



Medicare Payment
Advisory Commission

425 I Street, NW · Suite 701
Washington, DC 20001
202-220-3700 · www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Amol Navathe, M.D., Ph.D., Vice Chair
James E. Mathews, Ph.D., Executive Director

August 15, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1766-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) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements," *Federal Register*, vol. 87, no. 120, p. 37600 (June 23, 2022). We appreciate your staff's efforts to administer and improve the Medicare program for beneficiaries 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:

- Calendar year (CY) 2023 national standardized 30-day period payment rates,
- Proposed methodology for behavioral assumptions and adjustments under the home health prospective payment system (PPS),
- Proposed cap on wage index decreases,
- Comment solicitation on the collection of data on the use of telecommunications technology under the Medicare home health benefit, and
- Home health value-based purchasing: overarching principles for measuring equity and health care quality disparities across CMS quality programs

Calendar year 2023 national standardized 30-day period payment rate

CMS proposed a 2.9 percent update to the base payment rate for HHA services. This increase reflects payment adjustments mandated by statute: a 3.3 percent home health market basket update for 2023 reduced by the multifactor productivity adjustment of 0.4 percent.

Comment

The Commission recognizes that CMS must provide the statutorily mandated payment update, but we note that this increase is not warranted based on our most recent analysis of payment adequacy. In our March 2022 report to the Congress, the Commission found positive access, quality, and financial indicators for the sector, with margins of 20.2 percent for freestanding HHAs in 2020.¹ The Commission recommended that the Congress reduce the 2022 Medicare base payment rate for HHAs by 5 percent for the 2023 payment year. Though this payment update is offset by the proposed reduction discussed below, the Commission notes that the proposed rule found that the base payment rate for 2021 exceeded the estimated cost of a typical 30-day period by 34 percent.² Given the high margin, an increase in payments is not needed to ensure access to home health care services in 2023.

Proposed methodology for behavioral assumptions and adjustments under the home health PPS

The Bipartisan Budget Act of 2018 (BBA 2018) required CMS to change the unit of payment in the PPS from 60 days to 30 days and also mandated the development of a new case-mix system that does not use the number of therapy visits provided during home health care as a payment factor. The BBA 2018 required CMS to implement these changes on a budget-neutral basis; home health care spending in 2020 through 2026 is required to be the same as it would have been if the changes had not been made.

The statute requires CMS to increase or decrease the home health base 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 has the authority to make permanent adjustments when it determines that an observed deviation from expected behavior will continue in future years. The statute provides the authority for temporary (one-year) adjustments when CMS identifies overpayments or underpayments that occurred in a prior year.

In this proposed rule, CMS presents an analysis that estimates the aggregate expenditures that would have occurred under the prior case-mix system if it had been in effect for 2020 and 2021. To do this, CMS applied the 153-group payment system that was in effect in 2019 to a set of claims that were paid under the new Patient-Driven Groupings Model (PDGM) in 2020 and 2021.³ CMS estimates that the amount CMS would have spent in these two years under the prior case-mix system was \$2.01 billion less than the actual spending under PDGM, indicating that spending in 2020 and 2021 was above the levels required by BBA 2018. CMS estimates that the payment rate

¹ Medicare Payment Advisory Commission. 2022. *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.

³ The analysis relied on periods that could be converted into 60-day episodes without overlapping into another year (e.g., the 60-day period started in 2020 and ended in 2021). See rule text at 87 FR 37617 to 37618 for specific exclusions.

for a 30-day period under the PDGM system will need to be reduced by 7.69 percent to ensure that future spending is under the target.⁴

Based on this finding, CMS concluded that it is required to implement a permanent reduction of 7.69 percent to the base rate to ensure that payments remain under the limit established by BBA 2018 in 2023 and later years. This reduction would be offset by the home health payment update discussed above and would result in a net decrease in the base rate of 5.01 percent in 2023.

CMS notes that it is also required to recover the \$2.01 billion in overpayments that occurred in 2020 and 2021. However, CMS does not propose any remedy for these overpayments for 2023, instead soliciting comment on how best to collect the \$2.01 billion.

Comment

The Commission strongly supports the 7.69 percent reduction to lower home health spending as required by law. As noted in our March 2022 report to the Congress, Medicare has long overpaid for home health care, and lower payments would better align payments with costs. The method followed by CMS for computing the budget-neutral amount is reasonable, as applying the case-mix system in effect prior to 2020 reflects how Medicare would have paid in the absence of the BBA 2018 changes. In applying the prior case-mix system to the claims for 2020 and 2021, the method also incorporates the utilization and coding changes that occurred in these years. As the effect of the PHE is included in the estimated budget-neutral amount and actual home health expenditures, the method ensures that any difference between the two calculated spending amounts is not attributable to the PHE.

The net reduction in the base rate of 5.01 percent resulting from this policy is consistent with the 5 percent reduction to the base rate the Commission recommended in our March 2022 report to the Congress. Medicare margins for freestanding agencies averaged more than 15 percent from 2001 to 2020, and these overpayments do not help beneficiaries or the program. The Commission concluded that a 5 percent reduction in 2023 would not compromise beneficiary access to care or the quality of home health care they receive but noted that a reduction of this magnitude would likely be inadequate to align payments with costs.

The Commission strongly encourages CMS to further reduce payments temporarily in 2023 to recover the \$2.01 billion that CMS estimates was overpaid in 2020 and 2021. CMS could consider collecting the funds over several years, for example by implementing an annual reduction of \$502.5 million per year for 2023 through 2026. In our comments on the CY 2022 home health proposed rule, we encouraged CMS to begin these reductions as soon as possible because CMS has a limited time to recover these funds. Deferring recovery, as CMS did in last year's rule, increased the amount CMS must now recover. Implementing a reduction beginning in 2023 would forestall the need for larger reductions in future years, and it would ensure that Medicare spending for home health care remains within the budgetary limits required by law. As noted earlier, the

⁴ Specifically, the rate should have been 6.52 percent lower in 2020 and an additional 1.26 percent lower in 2021.

Commission's March 2022 report indicated that additional reductions beyond 5 percent would likely be necessary to align payments with costs, so this additional temporary reduction should not raise concerns about payment adequacy in 2023.

Proposed cap on wage index decreases

The payment rates for home health care services are adjusted to reflect the relative differences in area wage levels using geographic areas (called core-based statistical areas, or CBSAs) delineated by the Office of Management and Budget (OMB). The beneficiary's location determines the wage index area that applies to a 30-day period. For CY 2023 and subsequent years, CMS proposed applying a cap to limit any annual decrease to an area's wage index at 5 percent, regardless of the reason for the decrease. CMS contends that applying a 5 percent cap will help mitigate instability in HHA PPS payments from year to year.

Comment

The Commission supports the proposed 5 percent cap on wage index decreases. However, we contend that the cap should apply not just to wage index decreases but to increases as well, such that no provider would have its wage index value increase or decrease by more than 5 percent in any given year. Consistent with CMS's proposed approach, implementation of MedPAC's approach to the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be implemented in a budget-neutral manner.

Comment solicitation on the collection of data on the use of telecommunications technology under the Medicare home health benefit

During the COVID-19 public health emergency, CMS broadened the telehealth services⁵ permissible under the home health benefit to include additional services, such as two-way video and audio-only encounters. The services must be identified in a patient's plan of care and not replace in-person services. CMS later made these additional telehealth services a permanent element of the benefit. HHAs are required to report the cost of these services on the Medicare cost report, but there is currently no requirement to note the use of these services on home health claims.

In the rule, CMS proposes to require HHAs to report on claims when agencies use telehealth to provide home health care. CMS proposes three new G-codes for reporting these services on home health claims:

- Synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system

⁵ Medicare statute governing home health care uses the term "telecommunications services" in reference to what are now commonly referred to as telehealth services. The Commission uses the latter to be consistent with the contemporary term for these services.

- Synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system, and
- Collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring)

CMS now proposes voluntary reporting of these services beginning January 1, 2023, with mandatory reporting beginning on July 1, 2023. CMS requests comment on any other telehealth modalities that should be reported on claims, and whether the reporting should detail the type of service being performed via telehealth, such as: skilled nursing services performed for care plan oversight (for example, management and evaluation or observation and assessment) versus teaching; or physical therapy services performed for the establishment or performance of a maintenance program versus other restorative physical therapy services.

Comment

The Commission strongly supports the proposed requirement to report telehealth on Medicare claims, and we highlight that the proposal is consistent with a recommendation in the Commission's March 2022 report to the Congress. The report noted that collecting claims information would ensure that telehealth services are accounted for when analyzing beneficiaries' use of home health care services and when setting payments under the home health PPS. This would help the Commission and CMS assess the impact of telehealth services on access, quality, and cost for beneficiaries that receive home health care.

The proposed G-codes would likely capture a significant portion of the telehealth services provided by HHAs, and we encourage CMS to begin collecting this information as soon as possible. The Commission would also support additional codes for other modalities of telehealth if CMS identified other services provided by HHAs. Details on the type of service, such as care plan oversight and other specialized home health care services, would be beneficial, as would identifying the type of health care practitioner (e.g., registered nurse or licensed practical nurse) participating in the telehealth session. This additional detail would permit a better understanding of the cost of delivering telehealth services.

The HH VBP: Overarching principles for measuring equity and health care quality disparities across CMS quality programs

CMS is working to advance health equity by designing and implementing policies and programs that support health for all beneficiaries. Accounting for health care disparities in quality measures is a cornerstone of the agency's approach to advancing health care equity. CMS has proposed quality measure stratification (measuring performance differences among subgroups of beneficiaries) as a tool to address health care disparities and advance health equity. In this proposed rule, CMS requests information on principles and approaches that could be used in the Home Health Value-based Purchasing Program (HH VBP) and other quality programs to stratify measure results.

Approaches for measures stratification

CMS identifies two approaches for reporting stratified measures: 1) “within-provider disparity method,” which would compare measure performance results for a single measure between subgroups of patients with and without a given factor (e.g., dual-eligible beneficiaries and others), and 2) “between-provider disparity methodology,” which would report performance on measures for only the subgroup of patients with a particular social risk factor, allowing providers to compare their performance for the subgroup to state and national benchmarks.

Prioritizing measures for disparity reporting

CMS proposes a set of principles to prioritize measures for disparity reporting in quality reporting programs. These principles include prioritizing measures that: 1) meet industry standards for measure reliability and validity, 2) have evidence that the outcome being measured is affected by underlying health care disparities, 3) meet statistical reliability and representation standards, and 4) show differences in performance across subgroups.

Selecting social risk factors to use in stratification

Social risk factors are the wide array of non-clinical drivers of health known to negatively impact patient outcomes. These include factors such as socioeconomic status, housing availability, and nutrition (among others). CMS recognizes the limited availability of social risk data to use in stratification as a challenge. The agency names different sources of data that can be used to identify social risk, including patient-reported data, CMS administrative claims, area-based indicators of social risk, and imputed data sources.

Identifying meaningful performance differences

CMS proposes different approaches to identify differences in performance for stratified results. One potential approach is ranking health care providers based on their performance on disparity measures to quickly allow comparison of performance with that of similar health care providers. Another potential approach is benchmarking or comparing individual results to state or national averages.

Reporting disparity measures

CMS discusses different approaches by which stratified measure results can be reported. The agency cites that confidential reporting, or reporting results privately to health care providers, is generally used for new programs or new measures to give providers an opportunity to become more familiar with calculation methods and to improve before wider reporting is implemented. Measure results can also be publicly reported to provide all stakeholders with important information on provider quality. Public reporting relies on market forces to incentivize providers to improve and become more competitive in their markets without directly influencing payment from Medicare.

Comment

The Commission supports CMS’s overall efforts to measure and report health care disparities by stratifying quality measure results for different subgroups of beneficiaries. We recognize that optimal health outcomes can be adversely affected by social risk factors. The Commission has traditionally focused on modifying payment systems to incentivize health care providers and payers (e.g., Medicare Advantage plans) to deliver high-quality care in the most efficient manner. While strong incentives for achieving value-based care objectives are critical, it is also important to apply such incentives fairly—that is, to recognize when these incentives can undermine access to care for beneficiaries. The Commission’s recent work to account for differences in patients’ social risk factors in quality payment programs and revisit payment for safety-net providers aims to improve incentives to deliver high-quality and efficient care. In the past, we have highlighted some disparities in care when we have identified them in our payment adequacy analyses. Moving forward, the Commission plans to more deliberately incorporate analysis by social risk factors, in particular income and race/ethnicity, into our payment adequacy and other analyses.

Over the past several years, the Commission has recommended redesigned value incentive programs that incorporate peer grouping for hospitals, Medicare Advantage plans, and skilled nursing facilities.⁶ Rather than adjusting performance measures for patients’ social risk factors, which can mask disparities in performance, these programs would make adjustments to payments based on a provider’s performance compared with its peers. With peer grouping, each provider’s performance is compared with providers with similar mixes of patients (that is, its “peers”) to determine rewards or penalties based on performance. A provider would earn points based on its performance relative to national performance scales, but how those points are converted to incentive payments would vary by peer group, with larger multipliers (i.e., the payment adjustment per point) for peer groups with higher shares of beneficiaries at high social risk.

Selecting social risk factors to use in stratification

In our modeling of value incentive programs, we concluded that there is a need for better measures of patient social risk than are currently available.⁷ The National Academies of Sciences, Engineering, and Medicine (NASEM) outlined considerations to determine whether a social risk factor (measure) should be accounted for in a Medicare quality payment program.⁸ The social risk factor should have a *conceptual* relationship with the outcome of interest (that is, there should be a reasonable hypothesis positing how the social risk factors could affect a Medicare beneficiary’s

⁶ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁷ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁸ National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Washington, DC: The National Academies Press.

health outcome) and an *empirical* association with outcome measures (that is, there should be verifiable evidence of an association between the social risk factor and the outcome of interest).

Medicare beneficiaries who are disabled or low income are eligible to concurrently enroll in Medicaid. In our various value incentive program models, we tested a share of a provider’s patients who were fully dually eligible for Medicare and Medicaid as a measure of social risk because there is a conceptual relationship between dual eligibility and our outcomes of interest. There is a clear and established relationship between poverty, socioeconomic status, and health outcomes—including increased risk for disease and premature death.

Although there are many reasons to use dual eligibility as a proxy for beneficiary social risk, we recognize that it is an imperfect measure. One drawback is that Medicaid eligibility requirements and benefits vary across states. Also, dual eligibility may be too narrow because it reflects a beneficiary’s income but does not directly reflect other social risks, like food insecurity and limited access to transportation.

In the Commission’s recent work to identify safety-net hospitals, we expanded our definition of “low-income” as a proxy for beneficiary social risk.⁹ In this work, we defined “low-income” beneficiaries as those who are eligible for full or partial Medicaid benefits or receive the Part D low-income subsidy (LIS). Expanding the definition of “low-income” to include all LIS beneficiaries helps to reduce the impact of variation in state Medicaid policies. This expanded definition includes beneficiaries who do not qualify for Medicaid benefits in their states but who do qualify for the LIS based on having limited assets and an income below 150 percent of the federal poverty level. In our hospital safety-net work, we referred to this collective population as “LIS beneficiaries” because those who receive full or partial Medicaid benefits automatically receive the LIS. Compared to the non-LIS Medicare population, LIS beneficiaries have relatively low incomes and differ in other regards, including being twice as likely to be Black or Hispanic and three times as likely to be disabled. The Commission intends to continue to explore improvements to our definition of “low-income” as a proxy for beneficiary social risk.

The Commission also recognizes that another approach to capture beneficiary social risk would be to use area-level measures of social risk.¹⁰ We encourage CMS to test various area-level measures for their potential to account for differences accurately across providers in the social risk of their patient populations. More research is needed to understand the accuracy of any area-level measure for Medicare beneficiaries compared with the gold standard of person-reported information.

Identifying meaningful performance differences

The Commission encourages CMS to report stratified quality measure results that are reliable, meaning that they reflect true differences in performance and are not attributable to random

⁹ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁰ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

variation. Key steps for CMS include defining the reliability standard for measure results and selecting the strategies to ensure reliable measure results for as many providers as possible.

A high reliability standard should be used to determine the minimum number of observations required for a provider's performance to be stratified and reported. For providers with low patient volume, establishing reliable measure results is problematic because they do not have enough observations to ensure that the measure detects signal (actual performance) rather than noise (random variation). Unreliable measure results can lead to erroneous conclusions about a provider's performance: A low-volume provider can appear to have unusually good or poor performance when in fact its performance is not statistically different from the average.¹¹ In our illustrative modeling of a value incentive program for skilled nursing facilities, we used a reliability standard of 0.7, meaning that 70 percent of the variance in a measure's results was attributable to actual performance differences such that providers can be differentiated.¹²

Setting a minimum case count to ensure reliability inevitably means excluding some providers from the quality measurement program. One way to include as many providers as possible is to pool data across years, allowing a performance measure to be calculated for many small providers that would otherwise be excluded. Such pooling is consistent with other quality payment program designs and measures. For example, Medicare's Hospital Readmissions Reduction Program uses three years of performance data to calculate readmission results. Blending performance across years also encourages sustained high quality. However, pooling data across years could dampen a provider's drive to improve if their recent better results are blended with older, poorer performance. In such a case, the provider's improved performance would not be fully recognized in its incentive payment for several years. To counter this disincentive, CMS could consider weighting the more recent years more heavily. CMS could also pool data across years only for low-volume providers, while reporting just the most recent year's performance for providers that meet a minimum count in a single year.

Reporting disparity measures

The Commission supports moving to publicly reporting stratified measure results. Publicly reporting Medicare quality information has two main objectives. The first is to increase the accountability of health care providers by offering patients, payers, and purchasers a more informed basis on which to hold providers accountable (e.g., directly through purchasing and treatment decisions). The second objective is to maintain standards and stimulate improvements in the quality of care through economic competition (reputation and increased market share) and by appeals to health care professionals' desire to efficiently deliver high-quality care to Medicare beneficiaries.¹³ The Commission also contends that public reporting should enable comparisons of

¹¹ Garrett, B., C. Carter, and D. Wissoker. 2021. Evaluation of the reliability of Medicare spending per beneficiary for post-acute care. *Medical Care* 59, no. 8 (August 1): 721–726.

¹² Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹³ Marshall, M. N., P. G. Shekelle, H. T. Davies, *et al.* 2003. Public reporting on quality in the United States and the United Kingdom. *Health Affairs* 22, no. 3 (May–June): 134–148.

individual providers with state and national averages to give consumers meaningful reference points.

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 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 James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.
Chair