims for 2020 and 2021 and determined a permanent adjustment of −7.85 percent was needed; however, the agency implemented only half (−3.925 percent) of the required reduction.

- In the CY 2024 HH PPS final rule, CMS updated its analysis with 2022 claims data and determined a permanent adjustment of −5.78 percent was needed, but again implemented only half (−2.890 percent) of the amount required to meet its target.

In the proposed rule, CMS updates the budget-neutrality target using 2023 home health claims and reports that the base rate in 2025 needs to be reduced by an additional 1.125 percent to meet the BBA 2018 budget-neutrality target. CMS proposes a permanent adjustment to the 2025 base rate of −4.067 percent to account for the lower-than-required reductions made to the base rate in previous years and the additional −1.125 percent indicated by the analysis of 2023 home health claims. The permanent adjustment of −4.067 percent would adjust for overpayments that are expected to occur in 2025 and beyond.

The statute also requires CMS to implement temporary (one-year) adjustments when it identifies overpayments or underpayments that occurred in a prior year. The proposed rule updates CMS's estimate of the temporary reduction required to meet the BBA 2018 budget-neutrality target to include an additional year of claims data and finds that home health spending in 2020 through 2023 was $4.445 billion higher than the target. CMS indicates that the agency will address those prior overpayments in future rulemaking.

Comment

The Commission strongly supports the proposed permanent adjustment to the 2025 base payment rate of −4.067 percent, an adjustment that is required by law to ensure that home health spending in future years is the same as it would have been if the Patient-Driven Groupings Model (PDGM) system had not been implemented. The permanent reduction to the base rate proposed by CMS is lower than the update recommended by the Commission (−7 percent) as sufficient to maintain beneficiaries' access to care. As noted above, after applying CMS's proposed update of 2.5 percent, the net adjustment to the base rate of −1.5 percent would leave FFS Medicare home health payment levels well above the cost of providing care to beneficiaries.

CMS has not yet indicated the policy or timing for implementation of the required $4.455 billion temporary adjustment, and it would be appropriate for CMS to make public its planned approach for implementing the temporary adjustment as soon as possible. As the net −1.5 percent adjustment proposed by CMS is less than the update recommended in our March 2024 report to the Congress, the Commission encourages CMS to begin the reductions required by the temporary adjustment as soon as possible. Taking this action would better align payments with costs and also reduce the temporary reductions necessary in future payment years.

Plan of care development and scope of services home health patients receive

In the proposed rule, CMS seeks information about the current operational practices of HHAs and health care providers that order and supervise home health care services to better understand how these practices may affect patient access to home health care. The rule notes that CMS has received anecdotal reports that beneficiaries have experienced difficulty finding an HHA to provide services, and that in some instances home health care services are being altered or reduced without adequate justification. The rule also notes some reports that claim patient acuity at hospital discharge has been increasing.

The rule requests comments from stakeholders on the factors that HHAs consider when determining the services they offer to beneficiaries; any issues that limit the capacity of HHAs to serve beneficiaries (such as a rural location or staffing challenges); and the role of ordering physicians and other allowed ordering practitioners in determining the mix, frequency, and duration of home health care services. The rule also asks for comment on the experience of patients receiving home health care services (and their caregivers), and requests suggestions for improving the home health referral process and for safeguarding patient access to care. CMS indicates that this information will be used to inform future policymaking.

Comment

The Commission strongly supports the goal of ensuring access to care for Medicare beneficiaries. In our March 2024 report to the Congress, we noted several factors indicating that Medicare FFS payments are sufficient to ensure that beneficiaries have adequate access to home health care:[3]

- In 2022, over 98 percent of FFS Medicare beneficiaries lived in a ZIP code served by at least two HHAs, and 88 percent lived in a ZIP code served by five or more HHAs.
- The share of home health stays reported as being initiated in a timely manner (within three days of hospital discharge or a signed physician order) was 96 percent for the 12-month period ending September 30, 2022—a slight increase from prior years.
- The share of FFS Medicare inpatient hospital discharges that were followed by at least one 30-day home health period declined slightly to 18.7 percent in the first 10 months of 2022 relative to the prior year but remained higher than the rate in 2019.

While our access-to-care indicators were positive, we are aware of the reports that CMS cites and are sensitive to the concern that there may be geographic areas or patients with

[3] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

specialized care needs. The Commission will review responses to CMS's request for information to identify issues that may warrant future analysis.

The Commission will provide an analysis of home health access to care in our March 2025 report to the Congress. The Commission will also assess the effect of the PDGM on FFS beneficiaries' access to home health care as part of a Congressionally mandated report due March 15, 2026.[4] We plan to examine changes in home health use, number of visits provided during a home health stay, and duration of services for FFS beneficiaries overall and for FFS beneficiaries with selected clinical and demographic characteristics. While our current indicators do not signal any general issues with home health access, the mandated report will analyze changes in the patterns of care after the implementation of PDGM.

While the request for information does not address payment policy, we note that adequate payment for home health care services is also an important factor in ensuring access to care, and the Commission found that freestanding agencies had FFS Medicare margins in excess of 20 percent in 2022. These high margins indicate that, in aggregate, FFS Medicare has the resources within current payment levels to cover the costs of care, even for beneficiaries with very high costs.

Proposed adoption of the CBSA delineations for wage index

Since the start of the HH PPS, CMS has used general acute care hospital wage data to develop the HH PPS wage index. For the 2025 payment year, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

CMS also proposes to:

- update the wage index with newer wage data and Office of Management and Budget (OMB) revisions to the delineations of metropolitan statistical areas (MSAs) and CBSAs; and
- continue its policy of capping the wage index decrease a provider can experience in a given year at 5 percent.

Comment

The Commission supports CMS's annual process to update the HH PPS wage index with newer wage data and OMB revisions to MSA and CBSA delineations. The Commission also supports having a policy to cap and phase in the wage index reductions that a provider can experience in a given year. We continue to urge CMS to apply a cap to the wage index increase that a provider can experience in a given year as well.

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[4] BBA 2018 requires MedPAC to assess the impact of the implementation of the 30-day period for home health on access to care, quality of care, and financial performance.

However, the Commission has long been concerned with flaws in the wage index system that CMS uses to adjust HH payments to reflect geographic differences in labor costs.[5] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, home health agencies), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.[6]

We urge the Secretary to use existing authority to adopt the Commission's recommended approach for HHAs.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[5] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[6] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.