MEDPAC Medicare Payment Advisory Commission

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September 23, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1560-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: File code CMS-1560-P

Dear Ms. Frizzera:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice entitled *Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2010; Proposed Rule*. We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency.

Changes to the outlier policy

The rule proposes two changes to the outlier policy to address program integrity issues that have been identified in a number of areas. First, the rule would reduce the size of the outlier pool from 5 percent of total payments to 2.5 percent. Because statute requires that the outlier adjustment be budget neutral, the base rate would be raised by 2.5 percent to compensate for this reduction. Second, the rule would institute a cap on agency outlier payments that would limit outlier payments to no more than 10 percent of an agency's Medicare home health payments; currently there is no provider limit on these payments.

The anomalous outlier trends in recent years are compelling evidence that abusive and likely fraudulent practices are widespread in many areas, and increased safeguards are necessary to curb inappropriate outlier payments. The outlier policy is intended to compensate agencies for the costs of caring for high-cost beneficiaries; instead it appears that in many locales certain providers are exploiting the current system to yield extra payments for services that are unnecessary or not delivered. The changes proposed by the rule are reasonable areas for the focus of additional safeguards.

However, Medicare's policy assumes some financial loss from outlier episodes, but MedPAC's analysis of 2007 cost reports for free-standing agencies indicates that some agencies have costs lower than those assumed in the outlier policy. As a result, these agencies may be able to profit from abusing the outlier policy even with a smaller outlier pool and provider level cap. The

Commission is studying additional changes in the outlier policy to that may address remaining vulnerabilities.

Case-mix measurement analysis
In 2008 CMS found that 11.78 percent of the change in case-mix between 2000 and 2005 was not attributable to an increase in patient severity, CMS implemented payment reductions for 2008-2011 to lower payments by this amount (about -2.75 percent each year). This rule updates CMS's previous estimate of case-mix change to include data for 2007, and finds an additional 2.11 percentage point increase in CMI that is unrelated to patient severity. The rule proposes to keep the existing reduction planned for 2010, -2.75 percent, but asks for comment on three alternatives for increasing the cumulative reduction in case-mix to reflect the additional increase for 2007: take the additional reduction in 2009, spread the additional reduction over 2 years, or add the additional reduction in 2010 to the existing reduction of -2.75 percent and accelerate the planned reduction for 2011 to 2010.

MedPAC did not independently assess changes in case-mix. The finding of an increase in case-mix unrelated to severity in 2007 confirms the need for a continuing review of annual case-mix change. Information will be available soon for reviewing coding changes that have occurred in the first year of the HHRG153 system. Considering that changes in case-mix unrelated to severity have been found when major revisions were implemented in other payment systems, such as those for Medicare Advantage, skilled nursing facilities, inpatient hospital, and inpatient rehabilitation facilities, particularly scrutiny of the 2008 changes in case-mix appear warranted. If additional unwarranted change in case-mix is indicated, CMS should adjust payments as appropriate.

As for the appropriate reduction for 2010 and later years, the Commission has made recommendations for 2010 and 2011 that would significantly reduce payments in both years. We recommend a reduction of -5.5 percent in 2010, and that payments be re-based to a level equal to average costs in 2011. Consequently, the option of including the additional 2.11 percent reduction in 2011 would be most consistent with the Commission recommendation.

Proposed payment safeguards for home health agencies
The rule proposes three changes to ensure that home health agencies participating in Medicare are operating in accordance with program standards. First, the rule proposes to forbid multiple agencies from sharing a single practice location. Second, the rule proposes to require that agencies sold within 3 years of establishment be required to go through another survey or accreditation to ensure that they meet Medicare conditions of participation under the new ownership. Finally, the rule also would require that agencies which have been inactive for 12 months or more undergo a survey or accreditation before reactivation of Medicare billing privileges.

The instances of fraud and abuse that have been reported by CMS justify the changes that have been proposed. These changes will reduce the vulnerability of the program to fraudulent or abusive practices without creating access to care issues. Regarding the final proposed change, agency operations can change significantly in a year. CMS should consider consulting with other agencies with Medicare program integrity experience, such as the HHS Inspector General, General Accountability Office and the Department of Justice, for alternative perspectives on the appropriate period of inactivity to permit before requiring certification or accreditation.

Physician certification and recertification of the home health plan of care
The rule proposes to require a written narrative on the physician certification or recertification when home health services are being ordered for the purpose of evaluation and management of the patient plan of care. This additional clinical narrative would explain why the complexity or severity of a patient's condition requires that a nurse or therapist supervise the patient to ensure a patient's safe recovery. The inclusion of this narrative would serve several purposes: providing documentation to support the need for skilled evaluation and management services, encourage physicians to appropriately monitor the needs of these patients, and would encourage physician accountability for the home health plan of care when ordering these services. MedPAC supports the addition of the narrative, and, as discussed below, suggests that CMS consider implementing a requirement for other episodes.

Physician engagement in the home health episode
CMS has been concerned that some physicians may not be adequately interacting with patients when they order home health services. CMS requests additional comment regarding policies to encourage physician engagement in the home health episode, particularly for episode certifications and re-certifications. In a prior rulemaking, the FY 2009 Physician Fee Schedule rule, CMS asked for comment on a number of alternative policies. CMS did not make any changes at that time, but some parties suggested that Medicare clarify documentation requirements. In the current rule, CMS proposes the new documentation requirement listed above and asks for additional suggestions for policies to improve physician engagement in the home health episode.

Given the concern CMS has expressed, requiring a physician narrative for all home health episodes, regardless of the services ordered, could be an additional policy for encouraging physician engagement. The proposed narrative, as CMS notes, is intended to increase physician engagement for episodes where evaluation and management services are being ordered, but CMS's concern about a lack of physician engagement appears to apply more broadly than just these episodes. The Commission included a similar recommendation for a narrative as a part of its March 2009 report on the hospice benefit. This recommendation, based on a suggestion from a hospice industry expert panel, was based on the conclusion that such a requirement would encourage physician engagement in the recertification process by focusing attention on the clinical rationale for hospice services. It would seem that the circumstances of the home health benefit may present a similar opportunity, and broadening the requirement to all episodes could improve care and the administration of the home health benefit.

Wage index
CMS proposes to continue using the pre-floor, pre-reclassification hospital wage index for 2010. Because home health agencies operate in some areas that do not have hospitals, CMS proposes to continue to use the average of the hospital wage index for surrounding metropolitan areas as the wage index for rural areas. For metropolitan areas that lack a wage index, CMS propose to continue using the average of all urban areas within the state. In addition, for Puerto Rico CMS proposes to use the hospital wage index from 2005 because alternative data is not available.

MedPAC recommended a new approach to the home health wage index in our June 2007 report. The commission found that a revised approach based on BLS data would have several advantages, including more consistent values among neighboring markets and less year-to-year volatility in

values. In addition, the new methodology would utilize data that is available for all labor areas, eliminating the need for imputing an index for agencies in areas with no hospital wage index. The alternatives CMS proposes for areas that do not have hospital wage index information appear problematic. Implementing the revised wage index recommended by the Commission would eliminate the need to rely on these alternative measures, and we urge CMS to begin implementing the new wage index recommended in the 2010 payment year.

Number of visits assumed in the establishment of the 60 day episode base rate
In the 2010 proposed rule for the home health PPS, CMS indicated that the 60 day episode rate for home health services was based on an episode of 25.5 visits. We understand that this figure was taken from the discussion included in the final rule establishing the home health PPS (see FR 41186, July 3, 2000). The number cited in the 2010 proposed rule is incorrect because the figure includes low use episodes that had 4 or fewer visits that are not paid using the full 60 day episode rate. MedPAC has reported that the figure of 31.6 visits per episode was the number of visits assumed because it was an initial factor used by CMS in computing the full 60 day episode base rate (see Table 5, FR 41184, July 3, 2000). CMS should clarify how the 25.5 visits per episode figure relates to the 31.6 figure that was the basis for the 60 day episode base rate.

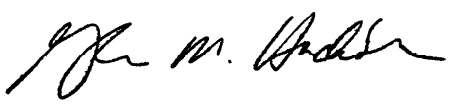
Implementation of Home Health Consumer Assessment of Health Plans and Providers Survey (HHCAHPS)

CMS proposes to require agencies to begin collecting HHCAHPS data from their patient beginning in 2010. The HHCAHPS is a 34 question National Quality Forum approved instrument designed to measure the consumer experience with the home health benefit. Each provider will be responsible for contracting with an approved survey vendor to conduct the survey on the behalf of the HHA. CMS anticipates it will begin public reporting of HHCAHPS data in early 2011. The addition of consumer experience information should be a useful supplement to existing performance measures.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values 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 Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/ec/wc