MEDPAC Medicare Payment Advisory Commission

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August 31, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1358-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-1358-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 program; home health prospective payment system rate update for calendar year 2013, hospice quality reporting requirements, and survey and enforcement requirements for home health agencies." We appreciate your staff's work on this rule, particularly given the competing demands on the agency.

The rule proposes to increase the base payment rate for home health agencies by 0.16 percent in 2013, a product of a 1.5 percent payment update and 1.32 percent reduction for coding change. In this letter we comment on the proposed payment reduction for coding, changes to quality reporting requirements for home health agencies, proposed changes to the home health grouper, alternative sanctions for agencies that fail to meet Medicare conditions of participation, and hospice quality reporting requirements.

Proposed reduction for coding change

In October of 2000 Medicare implemented a prospective payment system (PPS) for home health. Under the PPS episodes are reimbursed based on a case-mix index which measures patient severity. The case-mix index for an episode is determined through data on patient characteristics (diagnosis and treatments provided) reported by home health agencies. In 2007 CMS conducted a review of changes in the average case-mix index through 2005, and it has updated this review annually as additional years of claims have become available. These analyses have generally found that patient severity has not increased significantly since 2000, and that most of the rise in case-mix index was attributable to changes in coding practices. In last year's rule, CMS finalized a 3.79 percent reduction in 2012 and a 1.32 percent reduction for 2013. For the current proposed rule, CMS expanded its examination of claims data to assess changes in coding from 2000 to 2010.

The analysis found that payments would need to be reduced by 2.18 percent in 2013 to account for all coding change that occurred in this period. CMS proposes to hold the reduction for 2013 at 1.32 percent, but requests comment on this approach.

MedPAC believes that unwarranted overpayments attributable to changes in coding practices should be recovered. MedPAC has not independently analyzed the coding change in home health, but the finding of payment increases unrelated to patient severity is consistent with the experience of other payment systems. The proposed reduction of 1.32 percent in 2013 is problematic because it would not fully adjust for all of the coding increase CMS has concluded is unwarranted. The proposed adjustment would overpay home health agencies for the severity of their patients, and would unnecessarily increase home health expenditures for the federal government and beneficiaries. Aggregate Medicare margins for home health agencies in 2012 exceed 13 percent. Even if CMS applied the full reduction in 2013, most agencies would be paid well in excess of costs. Implementing a smaller reduction than necessary in 2013 will require that a larger reduction occur in future years. Consequently, CMS should take the full 2.18 percent reduction in 2013.

Home health quality program – reporting requirements

Home health agencies are required to submit to CMS data on the quality of care they provide in order to receive the full annual payment update, and agencies that do not meet this requirement have their updates reduced by 2 percentage points. Agencies meet this requirement by submitting patient assessment information from the Outcomes Assessment Information Set (OASIS) and consumer experience information from the Home Health Consumer Assessment of Health Providers and Systems (HHCAHPS). The proposed rule establishes a standard reporting period to include all episodes commencing on or after July 1, 2011 and before July 1, 2012 for 2013, with a similar reporting year in future years for the OASIS data.

The rule does not address a recent analysis by the Health and Human Services Office of Inspector General (OIG) that indicates that the existing OASIS reporting requirement could be strengthened. The OIG noted that CMS required the submission of a single OASIS record per agency in a reporting year to satisfy the OASIS pay-for-reporting requirement; consequently agencies with significant amounts of unsubmitted data are not penalized. The OIG found that 77 percent of agencies did not submit OASIS data for six or more of their home health claims in 2009. In total, HHAs failed to submit OASIS data for six percent of home health episodes, and OASIS data for 15 percent of episodes was submitted late. The OIG report recommended that CMS apply the pay-for-reporting penalty to any agency that fails to report OASIS data for all of their claims, and that Medicare establish enforcement actions for agencies that do not submit OASIS data within 30 days of completion of the assessment.

MedPAC believes that robust reporting is important to the integrity of quality measures. The missing OASIS data could compromise the accuracy of the quality measures CMS reports to agencies and the public, so ensuring adequate and timely reporting is crucial. We believe that, similar to the OIG's finding, the pay-for-reporting requirement should be strengthened to require agencies to report all of their OASIS data. In addition, we concur with the OIG's finding that CMS should implement enforcement measures to encourage timely reporting of data.

International Classification of Diseases, 10th edition (ICD-10) transition plan and grouper enhancement

In the home health PPS CMS has historically permitted agencies to report additional patient diagnostic information when HIPAA coding rules required the use of a V-code as a primary or secondary diagnosis. This additional information was deemed necessary because V-codes did not always provide adequate information about patient condition for setting payment. The other diagnosis information is recorded separately from the primary and secondary diagnosis fields on the OASIS. The additional diagnostic information identifies conditions that require additional resource use, and so reporting this information increases payment under the current case-mix system. In 2008 CMS released coding guidance intended to ensure that the additional diagnostic codes were reported appropriately. In this proposed, rule CMS reports that a contractor analysis has indicated that many HHAs reported codes in the additional diagnosis fields more frequently than required by revised guidelines, and proposes to limit the types of conditions that can be reported in these fields to certain fracture codes. CMS proposes changes to allow some of the conditions currently reported in the additional diagnosis fields (diabetes, skin and neurological codes) to be reported in the secondary diagnosis fields. However, the rule provides no indication of the status of reporting for other conditions that would no longer be allowed in the additional diagnosis field, examples of which include cancer, gastrointestinal disease and heart disease.

CMS needs to better substantiate its claim that the non-fracture codes are over-reported in the additional diagnosis fields, and that, when necessary, these conditions can be reported in the primary and secondary diagnosis fields. The additional diagnosis fields were originally created because there was a concern that some diagnoses could not be include in the primary and secondary condition fields due to other coding rules, and that space available in these fields would be inadequate for patients with numerous conditions. The proposed rule does not provide analysis that demonstrates that this has changed, and that the additional diagnosis fields are no longer necessary for all codes except fractures.

If the change results in agencies being unable to report some conditions used to assign episodes to a payment group, they will be underpaid under the home health PPS because the severity of their patients will be greater than reported. CMS has not provided an analysis indicating the magnitude of the payment impact of the proposed change. If CMS intends for this proposal to substantially reduce payments, it should provide the justification for such a decrease and a supporting impact analysis. Notably, CMS has not characterized this proposed change necessary to address a change in the way agencies code the aggregate severity of the home health population. As discussed earlier, CMS has already implemented reductions to address unwarranted increases in case-mix index related to coding changes. If CMS proceeds with also implementing this policy as a payment reduction, it should clarify how this reduction captures coding practices that are not accounted for in the 1.32 percent reduction for coding change CMS has included in the proposed rule.

CMS also needs to consider the impact of this proposal on the relative weights of the home health case-mix system. The home health PPS uses a multivariate regression model to set the case-mix relative weights; the relative weights for each condition change when other conditions are added or

subtracted from the model. In the past when CMS has removed conditions from the case-mix system, it has made compensatory adjustments to ensure the change did not increase or decrease aggregate payments. For example, in the 2012 rate year CMS eliminated two hypertension codes from the case-mix system, and it re-estimated the case-mix regression to ensure the change was budget neutral. In this rule, CMS has proposed a change that could limit the ability to report many conditions included in the current home health case-mix regression, suggesting that the case-mix weights assigned to the remaining conditions need to be re-estimated. A reduced frequency of the reporting of these codes could affect the values for these conditions in the case-mix regression model. If CMS proceeds with the proposed change, it should re-estimate the case-mix model and update the relative weights, or present analysis that demonstrates that the impacts on the relative weights from the dropped conditions are minimal and a re-calibration is not necessary.

Alternative sanctions for home health agencies with deficiencies

HHAs that participate in the Medicare program are required to meet a number of standards collectively referred to as the Conditions of Participation (CoP). In the proposed rule, CMS expands the sanctions it can use when an agency fails to comply with a CoP. Previously, the only sanction available for CMS to address poorly performing agencies was termination from the Medicare program, a sanction that was utilized infrequently. The new penalties include: suspension of payment for new patients and episodes, civil monetary penalties for each day of non-compliance, appointment of temporary management by CMS, and a directed plan of correction and/or in-service training. In selecting among these possible penalties, CMS will weigh the risk to patient safety from CoP non-compliance, duration of the violation, and whether it is a repeat violation or the agency (or its parent entity) has a history of poor compliance.

MedPAC supports the new sanctions because they would expand Medicare's ability to ensure compliance with CoPs, and help ensure that agencies participating in the program provide adequate care and meet other safety and program integrity requirements. Expanded tools for program compliance may be appropriate because of the program integrity problems Medicare has experienced with home health.

Hospice quality reporting

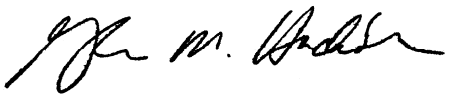
For the hospice quality reporting program, CMS proposed that the two quality measures in effect for payment year 2014 (i.e., an outcome measure focused on pain management and a structural measure indicating whether the hospice is tracking at least three patient quality measures) continue to be used for payment years 2015 and beyond. CMS also expressed interest in developing a more comprehensive set of hospice quality measures for payment years after 2015. CMS indicated that a standardized patient assessment instrument would potentially be needed to support the collection of a broader set of quality measures. CMS reported that it is in the early stages of developing and testing a patient-level data item set and may consider implementation as early as calendar year 2014. The Commission supports the concept of bringing standardization to the collection and calculation of hospice quality measures. A standardized patient assessment instrument is important to help ensure that quality data reported by hospices is as comparable as possible across providers. It also may offer an opportunity to obtain information about the clinical

characteristics and care needs of beneficiaries receiving hospice care, which could have implications for Medicare hospice policy more broadly.

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,



Glenn M. Hackbarth, J.D.
Chairman