



425 I Street, N.W. • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Jon Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

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Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1648-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled: “Calendar Year 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements,” published in the *Federal Register* vol. 81, no. 138, pages 43714-43788. We appreciate your staff’s efforts to administer and improve the Medicare payment system for home health agencies (HHAs), particularly given the competing demands on the agency.

This rule proposes a payment update for HHAs in payment year 2017, and details a number of additional proposals. We focus our comments on the rebasing reduction and payment update for 2017, the payment rate adjustment to account for nominal case-mix change, revisions to the outlier payment policy, the value-based purchasing program, changes to home health quality measures, and future revisions to the home health payment system.

Rebasing adjustments and proposed CY 2017 home health rate update

The Patient Protection and Affordable Care Act (PPACA) included a provision to rebase home health payments. Under this provision, CMS is required to adjust the home health payment rate based on its analysis of the adequacy of the rate compared to the average cost per episode. PPACA required that the payment reduction from rebasing be phased in annually over four years; limited the annual reduction to no more than 3.5 percent of the base payment rate in effect in 2010 (or \$80.95); and specified that any reduction be offset by the statutorily required annual payment update (indexed to the home health market basket). In 2017 CMS is implementing the fourth and final year of the rebasing required by PPACA, equal to a reduction of 2.8 percent. This rule also includes the payment update for 2017 of 2.8 percent, offsetting the rebasing reduction.

Comment

The Commission has noted in prior reports and letters that the PPACA rebasing reduction will not sufficiently reduce home health payments.¹ The Commission recognizes that CMS has implemented the maximum reduction for 60-day episodes permissible by PPACA, but we continue to be concerned that the reductions are too small. We project that home health agencies will have Medicare margins of 8.8 percent in 2016, and the rebasing adjustment will not lower payments in 2017 due to the offsetting statutory payment update.

Medicare has overpaid for home health care since the inception of the prospective payment system (PPS) in 2000, and more reductions are necessary to stop this pattern from continuing. The Commission recommended in our March 2016 report that Congress eliminate the payment update for 2017, and implement a rebasing reduction in the following two years to bring payments closer to costs. These additional reductions would better align costs with payments in 2017, and would provide a framework to ensure that payments in future years are at appropriate levels.

CMS reviewed beneficiaries' use of home health care in 2015 and found that service volume decreased by 4.8 percent in 2015, with most of this decline attributable to 3rd and subsequent episodes in a spell of home health. The decline continues a trend since 2010, when utilization peaked at 6.8 million episodes. About 70 percent of the decline in volume since the peak has been attributable to lower volume in five states (Florida, Illinois, Louisiana, Tennessee, and Texas). However, even with the recent declines, these five states had levels of per-capita home health utilization greater than double the per-capita rate for rest of the country.²

Though service volume has declined, policy and economic changes other than Medicare payment policy likely account for a significant portion of this change. The number of hospital discharges, a common source of referrals, has declined since 2009, mitigating the demand for post-acute services. The period has also seen relatively low growth in economy-wide health care spending. In addition, several actions have been taken to curb fraud, waste, and abuse in Medicare home health care. The Department of Justice and other enforcement agencies have launched a number of investigative efforts that scrutinize Medicare HHAs. CMS has implemented moratoria on new agencies in several areas that have seen rapid growth in supply and utilization. In 2011, Medicare implemented a PPACA requirement that required a physician have a face-to-face encounter with the beneficiary before ordering home health care. The number of agencies declined by two percent in 2014, with this decline concentrated in Florida, Michigan and Texas. These factors likely affected spending and utilization in recent years.

Further, as both CMS and MedPAC noted, this decline follows a period of considerable growth. Home health volume increased by 67 percent between 2002 and 2010. Given this prior rapid

¹ Medicare Payment Advisory Commission. 2014. *Report to the Congress: Impact of home health payment rebasing on beneficiary access to and quality of care*. Washington, DC: MedPAC.

² The five states averaged 33 episodes per 100 Medicare beneficiaries in 2014, while the remaining areas averaged 13 episodes per 100 beneficiaries.

growth, and the reasons for the decline in home health use since 2010, in the Commission's view, the decline in utilization since 2010 does not unduly raise concerns about beneficiaries' access to home health care. The base payment for 2017 will not fall due to rebasing, and should not have an impact on access to care. The Commission recognizes that statute limits CMS's ability to reduce payments, but we reiterate our recommendation that further reductions would be appropriate and would not negatively affect access to care.

Proposed reduction to the national standardized 60-day episode payment rate to account for nominal case-mix growth

In October of 2000 Medicare implemented a PPS for home health care. Under the PPS, episodes are reimbursed based on a case-mix index that indicates patient severity. The case-mix index for an episode is determined using data on patient characteristics (diagnosis and treatments provided) reported by home health agencies. In 2012 CMS conducted a review of changes in the average case-mix index through 2010. The review used regression analyses and other techniques to identify how coding patterns and patient severity had changed over time, and it concluded that most of the rise in reported case-mix was attributable to changes in home health agencies' coding practices and not to changes in patient condition. The empirical analysis concluded that 84 percent of the change in case-mix over this period was nominal growth (i.e., due to changes in coding practices).

In the 2016 home health PPS regulation CMS computed the total case-mix growth between 2012 and 2014, and applied the nominal growth factor from its prior research. CMS calculated that nominal growth accounted for 2.88 percentage points of the growth in case-mix over this period, and implemented a reduction of 0.97 percent per year from 2016 through 2018. The 2017 rule implements the second year of the three-year phase-in of the reduction to account for nominal case-mix growth.

Comment

Both the Commission and CMS have found that case-mix changes unrelated to patient severity occur frequently in Medicare PPSs. For example, CMS found that the reported rate of hypertension increased substantially after this code was added to the home health case-mix as a payment increasing condition. This nominal case-mix change results in increased payments even though patients' levels of illness and resource needs remain the same. The Commission has long held that it is necessary for CMS to make adjustments to account for nominal case-mix change to prevent additional overpayments. The Commission has not independently reviewed the nominal case-mix change in the home health PPS, but CMS's proposed reduction is consistent with the agency's past findings on trends in case-mix change in the payment system and thus is warranted to ensure the accuracy of payments under the home health PPS. A reduction of 0.97 percent should not significantly affect access to care.

Proposed changes to the methodology used to estimate episode cost

The home health PPS has an outlier policy that sets aside 2.5 percent of payments to compensate agencies for high-cost outlier episodes. Episodes with costs above the fixed-dollar loss threshold

are reimbursed for 80 percent of their losses, similar to other PPSs. Episode cost is determined by multiplying the per-visit rates established for Low Utilization Payment Adjustment (LUPA) episodes.

In this proposed rule, CMS reviewed outlier utilization and found that agencies with more outlier payments provide shorter visits during an episode, possibly indicating a financial disincentive to serve high-cost patients who need longer-than-average visits. Consequently, the rule proposes changing the way episode cost is calculated to capture visit length.

Under the proposed policy, the LUPA per-visit rates would be converted to cost-per-minute factors, and the reported minutes of service on a claim would be used to calculate episode cost. Episodes with costs above the threshold in the new calculation would receive outlier payments. CMS estimated the impact of the proposed approach with 2015 data, and found that about two-thirds of outlier episodes that qualified under current policy would continue to receive outlier payments. Episodes that dropped out generally had more visits with shorter visit lengths, while newly qualifying episodes had longer visits. CMS estimates that the policy would raise payments for certain classes of patients it believes may be underpaid in the PPS, such as those with extreme frailty or beneficiaries requiring functional assistance. The policy would raise payments for non-profit agencies and facility-based HHAs, and lower them for freestanding and for-profit agencies.

Comment

The Commission believes that the proposed policy improves the targeting of outlier payment funds. The current method relies on average cost per visit to compute outlier episode costs, even though these costs vary substantially among agencies. In the past, MedPAC observed that some agencies had per-visit costs even lower than the LUPA rates used by Medicare, creating opportunities to manipulate the outlier payment system. A minute-based measure of episode cost will better capture the variability in costs among agencies, and is similar to the method CMS uses in constructing the home health case-mix. The proposed method would better align payments with agencies' actual costs, and also reduce the vulnerability of outlier payments to manipulation. It would also, as CMS notes, reduce the disincentive for agencies to avoid patients who need longer-than-average visits under the PPS.

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

The Home Health Value-based Purchasing (HH VBP) model aims to improve the quality and 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 all HHAs' Medicare payments (upward or downward) based on their performance on a set of quality measures. The first HH VBP payment adjustment will begin January 1, 2018, applied to that calendar year based on 2016 performance data. The payment withhold will increase from 5 percent in 2018 to 8 percent in 2021. The initial rules of the program defined a starter set of 24 measures that included 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.

The HH VBP model adopts a scoring approach similar to that used in the hospital VBP program, including allocating points based on achievement or improvement, and calculating those points based on industry benchmarks and thresholds. For each measure, agencies will receive points along an achievement range, a scale between the achievement threshold and a benchmark. CMS will calculate the achievement threshold as the median of all agencies' performance on the specified quality measure during the baseline period, and calculate the benchmark as the mean of the top decile of all agencies' performance on the specified quality measure during the baseline period. In a departure from the hospital VBP Program approach, in which CMS uses a national sample to calculate the achievement thresholds and benchmarks, CMS for the HH VBP model will calculate the achievement thresholds and benchmarks separately for each selected state, and is considering the merits of similarly stratifying by agency size cohorts. Similarly, under the HH VBP model, CMS will calculate improvement points for each measure by assigning points along an improvement range, a scale indicating change between an agency's performance during the performance period and the baseline period. As in the HH VBP achievement calculation, the improvement benchmark and threshold will be calculated separately for each state and potentially also for agency size cohorts. CMS intends to use this approach so that agencies would be competing only with similar-sized agencies in their state, although the agency now believes that there may not be a sufficient number of home health agencies in some states to reliably calculate a small and large cohort.

An agency will be rated on a scale of one to ten in both improvement and achievement for the measures in the starter set that are already in use. The improvement or achievement result for each of the measures—whichever is highest—will be summed; that sum will constitute 90 percent of the agency's Total Performance Score (TPS) under the HH VBP program. The remaining 10 percent of the TPS will be based on whether the agency reports some or all of the four new measures proposed for the starter set.

Use of cohorts to assess and reward agency performance—In past rules, CMS indicated that the agency would calculate benchmark and achievement thresholds at the state and cohort size level. CMS has continued to evaluate this payment adjustment methodology using the most recent data available, and does not believe there will be sufficient number of HHAs in some states to reliably calculate a small and large cohort.

The Commission urges CMS to calculate benchmarks and thresholds, and score HHAs at the national level, especially given the potential difficulty in calculating separate cohorts of small and large agencies within each state. Medicare is a national program, and the value of HHAs should be determined by comparing HHAs across the nation. Using state level benchmarks and thresholds could reward low-quality agencies, if those agencies are in overall low-performing states. The HH VBP should drive all agencies to achieve a national level of performance on outcome-based quality measures.

Changes to quality measures—CMS’s proposed rule included a slightly revised set of 20, instead of 24, quality measures for the first performance year (CY 2016) of the HH VBP. During implementation of the HH VBP, CMS determined that four of the measures finalized for PY1 require further consideration before inclusion in the HHVBP Model measure set. Specifically, CMS is proposing to remove the following measures: (1) Care Management: Types and Sources of Assistance; (2) Prior Functioning ADL/IADL; (3) Influenza Vaccine Data Collection Period: Does this episode of care include any dates on or between October 1 and March 31; and (4) Reason Pneumococcal Vaccine Not Received.

Comment

Over the past few years, the Commission has become increasingly concerned that Medicare’s current quality measurement programs rely on too many clinical process measures that are, at best, weakly correlated with health outcomes of importance to beneficiaries and the program. Process measures are also burdensome on providers to report, while yielding limited information to support clinical improvement. The Commission supports removing the proposed four process measures.

CMS should also move quickly to eliminate other process measures in the measure set that weakly correlate with health outcomes, and those that measure basic standards of care on which providers have achieved full performance (i.e., most providers report scores at or near 100 percent). For example, the Commission supports removing the Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care measure because it is “topped out” as displayed in Tables 28 and 29 of the proposed rule with the lowest benchmark (i.e., mean of the top decile of all agencies’ performance) being 98.5 for the measure.

The Commission also strongly urges that the Acute Care Hospitalization: Unplanned Hospitalization during first 60 Days of Home Health measure in the starter set be modified to capture all the events that occur when a beneficiary is in home health care, as opposed to the first 60 days of home health, since many home health stays last longer than 60 days. The measure should also capture unplanned hospital admissions for 30-days post discharge. Expanding the time period covered by the measure to “stay plus 30 days” encourages providers to consider the care of beneficiaries over an episode and begin to align that measure with future payment reforms, which are likely to include some form of episode-based bundled payment.

Measuring performance on the basis of improvement—As discussed above, for each measure, agencies will receive points along an achievement range, a scale between the achievement threshold and a benchmark. CMS will also calculate improvement points for each measure by assigning points along an improvement range, a scale indicating change between an agency’s performance during the performance period and the baseline period. The HH VBP will use the higher of the achievement or improvement points for each measure.

Comment

The Commission is concerned that scoring improvement is not sufficiently beneficiary-focused, since what matters most to the beneficiary is an agency’s actual level of performance. Further, this methodology could create potential inequities in that agencies with equal or better levels of

achievement might receive lower payments than agencies with lower achievement scores but high improvement scores. Some allowance for improvement may help agencies adjust to a new HH VBP incentive, but the program should limit the use of improvement measures to the initial three years of operation.

Benchmarks should be established prospectively—The HH VBP will rely on annual relative rankings in performance to determine the Total Performance Score (and the resulting bonuses and penalties). For each measure, an agency’s performance will be compared to that of all other agencies in its state, and, potentially, to that of other agencies of its size (see discussion above).

Comment

The Commission believes that setting benchmarks after the reporting period is problematic because agencies will not know in advance the level of performance or achievement that is necessary to avoid a penalty or earn a bonus; this may discourage some quality improvement activities because the financial returns for a given investment in quality may be difficult to determine.

Instead, CMS should establish prospective benchmarks for each quality measure based on historical performance. Agencies would be scored based on their performance relative to the known benchmarks; those with higher scores could have their payment withheld returned, while those below the benchmark could have all or some of it withheld based on the magnitude by which they miss the benchmark. Benchmarks for measures should be set at levels that allow most providers a reasonable expectation of achieving them. The budget neutrality of the program could be maintained by redistributing withheld payments to agencies above the benchmark based on the degree to which they exceeded the benchmarks.

Measures for the Home Health Quality Reporting Program (HH QRP)

Beginning in 2007, the Home Health Quality Reporting Program (HH QRP) reduces an HHA’s home health market basket percentage by two percentage points if they do 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).

Removal of measures—In 2015, CMS undertook a comprehensive reevaluation of all 81 HH quality measures, some of which are used only in the Home Health Quality Initiative (HHQI), and others which are also used in the HH QRP. As a result of the comprehensive reevaluation CMS identified 28 HHQI measures that were either “topped out” and/or determined to be of limited clinical and quality improvement value by an expert panel. CMS proposed to remove those 28 measures from the HHQI, and six of those that are in the HH QRP. The six HH QRP measures proposed for removal are: (1) Pain Assessment Conducted; (2) Pain Interventions Implemented during All Episodes of Care; (3) Pressure Ulcer Risk Assessment Conducted; (4) Pressure Ulcer

Prevention in Plan of Care; (5) Pressure Ulcer Prevention Implemented during All Episodes of Care; and (6) Heart Failure Symptoms Addressed during All Episodes of Care.

Comment

As a general principle, the Commission does not support using process measures that weakly correlate with health outcomes; measures on which providers have achieved full performance; or measures that are designed to capture elements, processes, and requirements already incorporated into or assumed by Medicare's Conditions of Participation. We therefore support CMS's proposal to remove these particular measures from the HH QRP to avoid payment adjustments based on the reporting of weak measures.

New measures proposed—The IMPACT Act of 2014 required the implementation of several quality and resource use measures that are standardized and interoperable across post-acute care settings including measures of: function and cognition, skin integrity, medication reconciliation, incidence of major falls, the transfer of health information and care preferences, readmissions, discharge to community, and resource use. CMS proposed adoption of four measures beginning in the CY 2018 HH QRP: drug regimen review with follow up, the resource use measure (Medicare spending per beneficiary – PAC HH QRP), discharge to community, and potentially preventable readmissions 30-days post-discharge readmission measure for HH QRP. CMS invited comments on how socioeconomic (SES) factors should be used in the resource use and quality measures.

Comment

Because the goal of cross-cutting measures is to gauge and compare care provided across PAC settings, it is critical that each measure uses uniform definitions, specifications (such as inclusions and exclusions), and risk-adjustment methods. Otherwise, differences in rates across settings could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Our work on the design of a unified PAC payment system and the work of others indicate considerable overlap in where beneficiaries are treated for similar PAC needs. These results indicate it is imperative that quality and resource use measures are directly comparable across settings so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care. Separate measures will continue to evaluate each PAC setting in isolation rather than support cross-setting comparisons of PAC providers. We emphasize this principle in our discussion of the MSPB measure, but note that the principle applies to all four of the IMPACT measures discussed here.

The Commission recognizes that socio-economic status (SES) factors can play a role in quality and resource use measures. One way to consider SES factors is to include them in the risk adjustment method. The Commission does not support this approach because it results in adjusted rates (or spending) that hide the actual disparities in care, and could reduce pressure on providers to improve care for the poor. The Commission believes that a better way to address any differences in outcomes is to compare rates (or spending) that have not been adjusted for SES across “peer” providers that have similar shares of, for example, low-income, beneficiaries. This way, the outcome rates remain intact but the comparisons are “fair” because providers are compared with other providers with similar shares of low-income beneficiaries.

To promote transparency for beneficiaries and competition across providers, the Commission supports the public reporting of the cross-cutting quality measures. CMS should move towards reporting the cross-cutting measures quality measures for all providers in each setting.

Drug regimen review conducted with follow-up for identified issues—CMS proposed to adopt a drug regimen review measure that reports the percentage of home health episodes in which a drug regimen review was conducted at the start of care, during care and end of episode, and timely follow-up with a physician each time potentially clinically significant medication issues were identified. The purpose of the measure is to encourage PAC providers to perform a review of all medications a patient uses to identify and resolve any potential adverse effects and drug reactions (including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy).

Comment

The Commission supports CMS's proposed medication reconciliation measure. The medication and reconciliation and follow-up process can help reduce medication errors that are especially common among patients who have multiple health care providers and multiple comorbidities. In addition to the measure proposed, MedPAC encourages CMS to assess whether PAC providers conduct medication reconciliation when discharging their patients. For example, CMS could also measure whether a PAC provider sends medication lists to either the next PAC provider or, if being discharged home, to the patient's primary care provider.

Medicare spending per beneficiary (MSPB)—Post-acute care HH QRP—CMS proposed a measure of resource use that includes the average risk-adjusted total Medicare spending per beneficiary during the HH episode and the 30 days after the end of care from the HHA. By holding HHAs accountable for resource use over episodes of care, the measure will increase a provider's responsibility for care furnished during their own "watch," a safe transition to the next setting or home, and for care during the next 30 days. CMS is developing separate MSPB measures for each of the four PAC settings; the proposed rule describes the MSPB–PAC HH QRP measure.

Comment

The Commission supports the adoption of a resource use measure that promotes providers' responsibility for episodes of care. By reporting provider's performance regarding resource use during their patients' stays plus 30 days after the end of treatment, the measure will ready providers for broader payment reforms that extend providers' responsibility for episodes of care, such as bundled payments. However, the Commission does not support the development of setting-specific measures. We believe a uniformly defined resource use measure for all four PAC settings, rather than separate measures for each PAC setting (such as the MSPB–PAC HH QRP), will better meet the intent of the IMPACT Act and enable comparisons across PAC settings. Under a single measure, the episode definitions, service inclusions/exclusions, and risk adjustment methods would be the same across all PAC settings.

Until there is a uniform PAC PPS and payment differences between settings are eliminated, the Commission appreciates that a single measure would, without other adjustment, consistently advantage lower-cost settings and disadvantage higher-cost settings due to the large spending

differences associated with the initial PAC stay across the settings. Therefore, to assess providers' performance in the near term, CMS should use a single measure and compare providers within each setting (i.e., an HHA's spending would be compared with other HHAs' spending, an IRF's spending would be compared with other IRFs, et cetera). In the future, comparisons of the single measure could be made across all PAC settings.

Discharge to community—This measure is a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and do not have unplanned hospital readmissions during the 31 days following discharge to the community. CMS proposed to gather the discharge status from the PAC claim.

Comment

The Commission supports this measure; it has used a similar measure to track the quality of SNFs and IRFs for several years. However, the Commission urges CMS to confirm discharge status by matching claims between the discharging PAC provider and any subsequent institutional provider (a hospital, IRF, SNF, or LTCH). CMS evaluated the accuracy of the discharge status field on the PAC claim by examining the agreement between the “discharge status” on the PAC claim and the presence of a subsequent acute hospital claim. The agreement between the PAC claim and hospital claim was high (about 90 percent) but the agreement between PAC claims (for example, an LTCH claim indicated the beneficiary was discharged to a SNF and there was a subsequent SNF claim) was not reported. To ensure that rates reflect actual performance, “discharged to the community” should be confirmed with the absence of a subsequent claim to a hospital, an IRF, SNF, or a LTCH.

Potentially preventable 30-day post-discharge readmission—This measure assesses a facility's risk-adjusted rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days after discharge from the HHA.

Comment

The Commission supports this measure, believing that HHAs should be held accountable for avoiding preventable hospital readmissions after discharge from home health care by adequately planning the patient's discharge, explaining post-discharge instructions to the patient, and planning for appropriate follow-up ambulatory care. MedPAC has tracked a post-discharge readmission measure over multiple years for SNFs and IRFs. As noted above, the measure definition and risk adjustment should be identical across the four PAC settings so the post-discharge rates can be meaningfully compared.

Update on subsequent research and analysis related to section 3131(d) of the Affordable Care Act

PPACA directed CMS to conduct research into the costs of care for certain Medicare beneficiaries, including those with low-income, high medical severity, or residing in areas designated as medically underserved. In the proposed rule, CMS provides a high-level summary of an alternative payment system, referred to as the Home Health Groupings Model (HHGM), that it

developed from this research. The HHGM assigns patients to 324 payment groups based on the following categories:

- Episode timing. Services in the first 30 days of the 60-day episode would be classified as early, while any subsequent 30-day period would be classified as late. For example, if a beneficiary had two 60-day payment episodes, the first 30-day period would be classified as early, while the subsequent 30-day periods would be classified as late.
- Referral source. Patients were categorized based on the services received prior to the beginning of the episode: prior hospitalization, prior post-acute care, or admitted from the community.
- Clinical category. The new system creates six clinical categories that patients are grouped based on their reported conditions: 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 classifies patient cognitive and physical functioning using information from the OASIS home health patient assessment.
- Comorbidities. CMS is exploring two approaches to identifying comorbidities to add to the case-mix system, including using the most commonly occurring comorbidities in home health care and the list of comorbidities used in the inpatient hospital PPS payment system.

Comment

The information presented in the rule suggests that the alternative system could offer several improvements over the current system. Perhaps most importantly, the alternative system would end the use of therapy visits as a factor in the payment system. For many years MedPAC has been concerned about the incentives created by the use of therapy in the system. This concern has been echoed by the Congress and federal oversight agencies. The number of episodes qualifying for higher payments due to therapy use has risen for many years, and efforts to slow this growth through additional administrative requirements or modest payment changes do not appear to have substantially slowed this growth.

The Commission recommended eliminating the thresholds in our March 2010 and March 2016 reports to the Congress. Ideally, a revised system would base payment solely on patient condition, so that providers could focus on patient needs when determining services. Including specific services, such as therapy, as payment factors in the PPS creates a potential financial incentive that may cause providers to give less weight to patient needs, or even engage in selection favoring those patients that need the specific services. The alternative system discussed by CMS in this proposed rule would end the incentives created by the use of therapy visits, and would close a significant vulnerability in the current system.

Other elements of the alternative system also have the potential to improve Medicare payments for home health care, though information in CMS's forthcoming technical report will permit a more complete examination of the possible changes. Based on the summary information in the proposed

rule, the new system would have a less complex clinical classification system compared to current practice, and factor in important information such as comorbidities and the source of admission.

The Commission awaits more information and analysis for the early/late classification that changed payment for later 30-day home health segments. The Commission understands that this proposed aspect of the alternative payment system reflects differences in resource use between early and later segments. More information is needed to understand the incentives this policy could create.

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 Mark E. Miller, MedPAC's Executive Director, at 202/220-3700.

Sincerely,

A handwritten signature in cursive script that reads "Francis J. Crosson M.D.".

Francis J. Crosson, M.D.
Chairman