MEDPAC | Medicare Payment Advisory Commission

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1780-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) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements," *Federal Register*, vol. 88, no. 130, p. 43654 (July 10, 2023). 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) 2024 national standardized 30-day period payment rate
- Proposed methodology for behavioral assumptions and adjustments under the home health prospective payment system (PPS)
- Expanding the Home Health Value-Based Purchasing Model nationwide
- Discharge function score measure beginning with the 2025 Home Health Quality Reporting Program (QRP) and the Home Health Value-Based Purchasing Model
- Wage index adjustment
- Hospice Special Focus Program

Calendar year 2024 national standardized 30-day period payment rate

CMS proposed a 2.7 percent update to the base payment rate for HHA services. This increase reflects payment adjustments mandated by statute: a 3.0 percent home health market basket update for 2024 reduced by the multifactor productivity adjustment of 0.3 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 assessment of Medicare fee-for-service (FFS) payment adequacy. In our March 2023 report to the Congress, the Commission found positive access, quality, and financial indicators for the sector, with a historically high aggregate Medicare FFS margin of 24.9 percent for freestanding HHAs in 2021, indicating that payments far exceeded costs.[1] The report recommended that the Congress reduce the 2023 Medicare base payment rate for HHAs by 7 percent for the 2024 payment year. Though, as discussed below, the payment update would be offset by a budget-neutrality adjustment required by the Bipartisan Budget Act of 2018 (BBA 2018), CMS estimates that the net update to the base rate would be –3.1 percent (–1.8 percent after adjustments related to case-mix recalibration and changes to the wage index), far less than the reduction recommended by the Commission. We also note that in this proposed rule, CMS reports that the HHA PPS base payment rate for 2022 exceeded the estimated cost of a typical 30-day period by 45 percent.[2] These excess payments are not necessary to ensure access to home health care services; further, they undermine incentives for HHAs to furnish care efficiently. Given these excess payments, a 7 percent reduction to the base rate in 2023 would not compromise beneficiaries' access to care or the quality of home health care they receive; indeed, a reduction of this magnitude still would likely be inadequate to align payments with costs.

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

BBA 2018 requires CMS to change the unit of payment in the home health PPS from 60 days to 30 days, and it 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. BBA 2018 requires CMS to implement these changes on a budget-neutral basis, such that spending in 2020 through 2026 would 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 payment 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 to the home health base payment rate when the agency determines that an observed deviation from expected behavior will continue in future years. The

[1] Medicare Payment Advisory Commission. 2023. *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.

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 through 2022. 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 these years.[3] CMS concluded that the spending under the new case-mix system in this period was $3.439 billion higher than the amount CMS would have spent under the prior case-mix system, and consequently exceeded the budget limitations created by BBA 2018. In order to prevent future payment levels exceeding the BBA 2018 spending levels, CMS estimates that the payment rate for a 30-day period under the PDGM system will need to be reduced by 9.36 percent to ensure that future spending is under the target. Including the effect of the 3.925 percent reduction implemented in the 2023 final rule, the net reduction in 2024 to meet the BBA 2018 target is 5.653 percent. This reduction would be offset by the home health payment update discussed above, and result in a net decrease in aggregate spending of 2.2 percent in 2024.

The 5.653 percent base rate reduction for 2024 adjusts for overpayments that are expected to occur in 2024 and future years. In the rule, CMS notes that it is also separately required to recover overpayments that occurred in prior years, and it estimates that $3.439 billion in overpayments occurred in 2020, 2021, and 2022. CMS indicates that the agency will address recovering these funds in future rulemaking.

Comment

The Commission strongly supports the proposed 5.653 percent reduction required by law to ensure that home health spending in future years is the same as it would have been if the PDGM system had not been implemented. 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 to 2022, CMS accounts for the utilization and coding changes that occurred in these years. As the effect of the COVID-19 pandemic 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 pandemic.

The Commission encourages CMS to further reduce payments temporarily in 2024 to recover the $3.439 billion that CMS estimates was overpaid from 2020 to 2023. CMS has three payment years remaining to recover the funds. Deferring the recovery of funds another year increases the amount that must be recovered in a single year. For example, if CMS were to recover these funds in 2024, 2025, and 2026, it would require an annual reduction in total payments of approximately $1.1 billion per year. A recovery of funds over two years (2025 and 2026) would increase the required

[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 88 FR 43673 for specific exclusions.

annual reduction to about $1.7 billion. Given the excess payments and high aggregate margin described above, an additional reduction to recover amounts that were overpaid from 2020 and 2023 should not raise concerns about payment adequacy in 2024.

Expanding the Home Health Value-based Purchasing Model nationwide

In 2025, CMS will begin adjusting payments under a Home Health Value-Based Purchasing (HHVBP) Model. In the model, HHAs will have their Medicare payments adjusted upward or downward based on their performance on a set of quality measures relative to other HHAs and performance benchmarks. HHAs can earn points based on achievement of certain performance levels or improvement compared to a baseline year. The measures used in the HHVBP model rely on data from home health claims, Outcome and Assessment Information Set (OASIS) patient assessment data, and the Home Health Consumer Assessment of Healthcare Providers and Systems® (HHCAHPS) survey.

Computing an agency's VBP payment adjustment requires combining scores on several quality measures to yield a single provider-level composite score. The weight for each measure depends on the source of the quality measure and the provider's size. Under the proposed rule, small agencies would have their scores calculated on the basis of evenly weighted data from OASIS data and home health claims (50 percent for each category). Large HHAs would have 35 percent of their score determined by OASIS-based measures, 35 percent based on claims-based measures, and 30 percent based on HHCAHPS® measures. Table 1 displays the weights for the respective categories of measures and providers in the proposed rule.

Table 1: CMS proposed weights for HHVBP, 2024

	Proposed measure weights (percent)	
	Larger-volume HHAs	**Smaller-volume HHAs**
OASIS-based measures		
Improvement in dyspnea	6.000	8.571
Improvement in management of oral medications	9.000	12.857
Discharge function	20.000	28.571
Subtotal	*35.000*	*50.000*
Claims-based measures		
Potentially preventable hospitalizations	26.000	37.143
Discharge to community	9.000	12.857
Subtotal	*35.000*	*50.000*
HHCAHPs®		
Care of patients	6.000	Not applicable (not used due to small sample size)
Communications between providers and patients	6.000	
Specific care issues	6.000	
Overall rating of home health care	6.000	

Willingness to recommend agency	6.000	
Subtotal	*30.000*	
Total, all categories	**100.000**	**100.000**

Note: HHVBP (Home Health Value-Based Purchasing), HHA (home health agency), OASIS (Outcome and Assessment Information Set), HHCAHPS® (Home Health Consumer Assessment of Healthcare Providers and Systems®). The smaller-volume HHA category includes agencies that served fewer than 60 patients in a year.

Comment

The Commission has noted that providers have an incentive to report OASIS information in ways that raise payments and appear to improve performance without any real change in actual performance. In our 2019 report to the Congress, we cite numerous examples of providers responding to financial incentives in how they report patients' function, rendering the assessment data of questionable value for payment, quality measurement, and care planning.[4] Therefore, we are concerned that, under the HHVBP Model, 35 percent to 50 percent of an HHA's score will be based on this information. Though we believe that functional status is a key outcome for home health care, CMS should not rely on these OASIS-based measures of function in the HHVBP until their accuracy and integrity are improved.

Discharge function score measure beginning with the 2025 Home Health Quality Reporting Program and the Home Health Value-Based Purchasing Model

CMS proposes to add a cross-setting Discharge Function Score (DC Function) measure to the Home Health Quality Reporting Program (QRP) and the HHVBP Model beginning in 2025. This outcome measure evaluates functional status by calculating the percentage of home health care patients who meet or exceed an expected discharge function score (self-care and mobility activities) using the standardized patient assessment data from the OASIS.

The method to calculate the proposed DC Function Score measure uses an imputation approach to account for functional item responses that were coded as "activity not attempted" (ANA). Specifically, the proposed method uses a statistical imputation approach that recodes missing functional data to the most likely value had the status been assessed, rather than the lowest or near-lowest level of function.

[4] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Comment

Maintaining or improving function is a key outcome for patients receiving post-acute care. However, we advise caution in the use of provider-reported patient function measures, such as the DC Function Score measure. As noted previously, the inconsistency of post-acute care (PAC) providers' recording of functional assessment information, such as change in mobility, raises concerns about using such information for purposes of quality measurement and payment. In addition, in our March 2023 report to the Congress, we noted that the current imputation method recodes any ANA code to the most dependent level (or second most dependent level), which, all else equal, would lead to a lower motor score and a higher level of Medicare payment.[5] To the extent that some providers code patient function in response to payment incentives, it is possible that some of these practices will be manifested in functional improvement data submitted through the Home Health QRP and being subsequently used to compute payments in the HHVBP. This could result in publicly reported quality measures being inaccurate, and some HHAs receiving higher payments than warranted under VBP. As noted above, though we believe that a patient's functional status is an important element of home health outcomes, we do not support reliance on these OASIS-based measures of function for payment or quality measurement until their accuracy or integrity are improved. We encourage CMS to seek ways to improve the assessment of patient function.

That said, the Commission supports CMS's proposal to use statistical imputation to recode missing functional status data to the most likely value had the status been assessed. However, we also suggest that the agency provide clarity on its methodology. We note that, in its unified PAC PPS prototype design for CMS/Office of the Assistant Secretary for Planning and Evaluation, RTI International used a Rasch analysis to recode ANA codes to create a motor function score for PAC users.[6] We encourage CMS to more clearly explain its proposed approach to recoding, contrasting it with the approach used in the PAC PPS prototype, to ensure transparency, clarity, and clinical meaningfulness.

Wage index adjustment

Since the inception of the home health PPS, CMS has used the hospital wage data to develop the home health PPS wage index. For CY 2024, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index to adjust home health payments (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

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[5] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

[6] RTI International. 2022. *Report to Congress: Unified payment for Medicare-covered post-acute care.* Report prepared for the Centers for Medicare & Medicaid Services. Research Triangle Park, NC: RTI International. https://www.cms.gov/files/document/unified-pac-report-congress-july-2022.pdf.

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[7] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to HHAs), Medicare needs wage indexes that are less manipulable, that accurately and precisely reflect geographic differences in market-wide labor costs, and that limit how much wage index values can differ among providers that are competing with each other for patients and employees.

In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local-area-level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.

Given the Secretary's authority (per Section 1881 of the Social Security Act) to determine the appropriate wage index to adjust the portion of the home health base rate attributable to wages and wage-related costs, we urge the Secretary to adopt the Commission's recommended approach to the wage index for this sector.

Hospice Special Focus Program (SFP)

The Consolidated Appropriations Act 2021 directs the Secretary to establish a Hospice Special Focus Program (SFP), in which the Secretary identifies poor-performing hospices that have substantially failed to meet requirements of the Social Security Act and to conduct more frequent surveys (at least every six months) of providers in the SFP. In this NPRM, CMS proposes to establish the SFP, including the criteria for identifying poor-performing hospices based on defined quality indicators, the frequency of surveys for SFP participants, and the criteria to determine if a provider successfully completes or fails the SFP and the consequences.

Each year, CMS proposes to identify 10 percent of hospice programs with the worst (highest) scores on an algorithm that utilizes four types of quality information. CMS proposes to select among that 10 percent of hospice providers for inclusion in the SFP.

[7]Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC

CMS proposes that the algorithm would reflect providers' scores on four different types of quality information as described below.

- Number of condition-level deficiencies based on surveys over the prior three years, looking at subset of 11 conditions of participation most related to quality of care.
- Number of complaints with substantiated allegations in the prior three years.
- Hospice care index—a claims-based quality measure that identifies outlier care patterns in 10 areas.
- Hospice CAHPS survey—how frequently a hospice received the lowest box score in four areas (i.e., help for pain and symptoms, getting timely help, willingness to recommend this hospice, overall rating of the hospice).

CMS proposes to calculate a single quality score for each hospice by calculating a standardized quality score in each of the four areas and averaging the four scores (with the CAHPS score receiving double weight).

For hospices that CMS selects for inclusion in the SFP, CMS proposes to survey the hospices every six months over an 18-month period. CMS proposes that hospices would be considered to successfully complete the SFP if they have no condition-level deficiencies in any two SFP surveys in an 18-month period and no pending complaints of immediate jeopardy. Hospices that fail to meet these criteria for successful completion would be placed on track for termination from the Medicare program.

CMS proposes to publicly report the 10 percent of hospice programs with the worst (highest) aggregate scores determined by the algorithm and the providers selected for the SFP from that 10 percent.

Comment

The Commission has long supported efforts to focus more regulatory oversight on the subset of hospice providers with concerning patterns of care that signal poor quality. The Commission supports the intent of the SFP for hospice oversight and believes that the approach that CMS has proposed is reasonable. We support CMS's proposal to publicly report the 10 percent of hospices that are identified via the algorithm, and the subset of those hospices selected for the SFP. This information could be helpful to beneficiaries and families as they choose a hospice provider.

Although CMS lays out in detail how the agency proposes to identify the 10 percent of hospice providers that will be considered for the SFP, CMS does not provide information about how it will select providers from among this group for inclusion in the SFP. There are benefits to CMS having some flexibility in selecting among the 10 percent of hospices for inclusion in the SFP because survey resources may be limited and CMS may have additional information beyond the provider's algorithm score that could guide the agency in terms of where the SFP would have the most positive impact. Nonetheless, it would be helpful for the agency to articulate what factors it will

consider in selecting providers from among the 10 percent for the SFP. For example, the agency could consider the seriousness of issues identified in condition-level deficiencies or substantiated complaints and whether the provider has taken meaningful actions that resolve the issues. In addition, CMS may wish to consider the size of the provider in some cases; for example, if a large provider caring for many beneficiaries scores in the 10 percent of all providers with the poorest performance on the algorithm, prioritizing inclusion of the large provider in the SFP may have the potential to improve care for many beneficiaries. At the same time, small providers should not be exempt from selection for the SFP just because of their size if the care they furnish raises significant quality concerns. To the extent that CMS can only select a subset of the 10 percent each year for inclusion in the SFP, the agency could consider prioritizing these providers in upcoming years, particularly those who are repeatedly identified in the 10 percent group but have not been previously selected.

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 Dana Kelley, MedPAC's Deputy Director, at (202) 220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair