Submitter : **Date: 06/22/2007**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-30-Attach-1.PDF

#30

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1541-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: CMS-1541-P Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008

Dear Ms. Norwalk,

On behalf of our 145 members, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide input regarding the proposed refinements of the home health prospective payment system (PPS) to reflect current patient characteristics and agency practices. However, we believe that caution is critical when undertaking multiple changes simultaneously. Of particular concern is the CMS' plan to impose payment reductions at the same time that a major overhaul is being undertaken in the case-mix system. Our specific concerns are addressed below.

Behavioral Offset

The CMS proposes to reduce the marketbasket updates by 2.75 percent for the next three years, 2008, 2009, and 2010. The adjustment is based on the CMS conclusion that the increase in the national average case mix weight between 1999 and 2003 is due to factors unrelated to changes in patient characteristics. The original design of the case mix adjustment model set the average case mix weight at 1.0. That design is based on 1997 patient data. At the end of 2003, the average case mix weight is 1.233. The CMS concluded that the change in case mix weight between 1997 and 1999 (1.0 to 1.13) was due to changes in patient characteristics. However, the CMS determined that the change of 8.7% between 1999 and 2003 (1.13 to 1.233) was unrelated to changes in patient characteristics. As a result, CMS proposes to reduce the marketbasket update by 2.75% for each of the 3 upcoming years to offset anticipated CMI increases.

The MHA strongly opposes the 2.75 percent reduction in payment rates and believe it is based on an inaccurate calculation that the change in case mix weights is unrelated to changes in patient characteristics. Patient assessment data demonstrates that most, if not all, of the increase in case mix weights is directly related to changes in patient characteristics.

SPENCER JOHNSON, PRESIDENT
CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620
www.mha.org

The MHA urges the CMS to withdraw its proposal to reduce base payment rates by 2.75 percent in 2008, 2009, and 2010. This adjustment would decrease 2008 payments to Michigan HHs by $3.7 million, a cut that cannot be sustained. Instead, the CMS should develop an evaluation method to analyze changes in case mix weights using standards related to the home health concept of "patient characteristics" that includes both financial and clinical utilization data.

Outlier Payments

The CMS proposes to maintain the current standard in determining whether a case qualifies for an outlier payment. Specifically, the CMS proposes to continue using a .67 Fixed Dollar Loss ratio (FDL). **The MHA opposes this proposal since continued use of a .67 FDL will not utilize the 5 percent pool of funds set aside for outlier payments, as required by Medicare law.**

The CMS standards for outlier payment have failed to fully spend the outlier pool each year that the PPS has been in place. The CMS lacks evidence to demonstrate that it will spend an additional $130 million in outlier payments in 2008 through the use of the current standards.

Based on historical experience, the MHA recommends that the CMS reduce the FDL to a level that ensures full use of the outlier budget.

Medicaid Eligibility and Caregiver Access

The MHA remains concerned about the impact on HH patients that are Medicaid eligible and have limited caregiver access. Home health agencies report that both of these increase the HH resource use. We understand that the CMS conducted an analysis of Medicaid eligibility and found that Medicaid as reported on OASIS did not have a significant impact on resource use. The CMS analysis indicated that caregiver access did have an impact, but the CMS believes that adoption of this variable would be a negative incentive.

We disagree with the CMS conclusions as we believe the OASIS data does not effectively portray reality. Home health agencies frequently do not record Medicaid numbers in cases where Medicaid is not the payer, resulting in underreporting of Medicaid eligible patients. Also, the OASIS questions for caregivers do not accurately capture the actual skill and time of caregiver availability.

The MHA recommends that the CMS:

- **Compare the impact of Medicaid eligibility by studying resource use of a sample of home health patients enrolled in a Medicaid program from Medicaid files, against patients without Medicaid.**

- **Refine the OASIS caregiver access questions to capture more defined information about the role of caregivers in meeting the day-to-day needs of home health patients and the actual time caregivers spend with the HH patient.**

Additional Therapy Thresholds

The MHA supports the concept of multiple therapy thresholds and the smoothing effect of the graduated payment methodology as proposed. We are also pleased that the CMS plans to have the claims processing system automatically adjust the therapy visits, both upward and downward, according to the number of therapy visits on the final claim. This action will benefit both the home health providers and the Medicare contractors by ensuring accurate payment of claims while reducing burden.

However, we are concerned about the impact of changes made to the point allocation for OASIS functional variables in relationship to therapy. The current case-mix system allocates "6-9" points for M0700 (ambulation) deficits. However, the proposed system allocates "0" points for ambulation deficits in two of the three equations, including both equations for 14 plus therapy visits. In addition, no points are allocated for the gait disorder diagnosis in 14 plus therapy visit equations.

The MHA recommends that the CMS conduct further analysis of the impact of M0700 (ambulation) on service utilization in episodes with 14 plus therapy visits, or provide the rationale for eliminating points for this functional variable in 14 plus therapy episodes.

Low-Utilization Payment Adjustments (LUPA)

We appreciate the CMS' recognition of the fact that, in LUPA episodes, home health agencies do not have the opportunity to spread costs of lengthy initial visits over a full episode. We believe that the proposal to apply a LUPA add-on is a positive step toward ensuring adequate payment for LUPA episodes. However, the MHA oppose extending this policy to adjacent LUPA episodes.

In addition, it is unclear how the CMS intends to identify initial, only or adjacent LUPA episodes. The proposed policy states that payments for LUPA episodes will be increased by $92.63 for initial or only episodes during a series of adjacent episodes, with adjacent 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.

We also have concerns about the proposal to exclude LUPA episodes from the medical supply payment. This will be discussed under the Medical Supply section. **The MHA recommends that the CMS apply the LUPA add-on to all LUPA episodes.**

Non-routine Medical Supplies

The MHA is concerned about the CMS proposed model for medical supplies payments in light of the model's poor performance and R^2 of 13.7 percent. According to the analysis of home health claims and cost reports, only 10 percent of episodes include medical supplies. However, home health agencies indicated medical supplies are delivered to patients more frequently than documented on patient claims due to:

- Inability to submit on direct data entry screens (DDE)
- Incomplete or late invoicing by medical suppliers
- Without any financial impact on HH payment, there was no incentive for HH staff to spend administrative time to document supply usage.

HHA agencies identified the following expensive non-routine medical supplies that are not reflected in the medical supply case-mix. They include:

- Patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy).
- Closed chest drainage.

Failure to identify patient characteristics that would allow for payment for these, and other supplies not yet identified, will result in an underpayment of home health agencies.

While the elimination of SCICs may be appropriate, it is unclear how HH will obtain reimbursement for medical supplies utilized after the initial start of care assessment has been completed. HH cannot absorb the cost of these supplies without adequate reimbursement.

Other medical supplies common to LUPA episodes are wound care supplies used by home health patients and their caregivers. Since LUPA episode payments barely cover visit costs, to exclude these supplies from LUPA episodes could serve as a disincentive to teach patients and caregivers to be self-sufficient, resulting in home health agencies making additional visits to perform the wound care. By doing so, agencies would be eligible for both full episode payments and coverage of supplies.

Finally, LUPA episodes that are not final often have high supply costs. The most common medical supplies needed in LUPA episodes are those for patients that require urinary catheter changes. Failure to include medical supply payment for LUPA episodes to patients with indwelling catheters could result in a disincentive to home health agencies to admit these patients to service. The end result could be an increase in more costly emergency room visits by beneficiaries for catheter changes.

The MHA recommends that the CMS abandon the non-routine supply model as currently proposed as it would significantly underpay HHA for supplies utilized in the care of Medicare patients. The MHA recommends that the CMS conduct additional research to identify other diagnosis and patient characteristics before proceeding with a separate case-mix adjusted non-routine supply payment based on patient characteristics.

Thank you for the opportunity to submit these comments. We believe that the CMS has made many improvements in HHPPS and look forward to further refinements as highlighted in our comments above.

If you have any questions, please feel free to contact me at (517-703-8603 or via email at mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Finance

Submitter : **Mrs. Jana Smith** **Date: 06/22/2007**

Organization : **Bethesda Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1541-P-31-Attach-1.DOC

#31

BETHESDA
HOME HEALTH
1604 South First Street
Willmar, MN 56201
320-235-8364
Fax: 320-235-6968

June 22, 2007

Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-P
PO Box 8012
Baltimore, MD 21244-8012

Re: CMS-1541-P

This letter is written on behalf of Bethesda Home Health whose purpose is to serve clients in the most cost-effective manner to bring about the most positive client outcomes and functional improvement.

The Prospective Payment System for Medicare home health is based on the right principles as it facilitates outcomes-oriented client care planning that is focused on rehabilitation and self care. Bethesda Home Health agrees with CMS efforts to restructure the system and to replace a poorly functioning case mix adjustment model. However, we have grave concerns as addressed below.

Concern
CMS comment period is too brief.

Rationale
The brief comment does not allow providers time to understand the changes and the impact the changes will have on the business and make informed decisions. The temporary grouper is a valuable tool but we have not been allowed enough time to use it to determine financial impact.

Suggested Solution
Extend the comment period for this change and futuristically, allow enough time for providers to evaluate the impact of proposed changes.

Concern
Medicare's recently proposed changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. As part of the proposed rule to refine the home health prospective payment system, CMS added cuts in the base payment rate.

Rationale
CMS proposal assumes all increases in average case mix weight are entirely due to provider "gaming." To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying client assessments to garner higher payment for their agency. More realistically, the increase reflects the changing demographic of home care's client population and more intense staff training on OASIS which as resulted in more accurate OASIS answers.

Today, home care clients are older and more frail, with a significant number of clients being over age 80. The intensity of service they require has increase significantly due in large part to hospital DRG policy changes leading to decreased length of stay.

Over the past 10 years, the Medicare home health benefit has been cut nearly every year. Once comprising 8.7 % of Medicare spending today it comprises 3.2 % and is projected to drop to 2.6 percent by 2015. Given our growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish." Additionally, in the rapidly changing home care industry, it is unrealistic to plan a three year reduction. The environment could change significantly during that period of time.

In our agency every clinician that completes the OASIS assessment has completed CMS's OASIS web training and OASIS training through our state home care association. In addition, we review OASIS questions at our staff meetings to assure that all staff are completing the questions correctly and consistently. This training has been completed over time not just at the initiation of OASIS or PPS and has resulted in more accurate coding.

Suggested Solution
CMS should suspend its plan to cut home health payment rates based on unfounded allegations of case mix creep.

Concern
Low market basket adjustment compared to hospitals and skilled nursing facilities and post rural-floor, post reclassified authority wage index which is used for hospitals but not for home care.

Rationale
Home care is already experiencing a staffing shortage crisis. Home care providers compete for the same workers as do hospitals and skilled nursing facilities. The proposed lower market basket adjustment for home care places providers at a distinct disadvantage which will inevitably result in too few workers and an access to home care issue. This makes no sense in light of CMS's desire to save money and home care's ability to provide care at a more cost-effective rate than hospitals and skilled nursing facilities.

Suggested Solution
Increase the market basket adjustment to 3.3% to match the increase proposed for hospital and skilled nursing facilities and use the post rural-floor, post reclassified authority wage index for home care as you do for hospitals.

Concern
Failure to automatically adjust the identification of early or late episodes at final claim.

Rationale
Providers must rely on the Common Working File to determine whether or not a client had care from another provider within the past 60 days. This is an unreliable source as the CWF historically is not kept up to date. Additionally, it is unreasonable to penalize a provider because a previous provider/facility has not submitted a claim. As was accomplished with expected therapy visits, CMS should be able to automatically adjust final claims to accurately reflect whether or not the episode is an early or a late episode.

Suggested Soluation
Automatically adjust the final claim to accurately reflect early and late episodes of care rather than defaulting it to an early episode.

Concern
Implementation date of January 1, 2008.

Rationale
PPS Reform changes are significant. Providers will need to educate employees on the massive changes, work with vendors to initiate IT changes, and then implement changes throughout the organization including the clinical and financial areas. This will take a considerable amount of time to accomplish.

Suggested Solution
Push back the implementation date to October 1, 2008 to allow ample time for providers to make all the necessary adjustments. Release the revised Conditions of Participation to coincide with the implementation of the PPS reform requirements to ease the burden of staff training and make sure PPS changes are congruent with changes to the Conditions of Participation.

Concern
Requirement for OASIS assessment when there is a significant change in client condition

Rationale
The proposed PPS reform eliminates payment adjustments for significant change in condition (SCIC). With the elimination of SCIC, there is neither payment nor outcome-based reasons to complete an OASIS assessment when there is a significant change in client condition. The Conditions of Participation already require communication with the physician when there is a change in client condition. Therefore, there is no identified need to complete an additional OASIS when there is a significant change in client condition.

Suggested Solution
Eliminate the requirement to collect, enter and transmit an OASIS assessment at the time of a significant change in client condition.

Concern
Accuracy of outcomes data in states with multiple Medicaid waiver programs.

Rationale

Many of the Medicaid waiver programs authorize "skilled nursing services" that, in reality, are not "skilled" by Medicare's definition. Providers often complete and submit OASIS data on such clients. Clients on waiver programs tend to be chronically ill and show no improvement in outcomes but rather show stabilization of their condition. Stabilization for such clients is considered a successful outcome. In states with multiple waiver programs, there is a risk that submitting OASIS data skews provider outcomes as well as aggregate state outcomes.

Suggested Solution
Eliminate the requirement to complete OASIS assessments on non-Medicare clients.

Sincerely,

Jana Smith, RN, PHN
Director
Bethesda Home Health

Submitter : **Date: 06/22/2007**

Organization : **National HealthCare Corporation**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

CMS-1541-P-32-Attach-1.DOC

#32

RESPONSE TO PROPOSED RULE

Medicare Program: Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008
File Code: CMS-1541-P

Submitted by: NHC HomeCare, 100 Vine Street, Murfreesboro, TN 37130. We are a homecare provider with 31 offices in three states and have been providing home health services to patients since 1976.

1) Proposal: To reduce the base episode payment rate by 2.75% each year in 2008, 2009, and 2010 to adjust for "case-mix creep".

Comments: The basis for attributing the "creep" to factors unrelated to changes in patient characteristics fails to take into consideration that Medicare patients and their care has changed since the implementation of PPS. Patients are now older and there has been a shift away from home health aide usage with longer stays to rehabilitative services and shorter lengths of stay. In 2001, spending on each Medicare beneficiary receiving home health services that year averaged $3,812. By 2003, that spending actually *dropped* to $3,497. While the average case mix weight may have increased over that period, the change in care practices significantly *reduced* per patient expenditures.

Recommendations: Eliminate the 2.75% downward adjustment in rates proposed as an offset to "correct" for an allegedly unwarranted increase in average case mix weight.

2) **Proposal: Replacement of the 10 visit therapy threshold with thresholds of 6, 14, and 20 with gradual increase in payments for therapy visits between thresholds.**

Comments: Conceptually we believe the proposed rule offers a fairer method for paying providers and, therefore, provides a greater likelihood that patients will receive the therapy visits they need--but will not get *more* than they need. We have numerous patients who need nursing and therapy but get less than 10 therapy visits because they *need* less than 10 visits. As a result we have received no greater reimbursement than if the patient had 0 therapy visits. We also have patients who need and receive 20 or more therapy visits and get no greater payment than if the patient had only 10. We have heard of agencies with a "10-12" rule, meaning if the patient needs therapy at all they are to get at least 10 therapy visits but no more than 12. The various payment levels indicated in the proposed rule, we believe, will provide a greater likelihood that patients for *all agencies* will receive the number of therapy visits that matches their need, and that providers who are providing the number of therapy visits a patient *needs* will be compensated fairly and not put at a competitive disadvantage against those agencies that have been gaming the system.

MO825 has been an administrative burden requiring predictions, OASIS changes and corrected billings. Since MO826 is indicated to be an initial assessment only and Medicare will automatically adjust the HHRG and payment rate based on the final claim, why not eliminate this question entirely and just use the *actual* number of visits from the final claim.

Recommendation: Implement this provision effective January 1, 2008 but use current OASIS information for the clinical and functional dimensions. Eliminate MO826 question from OASIS. Base payment on *actual* number of therapy visits as indicated on the final claim.

3) **Proposal: Changing case-mix weights for clinical and functional dimensions.**

Comment: Increasing from 80-153 HHRG's appears to more specifically and appropriately capture the patient's condition but the data analysis and calculations are *very* complex. Staff training required to implement just the changes related to this portion of the proposal would be difficult to complete by the January 1, 2008 effective date.

Additionally, the case-mix weight changes will require major programming changes to our revenue and A/R systems (we have our own proprietary software) and it will be next to, if not, impossible to get all of these done before January 1, 2008. If we cannot get the reprogramming completed by the deadline, then we will be forced to either handle these manually or to delay filing of claims until we get the reprogramming completed. Either or both of these will require additional cash outlays for overtime required for programmers and/or for personnel to calculate revenue and submit claims manually. Completing claims manually will also increase the number of errors, thereby causing additional work when the errors have to be corrected—additional work for us as the provider but also for the intermediary processing the additional claims.

Recommendation: Postpone implementation of this provision until the later of October 1, 2008 or six months after the *final* rule is published.

4) **Proposal:** Eliminating MO175 from the case-mix classification.

Comment: Achieving accuracy in answering this question was impossible!

Recommendation: Eliminate effective January 1, 2008.

5) **Proposal**: Differentiation between "early" and "late" episodes with additional payment for episodes 3 and up.

Comments: On the surface this may sound like a good idea, but implementation will be an administrative nightmare. Asking about dates within our own agency is one thing, asking for those that represent dates with *another* agency are an entirely different matter. And then to complicate matters even more, an episode is considered "adjacent" if it begins within 60 days of the *conclusion* of a previous episode. MO110 will actually be even more of an administrative burden than was MO175. The accuracy will depend on the information in the Common Working File, but what if that isn't accurate? What if the patient has had 2 adjacent episodes *prior* to being admitted to our agency and we know it's the 3rd and we submit our claim as the 3rd, but the other agency hasn't submitted any of their claims yet? We are assuming our claim would be downcoded to reflect an early episode. But then what happens when the other agency submits their claim for the prior episodes? Will we be expected to continue to monitor the Medicare files to see when the other agency submits their claim, so we can then resubmit our claim in order to be paid the additional amounts we are due? Why should we have to file corrected claims when our information was right all along? This proposal certainly does not fit with CMS's words that "important in any requirement is maintaining an appropriate degree of operational simplicity".

Recommendation: Eliminate MO110 entirely. Pay all episodes, regardless of whether early or late, the same amount by redistributing the weighting to all episodes equally.

In the alternative, if payment is to be different for early and late episodes, then consider correcting an agency's response automatically—regardless of whether the adjustment is up or down. Postpone implementation of this provision until the later of October 1, 2008 or six months after the *final* rule is published in order to provide sufficient time to complete necessary programming changes.

6) **Proposal: Increase of $92.63 for LUPA episodes that occur as the only episode or the initial episode during a sequence of adjacent episodes.**

Comments: We are pleased that CMS has acknowledged that the initial start of care for a homecare patient involves more time and resources, therefore more cost, than a regular visit and has proposed an additional LUPA payment for only episodes and first episodes. We support this proposed change in LUPA payment. We are concerned that CMS proposed to eliminate the non-routine supply adjustment from the LUPA per visit rate.

Recommendations: Apply the same consideration to all LUPA episodes as the administrative costs which are spread over fewer visits in LUPA episodes are incurred for all episodes and not just the first. Also, do not eliminate the non-routine supply adjustment from the LUPA per visit rate. Supplies are required to appropriately care for all patients including low utilization patients.

7) **Proposal: Payment for Non-routine supplies based on severity levels and a national conversion factor.**

Comments: CMS's proposal for determining payment for supplies based on severity levels is positive and allows for a more accurate allocation of cost as compared to adding a set dollar amount per episode regardless of supply use as is currently done. Re-evaluation of the needs of those patients requiring very expensive supplies is still required as the highest severity level does not offer a per episode payment for supplies which is adequate for those patients requiring extensive wound care, ostomy care and other high cost supplies.

Recommendations: This proposal is a good start but we ask that CMS continue to study the supply issue with future data as the payment is still inadequate for patients with high cost supply needs. The proposal also does not provide for any additions or adjustments for payment of supplies after the initial assessment. If the status of the patient changes during the course of the episode, no mechanism has been proposed to allow additional payment for supplies that were not anticipated at the time of the initial assessment. Please also reconsider the removing of the supply allowance from LUPA payments as low utilization patients have supply needs which have not been addressed.

Submitter : Mr. Timothy R. Rogers **Date:** 06/22/2007

Organization : Association for Home & Hospice Care of NC

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please accept the following attached document as North Carolina's comments to CMS-1541-P.

CMS-1541-P-33-Attach-1.PDF

#33

Association for
Home & Hospice Care
of North Carolina

3101 Industrial Drive
Suite 204
Raleigh
North Carolina
27609

phone 919.848.3450
toll free (nc) 800.999.2357
fax 919.848.2355
info@homeandhospicecare.org
www.homeandhospicecare.org

June 21, 2007

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

RE: **CMS-1541-P Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008**

The Association for Home & Hospice Care of North Carolina is the largest and one of the oldest associations representing 98% of the Medicare certified home health agencies, serving 175,000 Medicare beneficiaries across the state of North Carolina. Thank you for the opportunity to review the HH PPS Proposed Rule Refinement and Rate Update for CY 2008. Please accept the following comments and recommendations.

Issue ~ 2.75% Case Mix Adjustment

- **Section Title** ~ Provisions
- **Discussion** ~ 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. AHHC believe that there has been real changes in the patient's condition. There are improtant reasons to explains that explain this increase in the average case mix rate as a real change. First, patient characteristics and case mix has changed. Patients now are different than those in 2000, 2003, and 2006. It is readily apparent that the age of the Medicare home health patient has increased, with a growth in the percentage of patients over 85 increasing from 17 to 23 percent nationally. At the same time, it also is apparent that the home health modality of care has dramatically changed with a shift to rehabilitative services and shorter lengths of stay. Therapy has greatly reduced the need for need for aide services by improving functioning and patient self-care. Second, although OASIS began prior to HH PPS, it is was implemented during a time of massive changes and conflicting instructions. Lastly, there are training issues for staff on all aspects of home health especially on OASIS, IPS (during that period), HH PPS, and ICD-9 coding. There was a significant learning curve in the midst of all the changes and clarification.
- **Recommendation** ~ AHHC recommends the elimination of the case mix adjustment of 2.75% in the base rate for 2008, 2009, and 2010. Changes in patient population, conflicting CMS instructions, and staff learning curves all play into the increase in the case mix. Further, the original rates were based on a relatively small sample and the refinement analysis is now too old for appropriate consideration. Rather CMS should

re-evalute the case mix weights used in the model and develop / refine an anaylsis strategy to include patient characteristics that more appropriately address home health patients in clinical, functional, and service utilization data. Further include factors in the analysis that capture changes in patient annual expenditures and changes in the overall Medicare program that may affect the nature of patients service under the Medicare home health benefit.

Issue ~ LUPA

- **Section Title** ~ Provisions
- **Discussion** ~ 15% of all episodes were less than 4 during the base year of HH PPS. The most recent data shows LUPAs at 13% of all episodes, CMS' proposal to increase the LUPA rate by $92.63 is appaluaded. However, what is being proposed does not go far enough, as it ONLY applies to the first SOC LUPA EP or the sole LUPA EP. Administrative costs are spread over fewer visits and often staff are forced to make visits that are not caputered in the claims data in order to adhear to the administrative timeline for recertification. Those visits, according to Medicare guidelines, are not reimbursed, yet factor into an agency's overall costs. Our inability to cover costs may negatively impact access to medically necessary care for those long-term care patients, i.e., catheter care or B12, who would otherwise be placed in a more costly alternative.
- **Recommendation** ~ AHHC supports CMS' proposed change to increase the LUPA rate by $92.60 for the first or sole LUPA episode. Further, AHHC encourages CMS to apply the same consideration to all LUPA episodes. Although LUPA EPs represent a relatively small number of patients, the administrative costs extend beyond the first LUPA episode.

Issue ~ SCIC

- **Section Title** ~ Provisions
- **Discussion** ~ CMS had a good concept when it developed the SCIC component. The profession advocated for this component at the implementation of HH PPS in 2000. It appeared to allow for significant changes in a patient's condition. However, the application of the concept has been an administrative nightmare. CMS agreed and established a policy that stated agencies did not have to claim a SCIC if it was going to negatively effect the agency. Despite this policy, data shows that agencies still claimed a SCIC even when it was a resource loser. Only 2.1% of all EP have SCIC. We praise CMS for taking this opportunity to eliminate the SCIC, especially since the new model is more complex. Agencies are having difficulty determining whether to apply the SCIC or not under the current model, the proposed model would only complicate matters.
- **Recommendation** ~ AHHC supports CMS' plan to eliminate the SCIC. This requirement will also need to be removed from the Medicare Conditions of Participation.

Issue ~ Non-Routine Supplies (NRS)

- **Section Title** ~ Provisions
- **Discussion** ~ CMS' proposal of developing non-routine supply (NRS) diagnostic categories is a positive step towards recognizing a more accurate allocation of costs.

However, the proposed changes are based on incomplete data and a poor preforming model. Nearly 40% of the cost reports were deemed partially unusable due to incomplete information and only 10% of the claims contained NRS charges. There are a number of contributing factors. Providers believed that since CMS was not specifically reimbursing for supplies, there was no need to include them on the claims. Another possibility was a delay in receiving the vendor invoice for the NRS that the claim was submitted without it. Additionally, some providers expressed difficulties in billing for NRS on the Direct Data Entry (DDE) system. In any case, the analysis used for this calculation under estimates the use of NRS. Further, some frequently used NRS are missing from the model. These missing items include medical supplies for caring of other ostomies, such as tracheostomy, gastrostomy, nephrostomy, urethrostomy, ureterostomy. Failure to include these items in the model would result in an underpayment of home health agencies.

- **Recommendation** ~ CMS' the concept of the NRS add-on is positive step towards recognizing a more accurate allocation of costs. However, it is important to recognized that the model is based on incomplete information and may inadequately reflect the providers' true costs. Abt Assoc. reported that nearly 40% of the cost reports were incomplete and unusable and only 10% of the claims data reported any supply charges. AHHC supports the proposed NRS add-on and encourages CMS to continue to study the supply issue with future data and make appropriate modifications to the model.

Issue ~ Non-Routine Supplies (NRS)

- **Section Title** ~ Provisions
- **Discussion** ~ The previous allocation in the LUPA rate of $1.96 assigned to NRS did not adequately cover the costs of a medically necessary NRS. This refinement excluded any update to NRS.
- **Recommendation** ~ The previous allocation in the LUPA rate of $1.96 assigned to NRS does not adequately cover the costs of a medically necessary NRS. This refinement excluded any update to NRS and may limit or negatively impact caring for patients. AHHC encourages CMS to develop a NRS add-on using diagnostic categories and to allow agencies to include NRS that surface after the initial start of care.

Issue ~ Outlier Issue

- **Section Title** ~ Provisions
- **Discussion** ~ CMS is projecting a net increase to the Medicare Home Health Program of 140 million dollars for 2008. However, 130 million of that amount is being held back, allocated for projected outlier payments, making the projected net increase to the program only 10 million dollars, not 140 million. The 130 million allocated for outlier payments represents 5% of the overall budget as required by Law. This represents a .67 Fixed Dollar Loss (FDL) ratio. In looking at what was spent since the inception of the HH PPS, CMS has not issued more than 2 – 2.5% in outlier payments, leaving 2.5-3% of the allocation on the table. It is suggested that the reason for a very low outlier rate is that outlier patients are more resource intensive to serve than covered by the outlier payment. Currently, the unused amount of the FLD ratio is **not** folded back into the Medicare home health program.

- **Recommendation** ~ AHHC encourages CMS to reduce current standard for applicability of outlier payments to a level that historically has been sufficient to cover the outlier payments. Further, any unused allocation should be folded back into HH PPS, if allowed by Law.

Issue ~ OASIS Changes

- **Section Title** ~ Provisions
- **Discussion** ~ The proposed changes on OASIS are positive. CMS wants to exclude M0175 & M0610; added M0470, M0520, and M0800 to the mix for payment purposes. The only condiseration is the elimination of the point allocation ofr M0700 (ambulation). Currently, the system allocates '6-9' points based on funtional deficits. The proposed model allocates '0' points for that same functional deficit in two of three equations. Additionally, AHHC encourages CMS to make changes to the Conditions of Participation (COPs) to allow therapists to conduct the initial and comprehensive assessment, even when nursing is ordered. If it appears that a patient will be predominately a therapy case, such as a stoke, it is very important that the therapist to be a part of that initial and comprehensive care planning process.
- **Recommendation** ~ AHHC supports CMS' plan to exclude M0175 and M0610; and to add M0470, M0520, and M0800. Additionally, AHHC encourages CMS to make the changes sooner than the 2009.
- **Recommendation** ~ AHHC recommends CMS to study the re-allocation of points for M0700 and its impact on for two of the three equations and refine the model accordingly.
- **Recommendation** ~ AHHC recommends CMS to make changes to the COPs to allow therapists to complete both the initial assessment and the comprehensive assessment, even when nursing is also ordered.

Issue ~ Therapy Auto-Adjust

- **Section Title** ~ Provisions
- **Discussion** ~ CMS is proposing a positive change in the handling of therapy claims.
- **Recommendation** ~ AHHC supports CMS' proposed change in the process of therapy claims.

Issue ~ Case Mix Refinement

- **Section Title** ~ Provisions
- **Discussion** ~ CMS' proposed refinement in the model from 80 home health resource groups (HHRG) to 153 is positive. Expanding the list, considering primary and secondary diagnosis combinations, recognizing manifestation codes, etc., attempts to capture more appropriately the patient's condition and comorbidities. Although it appears to be more specific, the net increase in the payment is questionable. The refinement is very complex and not easily compared with the existing model. It has added gastrointestinal, pulmonary, cardiac, cancer, blood disorders, and affective and other psychoses diagnosis groups. It appears that the overall trend is a reduction with a heavy therapy weighting. Further, the application of the four (4) equation model, with later episodes weighing more, further reduces the base rate and complicates the calculations. So, in reviewing the refinements in the case mix, two issues should be

addressed. First, case mix variables corresponding with ICD-9 coding, and second, the issue of early / late episodes, with the later weighing more. These two issues are discussed below.

Issue ~ Case Mix Refinement - Early / Late Episodes of Care

- **Section Title** ~ Provisions
- **Discussion** ~ Claims data indicates that the Episodes per beneficiaries is very low, Q12006 1.26 MSA, 1.31 Non-MSA for a 16-state region. For NC it is 1.2 episodes per beneficiary. Therefore, providers will not realize the higher weights allocated to Late Episodes because their service patterns generally do not take them into the third and subsequent episode. The small percentage of cases that fall into the Late EP, have an even smaller portion of patients with severely infected wounds, Parkinson's, ALS, stroke, etc., would be eligible for the full episodes. The remaining Late EP cases would either be long-term LUPA patients, such as B12 and catheter care, or Medicaid patients. Although the HH PPS only includes Medicare beneficiaries, OASIS data collects information on both Medicare and Medicaid, and M0150 identifies the payor source. The period under analysis was during a time where instructions dictated to collect all possible payor sources, not just ones that will pay. Therefore, the data includes Medicaid in the mix. However, those cases are not eligible for Late EP reimbursement. Lastly, the feature of Early / Late EP would create an administrative burden on providers. The agency would need to rely on the common working file, which is often slow in posting information and/or rely on the patient and/or family for information. CMS should address the CWF by developing a mechanism to allow for real-time data retrieval.
- **Recommendation** ~ Eliminate the Early / Late distinction and redistribute the weighting to all the episodes. This will simplify the 4-equation model by eliminating the Early / Late EP calculations, to a 2-equation model with therapy thresholds. Additionally, we encourage CMS to address the issue of the Common Working File (CWF). Specifically, to develop a process where the CWF provides real-time data based on claims processed. Currently, the system does not offer real-time patient eligibility information, often as old as 90-180 days, and is slow in posting claims processed making it difficult for agencies to clearly determine status and access to care. Adding the Early / Late EP distinction would magnify the complications and may limit or delay appropriate access to care.

Issue ~ ICD-9 Coding

- **Section Title** ~ Provisions
- **Discussion** ~ CMS has expanded the list and will consider primary and secondary code combinations in scoring. It has included scores for infected surgical wounds, abscesses, chronic ulcers, and gangrene. Further, it has added gastrointestinal, pulmonary, cardiac, cancer, blood disorders, and affective and other psychoses diagnosis groups. AHHC is pleased with the expanded diagnosis list. More comprehensive and precise coding will result not only in better care but also data leading to more informed policy decisions.
- **Recommendation** ~ AHHC supports the use of more variations in case mix variables.

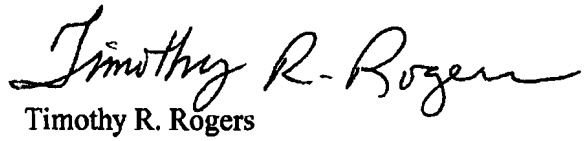
Issue ~ ICD-9 Coding - Updated Guidelines

- **Section Title** ~ Provisions
- **Discussion** ~ In review of the most recent coding guidelines and ensure they are being used in the model. One example points to using outdated information, specifically, the use of ICD-9 436. In 2005, that code was clarified to a more specific code; however, HH PPS model has kept it in allocating a score when the more specific code is now available.
- **Recommendation** ~ AHHC encourages CMS to proceed with caution when updating the ICD-9 tables related to HH PPS and follow coding rules when linking the case mix.
- **Recommendation** ~ Remove ICD-9 code 436 and add 434.91 (cerebral artery occlusion unspecified with cerebral infarction).

Thank you for the opportunity to comment on this proposed rule. We appreciate CMS' continued open dialogue through the teleconferences and *Open Door* forums. AHHC encourages CMS to provide opportunities for training and education. As related to the HH PPS proposed rule, careful consideration is warranted due to the seriousness and extent of the changes. Providers may not be able to accept patients where they are operating at a loss. This would limit access, especially in rural communities, and force patients into a more expensive option, such as skilled nursing facility (SNF) or delay hospital discharges.

Should you require clarifications on any of our comments please contact Sherry Thomas, Senior Vice President, at 919-848-3450, or at SherryThomas@homeandhospicecare.org.

Sincerely,



Timothy R. Rogers
Chief Executive Officer
Board Member, National Association for Home Care & Hospice

Submitter : **Ms. Heather Hulscher** **Date: 06/22/2007**

Organization : **Iowa Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

CMS must address its reasoning for listing an earlier deadline on the Internet for the submission of public comments, June 26, 2007, than the deadline published in the Federal Register, July 3, 2007.

GENERAL

GENERAL

See Attachment

CMS-1541-P-34-Attach-1.DOC

#34

IOWA HOSPITAL ASSOCIATION

June 25, 2007

Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1541-P
P.O. Box 8012
Baltimore, MD 21244-8012

Ref: CMS—1541-P Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Proposed Rule (72 *Federal Register* 25356), May, 4 2007.

Dear Ms. Norwalk:

On behalf of Iowa's 69 hospitals providing home health services to Medicare beneficiaries, the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the CY 2008 home health prospective payment system (PPS) published in the May 4, 2007 *Federal Register.*

Protecting access to home health care is critical to Medicare beneficiaries and Iowa hospitals. According to the most recent Census Bureau statistics, Iowa is fourth in the nation for percent of residents 65 years and older, and third in the nation for percent residents 85 years and older, making Medicare the single largest payer of health care services in Iowa. As a result of Iowa's heavy reliance on the Medicare program for reimbursement, Iowa's hospital-based home health Medicare margins are **negative 3 percent**. Since the implementation of the home health PPS, eight Iowa hospitals have closed their home health units.

To maintain access to home health care, it is essential the Medicare program recognize the importance of providing adequate reimbursement. In this rule, CMS is proposing **a negative 2.75 percent reduction to the market basket update factor for the next three consecutive years.** This reduction is a "behavioral offset", which implies that providers have up-coded since the implementation of the PPS. The rule suggests that since the number of home health visits has been on the decline and at the same time the case-mix index has increased, it necessarily follows that this is due to up-coding. IHA data indicates the contrary to CMS' position. During the most recent three-year period, the severity level of Medicare patients discharged from Iowa hospitals to home health care has steadily increased, which implies an increase in the case-mix index. **IHA opposes this drastic payment reduction based on an overly simplistic rationale for which CMS has failed to provide supporting documentation.**

If CMS moves forward and adopts these drastic reductions in payment, it will be increasingly difficult for Iowa hospitals to provide home health care services, and Medicare beneficiaries will find it increasingly difficult to access home health care within their community. The negative impact of such a policy decision will only continue to exacerbate with the Baby Boomer generation entering the Medicare program.

This rule also proposes the first major refinements to the home health PPS since its implementation in FY 2001. IHA appreciates CMS' efforts to release this proposed rule well in advance of the required time frame for public consideration. However, IHA is unable to make meaningful public comment because CMS has failed to release the impact file that would enable modeling of the proposed changes. More importantly, Iowa hospital-based home health agencies are unable to plan operationally and financially for these vast changes. **CMS should release the impact file and extend the public comment period by an additional 60-days**, thereby allowing the provider community ample opportunity to review the impact of the proposed changes and make meaningful qualitative and quantitative public comment.

Recently, the Medicare program proposed regulations that will begin implementation of hospital value-based purchasing. As part of this process, hospitals will be required to report if a patient develops a hospital-acquired condition as a result of an inpatient acute care stay, and in FY 2009, hospitals will no longer be reimbursed for the services necessary to treat hospital-acquired conditions. It is well documented that the longer a patient stays in inpatient acute care, the greater the risk of developing hospital-acquired conditions. It is also well documented the best place for a patient to recover is at home. Iowa hospitals are committed to providing the highest quality of care to their patients by ensuring patients receive the most appropriate care at right time and at the right place. CMS should also be committed to ensuring access to home health care services for Medicare beneficiaries by withdrawing its behavioral offset proposal.

Thank you for your review and consideration of these comments. If you have questions, please contact me at the Iowa Hospital Association at 515/288-1955.

Sincerely,

Heather D. Hulscher

Heather D. Hulscher
Director, Finance Policy
Iowa Hospital Association

cc: Iowa Congressional Delegation
Iowa Hospitals
CMS Kansas City Regional Office

Submitter : **Ms. Sherry Thomas** **Date: 06/22/2007**

Organization : **South Carolina Home Care Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Please accept the following attached document as South Carolina's comments to CMS-1541-P.

CMS-1541-P-35-Attach-1.PDF

#35

South Carolina
Home Care Association

3101 Industrial Drive
Suite 204
Raleigh
North Carolina
27609

phone 919.848.3450
fax 919.848.2355
info@homeandhospicecare.org
www.homeandhospicecare.org

June 21, 2007

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

RE: **CMS-1541-P Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008**

The South Carolina Home Care Association (SCHCA), established in 1978, is a non-profit association representing 80% of the Medicare certified home health agencies of South Carolina. Thank you for the opportunity to review the HH PPS Proposed Rule Refinement and Rate Update for CY 2008. Please accept the following comments and recommendations.

Issue ~ 2.75% Case Mix Adjustment

- **Section Title** ~ Provisions
- **Discussion** ~ 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. SCHCA believe that there has been real changes in the patient's condition. There are improtant reasons to explains that explain this increase in the average case mix rate as a real change. First, patient characteristics and case mix has changed. Patients now are different than those in 2000, 2003, and 2006. It is readily apparent that the age of the Medicare home health patient has increased, with a growth in the percentage of patients over 85 increasing from 17 to 23 percent nationally. At the same time, it also is apparent that the home health modality of care has dramatically changed with a shift to rehabilitative services and shorter lengths of stay. Therapy has greatly reduced the need for need for aide services by improving functioning and patient self-care. Second, although OASIS began prior to HH PPS, it is was implemented during a time of massive changes and conflicting instructions. Lastly, there are training issues for staff on all aspects of home health especially on OASIS, IPS (during that period), HH PPS, and ICD-9 coding. There was a significant learning curve in the midst of all the changes and clarification.
- **Recommendation** ~ SCHCA recommends the elimination of the case mix adjustment of 2.75% in the base rate for 2008, 2009, and 2010. Changes in patient population, conflicting CMS instructions, and staff learning curves all play into the increase in the case mix. Further, the original rates were based on a relatively small sample and the

refinement analysis is now too old for appropriate consideration. Rather CMS should re-evalute the case mix weights used in the model and develop / refine an anaylsis strategy to include patient characteristics that more appropriately address home health patients in clinical, functional, and service utilization data. Further include factors in the analysis that capture changes in patient annual expenditures and changes in the overall Medicare program that may affect the nature of patients service under the Medicare home health benefit.

Issue ~ LUPA

- **Section Title** ~ Provisions
- **Discussion** ~ 15% of all episodes were less than 4 during the base year of HH PPS. The most recent data shows LUPAs at 13% of all episodes, CMS' proposal to increase the LUPA rate by $92.63 is appaluaded. However, what is being proposed does not go far enough, as it ONLY applies to the first SOC LUPA EP or the sole LUPA EP. Administrative costs are spread over fewer visits and often staff are forced to make visits that are not caputered in the claims data in order to adhear to the administrative timeline for recertification. Those visits, according to Medicare guidelines, are not reimbursed, yet factor into an agency's overall costs. Our inability to cover costs may negatively impact access to medically necessary care for those long-term care patients, i.e., catheter care or B12, who would otherwise be placed in a more costly alternative.
- **Recommendation** ~ SCHCA supports CMS' proposed change to increase the LUPA rate by $92.60 for the first or sole LUPA episode. Further, SCHCA encourages CMS to apply the same consideration to all LUPA episodes. Although LUPA EPs represent a relatively small number of patients, the administrative costs extend beyond the first LUPA episode.

Issue ~ SCIC

- **Section Title** ~ Provisions
- **Discussion** ~ CMS had a good concept when it developed the SCIC component. The profession advocated for this component at the implementation of HH PPS in 2000. It appeared to allow for significant changes in a patient's condition. However, the application of the concept has been an administrative nightmare. CMS agreed and established a policy that stated agencies did not have to claim a SCIC if it was going to negatively effect the agency. Despite this policy, data shows that agencies still claimed a SCIC even when it was a resource loser. Only 2.1% of all EP have SCIC. We praise CMS for taking this opportunity to eliminate the SCIC, especially since the new model is more complex. Agencies are having difficulty determining whether to apply the SCIC or not under the current model, the proposed model would only complicate matters.
- **Recommendation** ~ SCHCA supports CMS' plan to eliminate the SCIC. This requirement will also need to be removed from the Medicare Conditions of Participation.

Issue ~ Non-Routine Supplies (NRS)

- **Section Title** ~ Provisions
- **Discussion** ~ CMS' proposal of developing non-routine supply (NRS) diagnostic categories is a positive step towards recognizing a more accurate allocation of costs. However, the proposed changes are based on incomplete data and a poor preforming model. Nearly 40% of the cost reports were deemed partially unusable due to incomplete information and only 10% of the claims contained NRS charges. There are a number of contributing factors. Providers believed that since CMS was not specifically reimbursing for supplies, there was no need to include them on the claims. Another possibility was a delay in receiving the vendor invoice for the NRS that the claim was submitted without it. Additionally, some providers expressed difficulties in billing for NRS on the Direct Data Entry (DDE) system. In any case, the analysis used for this calculation under estimates the use of NRS. Further, some frequently used NRS are missing from the model. These missing items include medical supplies for caring of other ostomies, such as tracheostomy, gastrostomy, nephrostomy, urethrostomy, ureterostomy. Failure to include these items in the model would result in an underpayment of home health agencies.
- **Recommendation** ~ CMS' the concept of the NRS add-on is positive step towards recognizing a more accurate allocation of costs. However, it is important to recognized that the model is based on incomplete information and may inadequately reflect the providers' true costs. Abt Assoc. reported that nearly 40% of the cost reports were incomplete and unusable and only 10% of the claims data reported any supply charges. SCHCA supports the proposed NRS add-on and encourages CMS to continue to study the supply issue with future data and make appropriate modifications to the model.

Issue ~ Non-Routine Supplies (NRS)

- **Section Title** ~ Provisions
- **Discussion** ~ The previous allocation in the LUPA rate of $1.96 assigned to NRS did not adequately cover the costs of a medically necessary NRS. This refinement excluded any update to NRS.
- **Recommendation** ~ The previous allocation in the LUPA rate of $1.96 assigned to NRS does not adequately cover the costs of a medically necessary NRS. This refinement excluded any update to NRS and may limit or negatively impact caring for patients. SCHCA encourages CMS to develop a NRS add-on using diagnostic categories and to allow agencies to include NRS that surface after the initial start of care.

Issue ~ Outlier Issue

- **Section Title** ~ Provisions
- **Discussion** ~ CMS is projecting a net increase to the Medicare Home Health Program of 140 million dollars for 2008. However, 130 million of that amount is being held back, allocated for projected outlier payments, making the projected net increase to the program only 10 million dollars, not 140 million. The 130 million allocated for outlier payments represents 5% of the overall budget as required by Law. This represents a .67 Fixed Dollar Loss (FDL) ratio. In looking at what was spent since the

inception of the HH PPS, CMS has not issued more than 2 – 2.5% in outlier payments, leaving 2.5-3% of the allocation on the table. It is suggested that the reason for a very low outlier rate is that outlier patients are more resource intensive to serve than covered by the outlier payment. Currently, the unused amount of the FLD ratio is **not** folded back into the Medicare home health program.

- **Recommendation** ~ SCHCA encourages CMS to reduce current standard for applicability of outlier payments to a level that historically has been sufficient to cover the outlier payments. Further, any unused allocation should be folded back into HH PPS, if allowed by Law.

Issue ~ OASIS Changes

- **Section Title** ~ Provisions
- **Discussion** ~ The proposed changes on OASIS are positive. CMS wants to exclude M0175 & M0610; added M0470, M0520, and M0800 to the mix for payment purposes. The only condiseration is the elimination of the point allocation ofr M0700 (ambulation). Currently, the system allocates '6-9' points based on funtional deficits. The proposed model allocates '0' points for that same functional deficit in two of three equations. Additionally, SCHCA encourages CMS to make changes to the Conditions of Participation (COPs) to allow therapists to conduct the initial and comprehensive assessments, even when nursing is ordered. If it appears that a patient will be predominately a therapy case, such as a or stoke, it is very important that the therapist to be a part of that initial and comprehensive care planning process.
- **Recommendation** ~ SCHCA supports CMS' plan to exclude M0175 and M0610; and to add M0470, M0520, and M0800. Additionally, SCHCA encourages CMS to make the changes sooner than the 2009.
- **Recommendation** ~ SCHCA recommends CMS to study the re-allocation of points for M0700 and its impact on for two of the three equations and refine the model accordingly.
- **Recommendation** ~ SCHCA recommends CMS to make changes to the COPs to allow therapists to complete both the initial assessment and the comprehensive assessment, even when nursing is also ordered.

Issue ~ Therapy Auto-Adjust

- **Section Title** ~ Provisions
- **Discussion** ~ CMS is proposing a positive change in the handling of therapy claims.
- **Recommendation** ~ SCHCA supports CMS' proposed change in the process of therapy claims.

Issue ~ Case Mix Refinement

- **Section Title** ~ Provisions
- **Discussion** ~ CMS' proposed refinement in the model from 80 home health resource groups (HHRG) to 153 is positive. Expanding the list, considering primary and secondary diagnosis combinations, recognizing manifestation codes, etc., attempts to capture more appropriately the patient's condition and comorbidities. Although it appears to be more specific, the net increase in the payment is questionable. The refinement is very complex and not easily compared with the existing model. It has

refinement is very complex and not easily compared with the existing model. It has added gastrointestinal, pulmonary, cardiac, cancer, blood disorders, and affective and other psychoses diagnosis groups. It appears that the overall trend is a reduction with a heavy therapy weighting. Further, the application of the four (4) equation model, with later episodes weighing more, further reduces the base rate and complicates the calculations. So, in reviewing the refinements in the case mix, two issues should be addressed. First, case mix variables corresponding with ICD-9 coding, and second, the issue of early / late episodes, with the later weighing more. These two issues are discussed below.

Issue ~ Case Mix Refinement - Early / Late Episodes of Care

- **Section Title** ~ Provisions
- **Discussion** ~ Claims data indicates that the Episodes per beneficiaries is very low, Q12006 1.26 MSA, 1.31 Non-MSA for a 16-state region. For SC it is 2.5 episodes per beneficiary. Therefore, providers will not realize the higher weights allocated to Late Episodes because their service patterns generally do not take them into the third and subsequent episode. The small percentage of cases that fall into the Late EP, have an even smaller portion of patients with severely infected wounds, Parkinson's, ALS, stroke, etc., would be eligible for the full episodes. The remaining Late EP cases would either be long-term LUPA patients, such as B12 and catheter care, or Medicaid patients. Although the HH PPS only includes Medicare beneficiaries, OASIS data collects information on both Medicare and Medicaid, and M0150 identifies the payor source. The period under analysis was during a time where instructions dictated to collect all possible payor sources, not just ones that will pay. Therefore, the data includes Medicaid in the mix. However, those cases are not eligible for Late EP reimbursement. Lastly, the feature of Early / Late EP would create an administrative burden on providers. The agency would need to rely on the common working file, which is often slow in posting information and/or rely on the patient and/or family for information. CMS should address the CWF by developing a mechanism to allow for real-time data retrieval.
- **Recommendation** ~ Eliminate the Early / Late distinction and redistribute the weighting to all the episodes. This will simplify the 4-equation model by eliminating the Early / Late EP calculations, to a 2-equation model with therapy thresholds. Additionally, we encourage CMS to address the issue of the Common Working File (CWF). Specifically, to develop a process where the CWF provides real-time data based on claims processed. Currently, the system does not offer real-time patient eligibility information, often as old as 90-180 days, and is slow in posting claims processed making it difficult for agencies to clearly determine status and access to care. Adding the Early / Late EP distinction would magnify the complications and may limit or delay appropriate access to care.

Issue ~ ICD-9 Coding

- **Section Title** ~ Provisions
- **Discussion** ~ CMS has expanded the list and will consider primary and secondary code combinations in scoring. It has included scores for infected surgical wounds, abscesses, chronic ulcers, and gangrene. Further, it has added gastrointestinal,

diagnosis groups. SCHCA is pleased with the expanded diagnosis list. More comprehensive and precise coding will result not only in better care but also data leading to more informed policy decisions.

- **Recommendation** ~ SCHCA supports the use of more variations in case mix variables.

Issue ~ ICD-9 Coding - Updated Guidelines

- **Section Title** ~ Provisions
- **Discussion** ~ In review of the most recent coding guidelines and ensure they are being used in the model. One example points to using outdated information, specifically, the use of ICD-9 436. In 2005, that code was clarified to a more specific code; however, HH PPS model has kept it in allocating a score when the more specific code is now available.

- **Recommendation** ~ SCHCA encourages CMS to proceed with caution when updating the ICD-9 tables related to HH PPS and follow coding rules when linking the case mix.
- **Recommendation** ~ Remove ICD-9 code 436 and add 434.91 (cerebral artery occlusion unspecified with cerebral infarction).

Thank you for the opportunity to comment on this proposed rule. We appreciate CMS' continued open dialogue through the teleconferences and *Open Door* forums. SCHCA encourages CMS to provide opportunities for continued training and education. As related to the HH PPS proposed rule, careful consideration is warranted due to the seriousness and extent of the changes. Providers may not be able to accept patients where they are operating at a loss. This would limit access, especially in rural communities, and force patients into a more expensive option, such as skilled nursing facility (SNF) or delay hospital discharges.

Should you require clarifications on any of our comments please contact me via phone or email at 919-848-3450, or at SherryThomas@homeandhospicecare.org, respectively.

Sincerely,

Sherry Thomas

Sherry Thomas, BSN, MPH
Senior Vice President
South Carolina Home Association

Submitter : Mr. David Burd **Date:** 06/22/2007

Organization : Nebraska Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1541-P-36-Attach-1.DOC

#36

Nebraska Hospital Association

June 22, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1541-P, Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Proposed Rule (Vol. 72, No. 86), May 4, 2007

Dear Ms. Norwalk:

On behalf of our 85 member hospitals and the 39,000 persons they employ, including 42 hospital-based home health agencies, the Nebraska Hospital Association (NHA) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule for the home health prospective payment system (PPS) refinements and rate updates for calendar year (CY) 2008.

CMS has proposed changes to the home health PPS that would provide the first major refinement to the system since its implementation in October of 2000. The proposed changes include refinements to the home health case-mix classification system that would increase the number of case-mix groups from 80 in CY 2007 to 153 in CY 2008, a 2.75 percent reduction to the national standardized 60-day episode payment rate for three years to address what CMS is considering coding changes, and changes to the current case-level payment adjustments.

While we support refinements to better align Medicare payment with the actual cost of delivering home health care, the proposed methodology overlooks additional steps that would further improve payment accuracy. Specifically, CMS should reconsider a payment adjustment for higher-cost patients such as dually eligible Medicare/Medicaid beneficiaries. CMS' finding that dually eligible status is not associated with higher costs contradicts the widely accepted correlation between Medicaid status and higher resource utilization. We urge CMS to revisit this issue and include an adjustment to help ensure that this vulnerable population receives the high-quality care it needs.

The NHA is very concerned about the proposed payment cut of 2.75 percent in each of the next three years. This payment cut would have a dramatic impact on the hospital-based home health agencies in the state of Nebraska. Hospital-based home health agencies are already losing money serving Medicare patients. Instead of making these significant cuts, we urge CMS to further analyze the increase in case mix due to the implementation of the home health PPS. We believe that the increase in case mix has occurred for legitimate reasons.

Many of the hospital-based home health agencies in Nebraska are located in rural areas and provide a valuable service to the people in those communities. Implementing a payment cut of this magnitude would have a large impact on these providers. The proposed cut would also be severe for those providers that often treat medically complex post-acute patients that are not admitted by community-based home health agencies. It is estimated that a cut of 2.75 percent would reduce payments by $600,000 per year for hospital-based home health agencies in Nebraska. Much of this impact would be absorbed by rural providers.

The NHA urges CMS to remove the payment cut of 2.75 percent for each of the next three years. We encourage CMS to implement measures to improve access and payments to rural home health agencies.

The NHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact David Burd, Senior Director of Finance, at (402) 742-8144 or dburd@nhanet.org.

Sincerely,

Laura J. Redoutey, FACHE
President

Submitter : Brian Ellsworth **Date:** 06/22/2007

Organization : CT Association for Home Care

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-37-Attach-1.PDF

#37

THE CONNECTICUT ASSOCIATION for **Home Care,** *Inc*

Incy S. Muir, RN, CNAA, MPA
Chair, Board of Directors

Brian Ellsworth
President/Chief Executive Officer

June 22, 2007

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

Re: CMS-1541-P Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for CY 2008

On behalf of 82 certified home health agencies serving over 50,000 elderly & disabled Medicare beneficiaries annually, the Connecticut Association for Home Care (CAHC) is pleased to submit the following comments on the proposed rule for refinement of the Home Health Prospective Payment System (PPS) and the rate update for 2008 that was published as a proposed rule in the *Federal Register* on May 4, 2007.

Overall

There are several welcome changes in the proposed rule that we are pleased to support, including: elimination of MO 175 & SCICs, automatic adjustment of rates based on common working file & final claim data, linking non-routine supplies to patient characteristics, extra payments for the interaction of multiple conditions and increased payment for LUPAs. In some cases, these changes are long overdue.

We have significant concerns, however. These include:

1) Unjust inclusion of episodes receiving more than 10 therapy visits in the coding creep calculation;
2) Failure to lower the threshold for qualification of outlier payments;
3) Lack of adequate research on the unique costs of patients eligible for both Medicare & Medicaid;
4) Partial episode payment (PEP) policy;
5) Unintended consequences of changes to hospital wage index policies;
6) Lack of payment for non-routine supplies in LUPAs
7) Timing and administrative burden

Our concerns are compounded by the absence of the Abt (CMS contractor's) Technical Report.[1] The exclusive reliance on descriptive statistics to justify the proposed 8.7 percent coding creep adjustment is of particular concern. Adjustments of this magnitude should be based on more thorough, inferential statistical analysis. CAHC requests that CMS extend the comment period to allow affected parties a chance to incorporate information from the Technical Report into their comments.

Unjust Inclusion of High Therapy Episodes in the Coding Creep Calculation

The Centers for Medicare & Medicaid Services (CMS) takes the position that all of the 8.7 % change in observed case mix between 1999 and 2003 is due to coding creep and not to actual changes in patient condition.[2] For a variety of reasons, this assertion is baseless.

In particular, our comments will focus on the inappropriate inclusion of "high therapy" episodes in the coding creep calculation. For purposes of this letter, "high therapy" episodes are defined as those episodes with 10 or more therapy visits.

According to CMS data, there was a 33% growth in the proportion of high therapy episodes from 1999 to 2003:

Year	Percent of High Therapy Episodes
1999:	27%
2003:	35%

CAHC calculates that the shift to high therapy episodes from 1999 to 2003 accounts for over 70 percent of the change in case mix in that time. This occurs because the average case mix weight for the payment groups with 10 or more therapy visits is significantly higher (case mix weight = 1.95 in 2003) than the remaining groups (case mix weight = 0.86 in 2003), driving overall case mix change.

Including the growth in case mix weights due to the shift to high therapy episodes in the coding creep calculation is completely inappropriate. There is no possibility of coding creep regarding a simple count of therapy visits over the course of an episode.

CMS simply dismisses the 33 percent growth in proportion of high therapy cases by wrongly implying that the increase was not justified by changes in patient's impairment levels. For instance, CMS claims that the pattern of decline in the functional impairment data from 1999 to 2003 is "suggestive of added numbers of marginally limited patients, not severely limited patients."[3] CMS' own data, however, does not bear this assertion out.

[1] See page 25393 of May 4, 2007 Federal Register.
[2] See page 25393.
[3] See page 25422.

Attachment A shows the Functional Domain data as presented in Table 8 of the proposed rule. CAHC subdivided the functional impairment data into high and low therapy episodes. When subdivided in this fashion, the data clearly shows that from 1999 to 2003, levels of functional impairment *declined* for the cohort of patients receiving *low* therapy and *increased* for the cohort receiving *high* therapy – the exact scenario to be expected. This conclusion is in stark contrast to CMS' conclusion of marginal functional decline – a simple artifact of lumping high and low therapy episodes together.

Attachment B shows data from a June 8, 2007 letter from CMS[4] that demonstrates an upward trend in the percentage of hospital discharges to home health for patients with: total knee replacements, total hip replacement and hip fracture. The CMS letter also indicates that total Medicare payments to home health agencies for those three conditions has increased significantly from 2000 to 2005.[5] In contrast to assertions in the proposed rule, this CMS data shows a clear upward trend in conditions requiring intensive therapy by home health agencies. It also shows the wisdom of investing in home health care for patients with high therapy needs: the cost per case for the conditions cited is by far the lowest of the post-acute provider types.[6]

Recommendations: For the foregoing reasons, as well as the fact that CMS has proposed significant changes to the therapy thresholds moving forward, we strongly recommend that the effect on case mix change of the shift to high therapy episodes under PPS be excluded from any assessment of coding creep. Moreover, we request that the remaining portion of the proposed coding creep adjustment be eliminated in its entirety in recognition of the significant un-reimbursed costs to be incurred by home health agencies in training staff and making operational modifications as a result of the transition to a refined, but more administratively complex, payment system.

Failure to Lower the Threshold For Outlier Payments

CMS' track record in home health PPS regarding outliers is to set the threshold too high, under-funding agencies that care for high cost patients not otherwise recognized by the payment system. Previous underpayments of outliers[7] resulted in an over $200 million annual shortfall in payments from the outlier pool.

Simple logic dictates that if a payment system is being refined in a way that significantly increases its ability to explain variation in costs of an episode of home health care, then there will be far fewer outliers. In order to fully expend the pool, the threshold for qualifying for outlier payments needs to be lowered. CMS acknowledges that

[4] Letter was to the general public justifying CMS' policies with respect to enforcement of the "75 percent rule" for Inpatient Rehabilitation Facilities (IRFs)
[5] This data is significant because it is independent of OASIS. It is based on Medicare claims data.
[6] See Figure 9 in Attachment B.
[7] For the first five years of PPS, outlier payments were approximately 60 percent of the amount carved out of payment rates for that purpose. See page 25434.

"preliminary analysis" shows that the outlier loss threshold could be lowered by as much as 37 percent (from a fixed dollar loss of 0.67 to 0.42).[8]

Recommendations: 1) CAHC strongly urges that the fixed dollar loss threshold for outliers be reduced to at least 0.42, and reduced further if analysis suggests doing so. Otherwise, CMS needs to explain why its refined payment system is not doing a better job of reimbursing high cost patients than the current system. 2) CAHC also recommends that CMS explore alternative outlier payment methods that recognize the differing variability of costs across payment groups.[9] In particular, CAHC suggests that "near outlier" episodes with a large number of home health aide visits be specifically examined and that CMS consider adjusting the outlier qualification threshold on a HHRG by HHRG basis to better capture these cases. The one size fits all fixed dollar loss threshold is not likely to be appropriate in a refined PPS.

Lack of Adequate Research on Unique Costs of Dually Eligible Patients

CAHC remains concerned about two considerations that were included in the case-mix research, but not in the proposed changes: Medicaid eligibility and caregiver access. CAHC has shared data with CMS, Abt Associates & MedPAC showing a very clear pattern of increased per episode costs for patients that are dually eligible for Medicare & Medicaid vs. Medicare-only patients in the same payment group.

CAHC continues to assert that the additional per episode costs of Medicaid patients are due to the unmeasured effects of: multiple chronic illnesses, patient non-compliance and tendency to live alone. While some of the proposed refinements begin to address these issues (e.g., interactions terms for certain clinical conditions), we remain concerned that many dual eligible cases will continue to be under-reimbursed.

We believe that the CMS findings that Medicaid "remains a marginal predictor [of costs], at best" are questionable because of how CMS operationalized the Medicaid variable. Home health agencies frequently do not record Medicaid numbers on the patient assessment form in cases where Medicaid is not the payer. It is well established underreporting of a variable will bias its statistical impact downward.

Recommendations: 1) Compare the impact of Medicaid eligibility by studying resource use of a sample of home health patients enrolled in a Medicaid program from Medicaid files, against patients without Medicaid. Base the inclusion of Medicaid eligibility in the case-mix system on the results of further study; 2) Improve the alignment of HHRGs and Medicare coverage guidelines for homebound status and medical necessity, particularly for cases that receive coverage under "Assessment & Observation" or "Management and Evaluation of the Care Plan" guidelines. Improved alignment of the payment system and

[8] Page 25434.

[9] Information from the Abt Technical Report might have been helpful in more specifically framing this recommendation.

coverage rules is critical to addressing ongoing disputes between state Medicaid agencies and the Medicare program regarding Third Party Liability.

Partial Episode Payment (PEP) Policies

CMS does not propose to make any changes to policies regarding PEPs despite longstanding complaints and its own evidence about underpayment. Member home health agencies are particularly concerned about PEPs in the situation where patients are discharged with plan of care goals met and return to the same agency within the 60-day period. In those cases, the home health agency can end up receiving a significant reduction in payment for the first episode despite the provision of a full set of visits pursuant to a plan of care. This reduction is due in part to the pro-ration methodology, but also simply to the application of PEP policy itself.

Also, questions have been raised about the interaction of PEP policy and the proposed payment distinction between early & late episodes.

Recommendations: 1) CMS should not apply PEP to cases where the patient is discharged with plan of care goals met and returns to the same home health agency with a new medical issue. 2) CMS should clarify how PEP policy will interact with early & later episode designation.

Unintended Consequences of Changes to Hospital Wage Index Policies

The Medicare wage index is a major component of the Medicare home health rate calculation. The wage index has become more problematic over time due to the unintended consequences of changes in hospital payment policies on other providers, such as home health agencies.

The hospital inpatient prospective payment system has features that mitigate the harmful effect of inadequate wage indices. Hospitals can apply to be "reclassified" to a neighboring region with a higher wage index. They also have a "rural floor" provision in their rule that states no hospital's index can be below the "rural" wage index for the state. No such provisions are available to home health agencies. As a result, there is a growing differential between what home health agencies and hospitals receive from Medicare for labor costs – putting home health agencies at a significant disadvantage when competing for labor.

In 2004, the Centers for Medicare & Medicaid Services (CMS) made a decision to exclude Critical Access Hospitals from the wage index calculation. This change disadvantaged home care agencies in suburban areas and the northeast in particular. In 2005, the geographic regions used in applying the wage index were revised, and "core based statistical areas" (CBSA's) were introduced. The impact of that change has also harmed a number of New England regions. CMS' cost analysis of the 2007 final rule for home health PPS showed that payment rates *were reduced by 1.2 percent* in New England

solely due to updating the wage index from one year to the next. This was easily the largest drop in the country and had the effect of wiping out one-third of the market basket update for New England home health agencies. In many counties, the wage index decline exceeded the market basket update.

Recommendation: We propose adoption of a "rural floor" policy for home health, comparable to the policy that exists for hospitals. Under this policy, home health agencies receive the higher of: the wage index for their CBSA or the rural region of the state. We believe CMS has the power to make this change in regulation. This proposal is the simplest, fairest, and most cost-effective solution to wage index problems and would serve as an important bridge to the longer-term wage index reform, which is likely to take years to enact.

Lack of payment for non-routine supplies in LUPAs

LUPA episodes, that are not final episodes, often have high supply costs. The most common medical supplies needed in LUPA episodes are those for patients that require urinary catheter changes. Failure to include medical supply payment for LUPA episodes to patients with indwelling catheters could result in a disincentive to home health agencies to admit these patients to service. The end result could be an increase in more costly emergency room visits by beneficiaries for catheter changes.

Other medical supplies common to LUPA episodes are wound care supplies used by home health patients and their caregivers. Since LUPA episode payments barely cover visit costs, to exclude these supplies from LUPA episodes could serve as a disincentive to teach patients and caregivers to be self-sufficient, resulting in home health agencies making additional visits to perform the wound care. By doing so, agencies would be eligible for both full episode payments and coverage of supplies.

Recommendation: Include payment for non-routine medical supplies for all episodes, including LUPA episodes that are not final episodes of care.

Timing and Administrative Burden

A final overall concern is timing and administrative burden. CMS has taken a long time to refine the PPS and initiate changes to OASIS. Further changes to PPS and OASIS will be needed to address Pay for Performance (P4P). There are also longstanding problems with OASIS that need to be addressed. Each round of changes entails significant costs for training, as well as operational and information technology (IT) changes.

Recommendation: CMS needs to explicitly recognize these transition costs. CAHC suggests eliminating the balance of the coding creep adjustment (after growth in high therapy cases is factored out) as a good first step. Also, to the extent possible, payment

system and OASIS changes should be combined and home health agencies given as much advance notice as possible. A clearly articulated strategic plan would be helpful.

Thank you for consideration of these comments. I would be pleased to answer any questions that you may have about these comments.

Sincerely,

Brian Ellsworth
President & CEO
Connecticut Association for Home Care

Attachment A

Change in Functional Status from 1999 to 2003
by High & Low Therapy Episodes

Table 8 - page 25936

Comparison of Severity Level Prevelance
IPS to PPS

	Level	IPS	PPS	
F0	Min	9.3%	6.2%	-3.12
F1	Low	28.6%	25.4%	-3.17
F2	Mod	45.2%	51.3%	6.12
F3	High	10.4%	10.8%	0.44
F4	Max	6.6%	6.3%	-0.27

Low Therapy Cases (S0,S1)

	Level	IPS	PPS	Diff
F0	Min	8.8%	5.8%	-3.0%
F1	Low	23.5%	19.9%	-3.6%
F2	Mod	30.4%	30.3%	-0.1%
F3	High	6.1%	5.3%	-0.8%
F4	Max	4.3%	3.7%	-0.6%

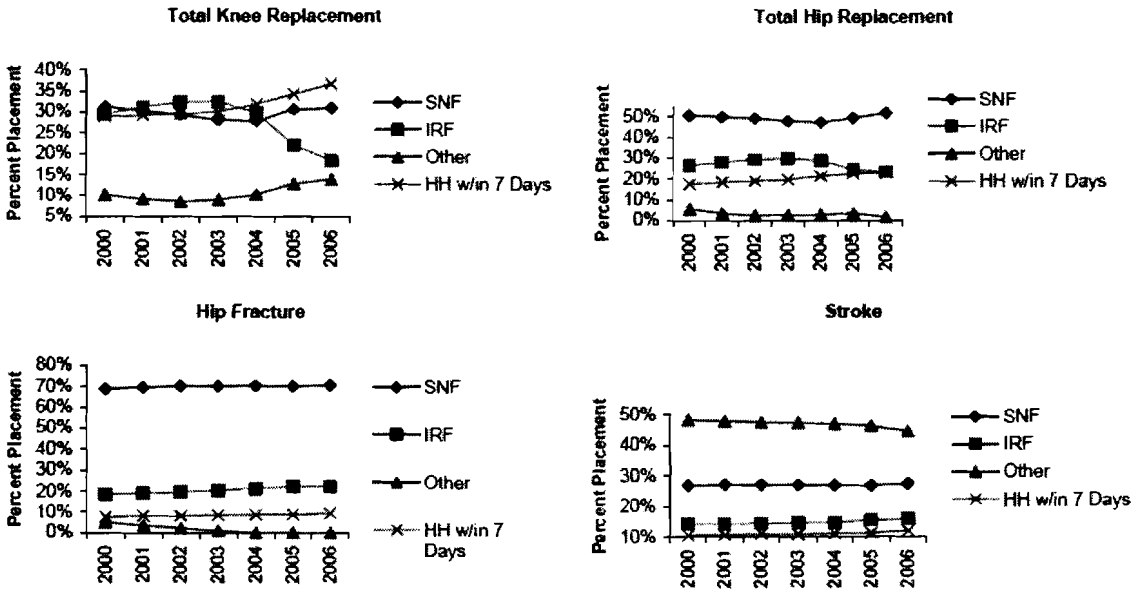
High Therapy Cases (S2,S3)

	Level	IPS	PPS	
F0	Min	0.4%	0.3%	-0.1%
F1	Low	5.1%	5.5%	0.4%
F2	Mod	14.8%	21.0%	6.2%
F3	High	4.3%	5.6%	1.2%
F4	Max	2.3%	2.6%	0.3%

Attachment B

Charts from June 8, 2007 CMS Letter on Inpatient Rehabilitation Facilities

Figure 7: Access to Rehabilitation Care 2000-2006



Note: Data for 2006 includes claims in the system for only the first half of calendar year 2006. Other includes home self-care, home health in more than seven days of acute care hospital discharge, outpatient therapy, expiration, LTCH, and other facilities. Also, a small percentage of cases may be counted in multiple settings if they received multiple sources of care within the narrow time window examined. For this reason, totals may not always add to 100 percent. Source, CMS claims data.

Figure 8: Total Medicare Payments to Rehabilitation Providers by Provider Type, Annual Growth Rate of Condition Incidence and Medicare Payments, 2000-2005

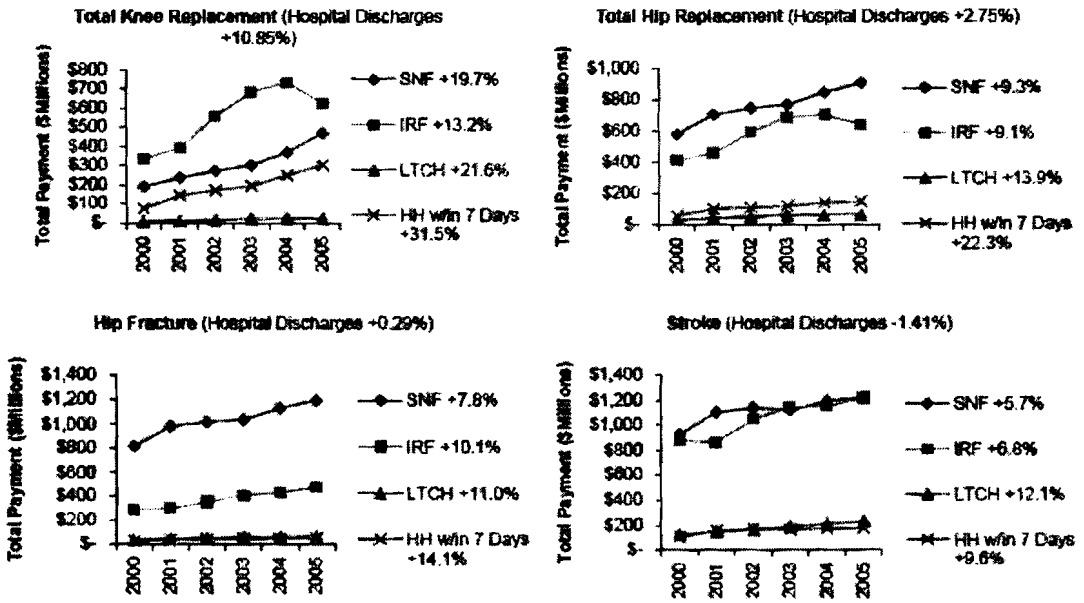
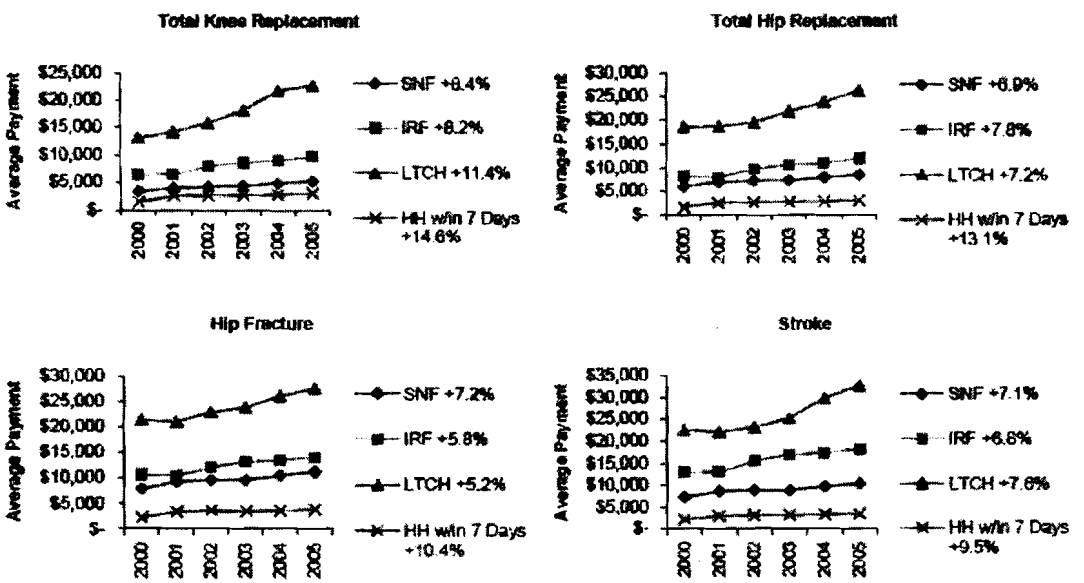


Figure 9: Average Medicare Payment to Rehabilitation Providers per Case and Annual Growth Rates, 2000-2005



Note: Growth rates in Figures 8 and 9 shown are compounded annual growth rates (CAGRs). This is the average compound rate at which 2000 levels grow to reach 2005 levels. The growth rate listed by each medical condition in Figure 8 is the 2000–2005 CAGR for all Medicare inpatient hospital discharges for that condition. The CAGRs listed by site of service in Figure 8 are growth rates for spending in each site. The CAGRs listed by site of service in Figure 9 are growth rates for average payment per case for each site. Source, CMS claims data.

Submitter : Mr. Keith Myers **Date:** 06/22/2007

Organization : LHC Group, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-38-Attach-1.DOC

#38

June 22, 2007

VIA ELECTRONIC FILING AND EXPRESS DELIVERY
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments to the Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 [CMS-1541-P]

Dear Sir or Madam:

LHC Group, Inc. ("LHC") appreciates the opportunity to submit these comments on the *Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008* (the "Proposed Rule").[1] Like the Centers for Medicare and Medicaid Services ("CMS"), LHC is committed to ensuring that health care services are provided in the least restrictive, most cost-effective, and most appropriate environment possible. Accordingly, we appreciate this opportunity to respond to CMS' requests for comments on the Proposed Rule.

LHC Group is a provider of post-acute health care services primarily in rural areas in the southern United States. We provide home-based services through our home nursing agencies and hospices and facility-based services through our long-term acute care hospitals and rehabilitation facilities. Our home health services include skilled nursing, in home rehabilitation, chronic disease management, complex care coordination, medication management and emerging technologies such as telehealth. These services are provided by a trained staff of over 4,100 nurses, physicians, therapists, and aides throughout our 142 locations in Texas, Louisiana, Mississippi, Arkansas, Alabama, West Virginia, Kentucky, Florida, Tennessee, and Georgia.

LHC provides over 55 percent of its home health services to beneficiaries residing in rural areas. Our home health agencies ("HHAs") providing services to rural beneficiaries, like rural home health agencies nationwide, stand in a particularly precarious financial situation. On average, their operating costs are higher than urban

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

HHAs' costs. These higher costs result from a combination of factors, including the built-in additional costs of providing home health services in a rural setting. For example, because rural beneficiaries are scattered throughout rural areas and not congregated in cities like their urban counterparts, rural HHAs face increased personnel and fuel costs and decreased efficiency due to the greater driving distances required. Another source of elevated costs for rural HHAs is the scarcity of skilled professionals, which most rural HHAs must combat by compensating their physical therapists, speech therapists, and medical social workers at higher rates than their urban or hospital-based counterparts. The fact that rural HHAs often function as the primary caregivers for elderly homebound patients, who have high resource needs, also increases the cost of rural home health services.

Because ensuring beneficiary access to medically necessary care is one of the Medicare program's central purposes, the threat to rural beneficiary access to home health services should be a primary concern as CMS finalizes the provisions of its Proposed Rule. Our comments on the Proposed Rule, however, apply to the wider home health community, not only to providers in rural areas.

I. Introduction

LHC generally supports several aspects of the changes CMS has proposed in Section II.A. of the Preamble to the Proposed Rule, specifically those relating to the following:

1. Multiple therapy thresholds and the smoothing effect of the graduated payment methodology;
2. Recognition of higher resource utilization in later episodes of care for chronic patients;
3. Low-Utilization Payment Adjustment (LUPA) Review; and
4. Significant Change in Condition (SCIC) Adjustment Review

LHC also agrees with CMS that it must better align payments with resource utilization.

However, we respectfully object to, and in support of our objections, offer more detailed commentary on the following sections of the Proposed Rule:

> II. Provisions of the Proposed Regulation; A. Refinements to the Home Health Prospective Payments System; 3. Description and Analysis of Case-Mix Coding Change Under the HH PPS.
>
> II. Provisions of the Proposed Regulation; B. Rebasing and Revising the Home Health Market Basket; 5. Labor-Related Share
>
> II. Provisions of the Proposed Regulation; E. Hospital Wage Index

We organize the remainder of our comments based on these sections of the Proposed

Rule.

II. Increases in Home Health Patient Case Mix Weight (Section II. A. 3.)

A. CMS' Position

In the Proposed Rule, CMS proposes to reduce the home health national standardized 60-day episode payment rate by 2.75% annually for three years to eliminate the effects of increases in the home health patient case-mix weight that CMS believes "were a result of changes in the coding or classification of different units of service that did not reflect real changes in case-mix."[2] CMS indicates that the average case mix weight has risen from approximately 1.135 in 2000 (when the Prospective Payment System ("PPS") was implemented) to 1.233 in 2003 (the most recent year for which data are available), but the agency fails to recognize that the home health patient population could have changed sufficiently over this period to account for this increase.[3] Instead, CMS concludes that the home health provider community has been "gaming" the system, or deliberately establishing a higher case mix weight to secure higher reimbursements under Medicare.

B. Unsubstantiated Assumptions Underlying CMS' Position

At its core, CMS' assertion of provider upcoding is unreliable because it is based upon unjustified assumptions that run counter to the actual data available. CMS has failed to utilize a sound methodology to determine the extent to which the increase in case mix weight is due to changes in patients or changes in coding behavior. In the Proposed Rule, for instance, CMS admits that HHAs have begun admitting more patients from skilled nursing facilities ("SNFs") and inpatient rehabilitation facilities ("IRF's") in the past few years.[4] CMS acknowledges that these patients uniformly have higher case mix scores than from other admission sources. One of the scoring factors in the home health PPS case mix adjustment model takes into account CMS' finding that home health patients admitted from SNFs have greater care needs than patients without recent SNF stays. However, CMS ignores its own finding about post-SNF and post-IRF home health admissions when the agency determines that "coding creep," not real change in patient mix, explains the entirety of the increase in case mix weight.

We are concerned that CMS has failed to recognize that the increases in therapy services may be related to changes in the nature of patients served. CMS' conclusion appears to be unsupported by medical review activity and claims denials, and ignores the significant rehabilitative gains of home health patients and the numerous structural changes in other care settings that impact the patient population served by HHAs. Instead, the primary justification that CMS offers for its conclusion is that HHAs have received policy clarifications and training on how to complete the patient assessment forms. Therefore it seems that the only objective evidence on which CMS bases its

---

[2] *Id.* at 25395.
[3] *Id.* at 25394.
[4] *Id.* at 25396.

conclusion is the overall increase in average case mix index; the agency's remaining "evidence" consists of its own subjective evaluations of Outcome and Assessment Information Set ("OASIS") assessments and other data.

Finally, CMS' recent findings of "coding creep" among other provider types, including long term care hospitals ("LTCHs")[5], inpatient rehabilitation facilities ("IRFs")[6], and acute care hospitals[7], further discredit the agency's conclusion about HHAs' patient case mix. CMS' subjective identification of "coding creep" by all types of health care providers is problematic. We submit that CMS' conclusion regarding increases in home health case mix is misplaced and that, instead, the evidence establishes that home health case mix increases are a result of patient demographic changes.

C. Evidence Rebutting CMS' Position

Recent data concerning LHC's home health agencies, in particular, and the home health industry nationwide demonstrate that, contrary to CMS' conclusion, the home health case mix has risen for legitimate (i.e. patient characteristic-related) reasons. For instance, LHC's overall case mix rose from 1.27 in October 2001 to 1.31 in October 2003. Industry data also indicates that the percentage of our patients over age 80 also rose from 24.9 percent to 34 percent during this same period. Because older patients tend to have more chronic health problems than younger patients, these patients require more time and resources in order to recover from illnesses or to learn to manage their chronic conditions. This translates into a higher level of acuity for this patient population. Accordingly, the increase in our case mix accurately reflects changes in our patients' demographic characteristics. HHAs across the country have experienced similar increases in patient age and acuity, with the intensity of service required by patients rising significantly since the late 1990s.

Medicare policy changes have also affected home health patient acuity. Some of these policy changes are alterations of coverage and payment standards that CMS has made with regard to IRFs and LTCHs. Because these settings generally have higher acuity patients than HHAs, any policy decisions that intensify admissions criteria for these settings or that otherwise discourage IRFs and LTCHs from accepting certain high acuity patients lead more patients with higher acuity to seek care from HHAs. As HHAs have absorbed these patients, their case mix has increased.

For example, the phasing-in of the "75 Percent Rule" since 2004 has led IRFs to deny admissions to many patients who do not meet the acuity and diagnosis

---

[5] CMS made this assertion regarding LTCHs in the RY 2008 proposed and final rules for the LTCH PPS. 71 *Fed. Reg.* 4776, 4784-4793 (February 1, 2007); 71 *Fed. Reg.* 26870, 26880-26890 (May 11, 2007).

[6] For instance, CMS has justified its reductions ("refinements") in the IRF PPS for FY 2006 and FY 2007 by indicating that the cuts were "implemented to fulfill the statutory mandate to adjust payments to account for changes in coding that do not reflect real changes in case mix." CMS memorandum, "Inpatient Rehabilitation Facility PPS and the 75 percent Rule" (June 8, 2007).

[7] CMS made this claim with respect to acute care hospitals in the FY 2008 IPPS proposed rule. 71 *Fed. Reg.* 24680, 24690-24697, 24708-24713 (May 3, 2007).

qualifications specified in the 2004 IRF PPS final rule. In fact, CMS in its June 8, 2007 memorandum on the 75 Percent Rule, noted that IRF admissions dropped 19 percent by 2006. Without inpatient rehabilitation care as a viable option, these patients are receiving care in SNFs and HHAs. Thus, patients who were, until just recently, receiving care as hospital inpatients are now being admitted to less acute settings of care and driving up the case mix at HHAs.

Likewise, restrictions on LTCH payments for short-stay outlier cases that CMS has implemented for 2007 (and 2008) have resulted in higher acuity patients seeking home health services. In addition, when CMS finishes developing and ultimately implementing patient- and facility-level criteria for LTCH admissions, the result will again be the shifting of long-term care and rehabilitation patients into HHAs. Cumulatively, the changes in admissions requirements for these intensive post-acute provider types have increased the number of rehabilitation patients in home health which is accurately reflected by the rising home health agency case mix.

These restrictions on IRF and LTCH admissions are part of CMS' initiative to ensure that beneficiaries receive care in the lowest acuity settings at which their medical needs can appropriately be met. Herb Kuhn, Acting Deputy Administrator of CMS, identified this policy goal in testimony before the Ways and Means Health Subcommittee, indicating that "CMS is committed to ensuring that beneficiaries have access to high quality rehabilitation services in these settings at an appropriate cost to taxpayers."[8] Thus, one of the agency's explicit goals involves encouraging rehabilitation patients to use the services of HHAs whenever clinically appropriate. Increased HHA case mix is the natural consequence of this policy, but CMS has ignored the effect of its own policy and has, instead, taken the position that HHAs' coding behavior has resulted in an unsubstantiated increase in case mix.

Yet another one of CMS' current initiatives that has resulted in increased home health case mix is the Home Health Quality Initiative. HHAs have improved the accuracy of their patient assessments and coding in response to CMS' emphasis on nurse education, training, and experience and in response to incentives for accuracy created by the launching of the Home Health Compare tool. Increased assessment accuracy naturally results in increased acuity scores as patients' clinical issues and functional limitations are more carefully identified and recorded. Thus, HHAs' average case mix has increased due to agencies' compliance with CMS' quality reporting requirements. Rather than acknowledge these providers for their improvements in this arena, CMS has proposed to reduce home health payments on this basis.

Growth in enrollment in Medicare Advantage ("MA") (formerly Medicare + Choice) plans has also contributed to the rising home health case mix. These plans have targeted low acuity Medicare beneficiaries for enrollment, which has shifted low acuity patients out of the traditional Medicare program. Beneficiaries remaining in the traditional Medicare program, then, tend to have higher patient care needs. We believe

[8] Herb Kuhn, "Standardized Payment and Patient Assessments in Post-Acute Care," Testimony before the Ways and Means Health Subcommittee, (June 16, 2005).

that among our home health patients, the MA (formerly M+C) plan enrollees demonstrate lower resource needs on average than their traditional Medicare beneficiary counterparts. Accordingly, the marketing and enrollment practices of MA and M+C plans have contributed to increases in HHAs' case mix.

D. Adverse Effects of CMS' Position

CMS' "coding creep" position is lacking objective justification and is contradicted by available data. It also undermines the agency's efforts to encourage utilization of care in the most appropriate, cost-effective settings and to encourage accurate coding and quality reporting. If finalized, the payment cuts in the Proposed Rule will deny HHAs the funds they need to cover the costs of the higher acuity patients they have begun admitting over the past several years. Without adequate Medicare reimbursement, HHAs – especially those serving rural areas – may be forced to scale back services or to close. Either of these outcomes would, in turn, force these patients to receive care in higher cost rehabilitative settings (IRFs, LTCHs, SNFs). This reduced access to high quality services in cost-effective settings will harm both beneficiaries and the Medicare program.

Likewise, CMS' Home Health Quality Initiative could also be undermined if the payment cuts in the Proposed Rule are finalized. As explained above, improvements in the accuracy of patient assessment and coding result in increased acuity scores (as nurses record patient conditions more precisely and uniformly). Moreover, patient acuity is further increased when the patients themselves present with more complex, severe health conditions, as has been the case in HHAs over the past few years. By punishing HHAs for accurate coding practices that result in higher patient acuity scores – and, as a result, higher case mix – CMS will create perverse incentives regarding coding and quality reporting. As a result, the outcomes measures reported on Home Health Compare will become less reliable, and CMS' plans to implement pay-for-performance based on quality outcomes data will be disrupted.

LHC submits that CMS' proposal to reduce the national standardized 60-day episode payment rate by 2.75 percent per year for the next three years is not justified by the available data and is therefore not within the agency's discretion. To LHC's knowledge, there is no objective evidence of intentional behavior on the part of home health providers to modify documentation to increase payments. Moreover, CMS has recently drawn similar, unsubstantiated conclusions that other provider types have engaged in inaccurate coding behaviors.

III. Home Health Wage Adjustment

A. Disproportionate Impact on Reimbursement of the Increase in the Labor-Related Share (Section II. B. 5.)

The labor-related share of the base payment rate is a significant factor driving Medicare reimbursement especially for providers serving rural markets. The Proposed

Rule increases the labor-related share from 76.775 percent to 77.082 percent, an increase of 0.307 percent which results in an adverse impact on reimbursement, particularly for services provided to rural beneficiaries.

The use of an accurate labor-related share is critical to determining accurate reimbursement to providers. The mechanics of the payment computation are such that a lower labor-related share will increase Medicare reimbursement for a provider in an area with a wage index below 1, and a higher percent will increase reimbursement for providers located in markets where the wage index is above 1.0. Therefore, overstatement of the labor-related share will result in payment inequities even if the applicable wage index is accurate. This is most apparent in rural areas, which, in most states, have statewide wage indices of less than 1.0, resulting in a disproportionate reduction in reimbursement.

Medicare rural wage indices are uniformly lower than urban wage indices, a reality that results in substantially lower Medicare reimbursement to the home health agency for the same services, provided to the same type of beneficiaries, as compared to urban agencies. The national average Medicare wage index is set at 1.0. Addendum A of the Proposed Rule shows rural wage indices ranging from 0.7216 to 1.1709 for the 50 states with an average rural wage index of 0.8445 and a median of 0.8588.[9] Only seven states have a wage index over 1.0 (Alaska, California, Connecticut, Hawaii, Massachusetts, New Hampshire and Washington).

B. Inappropriateness of Using the Hospital Wage Index to Adjust Home Health Wages (Section II. E.)

The home health provider community has long opposed CMS' use of the hospital wage index to establish home health wages. Differences in the occupational personnel pool and costs between hospitals and HHAs make use of the hospital wage index inappropriate in the home health setting. Hospitals benefit to a large extent from institutional efficiencies which are available to spread costs. HHAs do not have the same ability to shift costs as hospitals.

Congress has granted CMS discretion in establishing the home health wage index.[10] Despite this authorization, CMS has refused to establish a home health-specific wage index each year since implementation of the home health PPS system. The use of hospital wage index to adjust non-hospital reimbursement rates was originally intended to be an interim measure while CMS examined industry-specific wage data for HHAs, SNFs, IRFs, and other post-acute services.[11]

Despite repeated comments from home health providers opposing the use of the hospital wage index each year to its proposed rules, CMS has not developed a home

---

[9] 72 *Fed. Reg. 25459* (May 4, 2007).
[10] Social Security Act §1895(b)(4)(C).
[11] 65 *Fed. Reg.* 41127 (July 12, 2000); 65 *Fed. Reg.* 46770 (July 31, 2000); 66 *Fed. Reg.* 41316 (August 7, 2001).

health-specific wage index. CMS has cited the expense and administrative burden of data collection as its reasons for not developing a home health-specific wage index. This year, however, the data have been collected and analyzed by CMS in conjunction with its rebasing of the labor-related share in this Proposed Rule. The agency could use this data to develop a home health-specific wage index.

Beginning in FY 2004, CMS dropped critical access hospitals ("CAHs") from its calculation of hospital wage indices. Wage cost data from over 1,000 rural hospitals are no longer evaluated in establishing the hospital wage index. The Medicare Payment Advisory Commission ("MedPAC") correctly pointed out that the CAH exclusion issue affects other providers including HHAs.[12] As CAHs are located in rural areas, the absence of CAH wage data further compromises the accuracy, and therefore the appropriateness, of using a hospital wage index to determine the labor costs of home health agencies located in rural areas.

Further, hospitals have available several avenues for relief from an inaccurate wage index which are not available to home health providers.[13] For instance, in the hospital setting, a rural hospital with disproportionately high labor costs can apply for reclassification of its wage index. Such a hospital could, then, be paid at the same wage index-based rate as an urban hospital that had the same wage rates. HHAs are not eligible for reclassification. Moreover, the inequity is increased in rural areas in which the hospital can qualify as a CAH or sole community provider and receive higher reimbursements while the rural HHA in the same community has no access to these additional payments.

CMS has steadfastly refused to recognize geographic reclassification data for application of the hospital area wage index to the home health PPS. CMS' reasoning for refusing to apply reclassification data is that reclassification applies only to hospitals by statute. However, if hospital relative wages are thought to be a reasonable proxy for relative wages of home health providers, the impact of hospital reclassifications in an area should be applied to the hospital wage index which in turn is applied to the home health reimbursement.

IV. Conclusions: Recommendations to CMS

Continued beneficiary access to high-quality home health services requires that the Medicare program adequately reimburse home health agencies. If finalized in its current form, the Proposed Rule will threaten the ability of home health agencies to continue to meet beneficiaries' health care needs. The proposed reductions in the national standardized 60-day episode payment rate, increase in the labor-related share of the base payment rate, and continued use of the hospital wage index to adjust home health wages would all intensify the existing financial pressures on home health agencies. The financial strain would be especially great on home health agencies serving rural

---

[12] MedPAC's Comments on the FY 2006 IPPS Proposed Rule (June 23, 2005), p. 9.

[13] For example: Lugar counties; sole community hospitals; rural referral centers; Sections 508 and 401; special Secretarial exceptions; outcommuting adjustments; rural floor; and the hold harmless provision.

beneficiaries, which are already faced with higher costs and lower reimbursements than urban home health agencies.

In order to maintain beneficiary access to home health care, we make the following recommendations to CMS:

1. CMS should withdraw its proposal to reduce the national standardized 60-day episode payment rate – a proposal that is both based on unsubstantiated assumptions and is controverted by available evidence. We believe that CMS will agree that the base payment rate should not be reduced if the agency reconsiders the data it has already reviewed in light of home health industry data that correlate increases in patient acuity to changes in patient characteristics.

2. CMS should withdraw its proposal to increase the labor-related share of the base payment rate. This proposal in particular would severely harm home health agencies serving rural areas and, thus, threaten access for rural beneficiaries.

3. CMS should develop a home health-specific wage index based on data that the agency has already collected and analyzed when developing its proposal to rebase the labor-related share.

Thank you for the opportunity to submit these comments. LHC Group looks forward to working with CMS while these provisions of the Proposed Rule are being finalized. Please do not hesitate to contact us if you have any questions or concerns.

Sincerely,

LHC Group, Inc.

BY: _____
Keith G. Myers, CEO

LHC Group, Inc., 420 W. Pinhook Road, Suite A, Lafayette, Louisiana 70503
337.233.1307 Fax: 337.235-8037

Submitter : **Date: 06/24/2007**

Organization :

Category : **Home Health Facility**

Issue Areas/Comments

Consolidated Billing

Consolidated Billing

Removing the supply allowance for LUPA episodes will financially hurt our agency to the point we would have to examine whether we have the resources to continue providing services to patients with a LUPA. Currently, we lose over $50.00 for every visit done that is reimbursed as a LUPA. These patients tend to be foley catheter changes or ostomy changes (iliostomy, colostomy). These supplies are very expensive. Incurring cost for these supplies in addition to our current loss would be difficult.

There does not appear to be any consideration of Pleurex drain supplies or supply reimbursement for urinary ostomoies. Thes are very expensive supply items that are taxing to agencies to afford.

The proposed $367 will not be adcquatc supply reimbursement for many cascs where ostomies, catheters, wound supplies are needed. Again, given the financial cuts proposed, this will make agencies examine whether they have the financial resources to provide scrvices to patients with intensive supply needs. CMS needs to make a provision to financially accomodate the costs related to high supply utilization cases.

What will happen if a patient, who on admission or recert, does not need supplies, but then develops this need during the 60 day period? How will the agency be reimbursed for these supplies? If CMS develops an interim assessment, please make it much simpler and actually beneficial than the SCIC was!