CMS-1541-P-7 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Mrs. Pat West** **Date & Time:** **06/06/2007**

Organization : **Pioneer Home Health Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-P-7-Attach-1.DOC

#7

June 6, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS – 1541 – P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Sirs:

We are writing to comment on the proposed rule published on April 27, 2007 concerning the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008.

Background
In this section, you state, "The general goal of any refinements would be to ensure that the payment system continues to produce appropriate compensation for providers while retaining opportunities to manage home health care efficiently. Also important in any refinement is maintaining an appropriate degree of operational simplicity."

We question whether the proposed refinements achieve these goals. The proposed refinements increase the number of HHRGs from 80 to 153, distinguish between early and later episodes, expand the number of diagnostic codes, create three therapy thresholds, and introduce four separate regression equations.

These changes approximately double the complexity of the system. It will make it much more difficult for us providers to understand how the system works. It will make it more difficult for us to manage the level of services provided for each HHRG with the payment for that HHRG. This could decrease efficiency, not increase it. If operational simplicity is measured by the number of HHRGs, the proposed refinements

Provisions of the Proposed Regulations
We support the proposal to eliminate MO175 from the case-mix model. It has always been difficult for providers to code this item accurately. We also recommend that CMS stop the retrospective MO175 audits for the same reason and totally eliminate this OASIS assessment question.

We disagree with the proposal to reduce rates by 8.7 percent because of a "nominal" change in case-mix. First, it is unclear from Table 7 what "Average Resource Cost" is and what data source was used. Second, the separation of "real" vs. "nominal" seems arbitrary as do the dates chosen (HH IPS baseline and most recent data available from 2003). We do not think it is fair to penalize providers by eliminating almost all of the market basket increase by offsetting it with the case-mix creep adjustment when the nominal change in case-mix is so speculative. I believe, from working in the industry at ground level, that those we care for continue to be more complicated and sicker.

PEP Adjustments
The rule proposes no changes to current PEP policy. However, one problem with the current policy involves the transfer to another agency which occurs in 42 percent of PEPs. A second provider can admit a patient who has been discharged with goals met from the first provider. Currently, fiscal intermediaries do not review the medical necessity of such readmissions which we believe is a problem. We recommend that CMS analyze this issue to determine whether such readmissions appear to be medically necessary.

LUPA Adjustments
We support the proposal to create an additional payment of $92.30 for certain LUPAs. Currently, LUPA payments per visit are significantly less than providers' actual cost per visit. The additional payment will help address this issue. We also recommend that CMS consider applying the Non-routine Medical Supply adjustment to LUPAs.

SCICs
We support the proposal to eliminate SCICs. SCICs added complexity to the system which did not appear to have any benefit to anyone.

Non-Routine Medical Supplies
We support the proposal to provide additional payments for non-routine medical supplies based on the severity level. As stated above, we believe the NRS payment should also be applied to LUPAs since these frequently involve the use of NRS.

In summary, we have two major concerns with the proposed rule. The first is the case-mix creep adjustment which would effectively freeze rates for the next three years while the cost of providing care continues to skyrocket. There does not appear to be a firm basis for this adjustment and some of the data provided seem contradictory. The second concern is that the revised system significantly increases the complexity of the current system which is already quite complex, while still not addressing a majority of the patients' actual acuities and care needs. . We recommend that CMS carefully assess whether the increase in explanatory power of the proposed system is worth the increase in complexity.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

Pat West, Administrator
Pioneer Home Health Care
162 East Line Street
Bishop, CA 93514
760/872-4663

CMS-1541-P-8 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Mary McCusker** **Date & Time:** **06/06/2007**

Organization : **CareGroup Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

Collection of Information

Collection of Information

Re: File Code CMS-1541-P

Issue Identifier- PaperworkReductionActof1995/PRAL/list.asp#TopOfPage

Specifically-The issue of the HHA needing to identify whether the episode is early or late

Since CMS is the only organization that has accurate info to determine whether an episode is early or late, why place the burden of identification on individual agencies? HHAs have 18 months in which to bill Medicare and time point 9 s are often (unfortunately) not done timely by clinicians. The information on the CWF may not be up to date due to these factors. Therefore, the clinician doing the SOC OASIS is placed in the position of guessing as to whether an episode is early or late. CMS has removed M0175 as a question agencies have had to make an educated guess to answer and replaced it with another guess question as to whether an episode is early or late. Why can t CMS adjust automatically for this question as it proposes to do for the therapy need question?

Thank you for your attention to my comment.
Mary McCusker R.N.
Medicare Case Manager
CareGroup Home Care
Watertown, MA 02472

Submitter : **Ms. Carol Ward** **Date: 06/11/2007**

Organization : **APIC, Southern NJ Chapter 11**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

See ttachment

#9

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Ms. Jennifer Markley

Date: 06/12/2007

Organization : TMF Health Quality Institute

Category : Nurse

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-1541-P-10-Attach-1.DOC

#10

CMS-1541-P
Comments
Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008

1. Refinements to the Case-mix Model
    a. Analysis of Later Episodes

I am concerned that paying at increased amounts for later episodes may result in unintended consequences of maintaining patients on service for longer than appropriate. In Texas there appears to be a significant problem with agencies maintaining patients with chronic conditions after there is no longer a skilled need for services i.e. the patient's chronic condition is stabilized or when being seen under the management and evaluation provision patients do not qualify based on complex needs.

I believe that this pattern of over utilization, in part, due to the rapid and uncontrolled growth of providers in the state of Texas, which has contributed to heightened competition for referrals with some agencies not having a sufficient referral bases to sustain operations unless they maintain these chronic patients on service. As a result these agencies may not discharge patients appropriately from service, but rather recertify for multiple recurring episodes. This practice appears to occur primarily in small or medium sized agencies that lack a sufficient referral base and can be seen on outcome reports with hospitalization episodes that are 5-10 times higher than end result episodes and in high hospitalization rates.

Lastly, this utilization issue may go undetected due to the current fiscal intermediary concentration of review activities on larger agencies where there is the greatest potential risk of harm to beneficiaries or where there is the greatest potential recovery of Medicare funds. Providing increased funding for later episodes will, I believe, further exacerbate the problem and provide a further incentive to continue this practice unless it is addressed prior to implementation of the new rules and on an ongoing basis thereafter. Based upon anecdotal information, these concerns exist beyond Texas, and I would encourage/recommend further discussions and broad investigation of these issues prior to a final determination notice of payment restructure.

Thank you for the opportunity to comment.

Submitter : **Mrs. Cathy Sanders** **Date: 06/12/2007**

Organization : **Brookwood Medical Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

While I support CMS in their effort to idenfity adverse events or conditions that should not occur in hospitals, I do no support the inclusion of events that cannot always, even with excellant care, be prevented. Infections can be linked to many causitive factors and are not necessarily the result of poor care. Current definitions for device-related infections are surveillance definitions rather than clincial and may over estimate the relation of the device to the infeciton. Surgical Site infections are likewise not always preventable even when all guidelines are followed precisely.

While our healthcare system is far from perfect, I urge you to consider the possible far-reaching implications of further reducing payments for complications to hospitals. Many facilities found themselves in dire straights after DRG's were initiated. Facilities closed. Access to healthcare in some areas decreased. As facilities have to further tighten their budgets, where are the cuts made? Personnel? Building maintenance? New technology? I fear that these proposed changes in the payment system will only further weaken an already flawed system. Please give the utmost consideration to available information and do not act hastily.

Sincerely,
Cathy S. Sanders, RN, BSN, CIC
Infection Prevention Coordinator

Submitter : **Date: 06/12/2007**

Organization :

Category : **Home Health Facility**

Issue Areas/Comments

Annual Update

Annual Update

Large descrepencies exists in 3 West Virgina counties located in close proximity to the Washington, D.C. metropolitan area. Berkeley County(CBSA 25180)experienced tremendous growth 2003-2006 and has been distinguished nationwide as one of the top fastest growing areas in the United States. The result has been increased property values, which has had a dramatic effect on the wages that must be paid to employ home health staff, specifically nurses and therapists.Jefferson County(CBSA 47894)is located somewhat eloser to to the metropolitan area and has experienced many of the growth situations as Berkeley County, but has a significantly higher wage index. Hampshire County(CBSA 49020) has not experienced near the growth and subsequent property value increase and wage escalation as Berkeley County, but again has a higher wage index. Additional and perhaps more current factors need to be considered to determine the reason for the large differenees in wage indexes in similar areas.

Submitter : **Mrs. Sharon Niederhaus** **Date: 06/12/2007**

Organization : **South Coast Medical Center Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We are a small hospital based agency with an average census of 70. Our agency has not "made money" for several years. The hospital has kept us open because it is a faith based organization which wants to provide home care access to our community which is "land locked". More than 50% of our services are managed care with below costs reimbursement. The provisions of this rule could cause us to be unable to continue to provide access to care for the elderly population that we serve. One example is the denial of supply reimbursement for LUPA's. We have several clients who are simple catheter changes and do not require home health aide services so they are very predictable as LUPA's. Although the slight bump up in reimbursement is great, the supply costs are not covered at all. Secondly, the additional $92.63 for the first LUPA is great, why can't that be applied to all LUPA's? We have foley catheter dependent patients who have been recertified many times. Further, MO110 identifing later episodes, I understand that the common working file is not updated daily which means we will have to designate someone to check this several times during an episode, another use of our limited resources. Isn't this something that can be done from your end? And last of all, we have a very short time to educate, train, make system changes and be ready for all of this by 1/1/8 while running two systems simultaneously in order to cover 2007 and 2008. I attended a seminar last week provided by NAHC and feel very discouraged about the future of Home Care in our country. I appreciate the opportunity to voice my opinion. Respectfully, Sharon Niederhaus, RN

Submitter : **Ms. Bonnie Washington** **Date: 06/14/2007**

Organization : **Novartis Pharmaceuticals Corporation**

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

In the Prospective Payment System Refinement and Rate Update for Calendar Year 2008 proposed rule, published in the Federal Register on May 4, 2007, refining and updating the home health prospective payment system (HH PPS), the Centers for Medicare & Medicaid Services (CMS) invites comments on how to improve the performance and appropriateness of the HH PPS. I am writing on behalf of Novartis Pharmaceuticals Corporation (Novartis) to respectfully request that a new innovative osteoporosis treatment called Reclast? (zoledronic acid) Injection be included as a covered home health service under Medicare Part B. Coverage of Reclast? under the HH PPS will ensure that certain beneficiaries have access to this unique and effective treatment in the setting most appropriate to their circumstances.

CMS-1541-P-14-Attach-1.DOC

Barbara Washington
Vice President Health Policy

Novartis Pharmaceuticals Corporation
701 Pennsylvania Ave., Ste 725
Washington, DC 20004
One Health Plaza
East Hanover, NJ 07936-1080
USA
Tel 202-662-4378
Fax 202-628-4763
E-Mail bonnie.washington
@novartis.com
www.novartis.com

June 14, 2007

Kathleen Walch
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8012

Attention: CMS-1541-P

Dear Ms. Walch:

In the Prospective Payment System Refinement and Rate Update for Calendar Year 2008 proposed rule, published in the *Federal Register* on May 4, 2007, refining and updating the home health prospective payment system (HH PPS), the Centers for Medicare & Medicaid Services (CMS) invites comments on how to "improve the performance and appropriateness of the HH PPS."[1] I am writing on behalf of Novartis Pharmaceuticals Corporation (Novartis) to respectfully request that a new innovative osteoporosis treatment called Reclast® (zoledronic acid) Injection be included as a covered home health service under Medicare Part B. Coverage of Reclast® under the HH PPS will ensure that certain beneficiaries have access to this unique and effective treatment in the setting most appropriate to their circumstances.

Impact of Osteoporosis on Medicare Beneficiaries

Bone fractures caused by osteoporosis exact an extraordinary, though largely underappreciated, human and financial cost on Medicare and its beneficiaries. In a special report in *Bone Health and Osteoporosis,* the Surgeon General warned recently that unless immediate action is taken, by 2020 half of all Americans older than 50 will be at risk of fractures from osteoporosis and low bone mass. Today, 10 million Americans over the age of 50 have osteoporosis, while another 34 million are at risk of developing osteoporosis. Each year, about 1.5 million people suffer an osteoporotic bone fracture.

As the Surgeon General explained, hip fractures frequently cause an elderly person's health to spiral rapidly downward. Twenty percent of elderly people who suffer a hip fracture end up in a nursing home within one year; and a hip fracture makes an elderly person four times more likely to die within three months. Hip fractures account for 300,000 hospitalizations each year.

Half of women over age 50 with osteoporosis will suffer an osteoporotic fracture within their lifetime. Incidence of hip fracture in women is projected to rise 240% worldwide by 2050, as populations grow and age. The medical expense of treating osteoporotic fracture is $18 billion each year, according to the Surgeon General. The costs of long-term care and lost work add billions to this figure.

Background on Reclast®

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[1] 72 *Fed. Reg.* 25356, 25358 (May 4, 2007).

Reclast®, which has been approved for the treatment of Paget's Disease, is being investigated by Novartis for the treatment of postmenopausal osteoporosis. Reclast® is administered once-yearly by injection for this condition. New Phase III data supports that Reclast® is highly effective in reducing the incidence of hip and spine fracture—the most common fracture sites—in women with postmenopausal osteoporosis. The active ingredient in Reclast® is zoledronic acid. Reclast® belongs to a class of osteoporosis drugs called bisphosphonates.

A recent article in the *New England Journal of Medicine* concluded that patients treated with Reclast® experienced a remarkable 70% fewer new spine fractures and 41% fewer hip fractures over a three-year period than patients treated with placebo (a copy of this article is attached for your review).[2] The convenience of a once-yearly infusion will likely improve patient compliance over that of existing osteoporosis treatments. Moreover, over three quarters of study subjects preferred a yearly infusion over a weekly pill. Reclast® holds the potential to spare millions of elderly Americans premature death and disability and to save the health care system billions of dollars annually.

The Food and Drug Administration (FDA) approved Reclast® for the treatment of Paget's disease in April 2007 and is expected to announce its determination on the treatment of osteoporosis with Reclast® in August 2007.

Medicare Coverage of Reclast® as a Home Health Service

Reclast® may be administered in a variety of health care settings. Reclast® should be covered under Medicare Part B for those beneficiaries for whom the home health service is most appropriate.

Reclast® qualifies as a Part B covered home health service. Section 1861(m)(5) of the Social Security Act provides that the scope of "home health services" includes, among other items and services, a "a covered osteoporosis drug (as defined in subsection (kk))." Section 1861(kk) defines the term "covered osteoporosis drug" as,

> an injectable drug approved for the treatment of post-menopausal osteoporosis provided to an individual by a home health agency if, in accordance with regulations promulgated by the Secretary—
>
> (1) the individual's attending physician certifies that the individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and
> (2) the individual is confined to the individual's home . . . .

Currently two injectable drugs for the treatment of osteoporosis—calcitonin salmon (Calcimar®, Miacalcin®) and teriparatide (Forteo®) are covered under the Medicare Part B home health benefit.

Reclast® satisfies these criteria: it is an injectable drug that will soon be approved for the treatment of, among other indications, post-menopausal osteoporosis. Moreover, once approved, Reclast® could offer some beneficiaries safe and effective protection from fractures due to Osteoporosis with a once yearly infusion at home. Reclast® should, therefore, be included within the Part B home health

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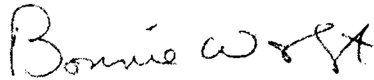
[2] Dennis M. Black, et al., "Once-Yearly Zoledronic Acid for Treatment of Postmenopausal Osteoporosis," 356 *New England Journal of Medicine* 1809 (May 3, 2007).

benefit when it is provided by a home health agency to female beneficiaries receiving services under an open home health plan of care.

Under this benefit, Reclast® would not be subject to the HH PPS. It would instead be covered on a reasonable cost basis using the provider's submitted charges. The home health visit by a skilled nurse to administer Reclast® would likewise be covered under the Part B home health benefit. Part B deductible and coinsurance rules would apply. *See* Medicare Benefits Policy Manual, Ch. 7, §50.4.3.

Thank you for your consideration of this issue of great importance to Medicare beneficiaries. Please do not hesitate to contact me should you require any additional information.

Sincerely,



Bonnie Washington
Vice President, Health Policy
Novartis Pharmaceuticals Corp.

Submitter : **Donna Goodwin** **Date: 06/14/2007**

Organization : **Family Home Care Corporation**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

CMS-1541-P-17 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Date & Time: 06/15/2007**

Organization :

Category : **Nurse**

Issue Areas/Comments

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

Since 10-1-2000 our LUPA percentage has remained steady at 15-19% of all visits. The CMS proposal to increase the LUPA rate by $92.63 during the first episode, is a much appreciated. However, our data indicates that administrative and supply cost continue to be steadily incurred throughout all LUPA episodes, not just in the initial episode. I encourage CMS to apply the same consideration to subsequent episodes, not just the initial episode. Our LUPA population is comprised of patients with long-term needs such as catheter care or B12 injections. In most instances, these patients also have more than 2 co-morbidities. Although in-home visit frequencies are < 4 per episode, we continue to provide 24-hour on- call access, education, telephone contact and reminders. Our actions serve to allow this population to remain safely at home. The industry's inability to cover costs may negatively impact access to medically mecessary care for these long-term patients, who without our care, would otherwise be placed in a more costly alternative.

The CMS proposal of developing NRS diagnostic categories will allow for a more accurate allocation of costs. I am concerned however, that the proposed changes are based on incomplete data. Nearly 40% of the cost reports were thrown out due to incomplete information and only 10% of the all calims contained NRS charges. Our agencies' claims did not include NRS charges. I am most concerned about our long-term, low frequency patients (i.e. LUPA episodes), as the current $1.96 assigned to NRS does not adequately cover the costs of medically necessary NRS and this population is exculded from the NRS proposed refinement. I urge you to allow a NRS add-on using diagnostic categories.
8.7% of the 23.3% change in the average case-mix is purported to be due to coding behavior, rather than real changes in the patient's condition. OASIS was implemented during a time of massive change (IPS and conflicting CMS instructions on implementing OASIS). In addition, ICD 9 coding had not been a focus at our agencies prior to PPS. This lack of ICD 9 knowledge was common in the home care industry...it had not been a priority. We trained, trained, re-trained and continue to train clinicians on the CMS interpretation of OASIS questions. We developed tools to assist managers to review OASIS data for consistency. We designated coding experts and trained them accordingly. A three year study of all agencies revealed that early-on, there was little inter-rater reliability and that staff misinterpreted OASIS questions 60% of the time. In the last 18 months, due to education and review, OASIS questions are correctly and consistently interpreted at a rate of 82%! Additionally, knowledgeable coding staff now consistently apply ICD 9 coding principles. This dramatic improvement in accuracy and reliability accounts for what may appear on the surface to case mix creep. Another factor impacting our average case-mix is our committment to changing patient behaviors and focusing our efforts on rehabilation and functional improvement. For example, our service patterns now include a 30% increase in OT services and a 57% improvement in Home Health Compare results. We no longer enable patients by utilizing daily home care aides, but give patients the tools and means reach maximum independence. Yes, our case-mix has increased due to hard work, accuracy and committment. I urge you to eliminate or reduce the 3 year proposed base rate reduction. Changes in patient population, conflicting CMS instructions, agency committment to accuracy and outcomes and staff learning curves all contribute to the increase in the case mix. The original rates were based on a relatively small sample and the refinement analysis is now too old for appropriate consideration.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The initial rationale of the SCIC component of PPS was commendable, as it seemed to allow for significant changes in a patient's condition. However, the application of the concept has been an administrative nightmare. Our agencies are having difficulty determining whether to apply the SCIC or not under the current model. The proposed model will only complicate the matter further and be of little to no benefit to the patient, the agency, the intermediary or to CMS. Claims data indicates that the episodes per beneficiary is very low. For NC it is 1.2 episodes per beneficiary. For my agencies, episodes per beneficiary is between 1.2 and 1.3. Our agencies, indeed most of the agencies in NC will not realize the higher weights allocated to Late Episodes as our service patterns and patient population do not support third and subsequent episodes of care. The exception is our population of low frequency, LUPA patients, or those receiving long-term Medicaid services. This population accounts for 85% of all third and subsequent episodes. Althought the HHH PPS only includes Medicare beneficiaries, OASIS data collects information on both Medicare and Medicaid, and MO150 identifies the payor source. The period under analysis was during a time where instructions dictated collection of all possible payor sources, not just the sources that will pay. Therefore, your data includes Medicaid in the mix. However, those cases are not eligible for Late EP reimbursement. Lastly, the determination of early vs late episode will create a significant administrative burden for our agency. We will need to rely on the common working file, which is often slow in posting information, and/or rely on patients and families for information (usually incorrect). We recommend elimination of the early/late distinction and redistribution of the weighting to all episodes. This will simplify the 4-equation model by eliminating the early/late EP calculations, to a 2-equation model with therapy thresholds. Additionally, it is imperitive that CMS address the issue of the CWF. Currently, the CWF does not ofer real-time patient eligibility information, often as old as 90-180 days. The system is slow in posting claims processed, making it difficult for agencies to determine status and access to care. Adding the early/late EP distinction will magnify these complications and may limit or delay appropriate access to care and timely care delivery.

#17

June 12, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS – 1541 – P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Sirs:

We are writing to comment on the proposed rule published on April 27, 2007 concerning the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008.

Background

In this section, you state, "The general goal of any refinements would be to ensure that the payment system continues to produce appropriate compensation for providers while retaining opportunities to manage home health care efficiently. Also important in any refinement is maintaining an appropriate degree of operational simplicity."

We question whether the proposed refinements achieve these goals. The proposed refinements increase the number of HHRGs from 80 to 153, distinguish between early and later episodes, expand the number of diagnostic codes, create three therapy thresholds, and introduce four separate regression equations.

These changes will make it more difficult for providers to understand how the system works. It will make it more difficult for providers to manage the level of services provided for each HHRG with the payment for that HHRG. This could decrease efficiency, not increase it. If operational simplicity is measured by the number of HHRGs, the proposed refinements nearly double the complexity of the system.

Provisions of the Proposed Regulations

We support the proposal to eliminate M0175 from the case mix model. It is often difficult for providers to code this item accurately. We also recommend that CMS stop the retrospective M0175 audits for the same reason.

We disagree with the proposal to reduce rates by 8.7 percent because of a "nominal" change in case mix. First, it is unclear from Table 7 what "Average Resource Cost" is and what data source was used. Second, the separation of "real" vs. "nominal" seems arbitrary as do the dates chosen (HH IPS baseline and most recent data available from 2003). We do not think it is fair to penalize providers by eliminating almost all of the market basket increase by offsetting it with the case mix creep adjustment when the nominal change in case mix is so speculative.

We believe the data displayed in Table 10 contradict the assumption that there is nominal case mix creep. If providers were artificially inflating case mix, we would expect OASIS data to change accordingly. However, the proposed rule states; "health characteristics as measured by the OASIS items were stable or changed little." It further states "otherwise, the rate comparisons of OASIS items are generally unremarkable."

PEP Adjustments
The rule proposes no changes to current PEP policy. However, one problem with the current policy involves the transfer to another agency that occurs in 42 percent of PEPs. A second provider can admit a patient who has been discharged with goals met from the first provider. Currently, fiscal intermediaries do not review the medical necessity of such readmissions, which we believe is a problem. We recommend that CMS analyze this issue to determine whether such readmissions appear to be medically necessary.

LUPA Adjustments
We support the proposal to create an additional payment of $92.30 for certain LUPAs. Currently, LUPA payments per visit are significantly less than providers' actual cost per visit. The additional payment will help address this issue. We also recommend that CMS consider applying the Non-routine Medical Supply adjustment to LUPAs.

SCICs
We support the proposal to eliminate SCICs. SCICs added complexity to the system that does not appear to have been necessary.

Non-Routine Medical Supplies
We support the proposal to provide additional payments for non-routine medical supplies based on the severity level. As stated above, we believe the payment should also be applied to LUPAs since these frequently involve the use of non-routine medical supplies.

Home Health Care Quality Improvement
The regulation proposes that two additional quality measures be added to the ten already required. In order to reduce the regulatory burden, we recommend that if CMS adds two new measures, you delete two of the existing measures to keep the total number of quality measures at ten.

In testing patient level quality measures and continuing to refine the current OASIS tool, we recommend that CMS make every effort to reduce the total number of OASIS items and, thereby, the regulatory burden of the OASIS on providers.

In summary, we have two major concerns with the proposed rule. The first is the case mix creep adjustment that would effectively freeze rates for the next three years. There does not appear to be a firm basis for this adjustment and some of the data provided appear contradictory. The second concern is that the revised system significantly increases the complexity of the current system, which is already quite complex. We recommend that CMS carefully assess whether the increase in explanatory power of the proposed system is worth the increase in complexity.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

Vicki Purgavie, Executive Director
Home Care & Hospice Alliance of Maine
20 Middle Street
Augusta, Maine 04330

CMS-1541-P-18 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Vicki Purgavie** **Date & Time:** **06/16/2007**

Organization : **Home Care & Hospice Alliance of Maine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1541-P-18-Attach-1.TXT

#18

June 12, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS – 1541 – P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Sirs:

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Provisions of the Proposed Regulations

We support the proposal to eliminate M0175 from the case mix model. It is often difficult for providers to code this item accurately. We also recommend that CMS stop the retrospective M0175 audits for the same reason.

We disagree with the proposal to reduce rates by 8.7 percent because of a "nominal" change in case mix. First, it is unclear from Table 7 what "Average Resource Cost" is and what data source was used. Second, the separation of "real" vs. "nominal" seems arbitrary as do the dates chosen (HH IPS baseline and most recent data available from 2003). We do not think it is fair to penalize providers by eliminating almost all of the market basket increase by offsetting it with the case mix creep adjustment when the nominal change in case mix is so speculative.

We believe the data displayed in Table 10 contradict the assumption that there is nominal case mix creep. If providers were artificially inflating case mix, we would expect OASIS data to change accordingly. However, the proposed rule states; "health characteristics as measured by the OASIS items were stable or changed little." It further states "otherwise, the rate comparisons of OASIS items are generally unremarkable."

PEP Adjustments
The rule proposes no changes to current PEP policy. However, one problem with the current policy involves the transfer to another agency that occurs in 42 percent of PEPs. A second provider can admit a patient who has been discharged with goals met from the first provider. Currently, fiscal intermediaries do not review the medical necessity of such readmissions, which we believe is a problem. We recommend that CMS analyze this issue to determine whether such readmissions appear to be medically necessary.

LUPA Adjustments
We support the proposal to create an additional payment of $92.30 for certain LUPAs. Currently, LUPA payments per visit are significantly less than providers' actual cost per visit. The additional payment will help address this issue. We also recommend that CMS consider applying the Non-routine Medical Supply adjustment to LUPAs.

SCICs
We support the proposal to eliminate SCICs. SCICs added complexity to the system that does not appear to have been necessary.

Non-Routine Medical Supplies
We support the proposal to provide additional payments for non-routine medical supplies based on the severity level. As stated above, we believe the payment should also be applied to LUPAs since these frequently involve the use of non-routine medical supplies.

Home Health Care Quality Improvement
The regulation proposes that two additional quality measures be added to the ten already required. In order to reduce the regulatory burden, we recommend that if CMS adds two new measures, you delete two of the existing measures to keep the total number of quality measures at ten.

In testing patient level quality measures and continuing to refine the current OASIS tool, we recommend that CMS make every effort to reduce the total number of OASIS items and, thereby, the regulatory burden of the OASIS on providers.

In summary, we have two major concerns with the proposed rule. The first is the case mix creep adjustment that would effectively freeze rates for the next three years. There does not appear to be a firm basis for this adjustment and some of the data provided appear contradictory. The second concern is that the revised system significantly increases the complexity of the current system, which is already quite complex. We recommend that CMS carefully assess whether the increase in explanatory power of the proposed system is worth the increase in complexity.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

Vicki Purgavie, Executive Director
Home Care & Hospice Alliance of Maine
20 Middle Street
Augusta, Maine 04330