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August 29, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1611-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-1611-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 and Medicaid program; calendar year 2015 home health prospective payment system rate update; home health 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 reduce payments by 0.3 percent. In this letter we comment on the payment update for 2015, changes to the face-to-face visit requirement, recalibration of the payments weights for the home health resource groups, changes to the pay-for-reporting program, and the value-based purchasing model.

Updates to the home health prospective payment system (PPS)

The Patient Protection and Affordable Care Act (PPACA) included a provision intended to rebase home health payments. Under this provision, CMS has the authority to adjust the home health payment base rate based on its analysis of the adequacy of the rate compared to the average cost of an episode. PPACA required that any payment reductions due to rebasing be phased in annually over four years, limited any reduction to no more than 3.5 percent of the base rate in effect in 2010 and that any reduction be offset by the annual payment update indexed to the home health basket.

CMS presented analysis in the 2014 home health payment rule that estimated payments were 13.6 percent in excess of costs in 2013, and set the reduction factor for the 60-day home health episode at 3.45 percent a year, a reduction of \$80.95 per year in each year from 2014 through 2017. In its 2015 proposed rule, CMS updates its analysis of the estimated cost of an episode in 2013, and

finds that it was lower than previously estimated. Based on this new data, CMS estimated that it would need to reduce the base rate annually by 4.29 percent over 4 years to bring payments in line with the estimated cost of an average episode.

CMS estimates that the aggregate home health payment will decline by 0.3 percent in 2014. The payment impact of the proposed rule will vary for different categories of HHAs, as the rule also includes changes to the case-mix weights and wage index which redistribute funds within the PPS. Table 34 in the proposed rule estimates the net impact of the proposed changes, and identifies the types of agencies that, net of all policies in the rule, gain or lose. Facility-based and non-profit agencies are estimated to have payments that will be 0.6 percent higher in 2015, while for-profit and free-standing agencies are expected to see reductions of 0.3 percent and 0.6 percent, respectively. As the Commission reported margins of 12 percent or higher for for-profit and non-profit home health agencies in 2012, we do not expect this rule to materially affect the operations of most agencies.

We recognize that CMS has implemented the maximum reduction for 60-day episodes permissible by PPACA, but we are concerned that this reduction will be too small. CMS estimates the net aggregate reduction in 2015 will equal a modest 0.3 percent, and due to the technical factors mentioned above many agencies will see reductions less than this rate or even experience payment increases. The Commission's estimated Medicare margin for all free-standing home health agencies in 2014 is 12.6 percent and the payment levels in the proposed rule suggest that payments are more than adequate. We recommended to Congress that rebasing be implemented in a shorter period, and also recommended eliminating the annual payment update. As we noted in our March 2014 report, additional changes to statute to address these shortcomings would help to bring payments closer to costs than the current approach to rebasing.

In the proposed rule CMS notes that in the past a significant portion, over 80 percent, of the change in case-mix weights has been attributable to changes in coding and not increases in patient severity. CMS adjusted payments in 2008 through 2013 based on an analysis of changes in coding and patient severity, but proposes no coding adjustment for 2015. Given the history of coding increases that are not attributable to severity, CMS should analyze the nominal change in the reported average case-mix for more recent years and implement additional payment reductions as warranted.

Proposed changes to the face-to-face visit requirement

Under current Medicare requirements, physicians must certify the eligibility and need for home health care, and supervise the delivery of care during the episode. PPACA added a provision that a physician must have a prior face-to-face visit with a beneficiary before certifying the need for home health.¹ Current regulations also require that the physician prepare a narrative indicating that the patient satisfies the Medicare's skilled need requirement and meets the homebound requirement for home health care. The narrative is only required at initial admission to home

¹ The requirement allows an encounter with a non-physician practitioner operating in collaboration with the certifying physician or telehealth to meet the requirement.

health care, and is not required for subsequent episodes in a multi-episode spell of home health. The proposed rule would eliminate the requirement for the physician narrative.

The Commission is sensitive to the burden that additional documentation requirements can create, but is also concerned about the history of program integrity issues in the home health care benefit. The narrative was intended as another safeguard to strengthen the integrity of the benefit. Eliminating the narrative increases the risk of unnecessary or unauthorized home health care services. The Commission believes that the narrative, perhaps in a modified form, should continue to be a requirement. CMS concurred with three recommendations in a recent audit by the Office of Inspector General: consideration of a standardized form for the narrative to simplify compliance, improved outreach efforts to physicians about the narrative requirement, and consideration of other forms of administrative review of the narrative.² CMS should keep the current requirement in effect for at least another year while it considers these potential improvements.

Proposed recalibration of the home health prospective payment system case-mix weights

In the home health PPS patients are assigned to a case-mix group based on the clinical indications, functional status, timing of episode and number of therapy visits provided in an episode. The standard 60-day episode payment for a case-mix group is the product of multiplying the case-mix weight by the home health base payment rate.

In 2011 CMS analyzed the relative profitability of therapy and non-therapy episodes, and concluded that manual adjustments to the case-mix weights were needed to rebalance the weights and ensure that therapy episodes were not disproportionately profitable relative to non-therapy episodes. The weights for episodes with five or fewer therapy visits were increased 3.75 percent, and the weights for episodes with 14 or 15 visits and 20 or more visits were reduced by 2.5 percent and 5 percent, respectively. In the recalibration of the case-mix weights in the CY2015 proposed rule, CMS intends to adjust the case-mix weights by these same factors.

The Commission supports updating the case-mix weights with 2012 utilization data, but has concerns that the new system retains the visit-based thresholds that tie payments to the number of therapy visits provided in an episode. Episode volume has typically shifted to those payment groups that are most profitable under the therapy thresholds. In our March 2011 Report to Congress we recommended that Medicare eliminate these thresholds and pay for home health care solely based on patient characteristics. Though CMS has made efforts to reduce payments for therapy episodes, the incentives of the thresholds, with more visits garnering higher payments, remain in operation.

The manual adjustment to the case-mix weights would not be necessary if CMS eliminated the therapy thresholds. However, to the extent that CMS is pursuing this policy for 2015 the agency should analyze the payment-to-cost ratios for the proposed payment weights before and after this

² Office of Inspector General, Department of Health and Human Services. *Limited compliance with Medicare's home health face-to-face requirement documentation requirements*. OEI-01-12-00390. Washington, DC:OIG

manual adjustment (similar to the analysis conducted when CMS first implemented this adjustment in the CY2012 payment rule). This additional analysis will allow CMS to assess whether these adjustments equalize the financial incentives for therapy and non-therapy episodes.

Home health quality reporting program requirements for CY 2015 payment and subsequent years

The Deficit Reduction Act of 2006 (DRA) included a requirement that agencies submit quality data in order to receive the full payment update in 2007 and subsequent years. Agencies that fail to submit quality data receive a two percentage point reduction payment reduction to the applicable annual payment update. CMS has established that an agency's submission of the Outcomes Assessment Information System (OASIS) data fulfilled the DRA requirement. However, the quantity of assessments an agency must submit to meet the requirement has never been set, and agencies that submit incomplete data have been credited as completing the requirement. The proposed rule would require that agencies submit 70 percent of their OASIS assessments in 2015, with the percentage increasing to 90 percent by 2017.

Ensuring that agencies submit complete OASIS data is necessary for quality reporting and program integrity purposes, and MedPAC supports the proposed change. The requirement for submission of OASIS data to receive a full payment update has been in effect for many years, and agencies should have many years of experience with the transmission of this data. CMS should consider phasing in the requirement faster given the familiarity of HHAs with these processes, perhaps raising the threshold to 90 percent in the second year.

HHA value-based purchasing model

Medicare has made several efforts to implement Value-Based Purchasing (VBP) across the program, and this rule proposes a VBP demonstration for home health agencies. The rule does not commit to a specific start date, but notes the demonstration could be implemented as early as 2016. The rule proposes several elements that could be included in the home health VBP demonstration:

- The demonstration could apply to agencies in five to eight selected states. All HHAs in a state would be required to participate. The rule requests comment on the factors that could be considered in selecting states.
- The demonstration's financial incentives could include both rewards and penalties. The assessment of performance determining the size of any financial incentive could examine both an agency's attainment (absolute level of performance) and improvement.
- A substantial share of payments should be at risk to provide maximum incentive for agencies under the demonstration, and CMS offers a range of 5 to 8 percent.

The Commission believes that VBP can be a valuable tool for incentivizing home health agencies to provide better care. In principle, the Commission believes that VBP should focus on outcomes measures, and provide clear incentives for providers to improve care. An initial approach to the

VBP could begin with the Commission's recent recommendation to establish a home health readmissions policy.

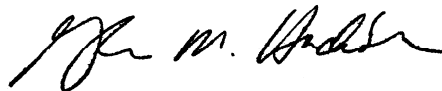
The Commission's readmissions recommendation for home health care included several parameters. The period of time covered by the VBP measure should include the entire home health stay, and also include readmissions that occur within 30 days of the end of home health care. The measure should be risk-adjusted, and count only those readmissions that are potentially preventable.

The financial incentives should be based on a benchmark readmission rate set in advance of the program's first performance period. Agencies with performance above the benchmark would be penalized, while those below would not be subject to penalties. Agencies that serve high shares of low-income patients should be compared to a peer group of providers so that agencies serving such populations are not unduly penalized given that these beneficiaries tend to have higher rates of readmission. The magnitude of the financial incentive should be sufficient to motivate improvement, and CMS' proposed five to eight percent could be low given the average profitability of home health agencies. The demonstration should focus on states with high rates of readmission, and participation in the VBP program should be mandatory for all agencies operating in the selected states.

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