MEDPAC Medicare Payment Advisory Commission

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August 26, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1450-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-1450-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "Medicare and Medicaid program; home health prospective payment system rate update for calendar year 2014, home health quality reporting requirements, and cost allocation of home health survey expenses." We appreciate your staff's work on this rule, particularly given the competing demands on the agency.

The rule proposes to decrease the base payment rate for home health agencies by 1.5 percent in 2014, a product of a 2.4 percent payment update reduced by a -3.5 percent rebasing adjustment and a half-percent payment reduction due to proposed changes in the PPS grouper. In this letter we comment on the rebasing adjustment, proposed changes to the home health grouper, and changes to quality reporting requirements for home health agencies.

Proposed rebasing for 2014 and later years

The 2014 rule included a provision of the Patient Protection and Affordable Care Act (PPACA) intended to lower home health payment rates that typically have been well above providers' costs. PPACA requires adjustments to be made in equal amounts over a 4-year transition and completed by 2017. The law sets a maximum adjustment of 3.5 percent a year. This annual adjustment is in addition to the payment update for each year.

CMS proposed separate rebasing adjustments for the three types of payments Medicare makes under the home health PPS: case-mix adjusted 60-day episode payments for episodes with 5 or more visits, low utilization payment adjustments (LUPA) for 60-day episodes with fewer than 5 visits, and a case-mix adjusted payment for non-routine supplies (NRS) covered under the home health PPS.

The calculation of the estimated costs relied on cost reports from 2011, and CMS made several adjustments to estimate costs for 2013 from this data.[1] Most notably, CMS audited the cost report data to ensure the accuracy of this information for the rebasing calculation, and the review concluded that agencies overstated their costs by an average of 8 percent in 2011. CMS did not adjust the cost per visit amounts to reflect this finding, and notes that the rule likely overestimates the average cost per episode as a result.

With these data CMS determined the estimated relationship of payments to costs in 2013 for each of the three payments, and then set annual rebasing factors to adjust the rates as warranted over the four-year period beginning in 2014. CMS concluded that payments were 13.63 percent in excess of cost for the 60-day episode payment, which would require a 3.6 percent reduction in the payment rate in each of the four years. The proposed annual reduction for the 60-day episode payment was set at the highest permitted rate of 3.5 percent. The average payment per episode for NRS exceeded costs by 9.92 percent, for a proposed annual reduction of 2.58 percent in 2014 through 2017.

In contrast, CMS found for the LUPA episodes that the average payment per visit in 2013 was significantly lower than costs, by 20 to 33 percent. The rule proposed to increase these rates by the maximum of 3.5 percent allowed by PPACA in 2014 and later years.

MedPAC has several concerns about the home health benefit, including the undefined nature of the benefit, the lack of beneficiary cost-sharing leading to potential overutilization, and the high profitability. The Commission acknowledges the action Congress and CMS are taking to begin to address Medicare's high payment rates, but it is concerned that margins may remain too high under the proposed rebasing. In past Reports to Congress we have noted that Medicare home health profit margins for freestanding agencies have averaged over 17 percent a year since the PPS was implemented in 2001.[2] CMS' recent audit findings potentially suggest that our past estimates of agency profitability may be too low and the urgency of the need to lower payments even greater then we previously concluded. These high margins, whether they averaged 17 percent or higher, did little to benefit patients and represented unnecessary Medicare spending financed by taxpayers and Medicare's beneficiaries.

MedPAC has concerns that the rebasing called for in PPACA will ultimately be too modest and leave agencies with substantial profit opportunities. The PPACA calls for the annual rebasing adjustment to be offset by the payment update for each year in 2014 through 2017. Over this period, the payment update will increase by 2.3 to 2.7 percent a year, offsetting much of the proposed rebasing reduction for 60-day episodes.[3] The positive impact of the annual payment

[1] The final file included 6,252 freestanding and provider-based home health agencies from an original sample of 10,327 agencies. Agencies were dropped for having anomalous or missing data, significant changes in key parameters compared to the prior year, statistical outlier values for certain parameters or having errors in reporting that raised questions about the accuracy of the data.

[2] All of the Medicare margins discussed in this letter were computed before CMS conducted its audit of cost reports. Though the audit suggests our estimates may have substantially understated financial performance, we use our previously reported estimates to be consistent with prior reports.

[3] This discussion focuses primarily on the impacts on the 60-day episode payments because they constitute over 95 percent of home health spending.

updates will raise payments by 10.6 percent over the 2014 through 2017 period, offsetting most of the 13.3 percent payment reduction for 60-day episodes resulting from re-basing. The cumulative net payment reduction after four years of rebasing will equal 4 percent.

Table 1. Impact of PPACA rebasing on payments for non-LUPA 60-day episodes

	2014	2015	2016	2017	Cumulative change
Proposed rebasing adjustment	-3.5%	-3.5%	-3.5%	-3.5%	-13.3%
2014 wage index budget neutrality factor	0.17%				0.17%
Legislated payment update	2.4%	2.3%	2.7%	2.6%	10.5%
Net annual payment reduction	-1.0%	-1.2%	-0.9%	-1.0%	-4.0%

Note: Based on December 2012Q4 forecast of home health market basket. Annual and cumulative impacts of payment changes are multiplicative. Does not include impact of half-percent reduction in 2014 due to proposed changes to the home health grouper.

The re-basing reductions are smaller than reductions implemented in 2010 through 2013, a period when the base rate was reduced by 7.6 percent. The four-year cumulative effect of the PPACA rebasing reduction is smaller than the 5.2 percent one-year payment reduction that occurred in 2011.

A re-basing reduction of 1 percent in 2014 will likely do little to reduce home health agencies' profitability under Medicare. MedPAC has projected that freestanding agencies would have a margin of 11.8 percent in 2013. Past experience demonstrates that agencies have been able to offset the impact of base rate and other payment reductions by increasing their average case-mix values and keeping episode cost growth low. Such actions could offset the effects of rebasing in 2014 and later years.

For example, a 1 percent annual increase in average case-mix value between 2014 and 2017 would effectively keep average payments through 2017 at the pre-rebasing 2013 payment level. For perspective, the annual average case-mix index has increased by about 1.2 percent a year between 2001 and 2011. The implementation of ICD-10 coding in October 2014 may provide an additional opportunity for increased coding that could lead to payment increases in excess of historical averages.

The PPACA rebasing provision assumes that future costs per episode will increase at the rate of the payment update, which would be high compared to historical experience. Agencies have been able to keep cost growth low, and even freeze costs in some years, by reducing the visits provided per episode and using lower-cost practitioners such as therapy assistants. The proposed rebasing does not adjust for changes in the average visits per episode or skill mix that could occur in 2014 through 2017, and if the trend of declining visits continues, costs per episode will likely grow at a rate significantly lower than the 2.4 to 2.7 percent assumed in the current annual payment update. The rebasing calculation also does not adjust for the overstatement of costs uncovered by the recent audit.

Conversely, the proposed increase for LUPA payments would be too low, and will leave payments well below costs. LUPAs are a small share of home health volume, comprising about 9 percent of episodes and 1 percent of payments. However, they play an important role in the payment system because they guard against the incentive that would be created by a full 60-day episode payment for episodes with very low visit counts. The incentive to exceed the LUPA threshold is already substantial, with the average LUPA payment equaling $344 compared to $3,056 for the average full episode in 2010. If LUPA rates remain below cost, agencies have even more incentive to provide more than four visits in an episode to qualify for the full episode payment. We urge the Secretary to closely review the applicable statutory provision to determine whether there is flexibility to further raise LUPA payments, and if not to seek legislative authority that would permit payments to be raised to the estimated level of cost.

We recognize that CMS has implemented the maximum reduction for 60-day episodes permissible by PPACA, but we are concerned that this reduction will be too small. We recommended to the Congress that rebasing be implemented in a shorter period, and also recommended eliminating the annual payment update. As we noted in our March 2014 report, additional changes to statute to address these shortcomings would help to bring costs closer to payments then the current approach to rebasing.

The Commission also recognizes that beneficiary access to care and quality of care need to be protected while rebasing is implemented. Payment reductions have the potential to be disruptive for some agencies, particularly those that are isolated low-volume providers that are the sole source of care in their area, or those that provide care to vulnerable populations. Each year, as part of fulfilling its statutory mandate to assess the adequacy of payments, the Commission will monitor our access to care and quality indicators to ensure that access problems are not occurring. If, in the course of the four-year phase-in of the home health PPS rebasing we identify specific access to care problems, the Commission would consider targeted payment policies that could address any such problems more effectively than holding payments at an inappropriately high level for all agencies.

Proposed ICD-9-CM grouper refinements, effective January 1, 2014

The 2014 rule proposed to remove 170 diagnostic codes that are currently included in the home health PPS grouper. The codes were selected for elimination after a recent review found that they were inappropriate for the PPS case-mix logic, either because they are customarily treated in inpatient facilities or were judged to be conditions that should not affect the need for home health care. The rule noted that eliminating these codes will lower the case-mix index value for some episodes, which will result in an estimated payment decline of a half-percent in 2014.

MedPAC recognizes that the clinical relevance of the diagnostic codes in the grouper is critical to the integrity of the PPS. We have not reviewed CMS's clinical justifications for the elimination of these codes, but we are concerned that the technical approach to removing them from the grouper software reduces the accuracy of the home health PPS.

The current grouper is based on changes to the case-mix system CMS implemented in 2008 through a multi-step process. The first step in these revisions was a regression that measured

home health service use based on an episode's clinical diagnoses, functional characteristics, and the number of therapy visits received. The regression model computed each characteristic's contribution to service use, controlling for the effects of the other characteristics in the model. Next, CMS assigned "case-mix points" to each characteristic for use in assigning episodes to payment groups, and these points are equal to the estimated impact on service use from the regression. Finally, CMS divided episodes with similar service use (based on each episode's total case-mix points) into payment groups and computes the case-mix relative weight for each group.

The case-mix points are critical for calculating the payment group an episode is assigned during claims processing. During the payment process, the payment grouper identifies the conditions reported for an episode that have been assigned case-mix points, and assigns an episode to the payment group that corresponds to the episode's total case-mix points (multiple conditions in an episode can contribute case-mix points). In this approach, the conditions agencies report through the grouper need to be consistent with the conditions included in the service use regression and the resulting payment factors (the case-mix points, payment groups, and case-mix relative weights). However, under the proposed rule 170 conditions that were included in the service use regression would no longer be accepted by the payment grouper software. CMS has not proposed to update the service use regression and resulting payment factors to reflect the elimination of the codes. Such an approach reduces the accuracy of the case-mix relative weights and lowers payment.

Impact on relative weights. Under the proposed approach the case-mix points and other payment factors would not accurately measure relative resource use, as these factors were developed from a service use regression that included the effects of the 170 conditions proposed for elimination. In the absence of these codes, the values of the remaining conditions would likely be different in the service use regression, resulting in different case-mix point totals for episodes, new payment groups, and revised case-mix relative weights. Because the effect of eliminating codes on other conditions is hard to predict, we do not know how such a re-estimation shifts payment. However, it is likely that some episodes would be overvalued or undervalued since these values frequently changed when the regression has been updated in the past. This mis-measurement could create opportunities for patient selection, and agencies may not be fairly compensated for the relative severity of their patients. CMS has updated these factors in the past when it changed the codes that are included in the grouper, such as when it eliminated two diagnostic codes for hypertension in 2012.[4]

Impact on aggregate payments. The national average case-mix relative weight declined under the proposed approach, and resulted in the half-percent payment reduction CMS described in the impact analysis. This decline would be appropriate if CMS believed that the aggregate severity of the home health population was overstated because of the presence of the 170 codes proposed for elimination. However, the rule's justification for eliminating the codes does not argue that aggregate severity has been overstated, and it is not clear how the inclusion of the codes in the original service use regression would have resulted in an exaggerated aggregate estimate. If the

4 The 2012 home health PPS rule eliminated the 401.1 (benign hypertension) and 401.9 (unspecified hypertension) diagnosis codes from the case-mix system. CMS implemented the change on a budget-neutral basis, and updated the service use regression and the resulting payment factors to reflect the elimination of the codes.

service use regression and resulting payment factors were updated to exclude the codes proposed for elimination, the proposal could likely be implemented on a budget neutral basis.

The Commission recommends that CMS provide further analysis to justify its decision to not update the service use regressions, case-mix points, and resulting relative weights after eliminating the 170 diagnostic codes from the grouper. If the analysis indicates the aggregate severity was not overstated and that the associated payment factors change significantly for some episodes, CMS should update these factors through a revised service use regression that includes only the codes that are valid in the revised grouper.

Home health rehospitalization and emergency department use without readmission claims-based measures

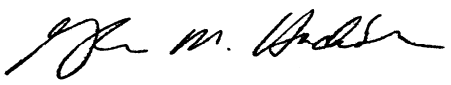
The proposed rule would add two additional quality measures to those reported for home health agencies: a claims-based measure of acute care hospitalization during the first 30 days of home health care, and a claims-based measure of emergency department use during the first 30 days of home health care. Both would focus solely on home health episodes that began after a hospitalization. Medicare would also continue to report the existing measures that track hospitalization and emergency department use for all home health stays, regardless of length or preceding service use.

The new measures will serve as useful compliments to those already collected by CMS. Existing measures cover hospitalization rates and emergency department use for all home health episodes, regardless of episode length or type of referral to home health care (including stays with and without a hospitalization prior to the start of the home health stay). As CMS proceeds in the development of value-based purchasing and other reforms that modify payments for home health care (such as bundling), it is important to emphasize measures that cover the full span of services provided by Medicare.

Conclusion

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 Commission staff on policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please contact Mark E. Miller, the Commission's Executive Director.

Sincerely,



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