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September 1, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1353-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-1353-P

Dear Dr. Berwick:

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 2012*. We appreciate your staff's work on this rule, particularly given the competing demands on the agency.

The rule proposed to reduce the base rate by 3.35 percent in 2012, a product of a 1.5 percent payment update and 5.06 percent reduction for coding change. In this letter we comment on the proposed payment reduction for coding, revisions to the relative weights, and the use of therapy assistants.

Proposed reduction for coding change

In October of 2000 Medicare implemented a prospective payment system for home health. Under the PPS, Medicare reimburses home health agencies for episodes of care, adjusted for patient severity, or case-mix (as well as other adjustments). The case-mix adjuster for an episode is determined by data on patient characteristics (diagnosis and treatments provided) reported by home health agencies. In 2007 CMS conducted a review of changes in case-mix through 2005, and it has updated this review annually as additional years of claims have become available. These reviews have generally found that most of the change in case-mix since 2000 is due to changes in coding, not patient severity. Consequently, CMS has implemented payment reductions from 2008 through 2011 for unwarranted changes in case-mix index, and proposed another reduction in 2012 of 5.06 percent. The reduction in 2012, combined with the reductions from prior years, will complete the adjustments necessary to account for increases attributable to coding changes from 2000 to 2009.

MedPAC believes that unwarranted overpayments attributable to changes in coding practices should be recovered when possible, including those which have occurred in prior years. The

purpose of the refined system was to distribute payments more accurately, and changes in coding practice should not increase aggregate payments. MedPAC has not independently analyzed the coding change in home health, but the reduction is consistent with the experience of other prospective payment systems. The payment reduction should not create payment adequacy or access to care issues. MedPAC projects that margins for HHAs in 2011 will exceed 14 percent, so in aggregate agencies will still be paid well in excess of costs after the proposed reductions.

In the proposed rule, CMS summarized an external review of its methodology for measuring increases in home health agencies' case-mix unrelated to patient severity. The external review examined several concerns raised by industry stakeholders, and finds that the methodology is generally appropriate. The external review did suggest that CMS integrate the CMS-Hierarchical Cost Conditions as an additional variable, which CMS has done in the proposed rule. MedPAC has reviewed the external report, and finds that it provides compelling support for the methodology in the proposed rule. CMS should continue to examine changes in observed case-mix in future years, and adjust payments if additional increases unrelated to patient severity are found.

Proposed revision of case-mix relative weights

The rule summarized MedPAC's analysis that concluded the home health relative weights overvalue episodes with therapy and undervalue non-therapy episodes. In our March 2011 Report to the Congress, we noted that the number of therapy episodes had increased much faster than non-therapy episodes, the specific amount of therapy provided in an episode appeared to be influenced by the per-visit payment thresholds in the PPS, and the most profitable agencies provided more therapy episodes than less profitable agencies. In response to these concerns, CMS proposed to raise the weights for non-therapy episodes by 7.5 percent. The weights for episodes with 14-15 therapy visits would be reduced by 5 percent, and the weights for episodes with 20 or more visits would be reduced by 10 percent (weights for the episodes between these thresholds were adjusted proportionately).

The Commission is encouraged that CMS has acknowledged the incentives to provide therapy in the home health PPS, and that it has proposed changes designed to level the incentives between therapy and non-therapy episodes. In our March 2011 Report to the Congress, the Commission recommended Medicare eliminate the visit thresholds and use patient characteristics to set payment for therapy, which would reduce, if not eliminate, the incentive to provide more therapy due to financial incentives. While the proposed rule would maintain the therapy thresholds, the proposed adjustments would increase payment for non-therapy episodes and decrease payment for therapy episodes. This redistribution, similar to the distributional changes under the Commission's recommendation, would improve access for patients who need non-therapy services, and reduce the incentive to manipulate therapy visits to reap higher payments.

However, some issues would still need to be addressed in future revisions to the PPS. The proposed therapy thresholds for 2012 may be prone to gaming because they still increase payment for additional visits, albeit the increases are now smaller. In addition, the adjustment factors for the relative weights were selected administratively by CMS, and not based on empirical analyses of the proper levels of payment for therapy and non-therapy services. It is possible that therapy may still be mis-valued relative to non-therapy episodes. A system that relied solely on patient

characteristics to pay for therapy, as the Commission has recommended, would address each of these issues. MedPAC's support of the proposed policy is motivated by the urgency of addressing the imbalance in the current system, and the Commission will continue to recommend that CMS eliminate therapy visits provided as a factor in the system.

Proposal for revision of case-mix weights – use of therapy assistants

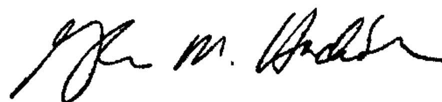
In the proposed rule CMS noted that the increased use of therapy assistants, as a substitute for more costly qualified therapists, may be one factor contributing to the overpayments for therapy. Medicare tracks data on occupational mix in home health through the Occupational Employment Survey (OES) conducted by the Bureau of Labor Statistics, a survey of providers conducted annually. The data from the Occupational Employment Survey indicated that 20 percent of therapy is provided by assistants, higher than the 15 percent currently assumed in the labor costs used to construct the HHA PPS relative weights. Therapy assistant wages were about 30 percent lower than those for qualified therapists in 2010, so this shift represented a significant cost reduction for agencies. CMS also reviewed data from the Post-Acute Care Payment Reform Demonstration which indicated that the use of therapy assistants in the demonstration was even higher than the OES rate. CMS does not propose to update its occupational mix assumptions in the 2012 refinements.

The increased use of therapy assistants should be reflected in the home health PPS's relative weights. The OES data clearly indicates home health agencies have shifted toward a lower-cost staffing mix at the same time they have increased the amount of therapy services provided. The resulting overpayment provides agencies with an incentive to favor therapy services over non-therapy services, and reduces the accuracy of the case-mix system. Health care delivery evolves rapidly, and it is imperative that assumptions like occupational mix are updated when they change significantly. Continuing payment based on obsolete data reduces the accuracy and efficiency of the PPS, undermining the core goals of prospective payment.

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.
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