

August 30, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1689-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "Medicare and Medicaid Programs; CY2019 home health prospective payment system rate update and 2020 case-mix adjustment methodology refinements; home health value-based purchasing model; home health quality reporting requirements; home infusion therapy requirements; and training requirements for surveyors of national accrediting organizations," *Federal Register*, vol. 83, no. 134, p. 32340 (July 12, 2018). 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.

This rule proposes a payment update for HHAs in payment year 2019 and details a number of additional proposals. We comment on the payment update for 2019, the rural add-on for 2019 through 2022, home health payment reforms in the Bipartisan Budget Act of 2018, the proposed Patient Driven Groupings Model (PDGM) for 2020, reporting of remote patient monitoring, changes to the Value-Based Purchasing program, revisions to the Home Health Quality Reporting Program, and payment for home infusion therapy services.

Proposed CY 2019 national standardized 60-day episode payment rate and impact of Patient Protection and Affordable Care Act payment rebasing

The proposed rule would implement a 2.1 percent update to the base rate, reflecting a 2.8 percent market basket reduced by 0.7 percent for multi-factor productivity.

The rule also assesses the impact of payment changes required by the Patient Protection and Affordable Care Act (PPACA) in 2014 through 2017, a payment policy referred to as home health rebasing. The review of costs indicates that the margin for the average full episode in 2016 was

16.8 percent, well in excess of providers' costs.¹ The review of utilization found that both the number of beneficiaries using home health care and the number of episodes have declined since 2013, the year before rebasing was implemented. The rule notes that the number of episodes has declined 12 percent since 2013. The per capita utilization declined from 17 episodes per 100 fee-for-service beneficiaries in 2013 to 15 episodes per 100 fee-for-service beneficiaries in 2017. Even with these declines, 8.4 percent of beneficiaries used home health services in 2017.

Comment

The Commission recognizes that CMS must provide the statutorily mandated payment update but notes that this increase is not warranted based on our analysis of payment adequacy. The Commission reported margins of 15.3 percent in 2016 for freestanding HHAs. The increase in payments under this rule will raise agency margins, and these additional expenditures will further strain the finances of Medicare beneficiaries and the program.

CMS's review of utilization is consistent with the Commission's findings on access to care. In our March 2018 report to Congress, we assessed the trends in utilization since 2011, the year of peak home health volume and spending. Our review found that episode volume fell 4.6 percent between 2011 and 2016, but over 90 percent of that decrease occurred in five states (Florida, Illinois, Louisiana, Tennessee, and Texas) that experienced unusually high growth between 2002 and 2011.

In our March 2018 report to Congress, the Commission recommended a payment reduction of 5 percent for 2019. We also recommended that a two-year rebasing be implemented beginning in 2020, concurrent with the removal of therapy visits provided in an episode as a factor in the payment system. We believe these reductions are necessary to better align Medicare's payments with the actual costs of HHAs. The Commission recognizes the increase is required by law, but notes that it will widen the gap between Medicare's payment for home health care and the average costs of providers.

In past years, CMS lowered home health payments to account for reported increases in home health case mix that were found to be unrelated to patient severity. The prior adjustments accounted for unwarranted case-mix growth observed in data through 2014, and CMS has not yet assessed changes in case mix that occurred between 2015 and 2017. The experience of CMS's past analysis, which has found that most of the annual increase in case mix is unrelated to an increase in patient severity, suggests that CMS should analyze this period and implement any reductions deemed appropriate.

Proposed rural add-on payments for CYs 2019 through 2022

The proposed rule would implement the rural payment add-on required by the Bipartisan Budget Act of 2018 (BBA of 2018) for payment years 2019 through 2022. The Act establishes three categories of rural counties and ties the duration and size of the payment add-on for each category

¹ A full episode includes five or more visits in a 60-day episode. Episodes with less than five visits are paid on a per visit basis.

to the population density and utilization levels of rural counties. CMS used Medicare data on patient location and service utilization from 2015 to compute these factors. Statute requires that CMS assign a county to one of three categories based on this data. This designation remains in effect for the 2019 through 2022 period. The categories include:

- **High-utilization counties.** Services furnished in rural counties in the top quartile of utilization would receive a payment add-on of 1 percent in 2019 and one-half percent in 2020. CMS computed the ratio of home health episodes to fee-for-service beneficiaries in 2015 for all counties (both urban and rural), and based on this distribution, rural counties with 17.8 episodes per 100 beneficiaries or more were classified as high-utilization areas.
- **Low-population counties.** Episodes provided in areas with a population density of six individuals or fewer per square mile and that are not high-utilization counties would receive a 4 percent add-on in 2019. The add-on would decrease by 1 percentage point each year and end after 2022.
- **All other counties.** Rural counties that are not categorized in either of the above categories would receive a 3 percent add-on in 2019, also decreasing by 1 percentage point each year to end after 2021.

Comment

The rural payment add-on policy for 2019 is an improvement that better targets Medicare's scarce resources. In general, MedPAC has not found systemic issues with rural access to care, and margins of rural home health agencies are generally above 10 percent a year, comparable to urban agencies. Average utilization is not significantly different between urban and rural areas, but there is some variation around this average, with high- and low-use areas found in both urban and rural counties. The proposed policy targets payments to areas with lower population density and limits payments to rural areas with higher utilization. This is consistent with our June 2012 report to the Congress, which noted that Medicare should target rural payment adjustments to areas that may have access challenges.

Changes to payment incentives and the unit of payment mandated by the Bipartisan Budget Act of 2018

The rule discusses implementation of two policies the BBA of 2018 requires in 2020: (1) the elimination of the number of therapy visits provided in an episode as a payment factor in the prospective payment system (PPS) and (2) a 30-day unit of payment. Both policies were proposed by CMS in last year's home health payment rule.

The statutory requirement to eliminate therapy visits would give a greater role to patient characteristics in setting payment for home health services. The number of therapy visits per episode has increased significantly since the home health PPS was implemented, raising concerns that financial incentives to provide more therapy were influencing patient care. CMS has made several attempts to reduce the incentives to provide more therapy under the current system, such as

reducing payments to higher-paying episodes with therapy visits. However, the share of episodes qualifying for additional payment has continued to increase.

In last year's rule, CMS proposed the 30-day unit of payment period to better align the unit of payment with utilization trends, noting that most episodes last fewer than 60 days, with 25 percent of episodes in 2016 complete by 30 days. CMS found that, in general, the number of visits declines with time, with the first 30-day period of the episode having a higher average number of visits than the second 30-day period. In addition, CMS found that the predictive ability of case-mix factors was higher for 30-day periods than for the current 60-day episodes.

Comment

Eliminating the volume-rewarding incentives created by the use of therapy visits as a payment factor would address a problematic vulnerability in the current system. For many years, MedPAC has been concerned about the incentives created by the use of therapy as a payment adjuster. We recommended eliminating the therapy adjustments in our March 2018 report to the Congress and in several prior reports. This concern has been echoed by the Congress and federal oversight agencies. Including services, such as therapy, as payment factors in the PPS creates a financial incentive for providers to give less weight to certain patient needs and even to engage in selection favoring admitting those patients who need specific therapy services. The alternative system proposed by CMS in conformity with the applicable statutory requirement would increase the role of patient characteristics in setting payment, thereby reducing a significant vulnerability in the current system. CMS should closely monitor the impact of moving to the 30-day unit of payment. As CMS notes, many episodes end before the 30th day. HHAs would now have an incentive to extend, when feasible, services past the 30th day to trigger an additional 30-day period and the resulting payment. Though CMS requires that agencies provide a certain number of visits to receive the full case-mix adjusted episode payment, agencies might need to provide only a few additional visits to surpass the threshold.

Implementation of the Patient-Driven Groupings Model (PDGM) in 2020

CMS proposes to implement the PDGM in the home health PPS for CY 2020, a revised version of the Home Health Groupings Model (HHGM) proposed last year. CMS developed the new system in response to a PPACA mandate to assess the home health PPS, and the new case-mix system is intended to address concerns cited by the Commission and others about incentives under the current system. The PDGM categorizes 30-day episodes into 216 payment groups based on the following characteristics:

- ***Episode timing.*** Services in the first 30 days of a spell of home health would be classified as “early,” while services in the subsequent 30-day period would be classified as “late.” For example, if a beneficiary had two consecutive 60-day payment episodes under the current system, the first 30-day period would be classified as early, while the three subsequent 30-day periods would be classified as later 30-day periods.

- **Referral source.** Cases would be categorized based on the services received prior to the beginning of the episode: prior hospitalization or institutional post-acute care (PAC), or admitted from the community.
- **Clinical category.** The new system would create six clinical categories based on patients' reported conditions: need for musculoskeletal rehabilitation; neuro/stroke rehabilitation; wound care; behavioral health care; complex care; and medication management, teaching, and assessment.
- **Functional/cognitive level.** Similar to the existing system, the HHGM would classify patients' cognitive and physical functioning using information from the OASIS home health patient assessment.
- **Presence of comorbidities.** CMS proposes to adjust payment for commonly occurring comorbidities in home health care. There would be a three-tiered adjustment for all selected comorbidities.

Comment

The PDGM and the 30-day unit of payment will be the most significant changes to the home health PPS since the system was implemented in 2001. The new case-mix system is intended to be less complex than the current system, while accurately describing a beneficiary's primary need for home health care. CMS's 2016 technical report noted the Commission's concerns that the home health benefit is ill-defined; the proposed grouping system seeks to more accurately characterize a patient's need for home health care. Below are our comments on two policies: the referral source case-mix factors (use of inpatient hospital or institutional PAC services prior to home health care) and the Medication Management, Teaching, and Assessment clinical category.

Referral source: Use of prior hospitalization or institutional PAC use as a payment adjuster.

The PDGM would use hospital or institutional PAC use in the 14-day window before admission to home health care to set payment; Medicare would pay more for cases with prior use of these services than for cases without them. CMS notes that this adjustment is consistent with patterns of service in home health care, as patients coming from the hospital have higher use of home health services initially.

Adjusting payment to reflect prior use of these services would improve the accuracy of the payments in the revised system, but it would also create incentives that need to be carefully considered. The adjustment would better align payments to costs, reflecting that post-hospital or PAC episodes tend to have higher resource use than community episodes. The absence of such an adjustment would relatively underpay post-hospital cases and relatively overpay for community episodes.

The disadvantage of the proposed adjustment arises for second or later 30-day periods in a spell of home health care. Under CMS's proposal, if a patient was hospitalized during the first 30-day period, payments for the second 30-day period would be higher than they would have been without

the prior hospitalization. The proposed adjustment may counter other incentives to avoid hospitalization, such as those CMS is seeking to create through Value-Based Purchasing efforts. CMS should review HHA-level trends in episode referral source and readmission rates after implementation of the new system. As discussed below, allotting more weight to measures of hospitalization in the VBP program could help to counterbalance the incentive created by the use of prior hospitalization in the case-mix system.

In response to comments from the public, the proposed rule explores an additional third category for referral source that accounts for emergency department use or hospital observation stays prior to home health care. The review finds that these episodes typically have an average cost that is higher than other community episodes (their assigned payment category in a system without a flag for the emergency department or observation stays), but lower than the average cost of post-hospital or institutional PAC episodes. However, CMS opted not to propose additional categories because the frequency of these services prior to home health care is relatively rare, and because they could create problematic incentives that rewards HHAs for the use of these services. MedPAC concurs with CMS's decision to adjust payments based on these referral sources.

Medication Management, Teaching, and Assessment clinical category. The six clinical categories include five that are characterized by reported diagnosis. A sixth category, Medication Management, Teaching, and Assessment (MMTA), would capture cases that do not fall into the other categories. The Commission is concerned that a residual group such as the MMTA category—which does not rely on reported diagnosis—would account for a significant share of home health cases. In 2016, about 60 percent of cases are assigned to the MMTA category.

The Commission comments for last year's proposed rule suggested that CMS examine approaches to subdividing the MMTA category into smaller groups, and the current proposed rule assesses the feasibility of this option. The analysis subdivides the MMTA group into six groups based on commonly occurring diagnoses. The results indicate that the mean resource use did not vary substantially for most of the subgroups, and therefore CMS does not propose subdividing the MMTA clinical group.

The limited variation in cost among subgroups supports CMS's decision, but the broad clinical definition of this group suggests that the agency should monitor the utilization for this group in the future. Avoiding the MMTA category can yield higher payments, as MMTA is a fallback category assigned when episodes do not have a diagnostic code assigned to one of the other five clinical categories. A review of coding after the implementation of PDGM should be conducted to check for any aberrant patterns.

Determination of the base rate for the 30-day unit of payment

The BBA of 2018 requires Medicare to set the base rate for 30-day episodes in a budget neutral manner. The statute requires CMS to account for expected changes in coding or other HHA practices when setting the base rate for 2020, and the rule details three behavioral responses by

HHAs that CMS estimates could result in a 6.42 percent increase in case mix unrelated to patient severity in 2020:

- Slightly increasing visits to qualify for a full-episode payment. Medicare currently makes a low-utilization payment adjustment (LUPA) for episodes with four or fewer visits under the current system. LUPA payments in 2016 averaged \$408 per episode, compared to \$2,998 for a full episode. In the new system, the LUPA threshold would vary based on payment group from two to six visits. CMS assumes that visits would increase for about one-third of episodes that are one or two visits below the new thresholds. Episodes would qualify for the higher-paying full episode payment as a result of this change, and CMS estimates this would increase average payment per episode by 1.75 percent.
- CMS assumes that more episodes will qualify for the comorbidity payment adjustment because administrative claims permit agencies to report more secondary conditions compared to the data used to construct the PDGM case-mix system. The OASIS patient assessment instrument, which allows HHAs to report up to five secondary diagnoses, was the data source for constructing the new case-mix system. Medicare will make payments based on administrative claims HHAs submit, and claims allow providers to report up to 24 secondary diagnoses. CMS estimates that the average payment per episode will increase by 0.38 percent because of the additional secondary diagnoses that HHAs can report on the claim.
- CMS assumes that the coding of primary diagnostic conditions will change to shift patients to higher-paying clinical categories. MMTA, as noted earlier, is one example of a lower-paying category HHAs may seek to avoid. CMS assumes that the coding of more clinical comorbidities will increase the average payment per episode by 4.66 percent.

Accounting for the behavioral adjustment above, CMS estimates that in 2019 the 30-day base rate would equal \$1,753.68.

The BBA of 2018 requires CMS to analyze data for CYs 2020 through 2026, the period after implementation of the 30-day unit of payment and new case-mix adjustment methodology, to determine how the actual aggregate home health expenditures differ from the expenditures expected under the assumed behavior changes. 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 deviate from the expenditures expected under CMS's assumptions. CMS has the authority to make permanent adjustments when it determines that a deviation from expected behavior will occur in future years. The statute provides the authority for temporary (one-year) adjustments when CMS identifies overpayments or underpayment that occurred in a prior year. For example, if CMS identified an overpayment or underpayment in 2020 during a review in a later year, it would adjust payments in a future year to recover or repay any amounts due.

Comment

The significant changes to the unit of payment and the case-mix system proposed for 2020 will likely lead to extensive changes in agency practices. The past experience of the home health PPS demonstrates that HHAs have changed coding, utilization, and the mix of services provided in reaction to new payment incentives. For example, when CMS implemented revisions to the home health case-mix system in 2008, subsequent analysis found that behavioral responses unrelated to patient severity caused payments to increase 4 percent—a rate that had averaged 1 percent a year in 2001 to 2007. CMS continued to find nominal increases in case mix unrelated to patient severity in later years and reduced payment by an average of 1.8 percent a year in 2008 through 2017 to account for this trend. The proposed episode payment reduction of 6.42 percent appears to be consistent with past trends in coding that CMS has reported. Assuming current trends continue, we would not expect that a 6.42 percent reduction would create payment adequacy issues for most home health agencies. However, the proposed adjustment may not represent all of the behavioral changes that could occur.

The proposed rule does not include any assumptions for changes in episode volume under the new system. This is a notable omission, as agencies could also respond to the new 30-day unit of payment by providing additional visits after an initial episode. Additional episodes in response to the shorter unit of payment would result in higher aggregate payments, and CMS should establish a behavioral assumption that accounts for an increase in episode volume. Since Medicare enrollment will increase in future years, the behavioral assumption could be tied to an average number of episodes per home health user. This would ensure that additional episodes attributable to an increase in enrollment would not trigger payment adjustments.

Proposed change regarding remote patient monitoring under the Medicare home health benefit

The proposed rule would allow the costs associated with remote patient monitoring to be an allowable cost on the home health cost report. CMS focuses on remote patient monitoring because of its potential benefit to patients and because it has demonstrated effectiveness for some patients according to the health services research literature. The rule contends that remote patient monitoring can be used by HHAs to identify changes in beneficiary health and update patient plans of care.

Remote patient monitoring typically involves the placement of a tablet or smart phone in a beneficiary's residence during a home health episode. The device will have peripherals that collect vital signs related to the patient's conditions, and it would transmit the data to the HHA or a monitoring service retained by the agency. CMS contends that remote patient monitoring does not meet the statutory definition of telehealth, and therefore existing statute that effectively prohibits a beneficiary residence from serving as an originating site for telehealth is not applicable.²

² Statute requires that an originating site be a "health care setting." This is generally interpreted as excluding a residence.

The proposed rule defines remote patient monitoring as the digital storage and transmittal of physiological data by the patient to a home health agency. Under the proposed change, agencies that used remote patient monitoring data for care planning will be permitted to report it as a Medicare-allowable cost in 2019 and later years, effectively expanding the home health benefit to include these services. Only costs associated with the equipment and services related to remote patient monitoring could be reported.

Comment

MedPAC notes that remote patient monitoring and other telehealth technologies have the potential to change how care is delivered in the home. The service may improve the quality of care and lower costs for beneficiaries and the Medicare program if properly implemented. However, like other health care services, the implementation of remote patient monitoring has the potential for inefficient or wasteful utilization that increases costs without yielding better outcomes if it is used inappropriately. Despite this concern, the Commission concurs with the proposal to classify remote patient monitoring as an allowable cost, and this information should be used to examine the impact of this service on resource use and outcomes.

Building this evidence base, and safeguarding beneficiary care, will require information about the frequency and duration of the use of remote patient monitoring services, and for these reasons the Commission recommends that HHAs also be required to report on the Medicare claim whether an episode included the use of remote patient monitoring. This would facilitate a review of the impact of the service on cost and outcomes, and it would also permit CMS to examine utilization patterns to ensure that the service is not being used as a substitute for face-to-face care. The information submitted should include the number of days remote patient monitoring was utilized, and a basic description of the physiologic data collected (which vital signs, *et cetera*). Permitting remote patient monitoring as an allowable cost without this information could weaken the oversight of the home health benefit, and it would also deprive CMS of the information it needs to understand the impact of this service on Medicare costs and outcomes.

The additional data is also necessary to ensure that CMS has the information it needs to set the relative weights in the home health PPS. In the future, it may be necessary to understand how remote patient monitoring affects the cost of specific categories of home health episodes. CMS already collects claims-level resource use information on other allowable costs in the home health benefit, such as the length and type of in-home visits and non-routine supply use, and similar treatment for remote patient monitoring appears necessary to ensure that these costs can be properly measured when setting payments.

Proposed provisions of the Home Health Value-based Purchasing (HH VBP) model

The Home Health Value-based Purchasing (HH VBP) model aims to improve the delivery of home health care services to Medicare beneficiaries by giving HHAs incentives to provide better quality care with greater efficiency. The HH VBP will adjust HHAs' Medicare payments (upward or downward) in nine model states based on their performance on a set of quality measures. The first

HH VBP payment adjustment began January 1, 2018, based on 2016 performance data. The pool of HH VBP dollars is funded by a payment withhold that increases from 5 percent in 2018 to 8 percent in 2021. The initial rules of the program defined a starter set of measures that include outcomes measures collected in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies, patient experience survey measures from the Home Health Consumer Assessment of Health Providers and Systems (HH CAHPS), claims-calculated measures (e.g., *Acute Care Hospitalization: Unplanned Hospitalization during First 60 Days of Home Health*), and a number of agency-submitted process measures.

Removal of measures. In the CY 2019 proposed rule, CMS proposes to remove the *Influenza Immunization Received for Current Flu Season* and *Pneumococcal Polysaccharide Vaccine Ever Received* quality measures for the fourth performance year of the HH VBP. CMS explained that the influenza measure does not accurately capture patients who declined the vaccine or where a vaccine was contraindicated. There has been a change in the clinical guidelines for administering the pneumonia vaccine, so CMS proposed to remove the out-of-date measure from the HH VBP. CMS also requested input on whether the agency should replace three individual OASIS measures (e.g., improvement in bathing, bed transferring, and ambulation locomotion) with two composite measures: *Total Normalized Composite Change in Self-Care* and *Total Normalized Composite Change in Mobility*. These composite measures are more comprehensive and assess magnitude of change (either improvement or decline) rather than just improvement.

Comment

The Commission has recently formalized a set of principles for measuring quality in the Medicare program. Overall, quality measurement should be patient-oriented, encourage coordination, and promote delivery system change. The Commission asserts that Medicare quality incentive programs should use a small set of outcomes, patient experience, and value measures that are not unduly burdensome to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, accountable care organizations (ACOs), and fee-for-service (FFS) in defined market areas, as well as those cared for by specified hospitals, groups of clinicians, and other providers. Process measures are burdensome on providers to report, while yielding limited information to support clinical improvement. Therefore, the Commission supports removing two process measures from the HH VBP and encourages CMS to remove other process measures from the HH VBP, such as *Shingles Vaccination*, *Influenza Vaccination* and *Advance Care Plan*. In addition, we are concerned that some measures, such as *Composite Change in Self-Care* and *Composite Change in Mobility*, represent reporting elements completely within the control of home health agencies. When data from such measures is used for risk-adjustment or to adjust payments under a VBP, providers may inappropriately respond to the intrinsic financial incentives simply by changing their coding practices. While we believe that improving a patient's functional ability is a goal of home health care, we urge CMS to be cautious in relying heavily on such measures.

Revising weighting methodology. Currently in the HH VBP, all quality measures are weighted equally. CMS is seeking comment on whether to differently weight OASIS, claims-based, and HH

CAHPS measures. CMS proposes the total weight for all OASIS assessment measures (e.g., change in self-care and mobility) to be 35 percent, the total weight of claims measures (i.e., hospitalizations, emergency department use) to be 35 percent, and the total weight of patient experience measures (e.g., communication, overall rating of care) to be 30 percent. CMS provides data (see Figures 5 and 6 in the proposed rule) demonstrating a steady improvement in OASIS-based measures, while improvement in claims-based measures has been relatively flat. The proposed weighting would notably increase the weighting of the claims-based measures from about 12 to 35 percent and decrease the weighting of the OASIS measures from about 56 to 35 percent. The patient experience weighting would slightly decrease from 31 to 30 percent. Within the claims-based measures, CMS proposes that *Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health* have three times the weight of the *Emergency Department Use without Hospitalization* claims-based measure, based on their understanding that HHAs may have more control over the hospitalization measure and hospitalizations have a greater impact on Medicare spending.

Comment

As previously stated, we believe that CMS should be mindful that measures, when used for risk-adjustment or to adjust payments under a VBP, may induce undesirable provider responses to the resulting payment incentives. CMS's analysis comparing performance on claims-based and OASIS-based measures in HH VBP model states and non-model states over time, supports this expectation. For all OASIS-based measures, except the *Improvement in Management of Oral Medications* measure and the *Discharge to Community* measure, there has been substantial improvement in both model and non-model states over time. However, there has been a slight increase (indicating worse performance) in both the claims-based *Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health* and *Emergency Department (ED) Use without Hospitalizations* measures. This flat performance of HHAs on the more objective claims-based measures confirms our concern about the validity of the assessment data.

Overall, we support the move to weight claims-based measures more than assessment-based measures. We encourage CMS to weight the patient experience, not just the claims-based, measures more than the assessment data. The Commission believes that patient experience can be an important way to assess quality of care, but it notes that CMS's proposed methodology would slightly reduce the patient experience weighting. As an alternative, we suggest that CMS weight the patient experience and claims measure domains at 35 percent each and the OASIS assessment measures at 30 percent.

Rescore the maximum amount of improvement points. In the HH VBP, HHAs can earn 0 to 10 points based on whether they achieved defined levels of performance on a measure. Agencies can also earn 0 to 10 points based on how much their performance improved from their baseline performance. CMS is proposing to reduce the maximum improvement points from 10 to 9 because, after several years of participation in the HH VBP, the HHAs should have had enough time to make the necessary investments in quality improvement efforts to support a higher level of care, warranting a slightly stronger focus on achievement over improvement on measure performance.

Comment

The Commission's principle is the Medicare quality programs should give rewards based on clear, absolute, and prospectively set performance targets. Therefore, we believe that CMS should only reward agencies on whether they achieve objective performance targets, not whether they improve over time. We encourage CMS to move away from scoring improvement in the HH VBP.

Proposed updates to the Home Health Care Quality Reporting Program (HH QRP)

Beginning in 2007, the Home Health Quality Reporting Program (HH QRP) reduces an HHA's market basket percentage by 2 percentage points if it does not report a set of OASIS, HH CAHPS and other quality measures to CMS on a regular basis. For their own quality improvement work, HHAs also have access to home health quality measures that are part of the Home Health Quality Initiative (HHQI), but these measures only included in the HHQI are not tied to payment (e.g., pay-for-reporting or performance).

Accounting for social risk factors in quality measurement. CMS has been reviewing public comments on the issue of accounting for social risk factors in Medicare quality measurement programs and reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine. CMS continues to consider options to address equity and disparities in value-based purchasing programs.

Comment

The Commission supports CMS's continued consideration of how to account for social risk factors in Medicare quality program. The Commission asserts that the Medicare program should incorporate differences in providers' patient populations—which affect providers' performance on quality measures, including social risk factors—and that Medicare should account for social risk factors in quality programs by adjusting payment through peer grouping. Medicare should also target technical assistance to low-performing providers.

Removal of measures. In October 2017, CMS launched the Meaningful Measures Initiative aimed at improving patient outcomes and reducing burden by using a reduced set of measures for patients, clinicians, and providers in quality programs. As a part of the initiative, CMS identified 19 high-priority areas for quality measurement with a focus on improving patient outcomes (e.g., admissions and readmissions to hospitals, patient's experience of care, transfer of health information, preventive care).

As a part of the Meaningful Measures Initiative, CMS proposes to remove a total of seven measures from the HH QRP. These measures include three topped-out (i.e., high performance and little variation in performance) measures, such as the *Depression Assessment Conducted* measure. Consistent with the HH VBP, CMS also proposes to remove the *Pneumococcal Polysaccharide Vaccine Ever Received* measure because there has been a change in the clinical guidelines for administering the pneumonia vaccine. CMS also proposes to remove three measures where a broader measure already exists in the program; for example, the *Rehospitalization during the First*

30 Days of HH (proposed for removal) is narrower than the other QRP measure of *Potentially Preventable 30-Day Post Discharge Readmission*.

Comment

The goals of CMS’s Meaningful Measures Initiative—to improve patient outcomes and reduce burden—align with the Commission’s principles for quality measurement. Therefore, the Commission supports removing the seven measures from the HH QRP based on the rationale CMS provided. As CMS continues to revise Medicare quality programs with a focus on meaningful measures, we encourage CMS to move toward using a uniform set of population-based outcome measures across settings and populations.

Payment for home infusion therapy services

Beginning in 2019, Medicare will cover home infusion therapy services in certain circumstances. Through the durable medical equipment (DME) benefit, Medicare Part B has historically covered roughly 35 drugs administered in the home with a DME-covered infusion pump. In these circumstances, the DME benefit covers the drug, infusion pump, and supplies associated with home infusion, but it does not cover nursing or other professional services. Beginning 2019, Medicare will cover home infusion therapy services for DME-covered home infusions. Home infusion therapy services are defined as professional services including nursing services, training and education (not otherwise paid for under the DME benefit), and remote and other monitoring services.

The BBA of 2018 establishes transitional payments for home infusion therapy services in 2019 and 2020. The statute specifies that the payment amount for each “infusion drug administration calendar day” be equal to the physician fee schedule (PFS) rate for 4 hours of infusion. The statute groups drugs into three categories, with each category crosswalked to different drug administration CPT codes under the PFS. CMS defines an infusion drug administration calendar day as “a day on which home infusion therapy services are furnished by skilled professionals in the individual’s home on the day of an infusion drug administration.” When billing for transitional payments, CMS will require home infusion therapy providers to report on claims the length of nurse visits in the home.

The 21st Century Cures Act establishes a payment system for home infusion therapy services beginning 2021. The unit of payment continues to be an infusion drug administration calendar day. Different from the transitional payments, CMS has some flexibility on how the rates are established. The statute specifies that the payment amount cannot exceed the amount that would have been paid if the infusion had been furnished in a physician’s office, and it cannot exceed the PFS payment for 5 hours of infusion. The statute requires CMS to adjust the payment amount to reflect patient acuity and complexity of drug administration. CMS states that the three drug categories used with the transitional payments are one way to account for acuity and complexity, but seeks comment on other approaches that could be considered. CMS notes that the statute permits outlier payments, and seeks comment on situations that might warrant outlier payments

and potential methodologies. Beginning 2021, CMS is required to geographically adjust the payments and is considering using the geographic practice cost indices (GPCIs), which are used to adjust payments under the PFS.

In 2019 and 2020, CMS indicates that the home infusion therapy services, drugs, infusion pump, and supplies would all be billed to the DME Medicare administrative contractors (MACs). Beginning in 2021, CMS proposes that the home infusion therapy services would be billed to the A/B MACs and the drug, DME pump, and supplies would be billed to the DME MAC. As a rationale for the 2021 change, CMS indicates that starting in 2021 a broader set of providers, including physicians and home health agencies, could be eligible to be home infusion therapy providers, and thus billing the A/B MACs for home infusion therapy services by these providers might be warranted. CMS also notes that the A/B MACs already have processes in place to adjust payments with GPCIs, which are the factors CMS is considering using for geographic adjustment beginning in 2021.

Comment

The Commission supports CMS's proposal to define an infusion drug administration calendar day as a day when home infusion therapy services are provided by skilled professionals in the individual's home on a day of an infusion drug administration. The home infusion payment rates for 2019 and 2020 specified in the statute are generally comparable and, in some cases, higher than the payment rates for an in-home nurse visit under the home health prospective payment system. For 2019 and 2020, the statute specifically ties the payment rates for an infusion drug administration calendar day to the payment rates for four hours of infusion in the physician's office. Using 2018 PFS rates as an example, the proposed rule indicates that the payment per home infusion drug administration calendar day would range from \$141 (category 1 drug) to \$224 (category 2 drug) to \$240 (category 3 drug). In comparison, under the home health prospective payment system for episodes with four or fewer visits, the payment rate for an individual nurse visit is about \$143 per visit in 2018 (with a higher rate of about \$265 for the first visit in an episode). Given that the level of payment for a home infusion drug administration calendar day is generally similar and, in some cases, higher than the payment rate for a home health nurse visit, we believe it is reasonable to conclude that this level of payment for home infusion services requires an in-home nurse visit.

We support CMS's proposal to require home infusion therapy providers to report the length of nurse visits in the home on their claims submissions. While the statute is prescriptive about how the payment rates will be set in 2019 and 2020, CMS has more flexibility in setting the payment rates beginning 2021. If CMS requires nurse visit time reporting on claims beginning January 2019, the agency could consider these data as it establishes the payment rates for 2021. Visit times reported on claims, combined with information on patient diagnoses and drugs administered, could inform the agency's consideration of potential payment adjustments based on patient acuity or drug administration complexity. This type of visit time claims data reporting would be similar to the claims data reporting required of home health agencies and hospices.

In our view, it would be premature to consider outlier payments for home infusion therapy at the outset of the payment system. Given that the scope of covered home infusion therapy services is limited, and CMS is required to adjust the payment amount for patient acuity and complexity of drug administration, there may not be a need for outlier payments.

CMS indicates that, beginning in 2021, the agency would require the submission of two separate claims for home infusion: one claim for home infusion therapy services to the A/B MACs and one claim for the drug, supplies, and equipment to the DME MAC. Medicare coverage of home infusion therapy services is dependent upon coverage of the infusion pump and drug under the DME benefit. From a program integrity perspective, it would be ideal that all related items and services be billed to the same entity. If CMS believes that there are operational reasons to split the billing between the A/B MAC and DME MAC, then it would be essential to establish processes to coordinate between those entities so that coverage, payment, and any reviews or audits be carried out consistently.

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 that reads "Francis J. Crosson M.D." The signature is written in a cursive, flowing style.

Francis J. Crosson, M.D.
Chairman