MEDPAC Medicare Payment Advisory Commission

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September 15, 2010

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1519-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File Code CMS-1519-P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare program; home health prospective payment system rate update for calendar year 2011; changes in certificate requirements for home health agencies and hospice*. We appreciate your staff's work on this rule, particularly given the competing demands on the agency.

Case Mix Measurement

From 2008 through 2010 Medicare reduced home health payments by 2.75 percent each year to offset unwarranted increases in observed case-mix (that is an increase in the relative weights of the codes assigned to patients, rather than a real change in severity of the patient population) that occurred in 2000 through 2007, with an additional reduction planned for 2011. This rule finds that in 2008, when a revised PPS was implemented, another increase in observed case-mix unrelated to patient severity occurred. Because of the changes in 2008 and earlier years, CMS proposes to increase the 2011 reduction to 3.79 percent. CMS notes that an additional 3.79 percent reduction in 2012 will be necessary to completely adjust for all unwarranted increases from 2000 through 2008.

An increase in observed case-mix in 2008 due to changes in coding is not surprising, as the revised PPS significantly expanded the role of diagnostic coding in setting payment. However, the refined system's goal was to redistribute payments more accurately through an improved measure of patient severity, and the revisions to the payment system were intended to be budget neutral. MedPAC has not independently assessed the changes in the home health case-mix, but the need for reductions is consistent with the experience of coding changes in other payment systems. CMS

should continue to review changes in observed case-mix in future years. If additional unwarranted change in case-mix is observed, CMS should adjust payments as appropriate.

As for the appropriate reduction for 2011, we note that the proposed reduction is smaller than the decline which would result from the Commission's 2011 payment recommendation. In our 2010 payment adequacy analysis, we found that the financial performance of home health agencies under Medicare was strong enough that the sector could absorb a significant reduction in payments, and that access to care should remain adequate even if the number of home health agencies declines.

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. The Patient Protection and Affordable Care Act (PPACA) added a provision that the physician must have a prior face-to-face visit with the beneficiary before certifying the need for home health.[1] CMS proposes that the encounter must take place no earlier than 30 days before or 2 weeks after the initiation of care. The rule proposes that the condition prompting the need for home health be assessed in the prior visit or encounter. Further, the rule proposes to require documentation of the factors supporting that the patient is homebound and needs home health services.

The Commission supports the proposed requirement, but believes some modifications are necessary. Under the rule, not all patients would be examined before home health begins because a visit could take place after the admission to home health, and thus the proposed rule does not appear to comply with the PPACA requirement for an examination prior to receiving home health. The rule does not make clear how visits with a hospital- or facility-based physician will be treated under the prior visit requirement. Finally, CMS should consider adjusting the period in which the prior visit must occur to account for the differing circumstances of beneficiaries referred to home health.

The Commission is concerned that allowing the visit or encounter to occur up to 2 weeks after an episode begins weakens the accountability that the face-to-face visit is intended to establish. The purpose of the requirement is that a prospective patient receives a complete and independent evaluation of the need for home health prior to the certification and initiation of services. Allowing an episode to begin before this examination creates the possibility that patients who are not eligible or not appropriate for home health could receive services. If a patient is found not to need services after an episode has commenced, beneficiaries could be confused when services are unexpectedly discontinued, and providers could incur costs for services that will not be reimbursed. Requiring that the visit occur before the initiation of home health would better achieve the original intent of the policy, and provide greater predictability for beneficiaries and home health agencies.

[1] The rule proposes to include an encounter with a non-physician practitioner operating in collaboration with the certifying physician or telehealth as meeting the requirement.

Under the existing guidance CMS expects that the physician certifying and ordering home health will also be supervising the care provided during the episode, however this may not be the case for hospital- or facility-based physicians. Since many home health episodes are preceded by a hospitalization or facility stay, CMS should clarify whether physician visits at these facilities will qualify for the face-to-face requirement. MedPAC believes that visits with a hospital- or facility-based physician should qualify as meeting the prior visit requirement. Though these physicians may not be treating a patient after discharge, they should have adequate knowledge of a patient's need for home health after treating them in the hospital or facility. However, allowing visits with hospital- or facility-based physicians to qualify should not weaken the requirement for physician supervision of home health services. In these instances, CMS should require that the home health plan of care identify the physician who will be responsible for supervising the episode once it begins.

CMS should consider adjusting the window for the prior visit to reflect differences in patient access to physician care. A 30-day window is appropriate for patients admitted to home health after a hospitalization, particularly because many of these patients may have a skilled nursing facility stay after hospitalization. It is likely that the only physician visit occurred in the hospital for these patients, and a window shorter than 30 days could limit access to home health for patients that have an intervening lengthy SNF stay. However, for patients admitted from the community (with no prior hospitalization), a shorter window, perhaps 15 days, could be more appropriate. Patients residing in the community have access to outpatient physician care, and a shorter window should not create an unreasonable burden. A shorter window would ensure the physician has current information about a beneficiary's condition when evaluating the eligibility and need for home health.

CMS should consider longer windows for patients who live in remote rural areas. Patients in these areas may have difficulty accessing physician services, and a shorter window may create access problems. Although it is not preferable that the examination precede the episode by too long a length of time, a longer window would maintain access for beneficiaries that live in remote rural areas with limited access to care.

Coding of hypertension

CMS proposes to eliminate hypertension codes 401.1 (unspecified essential hypertension) and 401.9 (benign hypertension) as conditions which increase a patient's case-mix adjustment. CMS states that changes in clinical and coding guidelines have resulted in the use of 401.1 and 401.9 for episodes that are less severe than assumed in the case-mix system. CMS notes that in an earlier review it eliminated codes that appeared to be ambiguous or represented minimal severity, and believes that these two codes should be removed for similar reasons. CMS is concerned that diagnostic and coding guidelines do not provide sufficient detail to ensure consistent coding practices for 401.1 and 401.9.

We concur with CMS's principles that the diagnoses in the home health PPS should be based on conditions that are appropriate for home health and supported by adequate coding guidance. Updating the diagnosis codes in the home health PPS as coding guidelines and disease definitions

change is critical to ensuring that the PPS is accurate. However, CMS's contention that the patients coded with these conditions are less severe than assumed in the case-mix system needs more substantiation. For example, the analysis focuses on visits per episode, even though other changes, such as the use of therapy assistants or changes in other beneficiary characteristics, may affect the cost of services beneficiaries receive during an episode.

CMS should provide additional analysis to substantiate that the severity of this population has declined since 2005, the year of data the revised case-mix system is based on. The analysis should assess how, controlling for differences in patient characteristics, the average number of visits per episode has changed for both the affected episode types and other episodes. The analysis should also consider the changes in resource use for the hypertension codes CMS proposes to retain. If the analysis indicates that the severity for these case types has declined after the case-mix system was set, then eliminating the codes should improve payment accuracy.

If additional study yields adequate evidence to proceed with eliminating the codes, CMS should provide an analysis of the payment impacts of this policy. An impact analysis would ensure that providers and the public understood the financial consequences of the proposed policy, and CMS includes an impact analysis for other provisions of the rule that affect payment. Any estimate would have some uncertainty associated with it. However, excluding a payment impact analysis provides a misleading and incomplete depiction of the policy.

Therapy coverage requirements

The proposed rule notes (and shares MedPAC's concern) that the utilization of therapy appears to be influenced by the payment changes in 2008, with use increasing for therapy visit intervals with higher payments under the new system and declining for those with lower payments. To address concerns that agencies may be providing unnecessary therapy, CMS proposes a number of clarifications to coverage requirements.

The revisions would create stricter standards for documenting the necessity, amount and nature of therapy provided during a home health episode. In addition, the plan of care would have to specify measurable treatment goals for the functional impairments requiring therapy. For patients receiving relatively high numbers of therapy visits, therapists would be required to re-assess the patient at the 13^{th} and 19^{th} therapy visit before additional visits would be covered. These reassessments would verify that the patient's condition requires additional therapy before the significant payment increases that occur at the 14^{th} and 20^{th} therapy visit.

MedPAC supports the proposed assessment and documentation requirements, as they would create greater accountability for therapy services. MedPAC and others have noted the vulnerability of the current payment system, which sets payment in part on the amount of therapy provided. Even with these revisions the provision of therapy will still be influenced by the incentives of the payment system, and, as discussed later, further revisions to the therapy payment system should be considered.

Collecting additional claims data for future home health PPS enhancements

CMS is concerned that current reporting requirements do not allow it to assess the accuracy of the occupational mix assumed in the case-mix relative weights or the appropriateness of some services. To address this, CMS proposes two new information collection requirements. First, CMS proposes to collect data on the type of practitioner delivering therapy services. This would allow CMS to measure, for example, the incidence of substitution of therapy assistants for licensed therapists. Since therapy assistants are less costly than licensed therapists, the relative weights could overstate costs if agencies use therapy assistants more than assumed. The new requirement would allow CMS to review the accuracy of its assumptions about the use of therapy assistants, and adjust the payment system if the use of assistants differs from the factors currently assumed.

In addition, CMS believes that additional data collection is needed to safeguard certain less frequently provided services that may be prone to over utilization and abuse. For example, under Medicare coverage guidelines it is expected that most home health nursing services will involve direct skilled care, and that any therapy care provided should be for restoring physical function. However, in some limited situations, Medicare will cover nursing care that does not involve direct skilled care (such as observation), and it will also cover therapy care for the purpose of maintaining current function. Though these types of care are expected to occur less frequently, Medicare does not currently track when these particular services are being provided. To address this, CMS proposes to require agencies to report when maintenance therapy or nursing for the purpose of observation is being provided. This would facilitate the study of these services to better understand their use, and permit CMS to identify potential over utilization.

The Commission supports the proposed requirements, and shares CMS's interest in improving the accuracy of home health payments and safeguarding against inappropriate use. CMS should consider requiring the reporting of other services that may not be accurately reflected in the current payment system or are vulnerable to abuse:

- **Use of licensed practical nurses (LPNs).** Nursing is a larger share of home health services than therapy, so improving the measure of resource costs for these services could potentially have a greater impact on payment accuracy then CMS's proposed therapy requirements. Similar to the use of therapy assistants, the use of LPNs as a substitute for registered nurses raises the possibility that agencies may have costs that are significantly lower than assumed in the payment system. CMS should consider requiring agencies to report the type of nurse when submitting claims for skilled nursing visits, similar to the proposed requirements for therapist assistants.
- **Use of therapists for wound care.** Current Medicare and state regulations permit both nurses and therapists to provide wound care. However, under the PPS home health payment for an episode can be higher if an agency substitutes a therapist instead of a nurse for wound care. The substitution of higher-cost therapists for lower-cost nurses is contrary to the incentives for efficiency the PPS is intended to promote. To determine whether this type of substitution is occurring, CMS should require agencies to report when therapy visits and nursing visits include wound care.

The reporting requirements proposed by CMS, and the additions above, should provide useful

information for assessing vulnerable services and improving the accuracy of payments. CMS should develop a means for reporting the data it collects so that home health agencies, Medicare beneficiaries, and the public can better understand the services delivered under the home health benefit.

Future home health PPS improvements

CMS also requests comments on options to improve the accuracy and incentives of the PPS. CMS mentions several possible options, such as reducing the number of co-morbid diagnoses included in the case-mix classification system and using claims data to better account for therapy resource use.

Any refinement of the current system should consider how the PPS's approach to therapy payments has shaped the delivery of services. Episode volume trends for 2008 suggest that even under the revised payment system agencies have an incentive to provide therapy episodes. The statements of some industry analysts and representatives suggest that therapy is a key driver of agency financial performance; agencies with higher Medicare profit margins in 2007 tended to provide more therapy than lower-margin agencies. To the extent that therapy can be beneficial for patients, this is not problematic. However, the growth in therapy coincided with the implementation of PPS and its method of basing payment, in part, on these services. While other factors may have influenced the growth in therapy, Medicare's method of payment played an important role.

Using a predictive model for therapy would curtail manipulation of the payment system through the amount of therapy services provided, and reduce the need for safeguards such as the additional therapy documentation and reassessment requirements proposed in the rule. More importantly, a predictive system would encourage providers to focus on patient needs and characteristics, and not financial incentives, when setting therapy plans of care.

Further refinements should also examine additional clinical and beneficiary factors that could improve the case-mix system, such as the data available from the Chronic Condition Warehouse and the CMS-Hierarchical Cost Conditions (CMS-HCCs). These factors may provide measures of patient severity that are not available through home health claims or OASIS data.

Home health agency capitalization

Medicare has long required that new home health agencies have an initial reserve operating fund (IROF) equal to the estimated costs of the first 3 months of operation. The requirement is intended to ensure that new home health agencies have adequate financial assets to deliver quality care and conduct legitimate business activities during their initial period of operation. Currently, Medicare contractors verify the IROF when reviewing an agency's application for billing privileges. The proposed rule would allow contractors to verify the IROF more than once during the process of reviewing a provider's application for billing privileges.

MedPAC supports the proposed requirement, as it would reduce the risks that providers entering

the Medicare program will have inadequate funds to operate. The provider enrollment process can take several months or more, so expanding Medicare's authority to verify the IROF more than once during the process, and up to three months after granting Medicare billing privileges, is a reasonable safeguard.

Hospice provisions

The proposed rule includes a provision implementing a PPACA requirement concerning hospice re-certifications. Effective January 1, 2011, PPACA requires that a hospice physician or nurse practitioner (NP) have a face-to-face visit with a Medicare hospice patient for the purposes of assessing continued hospice eligibility prior to the 180-day recertification and each subsequent recertification, and attest that such a visit took place.

This requirement is consistent with a recommendation made by the Commission. Our work on hospice, including input from an expert panel of hospice industry representatives, has indicated that more accountability is needed in the Medicare hospice benefit. A physician or NP face-to-face visit with long-stay patients prior to recertification will bring greater physician engagement and accountability in the recertification process.

The rule proposes that the required face-to-face visit occur no more than 15 calendar days prior to the 180-day recertification and subsequent re-certifications. We support this 15-day timeframe. We believe it strikes an appropriate balance between the need for current information about a patient's condition and the need for physicians and NPs to have sufficient time to conduct the visits. We note that for consistency purposes the rule also proposes that a 15-day timeframe be used for the completion of certifications and re-certifications. Currently, certifications must occur no more than 14 days prior to hospice election. The timeframe for re-certifications to occur prior to the expiration of the benefit period is unspecified. We believe it is reasonable to use a consistent 15-day timeframe for all of these purposes.

The rule also proposes requirements concerning the attestation of visits. The rule indicates that the attestation is a statement from the physician or NP that attests that the face-to-face visit occurred and that the findings from the encounter have been provided to the physician doing the recertification (if different from the physician or NP who provided the visit). The rule proposes that the attestation be either a separate distinct area on the recertification form or an addendum to the recertification form. The rule also proposes that the attestation include the name of the patient visited, date of visit, and be signed and dated by the physician or NP who made the visit.

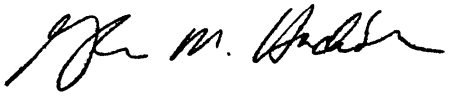
We agree with these proposals regarding the attestation. In addition, we believe that the attestation should include the national provider identifier (NPI) of the physician or NP who provided the visit and that a hospice should be required to report this NPI on the hospice claim for accountability purposes. Currently, hospices must report on Medicare claims the NPI for a hospice patient's attending physician and for the hospice physician(s) who certify and recertify the patient's eligibility. Reporting this information on the hospice claim provides added accountability, and we believe a similar reporting requirement should exist for the NPI of the hospice physician or NP providing the face-to-face encounter.

PPACA requires that the face-to-face visit for recertification purposes be carried out by a hospice physician or NP. In some rural areas where travel distances are long, there may be situations where hospices currently rely on physicians or NPs in local areas to provide face-to-face care with patients rather than the hospice medical director (or a physician or NP member of the hospice interdisciplinary group) traveling to visit patients. To address these types of situations, we believe that a hospice could be permitted to contract with a local physician or NP to perform the required face-to-face visit with long-stay patients. We believe that permitting hospices to contract with local physicians or NPs to perform these visits would facilitate access to care in rural areas while ensuring that the recertification of hospice eligibility for long-stay patients is informed by an in-person assessment of the patient's condition by a physician or NP.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals from CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

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