CMS-1541-P-1

Submitter : **Date: 05/23/2007**

Organization :

Category : **Nurse**

Issue Areas/Comments

Revising and Rebasing

Revising and Rebasing

Home Health Care is the largest growing sector of the healthcare industry, because due to the aging of the population and the limits to how long patients remain in facilities, caring for patients in the home is the only option for the care of many of these fragile and ill elders. How does it become feasible to continue to make cuts in a sector that is providing care and reducing hospitalizations or nursing home placements for so many. It would seem logical to me that home care is the cheaper alternative. Given the current nursing shortage and the need to retain all professional staff, that would not be possible with any changes in reimbursement in the home health sector. I would think that CMS would put into effect a payment system that measures patient outcomes by physician. This could save CMS money, since it would begin to align all CMS goals across a continium of care.

Submitter : **Mr. Robert Houck** **Date: 05/25/2007**

Organization : **Medstar Health VNA**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-1541-P-2-Attach-1.DOC

Comments on:

Federal Register / Vol. 72, No. 86 / Friday, May 4, 2007 / Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 484

[CMS–1541–P]

RIN 0938–AO32

Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008

On Page 25362 under b. Addition of variables. The following text appears:

"In Table 2a, the interaction scores are added to the case-mix score whenever the two conditions defining the interaction occur together in the episode. Interaction scores, therefore, do not substitute for scores of other variables in Table 2a that involve either only one or the other of the two conditions. " and "This means that an episode would not be eligible to earn more than one score for the same diagnosis group."

In the existing PPS model the case- mix scoring for MO-230/240/245 instructs " credit *only* the single highest value". Does the text on page 25362 mean that MO-230/240/246 case-mix scores can now be combined or should only the highest case-mix score be considered in evaluating the clinical dimension?

While some diagnosis, such as those that are based solely on primary diagnosis, are clearly mutually exclusive, there are other combinations in table 2a; which could occur simultaneously.

Example 1: Item 21 requires Primary or other diagnosis = Neuro 4 and either MO 670 = 2 or more or MO 680 = 2 or more. Item 22 requires Primary or other diagnosis = Neuro 4 and either MO 690 = 2 or more or MO 700 = 3 or more. A patient with MO 670 =2 and MO 700 = 3 would meet the conditions of both of these items. In this case would the points for both items be awarded or only the points for the item with the highest case-mix score since they both share the same diagnosis group?

Example 2: Item 2 provides a case-mix score for Diabetes as the primary diagnosis, item 29's case-mix score is for Cancer as an other diagnosis. Since the two diagnosis are not within the same diagnosis group would both case mix scores be added together when scoring the clinical dimension?

Table 2a should be clarified to avoid any ambiguity in awarding case-mix scores.

Tables 2a and Table 3

Under the existing PPS model no single case-mix item can change the clinical dimension from it's lowest value (C0) to it's highest value (C3).

It now appears that some individual items in table 2a have the potential to move the clinical dimension from lowest (C1) to highest (C3).

Examples :

Item 6 Primary Diagnosis = Skin 1 has case-mix scores under all four equations that would make the clinical dimension C3 without consideration of any other clinical items.

Item 43 MO 488 (Surgical wound status) = 3 earns a case-mix score of 6 under all four equations. Under equation3 this is sufficient to individually move the clinical domain above the 5+ threshold for a C3.

Is the intent that single items may now move the clinical dimension from lowest to highest?

2. Refinements to the Case-Mix Model

On page 25359 you state "We refer to the four separate regression models in this proposed case-adjustment system as the four-equation model."

Table 3: Severity Group Definitions: Four Equation model, actually contains a fifth equation for 20+ therapy visits. The break points for the clinical and functional dimensions match those for an "early" episode with 14 to 19 therapy visits (equation 2). Table 2a however does not indicate specific case weights to be used when 20 + therapy visits push the episode into the fifth equation.

Should episodes with 20+ therapy visits always use the "early" 14 to 19 visits case-weight scoring to match the table 3 breakpoints or should the case-weight vary depending on whether it is an "early" or "late" episode with 14+ therapy visits?

Should table 3 contain two separate columns for "early " and "late" episodes to match the scoring in table 2a for 14+ therapy visit cases?

. 2. Refinements to the Case-Mix Model

On page 25360 you provide the following definition of "early" versus "later" episodes:

"Based on exploratory analysis, we defined ''early'' episodes to include, not only the initial episode in a sequence of adjacent episodes, but also the next adjacent episode, if any, that followed the initial episode. ''Later'' episodes were defined as all adjacent episodes beyond the second episode."

On page 25359 you define adjacent episodes as:

"Episodes are considered to be ''adjacent'' if they are separated by no more than a 60-day period between claims"

The fact sheet published by CMS on 4/27/2007 adds "regardless of whether the same home health agency provided care for the entire series of episodes.

There are several issues with these definitions.

The phrase "separated by no more than a 60-day period between claims" can be interpreted different ways.

1.) The episodes must be contiguous ie. The "from date" on the episode must immediately follow the "thru date" of the preceding home health claim thus the starting dates of the two claims would be separated by no more than sixty days.

2.) A new series of adjacent episodes only start when there is at least a sixty day period in which no home health services are rendered. This seems to be supported by the more specific definition under **5. Low-Utilization Payment Adjustment (LUPA) Review** on page 25425 which states, "a sequence of adjacent episodes is defined as a series of claims with no more than 60 days between the end of one episode and the beginning of the next episode (except for episodes that have been PEP adjusted). " This would allow an adjacent series of episodes to contain a break in home health service, not to exceed 60 days, as long as the episode is one continuous spell of illness.

Which interpretation is correct?

If interpretation #1 applies, situations involving services by more than one home health agency would be extremely rare. The overwhelming majority of transfers between agencies occur as a result of a hospitalization during an episode where, upon hospital discharge, the patient elects to receive home care from a different agency resulting in a PEP episode for the initial agency. This would result in a gap between the thru date from the transferring agency and the from date of the receiving agency.

Problems could also arise in situations where the patient is hospitalized at the end of a PPS episode, and is not discharged until after the subsequent episode would have started. Currently patients in the hospital at the end of a PPS episode would be discharged as of the date of Hospitalization. When they are subsequently discharged from the hospital a new admission is generated and a new episode begins as of the new SOC date. Under the first interpretation this would create 2 series of adjacent episodes , one ending upon hospitalization and a second one starting upon discharge from the hospital, even though the two series appear to be clearly connected.

Interpretation #2 raises a different set of issues.

Under this interpretation multiple agencies could be involved, but determining whether an episode is "early" or "later" could prove difficult when multiple agencies are involved. When checking CWF and finding that there was another agency involved how would we determine where they were in their adjacent episode count?

This interpretation could also create a situation where the early and late episodes are not related to one another.

Example: Patient is admitted to hone care and receives fewer than 5 visits creating a LUPA situation. Within the 60 day period the patient is readmitted, for an unrelated condition. Does that episode then become the second adjacent episode, or is it the first episode in a new series of adjacent episodes.

It is also possible that the information on the prior agency may change. If, on admission we check CWF and another agency has a RAP on file extending into the early part of the 60 days preceding our admission, our admission could then be an episode 2 or 3+ depending on how long the other agency had the patient under care. Since the through date, based the RAP, would be the end of a full 60 day episode. which could change when the final claim is filed showing the actual discharge date. If that discharge date then is more than 60 days prior to our admit date that could change the MO-110 resulting in a change in the equation that applies. Is it your intention to establish an edit to down code episodes coded as "later" if CWF does not indicate two prior episodes? Since the "early/later" determination impacts both the case-weight scores as well as the break points within each of the dimensions, how will the down code be calculated with out having all of the OASIS responses that impact case-weight available? Will you also up code if an episode is billed as "early" but CWF indicates it is a "later" episode?

The last paragraph of **a. Analysis of Later Episodes,** suggests that:

"If an HHA is uncertain as to whether the episode is an early or later episode, we propose to base payment as though the episode were an early episode. ... Consequently, we believe that selecting early as the default is the best guess as to the eventual outcome of whether an episode is early or later."

While we concur with your conclusion that most episodes contain only a single episode it does not seem equitable to ask agencies to forgo the higher payment on "later" episodes unless it is your intent to "up code" episodes when you find that an episode is truly a "later" episode when considering all of the data in CWF. As with down codes , what would be your basis for up coding?

Series of adjacent episodes should be defined consistently and clearly throughout the regulation.

5. Low-Utilization Payment Adjustment (LUPA) Review

Similar issues apply to the proposed additional payment for "LUPA episodes which are either the only episode or the initial episode in a sequence of adjacent episodes".

The definition on page 25425, "a sequence of adjacent episodes is defined as a series of claims with no more than 60 days between the end of one episode and the beginning of the next episode (except for episodes that have been PEP adjusted). " appears to be fairly clear except for the reference to "(except for episodes that have been PEP adjusted). "

What does this refer to? Does a PEP episode automatically create a break in a series of episodes? Does this also apply to determining which equation is used for full episodes (early versus later)? Would services rendered by another home health agency in the preceding 60 days impact the determination of whether a LUPA is the only or initial episode in a sequence?

Will this determination be subject to down coding and up coding?

Example: Based on CWF we categorize a LUPA episode as **<u>not</u>** an only or initial episode because there is a RAP episodes showing from another agency with a thru date that would put our begin date within the 60 day window. Subsequently the final claim from the other agency adjusts the thru date on their episode (based on discharging the patient prior to the end of the 60 day episode) leaving more than 60 days between it and our LUPA start date. Will CMS up code that episode and pay us the additional LUPA amount since our episode would now be the only or first episode in a new sequence of adjacent episodes? Conversely will CMS down code if an earlier claim is subsequently filed by another agency? Will agencies be expected to cancel and re-bill these LUPA episodes any time there is a change to the underlying adjacent sequence of episodes information. Since LUPA's are not impacted by the four equation model the up coding and down coding would require no other information beyond what is in CWF.

c. Addition of Therapy Thresholds

The therapy threshold has been long overdue for reform. The proposed revisions seem to provide for a better matching of reimbursement to resource utilization. There are however a number of issues.

In reviewing table 5 there appears to be an inconsistency in the payment graduation for the 16 to 17 therapy visit between "early" and " later" episodes. In all the other gradients the "later" episode case weight increment is higher that the corresponding case weight increment for the gradient in the "early" episode. In the 16 to 17 therapy visit gradient however the case weight increases by only .1281 for the "later" episode versus .1866 for the "early" episode. Can you provide any explanation for why this one gradient has a lower case weight increment for a "later" episode than and "early episode, when all of the other gradients reflect a larger increase in the "later" episode?

We understand that CMS has expressed their intention to both down code **<u>and</u>** up code in situations where the therapy utilization on the final claim does not match HHRG based on the MO-826 therapy need

projected at the time the RAP. This has long been a point of contention, since under existing procedures CMS would only down code episodes putting an additional administrative burden on agencies to manually up code when the threshold was crossed. We appreciate CMS's desire to more fairly and equitably administer the therapy threshold.

We do, however, have a some questions.

1.) Will down codes and up codes be made for both the thresholds (6,14,20) as well as the gradients within each threshold?

2.) When a down code or up code causes a change in which equation applies (6 to 13 up to 14 to 19 or vice versa) will the entire episode be regrouped based on the equation scoring in table 2a and the breakpoints in table 3? If so, where will CMS obtain the OASIS responses to regroup the episode? Is it your intent to modify the billing process so that the bill contains all of the OASIS case-mix scoring variables? Will the information be obtained from the OASIS filings with the state and will the reconciliation of OASIS submission with claims data be timely enough to allow for claims processing.

3.) As mentioned earlier there does not appear to be any clear direction as to whether equation 2 or equation 4 scoring should be used for episodes with 20+ therapy visits. This needs to be clarified.

4.) While the 3 threshold with gradients model does provide for a better matching of reimbursement to resource utilization, it also increases the opportunity that a medical review will change reimbursement. Under the existing PPS model ADR reviews that resulted in disallowed visits only had a reimbursement impact when it changed the total therapy visits across the 10 visit threshold. Under the new model almost any change in Therapy visits between 6 and 20 will result in some change in reimbursement. Should we anticipate an increase in therapy ADR 's, at least initially, as you attempt to validate the appropriateness of the new therapy thresholds and the accuracy of provider coding? Any significant increase in such ADR's, even if they result, in no adjustments, will result in an unfunded increase in administrative cost to the home health industry.

Table 5 Error

There is an error in your revised table 5on the CMS web site, under all episodes, 20+ Therapy visits. The revised table, as published, lists 3 each of C1F1S1, C2F2S1, and C3F3S1, each with different case weights and values.
It appears to be just a typographical error in the sequence of the functional dimension. The proper sequence should be F1, F2, F3, F1, F2, F3, F1, F2, F3 not F1, F1, F1, F2, F2, F2, F3, F3, F3.

Nominal Case Mix Change

We are concerned about the assumptions underlying the reduction in the base PPS rate by 2.75% to begin to effect for the 8.7 % which you categorize as "a nominal change in the CMI that does not reflect a "real" change in case-mix.". This assumes that the "nominal change" is the result of an artificial increase in the case weight, implying that the industry engaged in an increasing systemic over coding of PPS episodes between 2000 and 2003. While it is possible that some individual agencies may have over coded you have provided no medical review data supporting an industry wide pattern. In fact Medical review should have prevented case mix creep by down coding the episodes where inappropriate up coding occurred.

Another one of your assumptions is that the relative stability of resource utilization during the period should have been matched by a corresponding stability in the CMI. This assumes that there was perfect understanding and application of the OASIS at the time PPS was implemented. An equally plausible assumption would be that agencies were systemically under coding and therefore under reimbursing

themselves at the outset of PPS and that as time and experience have been gained the coding has become more accurate.

The impact of this reduction can not be over stressed. Effectively this 2.75% reduction over the next 3 years amounts to a virtual freeze in home health reimbursement. The home health industry is already operating at a disadvantage in recruiting qualified staff due to the use of pre-floor, pre-reclassified wage index for home health agencies. A virtual 3 year freeze in reimbursement rates is going to make it almost impossible for agencies to pay competitive wages, resulting in additional attrition in staffing. This will potentially lead to reduced access to care as agencies are unable to attract and retain qualified personnel.

TABLE 4.—REGRESSION COEFFICIENTS FOR CALCULATING CASE-MIX RELATIVE WEIGHTS

"We used the predicted average resource costs for the 153 case-mix groups to calculate the relative case-mix weights."

Clearly the increase from 80 to 153 HHRG's is going to require corresponding changes to the HIPPS coding as well. When will a new crosswalk between HHRG| and HIPPS values be available? How will the "early" versus "later" episodes distinction be coded and how will the three therapy groups (0 – 13, 14 – 19, and 20+) be identified?

Submitter : **Mrs. Susan Hice** **Date: 05/28/2007**

Organization : **BayCare Home CAre**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

Home Care's labor costs have risen drastically - especially Therapy. The present wage structure does not reimburse us adequately. The nursing shortage has forced us to increase all our hourly and PRN rates. The current gas price crunch has also forced us to readjust our mileage reimbursement. The 2.75% cut each year planned over the next three years would drastically hurt the home care industry. Certainly those of us who are not-for-profit especially feel the cuts as we are already taking hits by trying to help all those patients in the community that the FOR profit agencies refuse to service. Please reconsider the cuts for the sake of our patients! Thank you for giving us an opportunity to comment!

Submitter : **Date: 05/28/2007**

Organization :

Category : **Nurse**

Issue Areas/Comments

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

See attachment

CMS-1541-P-4-Attach-1.DOC

Medicare Home Health PPS Proposed Rule
Comments

RE: File Code: CMS-1541-P

1. Issue Identifier: Provisions of the Proposed Regulations

Comment: This comment relates to the case-mix adjustment variables and scores (Table 2a). In the current OASIS document and in accordance with wound care standards of practice, a pressure ulcer cannot be staged if eschar is present. Since the ulcer cannot be staged, no case-mix points are scored in the clinical dimension. However, it is important to note if eschar is present, the ulcer must be a stage 3 or stage 4 due to the basic pathophysiology of pressure ulcers. The question is: is it a 3 or 4? This question is unable to be answered until the eschar is removed. Under the proposed rule, the same scoring rule applies – M0460, when a 3 or 4, generates 11-18 points depending upon if the episode is early or late, low or high therapy. In addition, if the patient has 2 or more pressure ulcers that are stage 3 or 4, 4-5 more points are generated. But, since eschar is present, those points are "lost". If a patient has an ulcer with eschar, most often, intensive treatment is required to remove the eschar. Until the eschar is removed, the ulcer will not begin to heal. The longer this takes, the more likely the ulcer will worsen (i.e. move from a stage 3 to a stage 4). This could result in extensive hospitalization and surgical procedures. Options for eschar removal include surgical debridement, which is not typically performed in the home setting and is quite costly. Another option, most common in the home setting, is use of a chemical enzymatic debriding agent. Application of this agent is done daily or twice daily. Failure to receive points in the clinical dimension for these ulcers has a significant impact on an agency's resources. I would like to recommend this issue be considered further and the case-mix scoring be revised to allow for points at M0450 and M0460 when the pressure ulcer contains eschar. Again, to reinforce: when a pressure ulcer has eschar, it MUST be a stage 3 or 4.

Comment: This comment relates to the non-routine supply diagnoses. Often, agencies provide care to patients who experience urinary retention, spinal cord injury and other urological and neurological conditions. These patients require intermittent straight catheterization more than daily. Some patients, due to other complications, must use a new catheter with each catheterization (upon orders of the physician). I do not see a diagnosis listed in the proposed rule to account for this patient population.

In addition, according to the PGBA Medicare Training Manual, **"Enteral nutrition may be considered for coverage under the home health benefit providing the following conditions apply. The beneficiary must be:**

- **Homebound and under a plan of care**
- **Have a temporary impairment of 90 days or less**
- **Unable to ingest anything by mouth, i.e., ice chips, sips of water, etc.**

When the beneficiary meets the above criteria for temporary impairment, and valid orders are present, Medicare may consider the following for coverage:

- **Visits for administration**
- **Nutrients**
- **Supplies associated with administration"**

The supply diagnosis list does not include any supplies associated with administration of enteral nutrition in the above situation. These supplies are quite costly for the agency. In addition, a gastrointestinal tube may still be present due to some other diagnosis and the agency is required to change the tube while the patient is a home health patient. I recommend including provisions for scoring these supplies.

Thank you for your consideration of my comments.

CMS-1541-P-5 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Mrs. Jean Snyder** **Date & Time:** **05/30/2007**

Organization : **Sacred Heart Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

Collection of Information

Collection of Information

On the revised OASIS set B-1 MO100 still includes RFA 5. If the SCIC is to be discontinued when would you ever use this RFA?

If HH Compare is going to include Emergent Care for Wound Infections then MO840 needs to be rephrased. As it is worded now, they can go into ED for a new skin tear and this would be checked therefore giving a false outcome for a wound infection.

We have been told for the last 3 years that MO700 would be reworded differently or have more options for answers with the next revision. As it is now, a patient can go from a 4WW to a single point cane and show no improvement. Before you go fully into pay 4 performance this needs to be addressed as does MO520 regarding incontinence and MO450 for a pressure ulcer that is covered with eschar at SOC which 20% of our pressure ulcers are. At least when there was a SCIC and the pressure ulcer opened we could get reimbursed for the care needed but now we will not even have the scic. Although that does not change the outcome and we still show an "increase in pressure ulcers" at DC.

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

The SCIC OASIS was the only avenue to increase reimbursement when an unobservable pressure ulcer or surgical wound became observable, if this SCIC adjustment is eliminated then we are left with a minimal HHRG to care for this patient. We get many of these patients and the care needs greatly increase when the wound finally opens and is able to be staged.

CMS-1541-P-6 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Mrs. Juliana L'Heureux** **Date & Time:** **06/04/2007**

Organization : **CHANS Home Health Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

This proposed rule does not take into account non-profit or other efficient home health agencies where the patients' cumulative case mix weight is decidedly beneath the criteria of "1" and thereby clearly should be held harmless for the penalty of 2.75 percent "take back" in the absence of corroborating evidence to support such a reduction of 2008 PPS reimbursement rates. Can home health care be considered for a hold harmless provision? Thank you.