Submitter : Mrs. Cynthia Poort **Date:** 06/25/2007

Organization : Pennock Homecare Services

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

My agency, Pennock Homecare Services, opposes the 2.75% decrease each year to Home Health Providers. This "behavioral offset" would decrease 2008 payments to Michigan home health agencies by approximately $3.7 million and virtually eliminate the 2.9 percent marketbasket update, resulting in a 0.15 percent payment update. Pennock Homecare Services also opposes the CMS's proposed changes for separate case-mix adjusted nonroutine supply payments based on patient characteristics and recommends that the CMS conduct additional research to identify other diagnosis and patient characteristics before proceeding. In addition, Pennock Homecare Services recommends that the CMS reduce the outlier fixed-dollar loss (FDL) ratio, since data indicates that continued use of the .67 FDL will result in the CMS not spending the 5 percent pool of funds set aside for outlier payments. The proposed diagnoses changes may negatively impact providers who are currently providing care to those in early episodes and providing 0 to 13 therapy visits. We have worked hard to help patients become independent and be rehabilitated as soon as possible.

Submitter : **Mrs. Karen Brady** **Date: 06/25/2007**

Organization : **Cleveland Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Non routine supplies: CMS' the concept of the NRS add-on is good. However, it was based on incomplete information and may inadequately reflect the providers' true costs. Abt Assoc. reported that nearly 40% of the cost reports where incomplete and unusable and only 10% of the claims data reported any supply charges. Support the proposed NRS add-on and encourage CMS to continue to study the supply issue with future data

Submitter : Mr. Roger Herr **Date:** 06/25/2007

Organization : Physical Therapist

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1541-P-42-Attach-1.DOC

#42

Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via electronic submission

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

Dear Ms. Norwalk:
I am a Physical Therapist submitting comments on the Home Health Prospective Payment System Refinement and Rate Update Proposed Rule (CY 2008). My background is that I have been in practice for twenty years, of which eighteen have been in the home health setting. In agencies, I have worked for the largest not for profit, largest for profit, a hospital based agency, too. I have also worked as an educator, site visitor for a deemed accreditation agency, and written and presented at many state and national home care conferences.

I want to convey the positive comments and perspective I see PPS bringing to the home health industry. I commend the refinements and wish to share my perspective on some of the issues.

OUTCOME ASSESSMENT INFORMATION SET (OASIS) DATA SET
I continue to applaud the ability of physical therapists, nurses, and speech language pathology professionals to complete OASIS and the comprehensive assessment. I hope Occupational Therapy will be allowed, should the bill be successful in Congress. Do know I firmly believe PPS and utilization of the OASIS data set have enhanced the universal standards of practice, documentation, and communication of home care. I wish to express my appreciation as this has brought the home health industry into current times, perhaps ahead of some settings! Do consider this opinion, as I fear you may hear the vocal minority that wants to reduce or return to documentation standards of years gone by. I applaud you upholding the universal data set, such as OASIS.

I do feel refinement of some items, in particular the functional items could provide more sensitive and significant resource identifiers. Please consider utilizing PTs and other resources from the American Physical Therapy Association (APTA), should there be any opportunity for OASIS item refinement.

CASE MIX MODEL AND CODING

I believe the expanded case mix diagnosis from 80 to 153 is important to identify patient to patient differences. It is exceptional on how the PPS model is patient focused and well rounded. The biggest challenge for the home care industry continues to be education to front line clinicians, office staff, and administration. I hope resources, such as the Quality Improvement Organizations (QIOs), will be one potential resource for consistent facts and education in this area.

I am impressed with the Clinical, Functional, and Service domains of some OASIS items. My one concern is that the service domain will now rest solely on the therapy visits provided. The removal of high or no therapy threshold was a good thing, as some providers did not consider short term therapy interventions an ideal situation. My hope is that the multiple therapy thresholds will not be micromanaged by policies or guidelines and patients will to receive the care that is appropriate, effective, and timely.

CASE MIX CREEP

I understand the concern regarding understanding the root for case mix creep. I must share that with PPS clinicians (RNs, PTs, SLPs) drive the ICD-9 coding. Prior to PPS, clinicians were not regularly involved in choosing the detailed ICD-9 coding to the fifth digit. I truly believe the case mix creep is mostly due to clinicians determining the detail. I am disappointed that the proposed rule leaned towards the assumption that the case mix creep was due to gaming. The best resource and opportunity is education. The industry challenge has been the differences in fiscal intermediary implementation, interpretation, or follow-up activities related to ICD-9 coding logic. Further education and consistency would help many aspects of the home health industry.

LOWER UTILIZATION PAYMENT ADJUSTERS (LUPA)

It was a wise incentive for initial LUPA episodes to receive fiscal enhancement, as compare to subsequent follow-up episodes that result in a LUPA situation.

SIGNIFICANT CHANGE IN CONDITION (SCIC)

I understand and agree with SCIC in the original PPS model, as it made good theory sense. Removing it at this time shows the volatility in patient status is less of an issue as compared to managing the patient status over time.

METHOD OF ACCOUNTING FOR NON-ROUTINE SUPPLIES (NRS)

No comment at this time.

OUTLIER PAYMENT ADJUSTORS

No comment at this time.

PUBLICALY REPORTED MEASURES OF HOME HEALTH.

I applaud the use and sharing of the publicly reported measures. I do wish the public and industry increase their utilization of this information. I trust education and transparency on the significance, impact, and trends of this information will become enhanced in the future. At this time, I see most providers not comfortable with how and factors affecting

the publicly reported measures. I realize this must frustrate people in your organization, but do see it as an education opportunity throughout the country.

CHANGES TO THE CASE MIX SYSTEM

I applaud the claims processing to automatically adjust for changes in therapy provided. This has been a challenge in the all or none mentality of MO 825 equal to ten or more therapy visits in a 60 day episode. The variety of therapy thresholds and time period is more challenging, so hopefully the automation will allow clinicians to focus on the patient and not be distracted by counting the visits!

Many of my peers in home care and outpatient settings would like to access and trust the Common Working File (CWF) for accurate and timely information. I do realize providers as well as patients may be difficult to reach or update information. Accessing an updated/maintained CWF would streamline patient access and updates to care.

In conclusion, I would like thank you for the excellent system and revisions. Thank you for the opportunity to comment, too!
Sincerely,

Roger A Herr, PT, MPA, COS-C
2921 10th Place West
Seattle, WA 98119
rahpt@msn.com
(206) 890-0878

Submitter : **Date: 06/25/2007**

Organization : **Celtic Healthcare**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-43-Attach-1.PDF

#413

CELTICHEALTHCARE

Corporate Headquarters
231 Crowe Avenue · PO Box 1179 · Mars, PA 16046-1179
Phone: 1-800-355-8894 · Fax: 1-800-931-4288

June 20, 2007

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

Submitted via electronic submission

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

On behalf of Celtic Healthcare, Inc., I would like to submit the following comments on the Home Health Prospective Payment System Refinement and Rate Update Proposed Rule (CY 2008). Celtic Healthcare, Inc. (Celtic) is a leading, regional home healthcare and rehabilitation services provider. Headquartered north of Pittsburgh, Pennsylvania, Celtic offers a comprehensive array of health-related services, including: Physical Therapy, Occupational Therapy, Speech/Language Pathology, Medical/Surgical Nursing, Mental Health Nursing, Medical Social Services, and additional services, through an integrated multi-organizational approach.

We appreciate the opportunity to provide feedback on the proposed rule recognizing the importance of refining the home health PPS and agree with many of the revisions found in the proposed PPS. We would like to offer the following comments for your consideration:

Negative impact of proposed implementation plans

We are concerned about the financial impact the implementation of this payment system, along with the payment reductions associated with the case mix creep adjustment and pending market basket cut, will have on our ability as a home health agency to provide the level of care needed for the communities and patients we serve.

We strongly urge CMS to consider implementing these new policies on a phased-in implementation schedule. These changes will result in significant clinical and financial implications to the payment system, home health agencies, beneficiaries and home health intermediaries. In addition, these proposed changes will require home health agencies and their health care providers to implement major operational changes to their everyday protocols. It is our fear that if these major changes are made to the system in one implementation phase, patients will be adversely affected due to limited access to home health care services. Also, as home health agencies and providers implement the new

system into their individual management programs and adjust business models to account for decreased payments will further hinder delivery of care.

Early and Late Episodes

We are pleased with the recognition of the different characteristics of patients and resource utilization in early versus late episodes of care. Our initial concern of the administrative burden of manually determining this data was answered when we learned that you plan to have the claims processing system automatically adjust final claims up or down. This is a great administrative burden relief for our agency and will allow our providers to focus on caring for our patients. Thank you.

Additional Therapy Thresholds

We support the proposed multiple therapy thresholds and the smoothing effect of the graduated payment methodology as proposed. We also would like to thank CMS for having 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 is great administrative burden relief for our agency and will allow our providers to focus on caring for our patients.

One concern we do have is the impact of changes made to the point allocation system for OASIS functional domains. Our analysis of current patients versus the proposed PPS has shown a significant reduction in resource allocation for most of our patients, specifically as it relates to their functional domain scores. Many of our patients reside in Assisted Living Facilities and have many functional deficits. Our concern is that the new Case Mix methodology is not capturing the appropriate points to allow for the necessary resources to provide an adequate number of therapy services for our patients.

Low-Utilization Payment Adjustments (LUPA)

We are pleased that CMS has recognized the significant financial loss involved with LUPA episodes and believe that the proposal to apply a LUPA add-on is a positive step toward righting this situation. We would ask that this policy be extended to adjacent LUPA episodes and would ask that LUPA episodes not be excluded from the medical supply payment.

Non-routine Medical Supplies

We see a number of costly non-routine medical supplies that are not reflected in the medical supply case-mix model. Some of these include: ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy) and supplies needed for closed chest drainage. We ask that CMS please recognize the need for these supplies for our patients and allocate the appropriate resources in order to afford us the ability to provide them to our patients.

Lastly, we would ask that CMS include the NRS payment for all LUPA episodes as we often find that our most common LUPA episodes are for our patients that require monthly urinary catheter changes and for many of our wound care patients who only require a few visits in order to teach the patient/caregivers to independently dress their wounds. It is already difficult to care for these patients, and we would not want to lose any additional resources.

Please also consider adding additional fields to MO240 to allow for multiple diagnoses that may be needed in order to capture the appropriate NRS resources.

Case Mix Creep Adjustment

In this proposed rule, CMS states that based upon review of trends in the national average case-mix index (CMI), the Agency is proposing an additional adjustment to the HH PPS national standardized rate to account for case-mix upcoding that is not due to change in the underlying health status of the home health beneficiary. We disagree with this assumption and would like to offer the following information in support:

- In the proposed rule, CMS does acknowledge that changes in payment (such as during the Home Health Interim Payment System) have resulted in significant changes in the type of patient admitted to home care. Specifically cited are long-term and the venipuncture patient populations, as well as the trend for decreased nursing and home health aide focus and services. We assert that based on these assumptions, even if the level of therapy services stayed the same, the overall percentage of therapy services for that particular home health patient would increase due the decrease in other home health disciplines. Thus, we ask that CMS note that the proportional increase in therapy services is due to both a decrease in other services and the underutilization of therapy services in past episodes of care prior to PPS.
- We strongly urge CMS not to solely base conclusions that an increase of therapy services is due to inappropriate use of services because it coincides with a financial incentive. Although we recognize this incentive exists and that changes are warranted, it should also be noted that there are other factors for CMS to consider when analyzing the CMI.
    - Therapists in the home health setting have become very efficient in their use of OASIS.
    - Therapists (Physical Therapists in particular) have learned to collaborate with their nursing colleagues to ensure that their OASIS data collection processes best describe and reflect the condition of the patient. Many home health agencies, including ours, have realized the importance of the therapists when assessing the patient, and as a result, have invited therapists in their agencies to be involved in staff education so that assessment strategies can be shared among all disciplines in home health.
    - CMS's own efforts to educate on accurate OASIS assessment strategies since the initiation of PPS have attributed to the home health community's increased accuracy in coding and use of the OASIS assessment tool.

- The increased involvement of therapists into home health agency operations has enhanced the functional component of the comprehensive assessment through gathering observational data and considering safety factors in determining patient ability to carry out Activities of Daily and Individual Activities of Daily Living (ADL/IADL). As a result of this more collaborative and critical assessment, the Home Health Resource Groups (HHRG) tend to be higher and more accurate than pre-PPS OASIS data, thus affecting the case-mix weights. We believe that this improved accuracy and educational outreach has, in large part, led to the coding behavior changes that CMS discusses in this proposed rule.

- Finally, we would ask that CMS provide a comprehensive rationale in the final rule of how the conclusion that a change in coding behavior was largely due to abusive practices and the delivery of inappropriate therapy services was formed. This rationale should consider and account for other factors besides financial incentives, such as national improvement of patient quality outcomes over the past few years in the home health setting, changes in average length of stay and the overall increased focus that has evolved around rehabilitation as a primary goal in the home care setting.

Access to Healthcare Providers

It is becoming increasingly difficult for us as a home health agency to compete with hospitals, nursing homes and other health care settings for the ever-decreasing supply of health care providers. As such, we would like ask that CMS replace its home health wage index policy with a method that achieves parity with hospitals in the same geographic market. In addition, we would like to re-iterate our initial points for CMS to consider the negative financial impact the implementation of this proposed rule will have on our ability to attract and retain the health care providers needed to care for our patients.

In conclusion, we thank you for the opportunity to comment on the Home Health Prospective Payment System Refinement and look forward to further refinements as outlined in our comments above. If you have any questions regarding our comments, please contact Kurt Baumgartel, Chief Operating Officer, at (724) 625-4280 or baumgartelk@celtichealthcare.com .

Respectfully submitted,

Kurt M Baumgartel

Kurt Baumgartel, MPT
Chief Operating Officer
June 20, 2007

Submitter : Mrs. N. JEAN BURGENER **Date:** 06/25/2007

Organization : ASPIRUS VNA HOME HEALTH

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

[redacted]
44

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

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

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

Submitter : **Debra Pletta** **Date: 06/25/2007**

Organization : **Stanley Jones and Associates**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

This letter is writtien on behalf of Stanley Jones and Associates whose purpose is to serve clients in the most cost-effecitive manner and to bring about the most positive outcomes and functional improvement. I have some concerns regarding the proposed rule changes. My first concern, is regarding Medicare's recently proposed changes to PPS which incorporates a pressumption 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. We believe that the CMS proposal assumes that all of the increases in the 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 patient assesments to garner higher payment for their agency. More realistically, the increase reflects the changing demographic of home care's patient population, more intense staff training on OASIS which overall has resulted in more accurate OASIS answers.

Today, home care patients are older and more frail, with a significant number of patients being over the age of 80. The intensity of services they require has increased due in part to hospitals DRG policy changes leading to decreased length of stay and changes in Inpatient Rehab Facility reimbursement has steered more sicker patients into home health services.

As a provider, it is noted that over the past 10 years, Medicare home health benefit has been cut nearly evedry year. Once comprising 8.7 percent of Medicare spending, today it is at 3.2 percent and is projected to drop to 2.6 percent by 2015. You do not see this kind of cut in other areas such as education, transportation ot in our armed forces. Given our growing population of elderly and disabled,the propsed cuts to the home health benefit will only prove to be "penny wise and pound foolish" It is unrealistic to plan a three year reduction given the future need of more home health care services.

I believe that CMS should suspend its plan to cut home health payment rates based on unfounded allegation of case mix creep.

The second concern is how CMS has placed the responsibilty of providers to identify whether or not the final claim is a early or a late episode. As a provider I have learned NOT to rely on the Common Working File to determine whether or not a client had care from another provider within the past 60 days. It is a unreliable source because many providers or facilities have not submitted a claim. Thus the information found on the CWF is not up to date. With the new proposal CMS is indicating they will be able to automatically adjust final claims to reflect the therapy change, why can't they also adjust the final claim to accurately reflect whether or not the episode is an early or a late episode.

Thank you for allowing me to make comments regarding the proposal.

Debra Pletta, RN
Case Manager

Submitter : **Ms. Cindy Osborne** **Date: 06/25/2007**

Organization : **St.Louis Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

Background

Background

BACKGROUND

Page 25357 references Section 1895{b} [3](a) the computation of the standardized PPS amount is based on the most recent audited cost report data available to the Secretary . The latest cost report information would be 2006 (or 2005 if 2006 has not been audited yet), on page 25358 it is stated Abt used data from 2001 and 2004. The validity of these reports for ascertaining costs is questionable. The QIO s did not begin to instruct agencies on accurate OASIS assessment until 2003. The OASIS instruction manual was revised in June 2006, projection of costs using no longer relevant data does agencies a disservice. Many agencies did not realize the importance of including supplies on cost reports. Information gathered from material in this time period is not a reliable reflection of the costs of providing care to patients.

Section 1895 (b)(5) total outlier payments may not exceed 5% of total projected payments. Why set aside 130 million dollars just in case ? Put 100 million back into the market basket and set aside 30 million for outliers (which were only 3% of PPS payments as stated on page 25434).

This proposal may achieve a more appropriate compensation for agencies but it in no way maintains an appropriate degree of operational simplicity . Which is the stated purpose of the proposal.

We agree any specific agency that does not submit quality data should experience a 2% decrease in their market basket.

Submitter : Mrs. N JEAN BURGENER **Date:** 06/25/2007

Organization : ASPIRUS VNA HOME HEALTH

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1541-P-47-Attach-1.DOC

#49.

June 20, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1541-P,
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Dear Mr. Kuhn:

I am writing on behalf of Aspirus VNA to comment on: Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P).

The 3-year cut in payments which has been proposed to account for CMS' estimate of nominal case mix increase since the inception of the PPS program will create tremendous hardship for our agency. This decrease will compromise our ability to maintain and increase access to cost-effective alternatives to institutional care and, in our view, is totally unjustified.

I am pleased with most changes in the case mix scoring methodology but disappointed that two variables important to determining resource use in home health have been deliberately excluded by CMS from the payment algorithm, specifically: Medicaid dual eligibility status and absence of informal caregivers.

We strongly support the elimination of the M0175 variable, the elimination of the single therapy cap , the expanded use of V-codes, adoption of higher case mix weights for third and subsequent episodes of care, the change in LUPA payments, and the change in non-routine medical supplies . With respect to the expanded use of V-codes we find the double code requirement inefficient and burdensome. With respect to therapy reimbursement the incremental caps need to be adjusted to assure that patient care is not compromised.

I am most disappointed and concerned about CMS' intention to cut 2.75% off of PPS payments for the next 3-years to adjust payment for nominal case mix growth or case mix "creep." I believe that CMS has not made a strong case for the existence of nominal growth nor has it made a credible estimate of the extent of such growth.

I believe that these proposed cuts to Medicare Home Health payments are unreasonable. The direction of our health care system is to provide services outside of hospitals and nursing homes. This requires that patient with health care needs are cared for by Home Health. These are sicker patients, which alone would account for higher scored OASIS assessments. This is not manipulation of the assessment process. It is,

however, a positive response to your focus of decreasing inpatient care in both hospitals and nursing homes. Our agency is a rural health provider. Should the proposed cuts become reality, rural access to home health care will be at risk as this is our most costly patient who does not fit into the urban productivity model.

Thank you for the opportunity to comment on these proposed rules.

Sincerely,

Jean Burgener
Vice President
Aspirus Extended Services

CC: Senator Feingold
Senator Kohl
Representative Obey

Submitter : Mrs. Cindy Osborne **Date:** 06/25/2007

Organization : St. Louis Home Health

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

OASIS REPORTING- Discussion regarding the accuracy of OASIS assessments and controversy about instruction manual updates. New instruction regarding surgical wounds, reverse staging pressure ulcers, incontinence on and on. Teaching and re-teaching clinicians does not immediately change old habits! If taught a Stage 2 pressure ulcer is always a Stage 2 pressure ulcer for years, that education does not just go away because you are now a home health care provider. ADLs (functional items on the OASIS) are a large part of the reimbursement equation in PPS it would be the smart thing to do to have a professional trained in assessing that aspect of a patient s abilities. Yet, the antiquated CoPs demand an RN must complete the initial (OASIS) assessment if there are any nursing indicators, because only the RN is qualified to determine if the patient qualifies for the home health benefit! Since when is an ADN RN better able to determine a patient is homebound over a Masters prepared therapist??? Due to the current and recurrent nursing shortage this Cop does not reflect the home health agencies of today. Many home health patients reason for home health is rehab, with the RN in a supportive role (protimes, staples) of the therapist; the patient s rehab needs cannot be met until an RN can be scheduled to determine this patient is homebound. This Cop prohibits agencies from meeting the needs of patients and creates staffing nightmares. We are asking for a reconsideration of the Cop 484.30 that requires a Medicare patient must be seen first by a nurse. Allow the appropriate professional to determine the patient s eligibility for home health benefit and appropriateness for home health care based on the patient s health needs.
Another OASIS requirement is the clinician completing the assessment must provide the Diagnoses in MO230, MO240, MO246. There is no way a field clinician can complete the new Diagnosis page. This will add the cost of hiring coders to accurately code each OASIS.
CMS has indicated in the past a willingness to improve the OASIS assessment. In June 2006 there were new instructions for many of the items previously mentioned. Why not revise the MO questions that were addressed in the updated instructions? Why not remove b. transfer into the tub/shower from MO670 since the clinician is not supposed to include that in the assessment? Why not clarify MO700 so a patient who improves from a walker to a cane can show improvement in ambulation?
HOME HEALTH QUALITY IMPROVEMENT- Publicly reporting Emergent care for wound infections does a disservice to every home health care provider. The Adverse Event listings are POTENTIAL adverse events. This list is available to state surveyors and the agency to investigate each case and determine if the agency acted in the best interest of the patient. In most cases the agency did everything right and the patient had a wound infection prior to admission to the agency. Post surgical patients occasionally have UTI s due to indwelling catheters while hospitalized, but don t develop symptoms until after admission to the home health agency. Should this be a penalty for the home health agency?
Home health agencies that want to lead the industry in providing the best health care a patient may encounter during their episode of illness are challenged every day by lack of and overworked staff, high energy prices, costs of keeping up with technology and educating/orienting staff. To take away from an industry that provides a vital service to this country s most vulnerable population clearly demonstrates the priorities of our leaders. The home health industry has the potential to keep people out of facilities, to keep families together, to provide wellness education and be an important ally in the Medicare prevention program. We are your most cost effective program-where can a patient get 60 days of care for less than $3000?

Provisions of the Proposed Rule

Provisions of the Proposed Rule

PROVISIONS OF THE PROPOSED REGULATIONS:

The inclusion of an Unknown answer for Early vs. later episodes and designating those unknowns to early episodes sets the same stage as the original PPS high vs. low therapy question. Some agencies answered high therapy knowing there would be payment reconciliation after the episode. Some agencies may answer this question as later if it is not known anticipating the payment will be adjusted down after the episode. This seems to be exchanging one problem for another, if this information is available in the CWF why have an unknown option? The CWF must be current, accurate and updated timely.

Coding-We like the use of all the diagnoses to describe the complexity of the patient s condition. V codes accurately describe our post joint replacement patients (>90% of our patients). There remains confusion regarding the use of V codes, do we use medical codes so we are paid appropriately or do we use V codes which better describe our services and don t displace a medical code? This is another example of the learning curve, such as occurred at the inception of PPS. Data derived after the use of V codes is not reliable data and if you are basing payment on coding you are correct to go back to 2003.

CASE MIX CREEP-The reasoning behind the 8.7% reduction in the base rate assumes that all agencies up coded for inappropriate reimbursement since the inception of PPS. It is possible that some agencies felt it necessary to game the system, it is also possible that many more agencies did not understand the PPS system and as they were instructed by QIO s in the proper use of the OASIS assessment tool a more accurate reimbursement was achieved. You use data derived from MO175 (which you propose not to use after 2008 because the information derived is not worth the administrativc overhead) to state on page 25396 that patients from a facility other than a hospital in the past 14 day period with less than 10 therapy grew by 25% and an increase of 64% for patients with more than 10 therapy visits. This is very important statistical information! A patient that was in rehab or a skilled facility for that long is indicative of a patient in need of a lot of resources! That patient is at higher risk for skin breakdown and generalized debilitation. If the CWF problems are addressed this information is a very good indicator.

Submitter : Ms. Gwen Toney **Date:** 06/25/2007

Organization : Ohio Home Care Organization/Ohio Hospice and Palli

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1541-P-49-Attach-1.DOC

#49

Ohio Home Care Organization

Ohio Hospice & Palliative Care Organization

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

June 25, 2007

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

To Whom It May Concern:

The Ohio Home Care Organization (OHCO), a division of the Ohio Hospice and Palliative Care Organization, is an advocacy organization representing home care agencies in Ohio and the Ohioans for which they care. This letter is to provide comments on the rule published in the May 4, 2007 Federal Register.

OHCO has observed that while Medicare is recommending severe changes to many of the provider payments systems, the state departments for Medicaid are rapidly moving toward consumer-directed care, in which the "consumers" will have the ability to train caregivers to their needs without the encumbrance of outcome-based or best practice regulations that are required of more formalized medical care. The federal and state governments are of the opinion that this type of care will prove more economic than other care available today. The governments, state and federal, continue to increase the requirements for traditional providers, driving up the cost of care and making it almost impossible for them to be competitive in the marketplace with the same finite personnel.

The majority of home care providers are small businesses, straining to cope with the continual onslaught of regulations, payment changes, and assessment requirements for which little relief is in sight. With these reflections in mind, OHCO provides these comments regarding the proposed refinements to the Home Health Prospective Payment System.

CASE-MIX CHANGES:

Medicaid Eligibility and Caregiver Access:

Home Care agencies often do not identify Medicaid patients when Medicare is the primary payer. The result of this is that Medicaid is underreported on the OASIS

assessments. OHCO believes the analysis conducted by CMS reporting that concluded that Medicaid does not have an impact on resource use is unreliable. The caregiver questions on the OASIS document do not provide objective information. Our providers, many of whom have been in health care since the Medicare program began, know that Medicaid patients often have few or no family members to provide support.

Suggestion:

Any analysis should be based on state Medicaid data that provides information on all care provided to these vulnerable individuals. This data should be compared to the data on patients that are not receiving Medicaid so a true comparison on resource utilization may be made.

OASIS questions should be revised to collect more detailed information on the true availability of caregivers and the time that they provide assistance on a daily basis.

DIAGNOSIS CODING:

With the implementation of HIPAA, home care was required to use exact ICD-9 coding conventions. Home care had used V-codes previously, but those codes were removed with the advent of OASIS. Later, CMS realized V-codes would be required due to HIPAA and instructed agencies to begin using them again. Since most agencies are small business, the billers and/or nurses began going to coding classes to try to understand the minutiae of coding.

V-codes made up only 1,000 patient diagnoses in 2001, according to CMS' Medicare Decision Support Access Facility. In 2004, 40 percent of claims now used V-Code diagnosis. These patients have multiple co-morbidities that are not reflected by using V-codes. ICD-9 codes resulted out of acute hospital care and instructions for agencies to use these V-codes has resulted in minimizing the severity of the medical conditions of patients home care agencies see on a daily basis.

To base the diagnosis coding on 2005 data is unsound. Home care coding has drastically changed since 2005. OHCO intuits that if CMS provides additional instructions to agencies and with the proposed expanded diagnosis listing, it will see more accurate coding that reflects the acuity of home care patients' medical issues.

Suggestion:

If CMS proceeds with the proposed changes, it must supply more detailed coding instructions and support that will enable the agencies to correctly code the claims and provide CMS with a more realistic understanding of the multitude of complex patients that are cared for in the home.

EARLY AND LATE EPISODES:

Home care has cared for the chronically ill since the inception of the Medicare home care program. The proposed change that reflects the requirements of long-term patients is appreciated. It is a welcome relief that CMS is planning on the FISS program to automatically adjust the claims up or down based on the CWF information. OHCO is pleased that the burden will not be placed on the agencies.

THERAPY THRESHOLDS:

OHCO has calculated the difference in therapy payments with the elimination of the points for two of the three therapy equations. Patients with ambulatory deficits (M0700) receive no points in two of the calculations and result in the loss of thousands of dollars even when the patients require 14 or more therapy visits. It is mystifying how CMS arrived at this decision.

Suggestion:

Please identify the rationale with which this decision was made. If the individual needs 14 or more therapy visits, that indicates a high functional need. Although the system will adjust the payments up and down, alleviating the necessity of the provider to track and adjust the claims, the extreme reduction in payment is not an equitable trade.

LUPAs (Low-Utilization Payment Adjustments)

OHCO commends CMS for realizing that LUPA episodes are more expensive and for increasing the reimbursement for the first LUPA episode to compensate for that cost. OHCO is concerned that CMS proposes not to include continuing LUPA episodes with the additional money. Many of the long-term chronically ill patients, such as catheter patients, require only two or three visits per episode. This means that an un-billable visit must be made in order to perform the OASIS assessment within the prescribed time frame. Since Medicare does not collect un-billable visit data, the cost of additional LUPA episodes is underrepresented.

OHCO is also concerned that supplies are not included in the LUPA episodes. With the example of catheter patients, these individuals require non-routine supplies regularly. If that person has a colostomy, the agency is responsible for all those supplies, regardless of the fact the colostomy plays no role in the current care.

The federal register was not definitive on how the adjacent episodes are decided. Rumors are that the LUPA continuing episode will look at claims where the SOC is the same as the "from" date.

Suggestion:

All LUPA episodes should include the additional $92.63. CMS should clarify how an adjacent episode will be established.

NON-ROUTINE MEDICAL SUPPLIES:

OHCO was distressed with the revelation that only 10 percent of agencies accounted for non-routine supplies on the claims and cost reports. Because agencies are often small businesses with few administrative staff, tracking and accounting for supplies is a time consuming and burdensome endeavor. After a change to the PPS, many agencies decided to abandon accounting for non-routine supplies since it was a herculean effort and it did not, they thought, impact payments.

According to our members, supplies represent a substantial cost. The types of supplies utilized and not represented in the case-mix model are: tracheostomy, nephrosotomy, ureterostomy, urethrostomy, and gastrostomy. Additionally, a supply that was previously not available in the home setting is the closed chest drains (Pleurex). This supply item is extremely costly and is not included in case mix non-routine supply information.

Wound care protocols are changed whenever it is needed to continue aggressive care to heal the wound as effectively and efficiently as possible. If these visits result in LUPA episodes, changes that occur after the initial OASIS submission will not be captured. This uncollected medical supply cost could dissuade a provider from teaching the family or caregiver, since a full-episode will allow coverage of the supplies.

Suggestion:

There are no OASIS items that provide for gathering documentation for other ostomies from V44.0 through V44.9, other artificial openings requiring attention. OHCO would request that patients with these codes be allocated additional points to cover the required resources and add the Pleurex closed chest drainage system to the non-routine supplies.

OHCO doubts the reliability of the proposed case-mix non-routine supply model and request that this proposed rule be eliminated until further data is collected.

CASE-MIX WEIGHT ADJUSTMENT:

CMS proposes to decrease payment rates by 2.75 percent from 2008 through 2010. CMS rationale is based on what they state is "case-mix creep". OHCO considers this to be based on a faulty theory. According to the OASIS outcome data, this change in patient characteristics is supported by the OASIS data and we believe more accurate completion of the OASIS assessments. It is surprising that CMS designed the OASIS using the clinical, functional, and service domains because it did provide patient characteristics and now has changed its mind and no longer feels that the 10 or more therapy visits identifies patient characteristics. CMS predicted that there would be an

increase in severity of patients from 1999 through 2003. That is exactly what happened and is reflected in the HHRG score changing from a C2 to a C3.

It defies logic that CMS would deduce that the patient characteristics changes were totally due to policy clarifications, provider training, and/or other factors not related to home care services. Medicare changed the rules for inpatient rehabilitation facilities making them more stringent. The results of these changes were an increase in patients referred to home care. Because of policy changes that predicated the decrease in rehab facilities admissions, the rates of home care admissions increased.

Another indication of the increase in acuity of home care patients is CMS' implementation of the transfer DRG imposed upon hospitals. This policy change reflected CMS' concern that patients were being discharged to home care too soon.

CMS recognized in the proposed rules that the numbers of patients discharged from SNFs denote a variation different than hospital discharged patients. It was acknowledged that these individuals require more care.

The data available for 2000 to 2003 shows that the care of patients' aged over 85 increased to 27 percent from 23 per cent. During this period of time, agencies changed how they cared for patients to demonstrate better patient outcomes. Home care pursued assisting patients to become more independent and self sufficient, and that required more physical and occupational therapy. Clinical and functional outcomes improvements resulted, and length of stays were decreased. That was the anticipated goal.

Another factor influencing the increased severity of home care patients' medical conditions is the encouragement of CMS for patients to join the Medicare Advantage plans. These people are in better health and require less care, leaving the high cost patients in traditional Medicare. Even with home care providing care for the sickest individuals, the annual expenditure dropped between 2001 and 2003 by over $300.00. This means that home care Medicare expenditures were controlled during this period. Contrast that with the increase in per patient inpatient hospital costs and SNF costs that increased $1443.00 and $448.00 respectively.

CMS' designed a program that encouraged providers to change practices by using more therapy and this resulted in positive outcomes for patients and decreased home care costs for Medicare. It logically follows that decreasing therapy use in home care by decreasing payments by 2.75 per cent for three years will lead to the consequence of increased patient and Medicare costs.

Suggestion:

OHCO recommends that CMS not diminish the base payment for home care agencies for the next three years. CMS should incorporate in any analysis factors such as: changes in per patient annual expenditures and changes to the Medicare system that drive patients from one provider setting to another that results in less cost to the overall system.

WAGE INDEX:

In the proposed rules, CMS continues the practice of using the pre-rural floor, pre-classified hospital wage index to adjust home care services. It is difficult to understand why this policy should be renewed. Hospitals have many ways to re-classify themselves. Home care faces the same market, personnel, and costs implications experienced by these providers and we must travel to each and every patient. OHCO protests the continuance of these archaic wage index calculations.

Suggestion:

CMS should develop a methodology that promotes equity between different provider types in the same geographic area. It is necessary to alleviate the volatility of the wage index by using rural floor standard. MedPAC recommended the BLS/Census Bureau method for calculating wage indices and we concur.

OUTLIER PAYMENTS:

CMS intends to continue with the existing .67 fixed dollar loss (FDL) ratio. When PPS began it was estimated that home care would use a 5 per cent outlier budget. Home care has never used the complete outlier budget since the implementation of PPS. How can CMS predict that home care will consume an added $130 million in these payments when home care has failed to meet the expenditure based on this method since PPS started?

Suggestion:

CMS should adjust its technique on calculating the FDL by using its historical data on actual outlays.

CONCLUSION:

While the homecare industry appreciates the recommended improvements to HHPPS, OHCO remains apprehensive about many of the proposed rules and question many of the premises on which these rules are based. OHCO trusts that CMS will consider the included suggestions and make further changes prior to filing the final rules. OHCO values the opportunity to provide feedback.

Sincerely,

Gwen Toney
VP of Government Affairs
Ohio Home Care Organization/Ohio Hospice and Palliative Care Organization
555 Metro Place North, Suite 650
Dublin, OH 43017
Ph. 614-763-0036 Ext. 202
Fax. 614-763-0050

Submitter : La Donna Blom-Antonio **Date:** 06/25/2007

Organization : Adventist Health System

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

The Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 is a comprehensive change that among other items provides new Codes, new OASIS items, expands HHRGs from 80 to 153, adds a new element of early and later episodes and adds new therapy utilization steps. These elements increase the complexity of home health administration and do not demonstrate the spirit of operational simplicity referenced in the background. The challenge of the complexity is exacerbated by the short time frame to implement the change.

Collection of Information

Collection of Information

The complexity of the change is impacted by the time frame to implement the change, January 1, 2008. The tools that are available in the industry give varying results and even the CMS Toy did not provide enough digits in the codes to effectively capture the degree of change needed and each case had to be added individually which was a huge task and then the results are confusing. The comment period has not provided adequate time for us to effectively know the impact of the change. At best it is an environment of educated guesses.

The magnitude of the change and confusing variation of results from modeling tools puts us in an environment of not being able to plan well. With final rules scheduled for October 2007 that leaves such little time to assimilate an effective change process by January 2008.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

HH PPS

It seems that the 2.75% cut is a subjective decision. The implementation of OASIS initially was a huge challenge to the industry. It takes years to develop the accuracy in assessment skills and coding to adequately reflect the condition of the patient. To assume this is "coding creep" is erroneous when we continue to get sicker patients. It was a healthy change to move from direct care provision of personal care to a teaching/rehabilitation focus to improve a patient and family's ability to attain optimum independence in daily life health needs. To propose this amount of change that has negative financial impact and also essentially remove the inflation index is a significant negative impact.

Another trend in our internal company modeling demonstrates that the smaller rural agencies are disadvantaged by the change. From our internal analysis an agency that does not have 12.5% of therapy episodes reaching 14 visits are again losing reimbursement. Rural areas do not have as much access to recruiting therapists. Some agencies are more creative in working with their patients through various technologies that do not necessarily equate to home visits, but do have costs attached i.e. physician portal and telehealth.

We are trying to make strategic plans for what business and payers we should be in and are concerned about being able to take the losses of Medicaid payments in many states along with uncertain Medicare reimbursement changes.

REFINEMENTS TO THE CASE-MIX MODEL 2A ANALYSIS OF LATER EPISODES

There is poor alignment of incentives in this refinement plan. In our health system an agency that exceeds all of the Home Health Compare national scores is one of the most negatively impacted by the change. Those that efficiently met patient s needs in a superior manner with quality and efficiency are losing reimbursement. The refinement proposing early and late episodes may actually encourage agencies to extend the length of stay of patients and be motivated to provide more care. This misalignment seems to create an environment that could encourage less efficient and effective care.

It is challenging to once again be searching for information for a time period other than the care we have or are providing. It would be nice for CMS to just provide the knowledge about whether the episode is early or later. This will add to the cost of every episode to do this investigation. The Common Working File is not current enough and does not provide data back far enough to adequately capture information to complete the OASIS properly to designate early or later episodes.

LUPA ADJUSTMENTS, 5

LUPA add-on for non-routine supplies should apply to all of the adjacent LUPA episodes and not merely the first one. Many LUPA circumstances are related to treatments i.e. catheter changes that have expensive non-routine supplies.

NON-ROUTINE MEDICAL SUPPLIES, 7

Payment for non-routine supplies has improved, but more help is needed. There are expensive ostomy supplies not included in the case mix and the industry is grappling with an efficient mechanism to consistently capture the supplies used. The usage of supplies is under reported and some of the more expensive supplies are not included in the non-routine rate calculation.

Submitter : **Date: 06/25/2007**

Organization :

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

1). Early/late episodes. The increase payment for later episodes (third and beyond) should be calculated by the Common Working File, not by agencies. There are many situations where the current agency may not have this information.
This item lends itself to the identical problems encountered with the MO175 OASIS item. If the CWF is not always current or updated timely, there will be incorrect payments. This will not be the fault of the agency. Given this, CMS should automatically correct an agency's response if it was not known that this was a third or later episode.
2) The premise behind the "case mix creep" is incorrect and will financially penalize agencies for having become educated on how to correctly perform icd-9 coding. This was an area, that when PPS became effective, home health was ignorant. Our coding is now correct when submitted. In fact, our agency does not have coding situations where the higher case mix is due to diagnosis coding. However, we are seeing sicker patients and our avg case mix has increased since the initial PPS. We have added specialty programs and have seen a much more high tech population than that of several years ago. This increase in acuity is not related to coding or "case mix creep" but related to the acutely ill patients with high tech needs we take care of!
CMS needs to not penalize agencies by 8.7% for the increasingly complex clientelle we provide services to.
Recent data shows the current PPS system is only 21% accurate in matching PPS payments to costs incurred by agencies. This has lead to our agency continuing to run a deficit for providing care in our rural area. I have to compete with hospitals, a veteran's home, a college town with a much higher CBSA than our area and can not afford the wages it takes to attract and retain professional and aide staff. Mileage in our rural area is another taxing issue. Our staff can spend over 1.5 hours a day driving to visits. To remain competitive, we reimburse the IRS maximum. Payments to home care agencies do not adequately fund this unavoidable expense.
Rural home health agencies need to receive the full reimbursement updates, including the 8.7% proposed to be cut
3) The LUPA add-on of $92.63 is an excellent recognition of the costs related to LUPA cases. However, LUPA patients who experience a recertification are costly and the rates do not adequately reimburse this expense. For example, the majority of our LUPA patients are catheter changes and ostomy changes. The cost of the supplies is already an unreimbursed expense to the agency. If the catheter or ostomy change does not fall in the 5 day recertification window, the nurse must make another visit that is not reimbursed to do the recertification assessment and comprehensive med review. This cost of the visit needs to be covered by CMS.

Submitter : Pam Tidwell **Date:** 06/25/2007

Organization : CarePartners-Home Health

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

Mo826. Changing to a distinct number of therapy visit will exacerbate the chaos around "coordinating care" Today, COPs require a RN to complete a start of care OASIS - even if therapy is the primary provider. Changing COPs to allow therapy to open a case would improve the ability to accurately project therapy requirements for patients.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Our patient population certainly support shift in case mix. In 2003 we added a strong disease management structure focused on cardiac, wound and orthopedic patient care. These program have improved access to home health. This could have increase our case mix.. The greater impact on Case Mix is to our diligent OASIS and coding education. I do not think patients changed - we changed to comply with CMS directives.

Early/Late Episodes of Care
The devil is in the detail. I do concur that costs are greater with our on-going patients. To simplify the distinction of early and late. Classify early as the 1st episode; all others are late. This may make research the CWF simplier. Additionally, the CWF must have timely information to be able to classify accurately.

Submitter : **Date: 06/25/2007**

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-53-Attach-1.DOC

#53

IOWA HEALTH SYSTEM

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June 26, 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:

Iowa Health System (IHS) 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 IHS affiliates. 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.

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. Iowa Hospital Association (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. **IHS 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 IHS affiliates 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. IHS appreciates CMS' efforts to release this proposed rule well in advance of the required time frame for public consideration. However, IHS 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, IHS affiliates are unable to plan operationally and financially for these vast changes. **CMS should release the impact file and extend the public comment period 60-days**, thereby allowing IHS and other providers 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. IHS affiliates are committed to providing the highest quality of care to their patients by ensuring patients receive the most appropriate care at the 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 (515) 362-5186 or charticr@ihs.org.

Sincerely,

Cristine Chartier
Senior Reimbursement Analyst

Submitter : Valerie Edison **Date:** 06/25/2007

Organization : Iowa Health Home Care

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

I am attaching my comments for CMS -1541-P on the Home Health Prospective Payment System Refinement and Rate update for Calendar year 2008

CMS-1541-P-54-Attach-1.DOC

#54

6/25/07

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

I welcome the opportunity to comment on the proposed changes to the PPS system for 2008. Many of the changes are positive such as the removal of M0175 from the case mix weight, the addition of key diagnoses to case mix weight, and the removal of SCIC adjustments. However there are some issues of significant concern. Some of the excerpts have come from our National Association for Home Care comments. I have added situations that apply to our organization, comments and recommendations.

Comments

Provisions of the Proposed Regulation

Diagnosis Codes

CMS plans to revisit the diagnosis codes found in the proposed rule, and consider revising them based on 2005 data. Major changes have occurred in home health diagnosis coding practices since the implementation of Health Insurance Portability and Accountability Act (HIPAA) requiring compliance with official coding guidelines, including ICD-9-CM codes. As a result of HIPAA changes there has been a great deal of confusion on the part of home health agencies about correct diagnosis coding, particularly the proper use of V codes.

One case-mix diagnosis was noted to be missing. Table 2b does not reflect the changes made to the 2005 official ICD-9-CM coding index which eliminated 436 (acute but ill-defined cerebrovascular disease) and added 434.91 (cerebral artery occlusion unspecified with cerebral infarction). This is the most appropriate code for many stroke patients.

Recommendation

Remove the ICD-9-CM code 436 from the list of case-mix diagnosis codes. Add ICD-9-CM code 434.91 code in accord with current diagnosis coding guidelines.

Analysis of Later Episodes

It is essential to have the claims processing system automatically adjust final claims to reflect correct responses to early/late episodes, both upward and downward based on information in the common working file (CWF). This action will alleviate the burden on home health agencies that would otherwise exist if they had to conduct ongoing monitoring of the CWF for adjacent episodes and withdraw and resubmit a revised claim should an error be discovered.

Additional Therapy Thresholds

Please evaluate 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. Nor are points allocated for the gait disorder diagnosis in 14 plus therapy visit equations.

With the addition of multiple payment tiers based on therapy usage, a problem has been identified for beneficiary notification of their financial obligation to pay for home health services. Many beneficiaries are now enrolled in Medicare replacement plans that require a co-pay on the episodic rate. The Conditions of Participation 484.10 require the home health agency to notify the patient in advance of their liability for payment. Some consideration needs to be made about the obligations of home health agencies to meet this requirement. It is virtually impossible to calculate the rate and provide notices of the changing rate (which changes with practically each therapy visit made) prior to providing service.

Recommendation

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. Construct the case-mix system in accord with findings.

Conduct analysis on the COP requirement for giving advance notice and waive the requirement for Medicare plans that have a co-pay.

Low-Utilization Payment Adjustments (LUPA)

The LUPA add-on is a positive step toward ensuring adequate payment for LUPA episodes. However, this policy should also be extended to adjacent LUPA episodes.

The administrative costs for doing a recertification OASIS and plan of care are still present at recertification. As a result of treatment timing, home health agency clinicians often must make an additional, non-chargeable visit for the sole purpose of completing an OASIS follow-up assessment in the required 5-day window. The costs for these visits are

not captured in the Medicare claims data since agencies are prohibited from billing Medicare for assessment only visits.

There are also concerns about the proposal to exclude LUPA episodes from the medical supply payment. Many of the LUPA cases are catheter and wound patients, resulting in numerous supply charges.

Recommendation

Apply the LUPA add-on to all LUPA episodes.

If the patient has catheter marked (response 2) in M0 520, devise a fair payment for 2 sets of catheter supplies. In addition for all the wound diagnoses identified in Tables 12a and b, provide for a wound care supply add on.

Non-routine Medical Supplies

There are a number of costly non-routine medical supplies that are not reflected in the medical supply case-mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that made their appearance on the home care scene after the start of PPS are those supplies needed for 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.

There is no mechanism to account for supply needs that surface after the initial start of care assessment has been completed. This could result in grossly inadequate payment.

LUPA episodes regardless of when they occur can have high supply costs. As mentioned earlier, the most common medical supplies needed in LUPA episodes are those for patients that require urinary catheter changes. Wound care supply needs are also commonly used in LUPA cases. The recommendations are listed above in the LUPA episode section.

More consideration needs to be given to skin conditions and the point value assigned based on whether it is the primary diagnosis or secondary. The obligation to provide wound care supplies is constant whether the diagnosis is primary or not. For example, on table 12a, 19 points are provided for an anal fissure, fistula and abscess if it is a primary diagnosis, however if it is not primary, only 8 points are awarded. Many patients have co-morbidities and the wound may not be the primary reason for home care, however all wound care needs are met and costly supplies are provided.

Recommendation

In light of the fact that there are no other OASIS items that will lend themselves to predicting non-routine supply use, give consideration to additional diagnosis codes that might meet this need. Consider including secondary (other) diagnoses of V44.0 through V44.9, Artificial Opening Status requiring attention or management, to identify patients needing supplies for other ostomies.

Either add pleural effusion as a supply case-mix diagnosis to capture those episodes during which chest drainage supplies are provided, or reclassify chest drainage catheters and valves as prosthetic devices, thereby capturing the payment for related supplies under that benefit.

Once a more reliable supply case-mix model has been created, include payment for non-routine medical supplies for all episodes, including LUPA episodes that are not final episodes of care.

Raise the point value in the NRS Case-Mix adjustment table for skin conditions in other diagnosis to be more in line with the primary diagnosis scores. Supply use is the same.

CASE MIX WEIGHT ADJUSTMENT

CMS concluded that the change between 1999 and 2003 (1.13 to 1.233) of 8.7% is an increase without any relation to changes in patient characteristics. As a result, CMS proposes to adjust the base payment rate by 2.75% for each of the 3 upcoming years to prevent expenditure increases that are due to factors unrelated to patient characteristics.

The National Association for Home Care has done research on the changes in patient characteristics and I concur with those findings they have sent with their comments. In addition the burden for compliance with the regulatory changes in the last 2 years has not been adequately compensated. I am referring to the BIPA notice and the HHABN requirements. We have run some preliminary numbers comparing our current reimbursement with the proposed changes. Reducing the base payment rate will create an overall decrease in reimbursement of 6% in 2008, 9% in 2009, and 11.50% in 2010.

The potential adverse impact to our agency will be in the following ways:

Reduction in staff resources. Staff cuts will adversely affect the ability to work on quality initiatives, best practices, disease management...all of which provide a higher level of patient independence and quality of life.

Reduction in the ability to purchase technology. Technology has been proven to provide efficiencies and improved quality through effective communication between clinicians Telemonitoring equipment, which is not reimbursed by Medicare, allows for just in time assessments and efficiencies in nurse visit time. Nurse shortages are a reality and the use of technology is essential to preserve this valuable resource, including the WOCN (Wound, Ostomy, Continence nurse). Our agency currently is well below the federal reference in acute care hospitalization. The monitors and other technology devices have assisted us to achieve this accomplishment. Other devices used are telephony, point of care documentation, and PT/INR machines.

Reduction in the ability to provide no charge services such as community based palliative care, financial assistance for patient who have no or limited sources of payment. We provide 60% Medicaid services with no cap on volume at this time. As we are one of the largest home care agencies in state, our mission is to provide care to all eligible patients in our service area. With such drastic cuts, we would need to face capping our acceptance of Medicaid and potentially Medicare patients. Many of these patients are dually eligible for Medicare and they would seek more costly venues for health care such as emergency rooms.

Reduction in patient access to care via the need to cap acceptance of patients based on payer source. Unreimbursed costs would cause financial implications requiring us to sustain a certain mix of payers and volume.

Recommendation

CMS should withdraw its proposal to reduce base payment rates by 2.75% in 2008, 2009, and 2010. See outlier section for recommendation to keep this budget neutral.

OUTLIER PAYMENTS

CMS should lower the FDL based on historical experiences to a level that ensures full use of the outlier budget.

The CMS standards for outlier payment have failed to fully use the outlier budget in every year that the prospective payment system has been in place. The CMS estimate that an additional $130 million in outlier payment will be expended in 2008 through the use of the same standards as in use in 2007 is without any basis. It is withholding 5% for outlier utilization. However based on our 2006 Medicare cost report data, only .3% of our revenue was contributed to outliers. We are a large urban Iowa agency and we take all patients including those requiring a lot of resources.

Recommendation: Reduce the outlier withhold to .5% -1%. This allotted money would be better spent in not reducing the base payment rate.

HOME HEALTH QUALITY IMPROVEMENT

I am in favor of adding Improvement of Status of Surgical wound to the the Home Health Compare measures. However the suggestion of adding an adverse event (Emergent Care for Wound Status) is not appropriate. Adverse event reporting is for the agency to determine potential adverse events. The instructions for OBQM (Outcome Based Quality Management) are for the agency to audit the record to determine if an adverse event has occurred. With the definition of emergent care being an unplanned physician visit within 24 hours, this reporting could be detrimental. In our area we have physician office availability that often encourages appointments to be made within 24 hours. It is seen as good practice rather than an adverse event.

Recommendation

Remove Emergent Care for Wound Infections, Deteriorating Wound Status for the home health quality measures.

Thank you for the opportunity to comment on these proposals.

Sincerely,

Valerie Edison, RN, BSN, MPA
Quality Manager
Iowa Health Home Care
11333 Aurora
Urbandale, Iowa 50322

Submitter : **Mrs. Julia Kelly** **Date: 06/25/2007**

Organization : **Floyd Memorial Home Health**

Category : **Individual**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

The early late episode portion of the proposed Home Health Care will be a problem for Home Health agencies to answer correctly. Home Health agencies are dependent on other agencies to have billed a RAP before Medicare eligibility is checked in the common working file. Many agencies do not bill the RAP until the OASIS has been submitted. The early late episode can only truly be answered correctly, after all billing is completed by all agencies. At that point in time it is too late to bill. This portion of the payment formula will create similar problems at the hospitalization question created in the current payment formula.

Submitted by:

Julia Kelly
Floyd Memorial Home Health
1915 Bono Road
New Albany, IN. 47150

Submitter : **Mrs. Lisa Sands** **Date: 06/25/2007**

Organization : **Floyd Memorial Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Low Utilization Payment Adjustment (LUPA)

Please consider adding supplies to LUPA episodes. Non-routine medical supplies will not be reimbursed in chronic patients who we see for one visit for Foley catheters for every episode. They are more apt to require on call visits that require supplies as well. This cost is placed on the agency. Supply costs need to be added to the LUPA episodes on top of national LUPA add on $92.63.

Thank you for the opportunity to submit comments.

Thank you
Lisa Sands
Floyd Memorial Home Health

Submitter : **Date: 06/25/2007**

Organization :

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The estimates for the CMS Paperwork Reduction Act supporting statements contain many estimates that are are not reflectove of the reality of providing home health.
1) Demonstrating compliance with the patient rights takes more than five minutes per admission. The average is closer to 8- 10 minutes of an RN time.
2) The written summary report to the physician takes an average of 20 minutes per patient to write. Surveyors have become completely obsessive about the content of this summary, and are mandating that it include summaries of lab values, med changes, major physical changes, summary of tests or procedures, etc that take much more than the 3 minutes CMS estimated. There is no way these would pass survey if the average were 3 minutes. Our agency is not computerized, and can not afford to implement a computerized clinical record. The progress reports are done manually by the clinician reviewing the chart.
3) The estimate of the clinician taking five minutes per admission developing and reviewing the initial plan of care is outrageously inaccurate! The clinician takes 30 or more minutes on a relatively straightforward case summarizing the data from the assessment to develop the 485 and the goals. This would not account for problems with the medication reconciliation and verifying with the doctor what meds the patient should be on. Even with a completely electronic record, there is no way the time to develop the 485 would be anywhere close to five minutes. For a patient with complex needs like tube feedings, IV therapy, wound care, trach care, the average time developing the plan would be 45 minutes or more.
4) The quarterly record review by a clinician takes 35-45 minutes per record by a nurse and therapist. The home health aide takes about 25 minutes to do the record review. The results of that quarterly review then needs to be summarized, which takes another 30 minutes. We have every discipline perform chart review- the cost is unreimbursed for this mandate.
5) My agency has a highly competent Professional Advisory Committee that truly guides our program. It takes the director an average of 5 hours to prepare for this meeting, the meeting is 1.5 hours per quarter, then 2-3 hours to do the minutes of the meeting.
6) The Agency annual evaluation is a document we put a lot of time and effort in to. The final product is approved by the Professional Advisory Committee, the hospital board of trustees and the Board of Health for the county. The annual eval takes 10 to 15 hours to complete, then is reveiwed by each of the above entities and discussed. The time to discuss, review and approve the report is an average of 30 minutes at each of the above 3 meetings.

I truly have a concern over where the CMS estimates came from, as they are so out of reality for a quality home health agency!!!! An agency that performed in the timeframes mentioned could not be in the top 100 agencies in the country (as my agency is according to Home Care Elite) nor would their outcomes be in the top 5% in country (as ours are) nor would they be able to survive state surveys!

CMS estimated a 28% OASIS burden decrease- I do not agree that the proposed changes would be a decrease! I would agree that there is a 28% increase! It takes many, many hours to change our OASIS written forms, print them, it's expensive to throw away old stock, educate staff and monitor their implementation of the changes!

I also had the concern about the lack of guidance for how wounds that can not be observed on admission or recert would be reimbursed! Under eschar, for example, the wound could be a Stage IV, but we would have to document as not observable. The subsequent treatment of that wound would be very expensive with no financial reimbursement to the agency.

Insufficient Information Available to Draw Accurate Conclusions Regarding "Coding Creep"

On pages 25393 and 25394 of the proposed rule, CMS states that "We would normally expect growth in the CMI to be accompanied by more consumption of services; but, to the contrary, we measure slightly lower resource consumption." This conclusion does not take into account that 1) payments to home health agencies during this period were not being fully adjusted for inflation during this time and therefore a natural reaction by agencies would be to improve efficiency and lower resource consumption when possible in order to survive; and 2) utilization of other clinical resources not recognized on the cost report such as telemonitoring has greatly increased but is not reflected in CMS' analysis. The information contained in a more recent Abt Associates Technical Report may provide clues as to the impact of these factors on resource use by agencies.

High Therapy Episodes As Justification for "Coding Creep" Adjustment

TAHC is 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. Nor are points allocated for the gait disorder diagnosis in 14 plus therapy visit equations. This proposed point allocation is counterintuitive. We recommend that 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.

CMS' justifications for the 2.75 percent reductions in payments in each of three years are based on the assertion that all of the change in case mix weights from 1999 and 2003 were unrelated to patient characteristics. CMS' own OASIS data provides a strong indication that the increase in therapy services, including those above the threshold of 10 visits, is directly related to changes in patient characteristics. The percentage of patients assessed at C2 and C3 increased from 1999 to 2003, and there were also statistically material increases in the assessment of functional limitations. CMS' rationale for all of these scoring changes in the clinical and functional domains were related to policy clarifications, provider training and other factors unrelated to patient characteristics. This conclusion seems extremely difficult to believe when other Medicare providers have also seen increases in patient acuity but those have not been "explained away" exclusively by non-patient characteristic related factors.

If CMS believes that non-patient characteristic related factors caused the 8.7 percent increase in case-mix, then additional information must be provided to justify that conclusion, including what percent of the case-mix increase from 1999 to 2003 is attributable to each factor. Furthermore, CMS' model is built on a 1% sample of claims. In many of the case mix groups, insufficient data lead to numerous substituted judgments. The explanatory power (R^2) of the model, originally estimated at 30+%, devolved to 22% by 2003 with a therapy adjustment element, and at an 11% R^2 in the absence of the therapy adjustment element (MO825). Since the CMS proposal rejects the therapy utilization element as relevant to patient characteristics in the case mix creep analysis, CMS is effectively expecting to use OASIS data elements that are unable to define patients correctly in 89% of all episodes to explain changes in case mix weights. MedPAC also found that the coefficient of variation exceeded 1.0 in over 60 of the current 80 case mix groups. It is clear that any growth in average case mix weights through 2003 is easily explained by the inherent weaknesses in the CMS model alone. TAHC recommends that the effect on case mix change of the shift to high therapy episodes under PPS be excluded from any "coding creep" assessment.

Failure to Address Impact of 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. This places home health agencies at a significant disadvantage when competing with hospitals for a limited pool of health care professionals, particularly nurses and therapists. As more and more hospitals seek reclassification to neighboring regions with higher wage indices and with the dramatic increase in Critical Access Hospitals who are excluded from the wage index calculation, CMS should adopt a "rural floor" policy for the home health wage index comparable to the policy that exists for hospitals. Under this policy, home health agencies would receive the higher of the wage index for their patient's CBSA or the rural wage index.

Impact of Medicaid Eligibility and Caregiver Access on Resource Use

CMS continues to assert that Medicaid "remains a marginal predictor [of costs], at best", which TAHC believes is a questionable conclusion due to how CMS operationalizes the Medicaid variable through the recording of Medicaid numbers on the OASIS assessment. This is particularly problematic in Texas, where no Medicaid long term care services are delivered through a Medicare-certified home health agency, and therefore the opportunity to obtain the Medicaid client number is limited. Furthermore, the OASIS questions relating to caregivers do not portray an accurate picture of their role in the patient's care.

TAHC recommends that CMS 1) analyze the impact of Medicaid eligibility by studying resource use of a sample of home health patients enrolled in Medicaid directly from Medicaid files against patients who are not enrolled in Medicaid and base the inclusion of Medicaid eligibility in the case-mix system on the results of further study; and 2) refine those OASIS items related to caregiver access in order to produce more reliable information about the actual roles caregivers play in meeting the needs of home health patients, and the amount of time that they are available.

Failure to Modify OASIS Data Collection Requirements

The proposed rule eliminates payment adjustments for significant change in condition (SCIC) and M0175. Therefore, OASIS data from SCIC assessments nor M0175 are no longer needed for payment purposes. OASIS SCIC assessment data has never been used for outcome measures. In light of the fact that home health agencies continue to collect, enter and transmit SCIC assessments. TAHC recommends that CMS 1) suspend the requirement for home health agencies to collect and transmit OASIS data for assessments for significant change in condition; and 2) eliminate the requirement to determine what inpatient facilities patients were discharged from in the past 14 days and accept "NA" as the default response to M0175.

Inadequate LUPA Payments

While we appreciate CMS' proposal to apply a LUPA add-on for initial or only LUPA episodes, we are concerned that additional changes were not made to payments for LUPA episodes. First, the proposed add-on does not apply to subsequent LUPA episodes even though the requirement for OASIS follow-up assessments within the 5-day window still apply. If the 5-day window does not coincide with a prescribed visit, then the agency must make an additional, non-billable visit. Second, 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 an adequate medical supply payment for LUPA episodes results in disincentives to accept such patients to home care services. TAHC recommends that CMS 1) include payment for non-routine supplies for all episodes; and 2) apply the add-on payment for all LUPA episodes, not just the initial episodes.

Non-Medical Supplies Not Recognized in Case Mix Model

There are many costly non-routine medical supplies not recognized in the medical supply case mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that made their appearance on the home care scene after the start of PPS are those supplies needed for closed chest drainage. Failure to identify patient characteristics that would allow for payment for these, and other supplies not yet identified, results in underpayment. Furthermore, although we agree that elimination of SCICs is a necessary reform, we fear that agencies will be unable to seek reimbursement for medical supplies as there does not appear to be a mechanism to account for supply needs that surface after the initial start of care assessment has been completed. This could also result in inadequate payments. TAHC recommends that CMS 1) 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; 2) give consideration to additional diagnosis codes that lend themselves to predicting non-routine supply costs; 3) add pleural effusion as a supply case-mix diagnosis to capture episodes during which chest drainage supplies are provided or reclassify chest drainage catheters and valves as prosthetic devices; and 4) ensure that payment is made for non-routine supplies in all LUPA episodes, not just those that are final episodes of care.

Lack of Changes to the Partial Episode Payment (PEP) Policy

CMS did not propose any changes to policies regarding PEPs in the proposed rule despite numerous complaints and its own evidence of underpayment of PEP episodes. Agencies are especially concerned with PEP situations where patients are discharged with plan of care goals met and they return to the same agency within the 60-day period, often for a condition that was not related to the first plan of care. In those cases, agencies can receive a significant reduction in payment for the first episode despite the provision of all visits authorized under a plan of care. Maintenance of the PEP policy in the current form also raises questions regarding how "early" and "late" episodes will be defined in the proposed payment system. TAHC recommends that CMS 1) 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; and 2) clarify how PEPs will interact with early and late episodes.

Submitter : Mrs. Joan Williams **Date:** 06/25/2007

Organization : Carolina East Home Care

Category : Home Health Facility

Issue Areas/Comments

Consolidated Billing

Consolidated Billing

We support the Non-Routine Supply add-on, but would like to see CMS to continue to study the supply issue with future data.

Market Basket Index

Market Basket Index

The Market Basket Index (MBI) is one of the items in the proposed rule changes that is being threatened. We are asking that Congress maintain at least a 2.9% MBI.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

After review of the proposed PPS rule changes, we would like to make some comments. It is predicted that in the next ten to fifteen years our 80 and older population will be higher than our 17 and younger population. This increase is due to baby boomers as well as advances in medical technologies that are allowing the elderly to live longer and healthier lives.

The Market Basket Index (MBI) is one of the items in the proposed rule changes that is being threatened. We are asking that Congress maintain at least a 2.9% MBI.

Our patient population has changed over the last five to ten years. Over the last five years alone we have seen a 3% increase in patients over 85. These patients have more need for rehabilitative services then the previous generations. We are finding that many of our post-operative patients are older now than they were ten years ago. Based on our findings, we would like to see the 2.75% base rate reduction either eliminated or reduced.

We still have a significant volume of LUPA s in our service area. Our LUPA rate has decreased somewhat over the last couple of years. The administrative expense on the LUPA is the same regardless of how many episodes the patient has. We would like to encourage CMS to increase the LUPA rate by $92.60 for not only the first episode, but also subsequent episodes.

We support the plan to eliminate the SCIC from the PPS rules.

We support the Non-Routine Supply add-on, but would like to see CMS to continue to study the supply issue with future data.

We completely support the proposed OASIS changes. We encourage CMS to make all of these changes at once.

We support the proposed changes to the processing of therapy claims.

Case Mix Refinement Early/late episodes of care and CWF. We do not typically see many patients past the second episode. Our average is 1.3 episodes per patient. We will not realize the higher weights allocated to Late Episodes because our service pattern does not typically take us into a third or fourth episode. Based on our findings we would like to see the elimination of the Early/Late distinction and redistribute the weighting to all the episodes. We would also ask that CMS address the many issues of the CWF. The system does not offer real-time data based on current claims processed

Submitter : **Anita Cardinal** **Date: 06/25/2007**

Organization : **Inter-County Nursing Service**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-60-Attach-1.PDF

#60

INTER-COUNTY NURSING SERVICE

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

This letter is written on behalf of Inter-County Nursing Service whose purpose is to serve clients in the most cost-effective manner to bring about the most positive client outcomes and functional improvement. Inter-County Nursing Service represents 150 clients per year.

The Prospective Payment System for Medicare home health is based on the right principles as it facilitates outcomes-oriented patient care planning that is focused on rehabilitation and self care. MHCA has strongly supported 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.

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 patient assessment to garner

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Pennington County Nurse (218) 681-0876 • Red Lake County Nurse (218) 253-4378

Estimate of supplies is based on inaccurate information. Providers have not always placed supplies on the claims either because they believed it was not required since supplies were bundled or because they did not want to hold up sending claims when working with an outside vendor who did not provide charges in a timely manner. Additionally, the complexity of supplies and getting the right supplies on claims has been confusing, making the accuracy of the cost of supplies nebulous at best.

Providers already provide LUPA visits at rates lower than the cost of care delivery. Failure to provide supply reimbursement for LUPA visits exacerbates this financial loss. This is especially valid for clients with catheters and ostomy supplies. For example, patients with catheters may only require a nurse visit once a month, yet supply costs are significant.

Suggested Solution
Build in reimbursement for supplies under LUPA visits, especially long-term patients who fall under the LUPA visits. Allow inclusion of reimbursement for supplies when there are changes from the initial assessment and from one episode to another. Include variable to recognize costly Pleurovax and ostomy supplies.

Concern
Estimated financial impact with a net increase of $140 million.

Rationale
The financial impact estimate for outliers is unrealistic. Providers historically have not needed outlier reimbursement because they are dissuaded from taking patients needing outlier payments and thus the monies set aside for outliers will remain on the table.

Suggested Solution
Re-look at the financial impact and adjust it to more accurately reflect the reality of the impact on home care.

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 has 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 Solution

Automatically adjust the final claim to accurately reflect early and late episodes of care rather than defaulting it to an early episode. Consider only one agency's episodes of care to determine if an episode is an early or late 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 of 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
Known pressure ulcers that are Stage 3 or 4 with eschar coverage.

Rationale
Because providers are currently not allowed to stage pressure ulcers covered with eschar, stage 3 and 4 pressure ulcers that are covered with eschar are not calculated into the case mix. These patients, however, require additional care to address the significant risk of infection and potential for further skin breakdown. By WOCN's own interpretation, this tissue is always at risk of breakdown due to underlying permanent damage. Therefore, it does not make sense to omit them from the case mix adjustment.

Suggested Solution
Known stage 3 or 4 pressure ulcers are to remain stage 3 or 4 pressure ulcers despite the presence or absence of eschar.

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 reason 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
The PPS reform proposed rule calls for the elimination of M0175 from the case-mix system because of the difficulty encountered by home health agencies in accurately responding to this OASIS item. However, CMS plans to continue to require that home health agencies report this information on the OASIS.

Rationale
Any client discharged from an institution may or may not need additional services and may or may not have experienced an improvement in condition. An institutional stay does not directly correlate to required services for home care.

Suggested Solution
Eliminate the requirement to determine what inpatient facilities patients were discharged from in the past 14 days and accept "NA" as a default response to M0175.

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,
Anita B. Cardinal PHN

Anita Cardinal, PHN
Director
Inter-County Nursing Service

Submitter : **John Reisinger** **Date: 06/25/2007**

Organization : **Home Health Care Affiliates, Inc.**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment:

CMS-1541-P-61-Attach-1.DOC

#61

Home Health Care Affiliates, Inc.

June 25, 2007

Executive Summary

Department of Health and Human Services
Centers for Medicare and Medicaid Services
ATTENTION: CMS 1541-P
VIA: Electronic submission to http://www.cms.hhs.gov/eRulemaking.

RE: Medicare Program; Home Health Prospective Pay System Refinement and Rate Update for Calendar year 2008

Please find enclosed a copy of this Executive Summary followed by my comments regarding the Proposed Rule Changes for the Home Health Prospective Payment System for calendar year 2008:

General Overview:

My general overview of CMS's steps taken to improve the HH PPS is in general positive and supportive. I feel that it is obvious that CMS has put in significant time and effort in their attempt to improve on HH PPS. I certainly have some reservations on the actual mechanics of how this system will work in the real word of day-to-day operations, but generally feel that this is a significant step in improving the resource allocations so as to better match cost and reimbursement.

That which I Agree With:

- Some aspects of the 'Refinements to the Case Mix Models'
- Some aspects of the 'Addition of Variables'
- Some aspects of the 'Addition of Therapy Thresholds'
- The elimination of the Significant Change in Condition

That which I Have Reservations and/or Disagree With:

- Some aspects of the 'Refinements to the Case Mix Models'
- Some aspects of the 'Analysis of Later Episodes'
- Some aspects of the 'Addition of Variables'
- Some aspects of the 'Addition of Therapy Thresholds'
- Many aspects of the 'Determining the Case-Mix Weights'
- The proposed 2.75% reduction for each of the next three years commencing in 2008
- Most aspects of the '12 Months Ending September 30, 2000 (HH IPS Baseline)'
- Some aspects of the 'Non-Routine Medical Supply (NRS) Amounts Review'
- Some aspects of the 'Outlier Payment Review'; we would rather see this provision eliminated
- Some aspects of the 'Rebasing and Revising of the Home Health Market Basket'
- Some aspects of the 'National Standardized 60-Day Payment Rate'
- The SCIC adjustment factor to the National Standardized 60-day Payment Rate
- CMS's viewpoint that is pervasive throughout the proposed rule that we in the industry are out to game the system as much as possible in search of maximizing our reimbursement regardless of the clinical need or reasonableness of our actions.

Please note that that the above are all discussed to varying degrees, within the following document.

Thank-you for the opportunity to comment on these proposed changes.

John M. Reisinger, CPA, VP
Home Health Care Affiliates, Inc.

Home Health Care Affiliates, Inc.

June 25, 2007

Department of Health and Human Services
Centers for Medicare and Medicaid Services
ATTENTION: CMS 1541-P
VIA: Electronic submission to http://www.cms.hhs.gov/eRulemaking.

RE: Medicare Program; Home Health Prospective Pay System Refinement and Rate Update for Calendar year 2008

From CMS Press Release of Friday, April 27, 2007

Details for: CMS PROPOSES PAYMENT CHANGES FOR MEDICARE HOME HEALTH SERVICES

CMS analysis of the latest available home health claims data indicates a significant increase in the observed case-mix since 2000 and that the case-mix increase is due to changes in coding practices and documentation rather than to treatment of more resource-intensive patients. To account for the changes in case-mix that are not related to a home health patient's actual clinical condition, this rule proposes to reduce the national standardized 60-day episode payment rate by 2.75 percent per year for three years beginning in CY 2008.

Comment:

This does not seem reasonable. There are a number of issues that would seem to make this course of action inappropriate, in addition to this persistent premise that CMS has regarding our industry that we are constantly looking toward gaming the system.

First, in any instances in which the Fiscal Intermediaries (FIs) find instances of inappropriate coding, they adjust the HHRG and pay at the adjusted rate. Therefore these amounts are recovered when identified. This is one of the primary functions the FIs serve. Additionally, many of these cases through ADR and ALJ are ultimately upheld in the agency's favor indicating that inappropriate coding and/or activities were not present and that the claim *"As Billed"* was proper. So CMS is proposing that the industry is to be penalized for the FIs not doing their job, when there seems to be little if any support for their contention that this increase in the average acuity level of the average patient is nothing more than a scam by the industry to inflate their payment rates!

Second, this will work as a *"double-dipping"* in so much as the claims that were identified as erroneously billed have already been adjusted and any identified overpayments have been recovered and now CMS is going to attempt to recover even more over and above what was in error by applying this *"penalty"* rate reduction to all episodes for 3-years!

Third, in reviewing the Original Proposed PPS Regs as per the Federal Register of Oct. 28, 1999, it appears that the preponderance of the data used to establish the Average Case-Mix Weight of 1.0000 (as well as cost data) was based on data that was obtained between 1993 and 1997. Therefore, let's look at the change in the population from 1993to 2004 **(data was obtained from the CDC web-site):**

- The overall population increased by 13.0%
- The Medicare population increased by 10.3%
- However, the population aged between 65 to 74 years *(inclusive)* dropped by 1.2%. This would generally be considered the healthiest portion of the Medicare eligible population.
- And the population aged between 75 to 84 years *(inclusive)* increased by 20.5%. A materially significant increase in a portion of our Medicare population that would not generally be considered the healthiest portion of the Medicare eligible population.
- And the population aged 85 years and above increased by a staggering 41.0%! Again, a materially significant increase in a portion of our Medicare population that would generally be considered to be the least healthy and most frail portion of the Medicare eligible population.

Therefore, based on the above summary of data from the CDC web-site, we believe that a reasonably prudent individual with no biases would agree that it would seem reasonable that the average acuity level of the average Medicare beneficiary utilizing home health services would have increased over this span of time. Further more, based on these trends, one would expect that the average acuity level would continue to rise as a greater portion of the Medicare eligible population continues to enter the 85+ years age group!

Fourth, this approach of reducing the national standardized 60-day episodic payment rate has the effect of penalizing the entire home health industry when in fact, the only parties that should be penalized are those that engage in these aberrant practices *(to the extent that they are not reasonable and sound based on clinical practice; just because they are aberrant does not "in and of its' self" make them improper!)*. One thing that I have found true is the saying: *"people pay more attention to what you inspect, not what you expect!"* Therefore, instead of implementing this draconian 2.75% reduction for the next 3 years *(if not more)*, why not re-introduce the Medicare review procedures of the past in both the clinical and financial operations of home health with monetary penalties and/or recoupments based on those reviews. That way you'll be able to operate and clean-up home health of the bad operators with the precision of a scalpel instead of a steam shovel.

Suggestion:

Eliminate the proposed reduction of the national standardized 60-day episodic payment rate by 2.75% each year for the next three years beginning in 2008.

From the Federal Register dated May 4, 2007

Provisions of the Proposed Regulation

Refinements to the Case Mix Model *(pg 25359)*:

> *To derive the resource cost estimate, the total minutes reported on the claim for each discipline's visits are converted to a resource cost. Resource cost results from weighting each minute by the national average labor market hourly rate for the individual discipline that provided the minutes of care. Bureau of Labor Statistics data are used to derive the hourly rate. The sum of the weighted minutes is the total resource cost estimate for the claim. This method standardizes the resource cost for all episodes in the analysis file.*

Comment:

This does not seem entirely reasonable. I understand the need for uniformity for performing analysis, but it does not seem realistic to attribute the same resource cost to Rural Beneficiaries as it does to Urban Beneficiaries that generally have many more social programs available to them. Additionally, this will in no-way account for the significant travel costs associated with Rural Beneficiaries generally not attributable to Urban Beneficiaries. I believe that this was why there has periodically been a Rural Add-On.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

Refinements to the Case Mix Model *(pg 25359)*:

> *... we propose that the case-mix adjustment be refined to incorporate an expanded set of case-mix variables to capture the additional clinical conditions and comorbidities; four separate regression models that recognize four different types of episodes; and a graduated, three-threshold approach to accounting for therapy utilization. We refer to the four separate regression models in this proposed case-adjustment system as the four-equation model. The first regression equation is for low-therapy episodes (less than 14 therapy visits) that occur as the first or second episode in a series of adjacent episodes (Episodes are considered to be ``adjacent'' if they are separated by no more than a 60-day period between*

claims). The second regression equation is for high-therapy episodes (14 or more therapy visits) occurring as the first or second episode in a series of adjacent episodes. The third equation is for low-therapy episodes (under 14 therapy visits) occurring after the second episode in a series of adjacent episodes. And the fourth equation is for high-therapy episodes (14 or more therapy visits) occurring after the second episode in a series of adjacent episodes

Comment:

Conceptually, this sounds much more appropriate than the current reimbursement methodology that seemingly under-reimburses for many clinically severe beneficiaries (wound-care pts, etc...) and over-reimburses many of the High Service Utilization (10+ PT visits/episode) episodes. This would seem to provide a mechanism to better match resource needs/costs with reimbursement. However, it also is going to be a much more complex methodology than currently exists and I question whether or not adequate time is available for implementation and training prior to the proposed implementation date of Jan. 1, 2008 *(because implementation and training have to be completed prior to that date).*

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

Analysis of Later Episodes *(pg 25360):*

The more recent data reflect both the inclusion of episodes beyond the first episode as well as behavioral changes of health care providers under the HH PPS. The R-squared statistic estimated from the more recent data is approximately 0.21. An appropriate comparison with the initial R-square statistic (0.34) is the R-squared value estimated from the more recent data's initial episodes, which is 0.29. We therefore believe the data reflect a more modest reduction in model performance of 0.05. However, the value of the R-squared statistic calculated on all the data, 0.21, is an indication that the case-mix model does not fit non-initial episodes as well as it fits initial episodes. Therefore, one focus of our refinement work was to investigate resource use in episodes that occurred later in treatment as well as early episodes.

Comment:

For those not statistically oriented; **R-squared is the relative predictive power of a model.** R-squared is a descriptive measure between 0 and 1. **The closer it is to one, the better your model is.** By "better", it means a greater ability to predict. A value of R-squared equal to one would imply that your model provides perfect predictions, whereas an R-squared of 0 would imply that your model has no predictive attributes at all! Therefore, an R-squared of .21 or .29 or .34, all have a very low predictive value. Therefore, although conceptually, the theory behind this new proposed PPS seems reasonable, it does seem fairly unreasonable to force on the industry a new reimbursement system that is based on such weak statistical significant correlations in the time-frame intended. We as an industry should be given more time to review and test the data as well as to model this reimbursement system. We as an industry just haven't had enough time to adequately model this out as we are dealing with our daily operations whilst working on preparing and submitting our comments to these proposed regulations within the 60-day time frame. Let's not forget the lessons of what happened with the implementation of IPS when nearly one-third of the agencies in existence either closed down or quit participating in the Medicare program.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

Home Health Care Affiliates, Inc.

Addition of Variables *(pg 25361):*

> *We propose to exclude OASIS item M0175, which the case-mix system uses to identify the patient's pre-admission location, from the case-mix models. Under this proposal, there would be no case-mix score for M0175. Operational experience with M0175 revealed that some agencies have encountered difficulties in ascertaining precise information about the patient's pre-admission location during the initial assessment. These difficulties, suggestive of unforeseen administrative complexities, contributed to our proposal to eliminate M0175 from the case-mix model.*

Comment:

We agree totally with the elimination of the OASIS item M0175. This item was an administrative nightmare of OASIS for us in Home Health. Too many beneficiaries were unable (for whatever reason) to answer this properly which created accounting headaches reconciling what the expected reimbursement was and what was ultimately received.

Suggestion:

Eliminate OASIS item M0175 from the scoring mechanism of PPS.

Addition of Variables *(pg 25361):*

> *We also propose to assign scores to certain secondary diagnoses, used to account for cost-increasing effects of comorbidities. An example is secondary cancer diagnoses, whose cost-increasing effects are not as large as those for primary cancer diagnoses. However, with most diagnosis groups, we did not make a distinction in the final model between primary placement and secondary placement of a condition in the reported list of diagnoses.*

Comment:

This does sound reasonable. We have always believed that there were numerous situations that these comordibities greatly increased the complexity (cost) of treating the beneficiary but were not readily identified by OASIS. We feel that this will be an improvement to both the OASIS and the resource allocation thorough PPS.

Suggestion:

Implement the scoring of secondary diagnosis to account for the cost-increasing effects of comorbidities.

Addition of Therapy Thresholds *(pg 25363):*

> *Adding therapy thresholds in the revised case-mix regression model improves the ability of the model to predict resource use. The R-squared values for a three-therapy threshold model increased substantially for both early and later episodes over the R-squared values for a single therapy threshold model.*

Comment:

What did this improve the R-squared to? Was it statistically significant? Plus, are there any concerns with the R-squared in so much as if the randomness that is being measured is indeed not random at all, the a linear regression model and therefore R-squared are not appropriate models for use?

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

Home Health Care Affiliates, Inc.

Addition of Therapy Thresholds (pg 25363):

During the analysis of the therapy threshold, we considered ways to provide for payment gradations between the therapy thresholds. We sought a way to implement a gradual increase in payment (see Table 1) between the proposed first and third therapy thresholds. We believe a case-mix model that increases payment with each added visit between the proposed first and third thresholds would achieve two goals. First, a gradual increase better matches payments to costs than the therapy thresholds alone. Second, a gradual increase avoids incentives for providers to distort patterns of good care created by the increase in payment that would occur at each proposed therapy threshold.

Comment:

We would agree conceptually with the theory identified above. With the multiple thresholds, it would seem reasonable to assume that this more-complex methodology would better match resource costs with reimbursement.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

Addition of Therapy Thresholds (pg 25363-25364):

However, as a disincentive for agencies to deliver more than the appropriate, clinically determined number of therapy visits, we are also proposing that any per-visit increase incorporate a declining, rather than constant, amount per added therapy visit. We implemented this in the case-mix model by decreasing slightly the added amount per therapy visit as the number of therapy visits grew above the proposed 6-visit threshold. Specifically, we began with a value determined from our sample--the estimated marginal resource cost incurred by adding a 7th therapy visit to the treatment plan. This is the first additional visit above the proposed six-visit therapy threshold. The estimated marginal cost of adding a 7th therapy visit to an episode with six therapy visits was $36. Using this value as our starting point, we required the case-mix model to add a slightly lower value to the total episode resource cost with each additional therapy visit provided, up to the 19th therapy visit. This proposed approach imposes a deceleration of the growth in payment with each additional therapy visit. However, this proposed approach does not reduce total payments to home health providers, because the regression analysis still predicts the full resource cost of the episode. Table 1 shows the values that we imposed in the four-equation model estimation procedure to implement a deceleration in the added resource cost for individual therapy visits between 6 and 20 therapy visits. The individual values begin at $36 and then decline at a constant rate of one resource cost dollar per therapy visit between 6 and 20 therapy visits. These values represent the score that was imposed in the model for adding each additional therapy visit.

Comment:

We totally disagree with this big-stick penalty as proposed. This is set-up as a disincentive for agencies to provide more than 6-therapy visits, because the agency is paid less "per therapy visit" for each-and-every therapy visit they do over 6 (starting at $36/visit for the 7th visit and going down $1 for each visit thereafter!). This will in no-way match resource costs with reimbursement! We need to be able to model this to get a feel for what the true impact of this is going to be and due to the complexities of this proposed change and the deadline for commenting *(as well as trying to manage our regular day-to-day operations)*, we do not expect to be able to adequately model this until after the comment period. We felt it much more important to adequately comment on the conceptual theory first and then work on modeling this change.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

Determining the Case-Mix Weights *(pg 25392):*

> *Based upon our review of trends in the national average case-mix index (CMI), we are proposing an additional adjustment to the HH PPS national standardized rate to account for case-mix upcoding that is not due to change in the underlying health status of home health users. Section 1895(b)(3)(B)(iv) of the Act specifically provides the Secretary with the authority to adjust the standard payment amount (or amounts) if the Secretary determines that the case-mix adjustments resulted (or would likely result in) a change in aggregate payments that are the result of changes in the coding or classification of different units of services that do not reflect real changes in case-mix. The Secretary may then adjust the payment amount to eliminate the effect of the coding or classification changes that do not reflect real changes in case-mix.*

Comment:

This is directly related to CMS's proposed 2.75% reduction for each of the next three years in the national standardized 60-day episode payment rate (as also identified above in the CMS Press Release of April 27, 2007). And we believe that the data used to support this contention was probably bad data and/or skewed and therefore this bad data would have generated bad, inappropriate results. This is not data that one can say we will hold everything constant except the year of the data being reviewed. This data is directly attributable to Medicare beneficiaries, who age each and every year. And throughout this aging process, become sicker and more frail as time wares on. Couple that with the fact that the Medicare population is growing at a faster rate than the total population; and that the oldest segments of the Medicare population are growing the fastest, it would seem reasonable that the average case-mix weight for the average Medicare beneficiary utilizing Home Health services would increase over time.

As noted in the comments to the CMS Press Release which identified this 2.75% reduction for each of the next three years, commencing in 2008, here again are the comments we made:

This does not seem reasonable. There are a number of issues that would seem to make this course of action inappropriate, in addition to this persistent premise that CMS has regarding our industry that we are constantly looking toward gaming the system.

First, in any instances in which the Fiscal Intermediaries (FIs) find instances of inappropriate coding, the adjust the HHRG and pay at the adjusted rate. Therefore these amounts are recovered when identified. This is one of the primary functions the FIs serve. Additionally, many of these cases through ADR and ALJ are ultimately upheld in the agency's favor indicating that inappropriate coding and/or activities were not present and that the claim *"As Billed"* was proper. So CMS is proposing that the industry is to be penalized for the FIs not doing their job, when there seems to be little if any support for their contention that this increase in the average acuity level of the average patient is nothing more than a scam by the industry to inflate their payment rates!

Second, this will work as a *"double-dipping"* in so much as the claims that were identified as erroneously billed have already been adjusted and any identified overpayments have been recovered and now CMS is going to attempt to recover even more over and above what was in error by applying this *"penalty"* rate reduction to all episodes for 3-years!

Third, in reviewing the Original Proposed PPS Regs as per the Federal Register of Oct. 28, 1999, it appears that the preponderance of the data used to establish the Average Case-Mix Weight of 1.0000 (as well as cost data) was based on data that was obtained between 1993 and 1997. Therefore, let's look at the change in the population from 1993to 2004 **(data was obtained from the CDC web-site):**

- The overall population increased by 13%
- However, the population aged between 65 to 74 years *(inclusive)* dropped by 1.2%. This would generally be considered the healthiest portion of the Medicare eligible population.

- And the population aged between 75 to 84 years *(inclusive)* increased by 20.5%. A materially significant increase in a portion of our Medicare population that would not generally be considered the healthiest portion of the Medicare eligible population.
- And the population aged 85 years and above increased by a staggering 41.0%! Again, a materially significant increase in a portion of our Medicare population that would generally be considered to be the least healthy and most frail portion of the Medicare eligible population.

Therefore, based on the above summary of data from the CDC web-site, we believe that a reasonably prudent individual with no biases would agree that it would seem reasonable that the average acuity level of the average Medicare beneficiary utilizing Home Health services would have increased over this span of time. And further more, based on these trends, one would expect that the average acuity level would continue to rise as a greater portion of the Medicare eligible population continues to enter the 85+ years age group!

Fourth, this approach of reducing the national standardized 60-day episodic payment rate has the effect of penalizing the entire home health industry when in fact, the only parties that should be penalized are those that engage in these aberrant practices *(to the extent that they are not reasonable and sound based on clinical practice; just because they are aberrant does not "in and of its' self" make them improper!)*. One thing that I have found true is the saying: *"people pay more attention to what you inspect, not what you expect!"* Therefore, instead of implementing this draconian 2.75% reduction for the next 3 years *(if not more)*, why not re-introduce the Medicare review procedures of the past in both the clinical and financial operations of home health with monetary penalties and/or recoupments based on those reviews. That way you'll be able to operate and clean-up home health of the bad operators with the precision of a scalpel instead of a steam shovel.

Suggestion:

Eliminate the proposed reduction of the national standardized 60-day episodic payment rate by 2.75% each year for the next three years beginning in 2008.

Determining the Case-Mix Weights *(pg 25392):*

1. A Cohort Admitted to Home Care From October 1997 to April 1998 (the Abt Case-Mix Study Sample Which Was Used To Develop the Current Case-Mix Model)

*There are several advantages to using data from this period of time as the baseline from which we measure the increase in case-mix. This time period is free from any anticipatory response to the HH PPS, and data from this time period were used to develop the original [[**Page** 25393]] HH PPS model. Also, this is the only nationally representative dataset from the 1997-1998 time period that measures patient characteristics using an OASIS assessment form comparable to the one adopted for the HH PPS. Because the Abt case-mix dataset was used to determine the current set of case-mix weights, the average case-mix weight in the sample equals 1.0. The sample's value of 1.0 provides a starting point from which to measure the increase in case-mix. The increase in the average case-mix using this time period as the baseline results in a 23.3 percent increase (from 1.0 to 1.233).*

However, agencies included in the sample were volunteers for the study and cannot be considered a perfectly representative, unbiased sample. Furthermore, the response to Balanced Budget Act of 1997 provisions such as the home health interim payment system (HH IPS) during this period might produce data from this sample that reflect a case-mix in flux; for example, venipuncture patients were suddenly no longer eligible, and long-term-care patients were less likely to be admitted. Therefore, we are not confident the trend in the CMI between the time of the Abt Associates study and 2003 reflects only changes in nominal coding practices, as will be explained in more detail further below in this section. Therefore, we are not proposing to use this baseline year to determine the baseline.

Comment:

First, the volunteer agencies didn't even represent 1% of the agencies in existence at the time. Hardly a statistically significant sample of the population!

Secondly, as you noted, venipuncture patients had previously been in the home health patient population when the PPS data set of '97-'98 was accumulated and these patients would generally have scored a very-

low case-mix weight *(generally in the MIN category)*, which would have pulled the average case-mix weight for the entire population down. Which, if venipuncture patients were included in the population sample that produced the 1.0 average case-mix weight, then that population sample was inappropriate and the results from using that data are incorrect. Therefore, the question is: **Were venipuncture patients included in the population from which the sample was selected?**

Thirdly, again as you noted, very high-acuity patients *(who were readily admitted into home health under cost-based reimbursement)*, were not as likely to be admitted to home health as early on in their course of treatment with the inception of the Interim Payment System (IPS) or PPS. That was because adequate resources were not made available to care for these patients in the home health setting so they very often had to move into other rehabilitation settings as they transitioned back to their home. This was mostly due to the fact that as time has gone on, we in home health care have been able to accept and successfully care for patients with increasingly greater acuity levels that what we could in prior years; and this is a trend that still is occurring today. However, when the reimbursement for our industry is based on data/service patterns that could be 5+ years old, it does not account for these types of higher-acuity patients *(and therefore, understates the true cost of dealing with the average current patient on our rolls)*.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this change in reimbursement methodology is reasonable and appropriate. We both would like to get this right the first time these new regulations are implemented.

12 Months Ending September 30, 2000 (HH IPS Baseline) *(pg 25393):*

> *Analysis of a 1 percent sample of initial episodes from the 1999-2000 data under the HH IPS revealed an average case-mix weight of 1.125. Standardized to the distribution of agency type (freestanding proprietary, freestanding not-for-profit, hospital-based, government, and SNF-based) that existed in 2003 under the HH PPS, the average weight was 1.134. We note this time period is likely not free from anticipatory response to the HH PPS, because we published our initial HH PPS proposal on October 28, 1999. The increase in the average case-mix using this time period as the baseline results in an 8.7 percent increase (from 1.134 to 1.233; 1.233-1.134=0.099; 0.099/1.134=0.087; 0.087*100=8.7%).*

Comment:

We have a problem with CMS proposing a 2.75% reduction in the standard 60-day episodic rate for the next three years on the results of a sample size that only represents a 1% sample of initial episodes. Why just initial episodes when your own research indicates that later episodes tend to be more resource intensive *(would not only using initial episodes have the effect of understating the true resource needs of the population)*? And since you have all the data, including the HHRG score and case-mix weight, why couldn't you just average out what the population score was? And this is something that could have been done with the '97-'98 data as well as the '99-'00 data. This is not data that works favorably with statistical sampling because the data is constantly changing on multiple levels *(# of users, age of users, acuity of users, etc...)*, each and every year, and that is something that is a bit more problematic with statistical sampling and projections based on those samples.

Additionally, when observing what happened with the average age of the Medicare beneficiary *(which does not appear to have been very much considered)*, you would find that the population change from 1997 to 2000, for the group aged 65 - 74 *(which would generally speaking, have to be considered the healthiest portion of the Medicare eligible population)*, that this group actual declined 1.6%. However, for that same span of time, the group aged 75 - 84 increased 4.6% and the group aged 85+ years aged 8.6%. And these two later groups would have to be considered less health in general, which would mean that as a portion of the population; the older and more frail groups now make up a greater percentage of that population than they did in 1997; which would imply that the average acuity level *(i.e., case-mix weight)*, would have increased for the entire

population over that period of time. Yet it seems that the CMS's position is that this increase in case-mix weight was due to inappropriate activities being perpetrated by those in the home health industry to inflate their reimbursement and had nothing to do with what was happening to the Medicare population!

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this data is being reviewed in its' entirety in a reasonable, proper and non-biased manner. We both would like to get this right the first time these new regulations are implemented.

12 Months Ending September 30, 2000 (HH IPS Baseline) *(pg 25393):*

Since the HH IPS, reported severity has increased as episodes have shifted from low severity groups to high severity groups. Concurrently, there has been a reduction in resource utilization. For example, the number of visits per episode has significantly declined under the HH PPS since 1999. This decline is illustrated in Table 6.

Table 6.--Average Number of Home Health Visits per Episode

Year	Total home health visits (excluding LUPAs)
1997	36.04
1998	31.56
IPS	25.51
2001	21.78
2002	21.44
2003	20.98

Comment:

We feel that the problem with this premise is it falls under the guise: ***"A little bit of information can be a dangerous thing!"*** Picture it as though all the necessary information for proper decision making is represented by a pie. The information represented above in Table 6 amounts to a single small piece of that pie. And it would generally be deemed very imprudent to make a decision based on only a portion *(piece of the pie)* of the data/information needed to make a fundamentally sound business/operational decision. Taken in a vacuum, one could easily surmise that the true resource cost per episode since the inception of IPS has been dropping. However, that would be making a decision that would be based on imperfect, incomplete data! A reduction in resource utilization does not necessarily indicate a reduction in resource cost. Looking at it from a strictly "visit" perspective, this just means that there were fewer visit per average episode in 2003 than in 2000; it says absolutely nothing about the type of visits utilized in 2000 versus 2003 *(or therefore, the cost associated with those visits)*. If the reduction in visits was weighted toward lower cost visits *(e.g., Home Health Aide, Certified Nursing Assistant,[HHA, CNA], etc...)*, then that would imply that a greater portion of the visits done in the years subsequent 2000 were the higher cost visits *(Nursing, Therapy and/or Social Worker)*, which would mean that the Avg. Resource Cost per Visit would indeed be higher in those subsequent years, which could mean that the total resource cost per episode was also greater. One example of what could have caused this to happen would have been the elimination of venipuncture as a qualifying skill. Because the average venipuncture patient would receive a nursing visit every one to two months but could have received a daily HHA visit. That could work out to 50+ HHA visits for every nursing visit per episode. Therefore, understanding all the pertinent information is of paramount importance when making important decisions; especially ones of such magnitude as what this change would create.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this data is being reviewed in its' entirety in a reasonable, proper and non-biased manner. We both would like to get this right the first time these new regulations are implemented.

12 Months Ending September 30, 2000 (HH IPS Baseline) *(pg 25393):*

> *We believe that change in case-mix between the time of the Abt Associates case-mix study and the end of the HH IPS period reflected substantial change in real case-mix. First, throughout most of this period, HHAs had no incentive to bring about nominal changes in case-mix because case-mix was not a part of the payment system at that time.*

Comment:

Again this preceding statement is not entirely correct. This is a totally subjective opinion presented by CMS to help justify this draconian 2.75 reduction proposed for the next three years. Just because the CMS opines that *"HHAs had no incentive to bring about nominal changes in case-mix because case-mix was not a part of the payment system at that time"*, that does not mean actions taken by HHAs across the industry could have affected the case-mix weight, and done so in a manner not anticipated or responded to by the CMS. Nor does it identify that there may have been several other variables that existed in one manner during the study and existed in a different manner subsequent the implementation of IPS and PPS. One example of actions taken by the HH industry was with the implementation of IPS, venipuncture patients *(whose case-mix score would have been low and therefore pulled down the national average)*, were quickly discharged and no longer admitted *(solely as venipuncture patients)* to home health. And an example of a variable that existed in a different state after PPS as what existed when the study was performed, was the average age of the Medicare population has increased. And a reasonable and unbiased person would expect that the acuity level of the average Medicare beneficiary utilizing home health services would have increased correspondingly; it is unrealistic to believe that the average case-mix weight *(which is supposed to be THE indicator of acuity level)*, would remain constant as the average age of the Medicare beneficiary increases. Therefore we believe that the portion of this rule based on this static case-mix weight is improper and needs to be corrected to account for the true realities of the Medicare population were serve.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this data is being reviewed in its' entirety in a reasonable, proper and non-biased manner. We both would like to get this right the first time these new regulations are implemented.

12 Months Ending September 30, 2000 (HH IPS Baseline) *(pg 25393-25394):*

> *An important implication of these studies and our comparative OASIS data is that patients with intensive or lengthy needs for nursing and personal care services as opposed to short-term or rehabilitative needs were less likely to be found in the national home care caseload as a result of the HH IPS. This would mean that a larger share of patients in the caseload would have acute, post-acute, and rehabilitative needs. Practice patterns began to change concomitantly with the share of visits shifting towards rehabilitation services and, to a lesser extent skilled nursing. In 1997 through 1998, the average number of therapy visits per 60-day period was about 3, whereas by the last year of the HH IPS, it rose to 4.4, with growth moderating thereafter. Skilled nursing visits declined from more than 12 at the beginning of the HH IPS, and stabilized at slightly more than 9 under the HH PPS. Aide visits declined by 44 percent from 1997 to 2000, the last year of the HH IPS, and continued to decline at a slower rate under the HH PPS. An issue in interpreting these trends in the utilization data is the uncertainty about how much of the startling change in therapy provision was driven by patient case-mix, and how much was driven by an anticipatory response of the practice pattern itself to our proposals for the original HH PPS case-mix system. By using a 10-visit therapy threshold, the proposal installed a substantial payment increase for high-therapy episodes. If providers started responding to the incentives in the anticipated HH PPS even before it became effective, then our measure of case-mix change between the time of the Abt Associates case-mix*

study sample and the HH IPS baseline is affected by provider behavioral change that is not strictly reflective of the case-mix of the treated population.

In contrast to the 13.4 percent increase that we consider a real case-mix change, we believe that the 8.7 percent increase in the national case-mix index between the HH IPS baseline and CY 2003 cannot be considered a real increase in case-mix. The trend data on visits (Table 6), resource data (presented below), and our analysis of changes in rates of health characteristics on OASIS assessments and changes in reporting practices (presented in section II.A.3.c of this proposed rule) all lead to the conclusion that the underlying case-mix of the population of home health users actually was essentially stable between the IPS baseline and CY 2003. Our research shows that HHAs have reduced services (see Tables 6 and 7) while the CMI continued to rise (see Table 7). We would normally expect [[Page 25394]] growth in the CMI to be accompanied by more consumption of services; but, to the contrary, we measure slightly lower resource consumption.

Comment:

Again, this is based on CMSs position that time does not affect anything, nor does the type of services provided. As CMS has stated in their own reviews, the level/volume of custodial services provided by HHAs since the inception of IPS *(which began after the Abt Assoc study and analysis had been performed which created the initial baseline for the national average case-mix weight)*, has dropped. This would have the compounding effect of:

- Reducing the average number of visits per average episode and
- Increasing the average *'Cost-per-Visit'* for the average episode *(and this would happen without any incremental changes in the discipline costs)*

Additionally, during this time, agencies were incurring increasing costs to train and maintain staff at their agencies and in the industry in general, which were not included in the data from which the IPS and initial PPS were based on. Competition from Hospitals for nurses and therapists was ever increasing as the better-reimbursed Hospitals across the country were offering higher wages and significant sign-on bonuses to attract these individuals from the home health industry. Also, most agencies across the nation were improving and or implementing their computers systems, incurring significant costs, which again were not adequately represented in the data from which developed IPS and PPS.

In addition to the above, many of the most acute patients that had previously gone directly from the hospital to home health now had to spend an extra few days in the hospital or some other sub-acute care setting prior to discharging to home health. Additionally, the rehabilitation necessary for many types of patients has changed over this time period *(e.g., total hip and total knee pts)*. This was greatly due to improvements in the procedures for performing these types of surgeries and therefore, their rehabilitation process improved also.

This is just the CMS looking to penalize the home health industry for perceived improprieties because the CMS has always viewed the home health industry as an inviting place to try to recoup funds from the national health care spending coffers. If there was this much impropriety in the billing of home health agencies across the country why hadn't the CMS or FIs been inundated with overbilling recoupments? Fore if this was actually going on, this is something that the CMS and FIs are charged with preventing! Maybe this had to do with the industry as a whole becoming more educated and precise in the OASIS used to establish patient acuity and therefore patient case-mix weight. This does not seem to be something that the CMS even begins to consider, even though the OASIS was first implemented in the early period of the Abt Associates study. And it would seem reasonable that as the industry worked with the OASIS documentation, their documenting would improve as time went on and they got more and more practiced as using this document.

Suggestion:

Meet with industry representatives (e.g., National Association representatives as well as some top financial, clinical and statistical people employed by home health agencies) to establish whether or not this

data is being reviewed in its' entirety in a reasonable, proper and non-biased manner. We both would like to get this right the first time these new regulations are implemented.

Significant Change in Condition (SCIC) Review *(pg 25426):*

> *The results of eliminating the SCIC policy suggested little impact on outlays--an increase of 0.5 percent of total payments. The difference in total payments was less than one-half of one percent for all categories of agencies (urban versus rural, by size, and ownership).*
>
> *Based on these findings, we are proposing to eliminate the SCIC adjustment from the HH PPS.*
>
> *Episodes that are currently SCIC adjusted would be treated as normal episodes and will receive payment for the entire 60-day period based on the initial, and only, HHRG code. The national standardized 60-day episode payment rate in section II.A.2.c of the proposed rule takes into account this proposed change in SCIC policy and is, therefore, slightly lower than it would have been without proposing this change. We believe the elimination of the SCIC adjustment policy would have a minor impact on home health agency operations and revenues, because SCIC episodes are very infrequent. Our estimate of the cost of eliminating the SCIC policy, implemented in a budget neutral manner as a reduction to the national standardized 60-day payment rate, is presented in section II.D and reported in the accompanying table (Table 23b). The estimated reduction is $15.71.*

Comment:

We agree that there would certainly be a relief of administrative burden if the SCIC policy was eliminated. However, the question becomes *'at what cost?'* This adjustment is going to impact EVERY episode that is Full w/no Outliers; Full w/Outliers and/or a PEP. This begs the question as to whether or not the $15.71 *'per-episode'* reduction is reasonable. I think that this is going to be an overcharge on a per-episode basis. We feel that this overcharge is too much by at least $3.07 per episode based on CMS's data. This is based on the preceding citations from the proposed rule that indicated that the review performed by CMS *"suggested little impact on outlays-an increase of 0.5 percent of total payments."* Therefore, if the pre-adjusted national standardized 60-day episodic rate equals $2,527.17; it would seem reasonable that the adjustment to this rate for the elimination of the SCIC should be 0.5% of this amount. This would equate to an adjustment of $12.64 ($2,527.17 x 0.5), not the $15.71 as proposed in the Federal Register. This would appear to be an overstatement of the adjustment needed to offset the elimination of the SCIC by $3.07.

Suggestion:

Reduce this adjustment to $12.64.

Non-Routine Medical Supply (NRS) Amounts Review *(pg 25430):*

> *..., we are not proposing any additional payments for NRS costs for LUPA episodes. However, we are specifically soliciting comment on alternative approaches for NRS payment in LUPAs.*

Comment:

We disagree that there should not be any payment for NRS costs for LUPA episodes. A basic principle of the foundation of the Medicare Program was that the Program would pay its' fair-share of the costs attributable to providing care for Medicare Beneficiaries and that it would pay the costs for any and all costs directly attributable to Medicare Beneficiaries. This is in complete conflict with that principal. These are true and clinically necessary costs incurred for the care of our clients and if for any reason the episode turns into a LUPA, that should not be reason enough to exclude these costs from reimbursement. Many times these are the most acute of patients we service and they become LUPA episodes because their acuity forces them back into an acute care setting; not due to any fault of the agency and/or staff providing care. And in these instances, the medical supplies used can be very costly and to just say that we are not going to pay for these costs because that are applicable to a LUPA episode is just plain wrong! The total costs (at least) incurred for the delivery and use of these medical supplies should be paid in addition to the LUPA reimbursement. And although there is no reasonable and/or equitable way to do this simply, we believe the program should reimburse the provider 200% of the direct cost of these medical supplies to also cover the overhead allocation (of Admin & Gen'l costs) that is applicable to all direct costs that any and every

agency across this country incurs. Either that or establish a fee schedule that identifies how much each medical supply will be reimbursed for. A LUPA episode is not a legitimate reason to penalize a home health agency.

Suggestion:

Establish a reasonable and prudent business practice for reimbursing medical supply costs incurred within a LUPA episode. Maybe reimburse at 200% of the cost from a non-related vendor or establish a fee schedule that lists out the reimbursement rate for the medical supplies.

Outlier Payment Review *(pg 25434-25435):*

Section 1895(b)(5) of the Act allows for the provision of an addition or adjustment to the regular 60-day case-mix and wage-adjusted episode payment amount in the case of episodes that incur unusually large costs due to patient home health care needs. This section further stipulates that total outlier payments in a given CY may not exceed 5 percent of total projected estimated HH PPS payments.

Under the HH PPS, outlier payments have thus far not exceeded 5 percent of total HH PPS payments. However, preliminary analysis shows that outlier payments, as a percentage of total HH PPS payments, have increased on a yearly basis. With outlier payments having increased in recent years, and given the unknown effects that the proposed refinements of this rule may have on outliers, we are proposing to maintain the FDL ratio of 0.67. By maintaining the FDL ratio of 0.67, we believe we will continue to meet the statutory requirement of having an outlier payment outlay that does not exceed 5 percent of total HH PPS payments, while still providing for an adequate number of episodes to qualify for outlier payments. Some preliminary analysis shows the FDL ratio could be as low as 0.42 in a refined HH PPS. We believe that analysis of more recent data could indicate that a change in the FDL ratio is appropriate. Consequently for the final rule, we will rely on the latest data and best analysis available at the time to estimate outlier payments and update the FDL ratio if appropriate.

Comment:

After several years of results regarding the Outlier Provision of the Home Health PPS, it appears to be more costly and punitive to our industry than was originally envisioned. The 5% that has annually been withheld to fund the outlier provision has never been fully expended in any given year; therefore the true cost to the industry is greater than the 5% it was established to be. In the documentation that I have gone through, the outlier payments paid out equal 0.05% of the non-Outlier payments. That equates to 1/100th of the 5% that each and every agency has paid in to the Outlier Fund. This provision is fiscally punitive to our industry and just appears to be a back-door mechanism that reduces the amount to be paid to our industry.

Suggestion:

Eliminate the Outlier Provision and revise the National Standardized 60-day Episodic Rate to include the additional 5% that had been attributed to the Outlier Provision.

Additionally, eliminate this for 2007 also!

Rebasing and Revising of the Home Health Market Basket *(pg 25435-25436):*

1. Background

Section 1895(b)(3)(B) of the Act, as amended by section 701(b)(3) of the MMA, requires the standard prospective payment amounts to be adjusted by a factor equal to the applicable home health market basket increase for CY 2008.

Effective for cost reporting periods beginning on or after July 1, 1980, we developed and adopted an HHA input price index (that is, the home health ``market basket''). Although ``market basket'' technically describes the mix of goods and services used to produce home health care, this term is also commonly used to denote the input price index derived from that market basket. Accordingly, the term ``home health market basket'' used in this document refers to the HHA input price index.

2. Rebasing and Revising the Home Health Market Basket

We believe that it is desirable to rebase the home health market basket periodically so the cost category weights reflect changes in the mix of goods and services that HHAs purchase in furnishing home health care. We based the cost

category weights in the current home health market basket on FY 2000 data. We are proposing to rebase and revise the home health market basket to reflect FY 2003 Medicare cost report data, the latest available and most complete data on the structure of HHA costs.

Data on HHA expenditures for nine major expense categories (wages and salaries, employee benefits, transportation, operation and maintenance, administrative and general, insurance, fixed capital, movable capital, and a residual "all other") were tabulated from the FY 2003 Medicare HHA cost reports. As prescription drugs and DME are not payable under the HH PPS, we excluded those items from the home health market basket and from the expenditures. Expenditures for contract services were also tabulated from these FY 2003 Medicare HHA cost reports and allocated to wages and salaries, employee benefits, administrative and general, and other expenses. After totals for these cost categories were edited to remove reports where the data were deemed unreasonable (for example, when total costs were not greater than zero), we then determined the proportion of total costs that each category represents. The proportions represent the major rebased home health market basket weights.

See Table 14 (Not Represented Here)

Comment:

After reviewing numerous Cost Reports, it appears that we disagree with the Cost Category Weight attributed to three broad areas of costs: 1) Wages; 2) Benefits and 3) Transportation. A comparison of the results from CMS versus our review follows:

- CMS has assigned (as per Table 14) a Cost Category Weight to Salaries of 64.484%, whereas, our review of numerous cost reports estimated a Cost Category Weight of 56.0%;
- CMS has assigned (as per Table 14) a Cost Category Weight to Benefits of 12.598%, whereas, our review of numerous cost reports estimated a Cost Category Weight of 8.40%, and
- CMS has assigned (as per Table 14) a Cost Category Weight to Transportation of 2.494%, whereas, our review of numerous cost reports estimated a Cost Category Weight of 4.50%.

Regarding Salaries and Benefits: If the Cost Category Weight is actually closer to 65% as opposed to the 77% per the proposed rule, then agencies that have a labor index of less than 1.000 will be penalized to the benefit of those agencies that have a labor index of greater than 1.0000.

Regarding Transportation Costs: If the Cost Category Weight is actually closer to the 4.5% as opposed to the 2.5%, any and all agencies will be penalized for the use of incorrect weights to determine costs; especially in light of the fact that gasoline costs (alone, and that is just one-factor of transportation costs), have risen more than 175% since 2001 (and have approximately doubled since 2003). It would also be reasonable to expect that agencies that have higher transportation costs (especially rural agencies), will be more adversely affected by an incorrect weighting.

Additionally, there is a significant understatement of expenses if the current high cost of gasoline is not accounted for in this model.

Suggestion:

Meet and work with industry representatives to ensure that the Cost Category Weights are appropriate and reasonable for the industry.

Also include an new additional adjustment factor to account for any Cost Category whose costs have far outpaced the other Cost Categories for the period of time from the base period to the most current period for which data is available [e.g., in this instance, Gasoline. That government data shows that the price of gasoline has increased 99% from 2003 (therefore, the dollar amount that you specified for gasoline in your update should be doubled)].

National Standardized 60-Day Episode Payment Rate *(pg 25442):*

The Medicare HH PPS has been effective since October 1, 2000. As set forth in the final rule published July 3, 2000 in the Federal Register (65 FR 41128), the unit of payment under the Medicare HH PPS is a national standardized 60-day episode payment rate. As set forth in Sec. 484.220, we adjust the national standardized 60-day episode payment rate by a case-mix grouping and a wage index value based on the site of service for the beneficiary. The proposed CY 2008 HH PPS rates use the case-mix methodology proposed in section II.A.2 of this proposed rule and application of the wage index adjustment to the labor portion of the HH PPS rates as set forth in the July 3, 2000 final rule. As stated above, we are proposing to rebase and revise the home health market basket, resulting in a revised and rebased labor related share of 77.082 percent and a non-labor portion of 22.918 percent. We multiply the national standardized 60-day episode payment rate by the patient's applicable case-mix weight. We divide the case-mix adjusted amount into a labor and non-labor portion. We multiply the labor portion by the applicable wage index based on the site of service of the beneficiary.

Comment:

Please see the preceding comments regarding Salaries and Benefits in regards to revising the HH Market Basket.

Suggestion:

Meet and work with industry representatives to ensure that the Cost Category Weights (i.e., the Labor Related portion of costs) are appropriate and reasonable for the industry.

Proposed CY 2008 Rate Update by the Home Health Market Basket Index (With Examples of Standard 60-Day and LUPA Episode Payment Calculations) *(pg 25443-25444):*

In order to calculate the CY 2008 national standardized 60-day episode payment rate, we are proposing to first increase the CY 2007 national standardized 60-day episode payment rate ($2,339.00) by the proposed estimated rebased and revised home health market basket update of 2.9 percent for CY 2008.

*Given this updated rate, we would then take a reduction of 2.75 percent to account for nominal change in case-mix. We would multiply the resulting value by 1.05 and 0.958614805 to account for the estimated percentage of outlier payments as a result of the current FDL ratio of 0.67 (that is, $2,339.00 * 1.029 * .9725 * 1.05 * 0.958614805), to yield an updated CY 2008 national standardized 60-day episode payment rate of $2,355.96 for episodes that begin in CY 2007 and end in CY 2008 (see Table 23a). For episodes that begin in CY 2007 and end in CY 2008, the new proposed 153 HHRG case-mix model (and associated Grouper) would not yet be in effect. For that reason, we propose that episodes that begin in CY 2007 and end in CY 2008 be paid at the rate of $2,355.96, and be further adjusted for wage differences and for case-mix, based on the current 80 HHRG case-mix model. We recognize that the annual update for CY 2008 is for all episodes that end on or after January 1, 2008 and before January 1, 2009. By paying this rate ($2,355.96) for episodes that begin in CY 2007 and end in CY 2008, we will have appropriately recognized that these episodes are entitled to receive the CY 2008 home health market, even though the new case-mix model will not yet be in effect.*

See Table 23A (Not Represented Here)

*Next, in order to establish new rates based on a proposed new case-mix system, we again start with the CY 2007 national standardized 60-day episode payment rate and increase that rate by the proposed estimated rebased and revised home health market basket update (2.9 percent) ($2,339.00 * 1.029 = $2,406.83). We next have to put dollars associated with the outlier targeted estimates back into the base rate. In the 2000 HH PPS final rule (65 FR 41184), we divided the base rate by 1.05 to account for the outlier target policy. Therefore, we are proposing to multiply the $2,406.83 by 1.05, resulting in $2,527.17. Next we need to reduce this amount to pay for each of our proposed policies. As noted previously, based upon our proposed change to the LUPA payment, the NRS redistribution, the elimination of the SCIC policy, the amounts needed to account for outlier payments, and the reduction accounting for nominal change in case-mix, we would reduce the national standardized 60-day episode payment rate by $6.46, $40.88, $15.71, $94.02, and $69.50, respectively. This results in a proposed CY 2008 updated national standardized 60-day episode payment rate, for episodes beginning and ending in CY 2008, of $2,300.60 (see Table 23b). These episodes would be further adjusted for case-mix based on the proposed 153 HHRG case-mix model for episodes beginning and ending in CY 2008. As we noted in section II.A.2.d., we increased the case-mix weights by a budget neutrality factor of 1.194227193.*

See Table 23b (Not Represented Here)

Home Health Care Affiliates, Inc.

Comment:

As previously commented on, we do not think that the SCIC adjustment has been properly calculated. Nor do we feel that the overall effect of the Outlier Provision has worked in the manner in which it was intended.

Additionally, as noted in several other sections of this comment letter, we feel that the 2.75% reduction of the National Standardized 60-day Episodic Payment Rate for the next three years is inappropriate. Please see those earlier comments for further details.

Suggestion:

Adjust the SCIC adjustment factor to the appropriate amount as indicated earlier.

Eliminate the Outlier Provision and increase the 2008 National Standardized 60-day Episodic Payment Rate by that 5% that had previously been removed to fund the Outlier Provision.

And also eliminate the scheduled 2.75% reduction for the next three years to the National Standardized 60-day Episodic Payment Rate.

If you have any questions/suggestions, please let me know.

Sincerely,

John M. Reisinger, CPA
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Home Health Care Affiliates, Inc.
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Ph2# (601) 983-3190 ext 1301

Submitter : Mr. Timothy Burgers **Date:** 06/25/2007

Organization : Home Care Alliance of Massachusetts, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-P-62-Attach-1.DOC

#62

June 22, 2007

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

Re: File Code CMS-1541-P

Dear Sirs:

The Home Care Alliance of Massachusetts (HCA), on behalf of our member home health care agencies, appreciates this opportunity to submit the following comments on the proposed rule for the FY 2008 Home Health Prospective Payment System Rate Update.

PROVISIONS OF THE PROPOSED REGULATIONS

A. Refinements to the Home Health Prospective Payment System

We wish to thank CMS for the extensive research and review that went into the refinements that have been proposed to the case-mix model. In particular, we support the proposals to increase payments for later episodes, replace the current single therapy threshold with a graduated rate adjustment, and include additional diagnosis variables in the case mix adjustment. The point system for wounds, cardiac, oncology and other diagnoses will allow home health agencies to be appropriately reimbursed for the care provided to these patients. We are hopeful that the increased complexity of the case mix model will more accurately reflect the true cost of providing an episode of home health services.

We are particularly pleased that CMS has proposed to remove OASIS item MO175 from the case mix calculation. As you note in the Federal Register notice, agencies have found it difficult to obtain and report accurate data on prior inpatients stays. We also support the $92.63 adjustment for LUPA episodes that occur as the only or initial episode in a sequence of episodes. We appreciate that CMS has recognized that the assessment visit is significantly longer and more costly for agencies. We also support the elimination of the Significant Change in Condition (SCIC) adjustment. The administrative burden of tracking and adjusting claims for SCICs has proven to far outweigh the small benefit that agencies receive from the occasional increase in reimbursement.

We are cautiously supportive of the change in the way the PPS recognizes and reimburses for non-routine medical supplies. We appreciate CMS' proposal to base NRS payments on five severity groups. However, we question the accuracy of the data that CMS used to identify NRS costs. Under the current PPS system, agencies have no financial incentive to ensure that all NRS are properly reported on their claims. We also have serious concerns that the proposed NRS payments do not adequately reflect the very high cost of NRS for ostomy and wound care patients. We encourage CMS to modify the NRS payments to more accurately pay for the costs of serving patients with

these needs, perhaps by adding another level of severity and payment amount for diagnoses that require extremely high NRS costs.

Case Mix Weight Adjustment

We strongly oppose CMS' proposal to reduce base rates by 2.75% over each of the next three years. We believe the rationale that CMS gives for such a rate reduction – that the increase in the average case mix weight for Medicare home health patients from 2000 to 2003 is entirely due to "upcoding" that is not related to patients' condition – is extremely weak.

There are a number of external factors that could reasonably be expected to increase the average case mix weight of home health patients, including an increase in the average age of Medicare beneficiaries, changes in hospital, IRF and SNF reimbursement systems that encouraged earlier discharge to home health, and the growth in Medicare + Choice and Medicare Advantage plans, which tend to attract healthier Medicare beneficiaries. As one example: a June 8, 2007, report by CMS ("Inpatient Rehabilitation Facility PPS and the 75 Percent Rule") reviewed Medicare beneficiaries' access to rehabilitation care and found a strong upward trend in the percentage of hospital discharges to home health for patients with total knee and total hip replacements between 2000 and 2003 (and that increase has actually accelerated since 2003). CMS has completely ignored the impact of this trend on average case mix weights of Medicare home health patients.

Furthermore, the only case mix item that agencies have direct control of – the 10-visit therapy adjustment – will be eliminated in the new case mix system and replaced by a more gradual increase in rates related to increases in the use of therapy services. By removing the incentive to hit an arbitrary 10-visit therapy threshold, CMS is eliminating the primary reason for any possible case mix creep. Without this incentive, we expect the case mix system will be self-correcting. The 2.75% case mix weight creep adjustment that primarily reflects growth in therapy utilization is unnecessary and punitive.

We also take exception to the fact that the proposed regulation makes no allowance for the administrative costs to agencies of complying with the large number of changes being proposed to the HHRG scoring and OASIS data collection and reporting requirements. Because of these changes, forms and software need to be changed, staff need to be reeducated, and changes in process may need to occur. These all cost agencies a great deal of time and resources which equate to money.

We strongly recommend that CMS eliminate the 2.75% reduction to base rates.

Outlier Payments

CMS proposes to continue use of a .67 Fixed Dollar Loss ratio (FDL) before outlier payments kick in, and the .80 loss-sharing ratio for outlier payments. We believe that the .80 loss-sharing ratio to be adequate; however, we strongly recommend that CMS re-evaluate and set a lower FDL for outliers. CMS has historically been very conservative in setting outlier payment thresholds for home health PPS: The CMS standards for outlier payment have failed to fully use the 5% outlier budget in every year that the home health prospective payment system has been in place. In the proposed

rule CMS states that "preliminary analysis shows the FDL ratio could be as low as 0.42 in a refined HH PPS." We strongly urge CMS to lower the FDL based on historical experiences to a level that ensures full use of the 5% outlier budget.

Wage Index

We strongly oppose the continued use of the pre-rural floor, pre-reclassified hospital wage index to adjust home health payment rates. Because home health agencies and hospitals compete for the same staff in a given geographic area, their wage indices should be comparable. We urge CMS to replace its home health wage index policy with a method that achieves parity with hospitals in the same geographic market by applying the same rural floor provision used for acute care hospitals and by applying some form of proxy for hospital reclassification. Alternatively, we recommend that CMS replace the entire hospital wage index system with a wage index based on BLS/Census Bureau data as recommended by MedPAC.

We note that the wage index for Rural Massachusetts is listed as 1.0661 in the proposed rule. We believe this to be a typographical error. Using the methodology that CMS has proposed to calculate the rural MA wage index as the average of the indices of all contiguous CBSAs, the current wage index for Rural Massachusetts is 1.1661. We would appreciate a correction in the final rule.

Thank you for this opportunity to comment. We would be happy to discuss our recommendations further.

Sincerely,

Timothy Burgers
Associate Director

Submitter : **Kristy Bourassa** **Date: 06/25/2007**

Organization : **HealthEast Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

See attachment

CMS-1541-P-63-Attach-1.DOC

#63

HealthEast Home Care
1700 University Ave W
St. Paul, MN 55104

June 25, 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

Please find below our agencies comments on the proposed PPS changes. We are a comprehensive Medicare certified, state licensed agency in St Paul, MN. We service the Twin City Metropolitan area and serve over 1300 elderly and disabled Medicare beneficiaries annually.

We support the efforts of CMS to restructure the Medicare payment system for home health. There are several welcomed changes in the proposed rule that we are pleased to support, including: linking non-routine supplies to patient characteristics, payment adjustments based on the interaction of multiple conditions and increased payment for LUPA episodes. However, we feel it is important to share our concerns related to the following.

Concern
CMS comment period is too brief.

Rationale
The brief comment period does not allow providers time to understand the complexity of the proposed changes and make determinations about the potential impact on the agency. Many of the proposed changes require software modifications in order to be able to project what the impact will be. Our vendor was able to assist us with this and we had access to some software as of Friday, June 22nd, which unfortunately has only allowed us one day to evaluate what these changes will mean from a financial perspective.

Suggested Solution
Extend the comment period to 90 days to allow enough time for providers to evaluate the impact of proposed changes.

HealthEast Home Care
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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 the increases are attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase reflects the changing demographic of home care's patient population and six years of experience in learning how to appropriately interpret the OASIS question and answer set, which ultimately has led to increased accuracy with our OASIS assessments.

Today, home care patients are older and more frail, with a significant number of patients being over age 80. The intensity of service they require has increased significantly due in large part to hospital DRG policy changes leading to decreased length of stay and changes in Inpatient Rehab Facility reimbursement that have resulted in home care agencies taking care of patients with a higher acuity level than in the past.

Over the past 10 years the Medicare home health benefit has been cut nearly every year. Once comprising 8.7 percent of Medicare spending, today it is 3.2 percent and is projected to drop to 2.6 percent by 2015. Given our growing population of elderly and disabled, these kinds of cuts will make it impossible for agencies to provide high quality care or any care at all.

Proposing additional cuts to the base payment rate over the next 3 years and multiple changes to the payment system at the same time seems blind sited. It would be wiser to evaluate the ramifications of the PPS changes after the first year and then determine any additional changes that may be required. It would be devastating to see another repeat of the impact that IPS brought, resulting in the closing of agencies all over the country and ultimately impacting many elderly and disabled Medicare beneficiaries.

Suggested Solution

CMS should suspend its plan to cut home health payment rates based on unfounded allegations of case mix creep and should delay any changes to the base rate that affect future years until an analysis of the impact can be completed.

HealthEast Home Care
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St. Paul, MN 55104

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 health agencies and hospitals compete for the same staff in a given geographic area. The growing differential between what home health agencies and hospitals receive from Medicare for labor costs is putting home health agencies at a significant disadvantage. As such, the applicable wage indices should be comparable. Further, the use of a mechanism that limits year-to-year fluctuations in the wage index will offer predictability and stability to annual budgeting.

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

Concern
Supply reimbursement for LUPA episodes and lack of adequate reimbursement for high cost supplies.

Rationale
Providers already provide LUPA visits at rates lower than the cost of care delivery. Failure to provide supply reimbursement for LUPA visits exacerbates this financial loss. This is especially valid for patients with catheters and ostomy supplies. For example, patients with catheters may only require a nurse visit once a month, yet supply costs are significant.

Over the past 2-3 years, we have seen pleural drainage systems being ordered and used in the home care setting to manage pleural effusions. The cost for one of these Pleural Drainage Kits (i.e., Pleurx) runs around $100.00. Depending on the amount of drainage a patient experiences, a new Kit is needed approximately every 2-3 days. This is a significant cost and very quickly becomes cost prohibitive.

Suggested Solution
Build in reimbursement for supplies for LUPA episodes.
Reimburse for supplies needed mid episode as a result of a new diagnosis/treatment which was not indicated at the time of initial OASIS assessment. Include variable to recognize higher cost supplies, including Ostomy supplies, Pleurx and other home management supplies that will emerge in the marketplace.

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Concern
Outlier Payments

Rationale
Continued use of a .67 fixed dollar loss ratio (FDL) will not utilize the 5% outlier budget as required by Medicare law.
The CMS standards for outlier payment have failed to fully use the outlier budget in every year that the prospective payment system has been in place. The CMS estimate that an additional $130 million in outlier payment will be expended in 2008 through the use of the same standards as in use in 2007 is without any basis.

Suggested Solution
Lower the FDL based on historical experiences to a level that ensures full use of the outlier budget.

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

Rationale
Providers need to use the Common Working File (CWF) to determine whether or not a patient has had care from another provider within the past 60 days. The CWF can only reflect data when a claim has been filed. If a claim has not yet been filed, there is no way that an agency can identify what sequence of an episode the patient may be in. In theory, this sounds simple, but we believe it would be an administrative nightmare to determine this with any accuracy. We believe that it would make more sense to look at this only from an individual agency cost perspective.
Defaulting to the early episode is not an acceptable solution for inability to determine the sequence of episodes.

Suggested Solution
Please take the complexity out of this regulation by allowing agencies to determine whether the patient is in an early or late episode based solely on the individual agency's provision of services. Do not hold agencies accountable for information that is difficult at times to ascertain, either from CWF and/or the patient/family.

Concern
Staging wounds that are Stage 3 or 4 with eschar coverage.

Rationale
Because providers are currently not allowed to stage wounds covered with eschar, stages 3 and 4 that are covered with eschar are not calculated into the case mix. However, these

patients need additional care and are at a significant risk of skin breakdown since these wounds were known at one time to be stages 3 or 4. By WOCN's own interpretation, this skin is always at risk of breakdown due to underlying permanent tissue damage. Therefore, it does not make sense to omit them from the case mix adjustment.

Suggested Solution
Allow previously staged 3 or 4 wounds to continue to be staged as such regardless of the presence or absence of eschar.

Concern
Requirement for OASIS assessment when there is a significant change in patient 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 reason to complete an OASIS assessment when there is a major change in patient condition. The Conditions of Participation already require communication with the physician when there is a change in patient condition. Therefore, there is no identified need to complete an additional OASIS when there is a significant/major change in patient condition.

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

Release the revised Conditions of Participation to coincide with the implementation of the PPS reform requirements to make sure PPS changes are congruent with changes to the Conditions of Participation.

Concern
The PPS reform proposed rule calls for the elimination of M0175 from the case-mix system because of the difficulty encountered by home health agencies in accurately responding to this OASIS item. However, CMS plans to continue to require that home health agencies continue to report this information on the OASIS.

Rationale
Any patient discharged from an institution may or may not need additional services and may or may not have experienced an improvement in condition. An institutional stay does not directly correlate to required services for home care.

HealthEast Home Care
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Suggested Solution
Eliminate the requirement to determine what inpatient facilities patients were discharged from in the past 14 days and accept "unknown" as a default response to M0175.

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 patients. Patients on waiver programs tend to be chronically ill and show no improvement in outcomes but rather show stabilization of their condition. Stabilization for such patients is considered a success 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 patients or report outcomes only for patients receiving Medicare services.

Thank you for the opportunity to submit these comments. We believe that CMS has made many improvements in HHPPS and look forward to further refinements in line with the comments set out above.

Sincerely,

Kristy Bourassa, RN
Director of Compliance/Regulatory Affairs
HealthEast Home Care
651-232-2813

Laurie Bauer
Utilization Review Analyst
HealthEast Home Care
651-232-2841

Submitter : Ms. April Anthony **Date:** 06/25/2007

Organization : Encompass Home Health

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

attachment

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

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

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

Submitter : Amy Potter **Date:** 06/25/2007

Organization : Home Therapy Specialists

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1541-P-65-Attach-1.DOC

#65

Home Therapy Austin
8701 North Mopac Expressway
Suite 310
Austin, TX 78735

June 25, 2007

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

Via: Electronic Submission

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

Federal Register Volume 72, Number 86 (May 4, 2007)

File Code CMS-1541-P

To Whom It May Concern:

Thank you for the opportunity to provide comments on the above referenced Proposed Rule. Your consideration of the comments provided below is appreciated.

Section II.A.2.a Early and Late Episodes

Although, there is appreciation for the effort to support distribution of funds for care of the long term patient, we are concerned about administrative burden and related costs associated with documenting the episode sequence, the incentive the additional payment for later episodes will provide for unwarranted recertification of episodes, the lack of clear definitions of higher resource use and the costs associated with training and system adjustments due to the move from 80 to 153 case-mix groups. These concerns result in an overall unfavorable position on the early and late episode change.

Section II.A.2.c Revised Therapy Thresholds

We are in agreement that the ten (10) therapy threshold system is flawed and support a revision. However, we do not agree that the smoothing will address the concern of gaming. We believe that those who are gaming at the 10 threshold will game at the 14 threshold. More oversight is needed. We encourage a system that ensures that clinical decisions are driving care.

Case Mix Weight Adjustment/ Case Mix Creep

This proposal is the most disturbing of the proposed changes in that it is based on an inaccurate calculation that the change in case mix weights is unrelated to changes in patient characteristics and because it implies that the industry as a whole has practiced in a dishonest fashion. We concur with the National Association of Home Care's position, "CMS should withdraw the proposal to reduce the base payment rate in the next three years and create an evaluation method to analyze changes in case mix weights that utilize proper standards related to case mix adjustment model and includes factors such as changes in per patient annual expenditures, clinical, functional and service utilization data and dynamic factors within the health care industry and Medicare system that impact patients served."

Wage Index

The use of the pre-reclassified hospital wage index to adjust home health payments is inequitable. We request a method that will put the home health industry on a level playing field with local hospitals.

Again, my thanks for this historic opportunity to comment on these critically important proposed updates and refinements to the Medicare Health Prospective Payment System.

Sincerely,

Amy Potter
President and Chief Executive Officer
Home Therapy of Austin, LLC
Home Therapy Specialists, Inc

Submitter : **Mr. Ambler Hall** **Date: 06/25/2007**

Organization : **Kare-In-Home Health Services**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Attached letter containing comments.

CMS-1541-P-66-Attach-1.DOC

#66

KARE-IN-HOME
HEALTH SERVICES
Healthcare Brought Home.

June 25, 2007

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

Dear Sir or Madam:

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

Kare-In-Home Health Services has been a Medicare certified home health agency since 1975, providing home health services to residents in seven counties of South Mississippi. WE appreciate the opportunity to provide comments on the proposed changes to the Home Health Prospective Payment System (PPS).

Summary of Home Health Payment Research

You make note of two Technical Expert Panel meetings that were conducted as part of the research to these changes. It would have been useful for the home health industry at large to have been able to see the recommendations that were shared and allowed to provide feedback in the development of this proposed rule change.

Provisions of the Proposed Regulation
Addition of Therapy Thresholds

While on the surface the addition of more therapy thresholds seems like a good idea, I believe this will lead to further confusion with respect to the case-mix scoring of patients. Currently, there is one critical point for differentiating in payment for therapy services, that being whether the patient receives ten or more therapy visits. The proposed rule establishes nine different payment points: 1. under six; 2. six; 3. seven to nine; 4. ten; 5. eleven to thirteen; 6. fourteen; 7. fifteen to sixteen; 8. eighteen to nineteen; 9. twenty or more.

Yes, this definitely creates payment variation which should seemingly create more payment fairness. However, in running differing scenarios through the Toy Grouper, the payment changes at the various break points do not seem to make sense. My initial interpretation of the rule left me with the impression that for each single visit provided above five, the payment would vary at decreasing rates. However, the Toy Grouper does not produce that result, rather it provides for additional payments at the various breakpoints.

I admit, I am confused. The proposed rule states "First, a gradual increase better matches payments to costs than the thresholds alone. . . . we are proposing that any per-visit increase incorporate a declining, rather than constant, amount per added therapy visit." I was going to take strong exception to your statement that "The

estimated marginal cost of adding a 7th therapy visit to an episode with six therapy visits was $36." However, the grouper produced an increased payment of approximately $402 for that seventh visit.

I am not sure whether I was making valid input into the grouper and/or perhaps the grouper was not functioning properly, but the additional payment at the fourteen visit threshold and at the twenty visit threshold was very significant. I believe the changes being made to the therapy threshold and related case-mix confounds the issue further that relates to the contention by CMS that the case mix has increased as a result of scoring and requires the adjustment in payment to be phased in over the next three years.

I believe that the payment for therapy services should be better thought out as far as these services relate to an impact on the case-mix and payment determination. It appears to me that the research has simply worked at fitting the episodes that have occurred into a payment model that will predict what payments have already been made, rather than truly analyzing what payment results are obtained at the varying levels along the way.

Determining the Case-Mix Weights

The proposed change to adjust for the nominal change in case-mix by reducing the national standardized payment rate should not be implemented. You have constructed an argument that the case-mix increase is not driven by underlying patient characteristics, but without adequate substantiation.

Taken together with the changes proposed to the therapy thresholds, I believe the case-mix is going to change dramatically and produce significant payment reductions to home health agencies. The proposed rule speaks of testing some of the proposed changes to see what the impact to payments are, such as with the SCIC changes. However, I did not see any mention of what these proposed changes would produce in the case-mix. CMS could have tested these changes against the claims data base to see what the change would be.

The magnitude of this proposed change should be more carefully undertaken and more thoroughly researched and impacts disclosed. The change in the scoring system has changed so dramatically, that I am afraid CMS will reap a double benefit. First a decrease in case mix due to the significant changes made in the system, and a second decrease in overall payments as a result of factoring in the arbitrary rate decrease for the "nominal case mix change."

Overall

Your analysis is full of comments that "we believe" and "we assume". In the change of this magnitude, I would appreciate a better factual based determination of the proposed changes.

Sincerely,

A. Corrie Hall, CPA
Chief Operating Officer

Submitter : **Carmen Deal** **Date: 06/25/2007**

Organization : **N.E. Washington Health Programs**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-P-67-Attach-1.DOC

#67

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

N.E. Washington Health Programs is a small rural health provider in Northeast Washington State that includes medical and dental clinics, home health, hospice and assisted living. The home health component provides care for people in a 3.5 county area that covers 6500 sq. miles. Our monthly census ranges from 150-200 cases, mostly between the ages of 60-90 years old. As one would expect, most patients have acute and/or chronic disease processes.

Case-Mix

Medicaid Eligibility and Caregiver Access

After evaluation of the comments regarding Medicaid eligibility and caregiver access, I have to disagree with the conclusion that Medicaid as reported on the OASIS did not have a significant impact on resource use. Medicaid numbers are not consistently reported because it is not the primary payor. Staff frequently overlook this item because it has no effect relative to payment. The caregiver questions do not reflect caregiver availability related to the patients' needs. Our Medicaid patients are usually more ill and have limited resources related to caregiver support because they cannot afford to buy care and the COPES program has a limited number of hours to offer.

Diagnosis Codes

We would request that any revision of diagnosis codes reflect the most current year's coding rules per the ICD-9 CM coding guidelines. Coding accurately and updating our education related to coding is an on-going process. Since nurses and therapists are not coding experts, we try to follow the new rules as they become available. I know there are some care plans that are not coded as accurately as possible due to a limited understanding of coding. We do not report every diagnosis that could impact the plan of care due to potential length of the list.

Early and Late Episodes

The early and late episode issue will not be followed closely by the clinical staff. They will do their best to ascertain that information, but if a patient is seen by another agency, it may be difficult to obtain accurate information. Due to the age of the people we serve and their multiple medical problems, they are often poor historians regarding

their health history, hospital dates, etc. They also will not remember if they have had previous episodes of home health care. The default to early episode will provide an agency less payment because we cannot retrieve that information. Since many patients only have one episode per year, it is usually related to an acute new diagnosis or an exacerbation of a chronic diagnosis. Due to the acute level of their problem, they require multiple disciplines to return them to a wellness level. Approximately 8% of our patients stay beyond the first episode, usually with a diagnosis related to wound care, neurological problems, CVA or trauma/burn injuries.

I would recommend a methodology that would allow Home Health agencies to access that information: early episodes should be paid at an equal or greater rate than later episodes.

Additional Therapy Thresholds

Multiple therapy thresholds will certainly refine the therapy process. We believe you have selected numbers for the therapy threshold that will minimize our payment for the orthopedic cases. Many of our patients need approximately 12 visits for their most acute period over 1 month and then are ready for outpatient follow-up. We will not receive adequate funding to manage those cases due to the 6 and 14 therapy threshold levels. Any change in the number of points related to M0700 (ambulation) will potentially reduce reimbursement and inhibit our ability to provide adequate service.

I recommend the therapy threshold be changed to 6, 12 and 20 to allow agencies to receive adequate compensation for therapy visits. My second recommendation is to maintain the point system as it currently exists for M0700.

Partial Episode Payment Adjustment (PEP) Review

PEP adjustments have required a significant amount of resource utilization for our agency with minimal reimbursement. We try to front-load visits and have developed strategies to try and assist patients to minimize hospitalizations and/or nursing home admissions, but often cannot impact either the patient's level of acuity and/or social situation to prevent a re-hospitalization which often results in a PEP. This continues to be an administrative and clinical nightmare.

Our recommendation is to eliminate the PEP due to its adverse clinical/administrative and financial impact.

LUPA Adjustments

The LUPA episode has been a loss of revenue since the inception of the process, mostly due to the cost of supplies, travel time, mileage and staff wages. The $92.63 add-on for an initial episode is an excellent idea. The add-on does not address the following issues:

- Recertification costs related to the administrative cost because most recertification visits do not naturally fall in the 5-day window (catheter patients).
- The cost of the supplies, especially for catheter patients (our cost per catheter change averages $21 - $28/month at a minimum).
- 85% of our LUPAs are due to patients with catheters.
- The high cost of the first few visits especially when an acute patient transfers to the hospital or to SNF and never returns to home health care.

We recommend full reimbursement of supply costs for LUPA visits; the $92.63 add-on for each episode; payment for the recertification visit that is required in the 5-day window; a higher reimbursement level for those acute patients who cannot remain at home and become a LUPA by no fault of the home health agency.

Non-Routine Supplies (NRS)

Non-routine medical supplies continue to cost our agency resources that are not reimbursed. The following supplies are not adequately reimbursed on a routine basis: any dressing product other than gauze (i.e., Alginates, absorptive dressings); Pleur-X kits and/or extra bottles; ostomy supplies (tracheostomy especially). The range of unreimbursed costs for dressing per episode averages from a low $105 to a high of $1,705. Wound care losses for 2006 = $11,265.

The Pleur-X kits must be ordered in a case of 10 and are currently $603 for the kits including shipping. The 500 ml bottles are $345 for a case of 10. We cannot order less than a case from the vendor.

Colostomy, urostomy and tracheostomy supplies are always greater than reimbursement Most colostomy, ileostomy and urostomy supplies are ordered monthly and range from $55 to $165 per patient, depending upon wear time and the status of the ostomy. There is no provision to deal with Stage 4 non-observable wounds that will need wound supplies as soon as they are debrided.

We recommend the following changes:

- Adequate reimbursement of NRS costs across all episodes – the range from $12.96 to $367.34 will not cover the cost for those high cost patients.
- A method for supplies to be reimbursed if the need for NRS occur after the start of care.
- Either a supply case-mix diagnosis or other method to identify high supply costs beyond the current upper limit as proposed (Pleur-X, tracheostomy, etc.)
- LUPA episode NSR costs

Case-Mix Weight Adjustment

Our agency is appalled by the proposed case-mix weight adjustment of -2.75% for 2008, 2009 and 2010. We disagree with the conclusion that a change in patient

characteristics was not the cause of the shift in case-mix weight. The utilization of increased therapy services is reflected in the age of the population (65-90 year-olds); the number of acute orthopedic patients [total knee repairs/replacements; hip repair/replacement and back (lumbar/sacral)] due to age, trauma, obesity and the desire of patients to maintain and improve function, especially mobility; the number of eligible beneficiaries who utilize home health services; increasing co-morbidities (diabetes, COPD, CHF, obesity, cognitive deficits); the nature of home health patients acuity level due to the discharge policies at hospitals, skilled nursing facilities and rehabilitation centers related to Medicare payment.

The increase in the use of physical and occupational therapy has also increased the cost of doing business due to supply and demand for therapists.

Our recommendation is to eliminate the proposal for the -2.75% reduction in the base payment for 2008, 2009 and 2010. It is counterproductive in a time when the need and cost for all therapies are increasing. If a patient can be restored to their maximum level of function, it promotes safety and provides improved overall health (i.e., bowel, bladder, cardiac, respiratory function, skin integrity). Home health is and will continue to be the most cost-effective setting for therapy services.

Wage Index

Our agency continues to disagree with the methodology that CMS has used for years related to the home health wage index. The wage index is based on prior years (old data) that never comes close to reflecting the true cost of wages and benefits that currently exist. The wage index uses geographic data that assumes it is less expensive to live in a rural area , therefore wages should be less. That is an untrue assumption related to healthcare. Our proximity to Spokane, Washington limits our ability to recruit. Home health is forced to pay, especially its nursing and aide workforce, less money than hospitals due to the limited reimbursement. Rural agencies such as ours struggle every day with recruitment of qualified staff, especially nursing, aide and administrative staff. We have been forced to use our resources to seek, recruit and retain therapy staff at a reimbursement rate above SNFs, rehabilitation facilities and hospitals just to obtain their services, which impacts our ability to recruit and retain nurses. The other issue is the amount of money we pay for mileage and travel times vs. our urban counterparts.

Our recommendation is as follows: Wage indexes should be based on current data (within one year of the current timeframe); be comparable to hospitals in a given geographic area (i.e., Eastern Washington vs. Western Washington or statewide); wage indexes should be updated yearly to assist agencies to budget appropriately.

Outlier Payments

The outlier standards minimize an agency's ability to be appropriately compensated for cases that have multiple discipline needs. I believe our agency has only

received $500-$600 for outlier payments, which did not begin to cover our actual expenses.

Our recommendation is that the standards for outlier payments be changed to allow agencies to recover their costs for those most expensive, high-needs patients. This would encourage agencies to accept these cases and provide an appropriate level of care.

General Comments

- We agree M0175 should be eliminated due to the degree of difficulty of obtaining accurate information; the potential for fraud and abuse charges; not always a true reflection of payment related to the patient status.
- The case-mix groups at 153 is at best difficult due to the sheer numbers; the methodology utilized for the rates has the potential for adverse financial impact.
- Therapy visit payments that decrease as the number of visits increase does not reflect the cost of therapy time travel and mileage, which is not altered due to the number of visits.
- The elimination of the SCIC is an excellent idea, it was difficult to operationalize from a clinical and financial standpoint.
- Change the COPs to reflect the elimination of the SCIC by 1/2008.

N.E. Washington Health Programs appreciates the opportunity to comment on the proposed CMS-1541-P regulations.

Submitter : **Date: 06/25/2007**

Organization : **American Health Information Management Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-68-Attach-1.DOC

#68

June 25, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1541-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Norwalk:

The American Health Information Management Association (AHIMA) is pleased to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed refinement to the Medicare Home Health Prospective Payment System (HH PPS) and calendar year (CY) 2008 Rates, as published in the May 4, 2007 *Federal Register* (CMS-1541-P).

AHIMA is a professional association representing more than 51,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnosis and procedure classification systems that serve to create the diagnosis related groups (DRG) discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM). AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including that associated with quality measurement and in the development, planning, implementation and management of electronic health records.

We urge CMS and HHS to take immediate action to secure the adoption and implementation of ICD-10-CM as a replacement of the ICD-9-CM diagnosis coding system, and supporting transaction standards, as early as possible. The refinements to the HH PPS described in this proposed rule, as well as any future refinements, would greatly benefit from the greater level of specificity and clinical detail in ICD-10-CM.

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phone (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

II-A: Refinements to the Home Health Prospective Payment System (72FR25358)

II-A-2b – Addition of Variables (72FR25357)

AHIMA agrees with the CMS proposal that an episode should not be eligible to earn more than one score for the same diagnosis group. This is comparable to the CC Exclusion List used in the hospital inpatient PPS, whereby complications/comorbidities that are closely related to the principal diagnosis do not cause a case to be assigned to a higher-weighted DRG.

We also support the proposals to assign scores to certain secondary diagnoses used to account for the cost-increasing effects of comorbidities and to combinations of certain conditions in the same episode.

II-A-2c – Addition of Therapy Thresholds (72FR25362)

We appreciate CMS' support for adherence to the coding guidelines concerning proper sequencing of etiologies and manifestations, as stipulated in the *ICD-9-CM Official Guidelines for Coding and Reporting*.

The proposed rule notes that V codes are less specific to the clinical condition of the patient than numeric diagnosis codes. It further indicates that medical review activities continue to report an excessive utilization of the V57 codes, signaling a possible non-compliance with correct coding practice related to the V codes. According to the *ICD-9-CM Official Guidelines for Coding and Reporting*, there are a number of instances when V codes must be used instead of the code for the acute clinical condition. For example, V codes for aftercare must be used instead of the code for the acute condition when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of a disease. Additionally, when the primary reason for the admission to home health is rehabilitation, the appropriate V code from category V57 should be assigned. Aftercare and rehabilitation are common reasons for admissions to home health care, and therefore, it is not unreasonable that these V codes would be frequently used for reporting of home health services. However, prior to allowance of V codes on OASIS, we believe there was significant non-compliance with the official coding guidelines pertaining to the use of V codes.

Since the *ICD-9-CM Official Guidelines for Coding and Reporting* were named as part of the ICD-9-CM coding standard under the HIPAA regulations for electronic transactions and code sets, V codes must be used in accordance with these guidelines and codes for acute conditions may not be assigned when prohibited by the guidelines.

II-A-2d – Determining the Case Mix Weights (72FR25386)

AHIMA opposes CMS' proposal to reduce the HH PPS standardized payment rate by 2.75 percent each year up to and including CY 2010 to eliminate the suggested effect of changes in coding or classification that do not reflect real changes in case mix. This proposed annual reduction percent is based on CMS' estimate of the nominal change in case mix that occurred between the HH interim payment system (IPS) baseline and 2003. It has no basis in actual current data or research pertaining to home health coding practices and their impact on case mix.

AHIMA has long been an advocate of consistent coding practices and serves as one of the four Cooperating Parties responsible for development of the *ICD-9-CM Official Guidelines for Coding and Reporting* and the content of the American Hospital Association's *Coding Clinic for ICD-9-CM.* These publications provide official industry guidance on complete, accurate ICD-9-CM coding, without regard to the impact of code assignment on reimbursement. AHIMA's Standards of Ethical Coding stipulate that "coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data." Therefore, AHIMA believes that all diagnoses should be coded and reported in accordance with the official coding rules and guidelines and does not advocate the practice of coding diagnoses only when they affect reimbursement.

AHIMA does not believe any payment adjustment to account for case mix increases, which are attributable to coding improvements, should be made until CMS has conducted appropriate research involving current data to determine the extent of the actual impact of coding practices on case mix at the present time. We acknowledge that at the time the HH PPS was first introduced, coding accuracy by home health agencies was not at the level it should have been. However, much has changed since then. Increased attention to the quality of coding and documentation as a result of the role coding plays in reimbursement has led to much-improved coding practices. Also, coding quality among home health agencies likely varies, so making an across-the-board payment reduction raises an equity issue that CMS needs to consider.

II-F: Home Health Care Quality Improvement (72FR25449)

AHIMA supports CMS' proposal to add two additional quality measures for emergent care for wound infections, deteriorating wound status, and improvement in status of surgical wound.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed refinements to the Medicare HH PPS program for CY 2008.

We recommend that CMS promote adherence to the ICD-9-CM coding rules and the *ICD-9-CM Official Guidelines for Coding and Reporting*, including the rules and guidelines pertaining to the appropriate use of V codes, by home health agencies. In order to ensure that CMS' own reporting instructions are consistent with ICD-9-CM rules and guidelines and promote accurate and consistent coding, we recommend that CMS collaborate with AHIMA on any updating or other revision of their instructions pertaining to the reporting of ICD-9-CM diagnosis codes.

AHIMA does not believe any payment adjustment to account for case mix increases, which are attributable to coding improvements, should be made until CMS has conducted appropriate research involving current data to determine the extent of the actual impact of coding practices on case mix at the present time.

AHIMA urges CMS to actively promote HHS' adoption and implementation of the ICD-10-CM coding system in order to ensure the availability of appropriate, consistent, and accurate clinical information reflective of patients' medical conditions. The greater level of clinical detail and specificity in ICD-10-CM will provide much better data to support the refinements to the HH PPS outlined in the

proposed rule for CY 2008, as well as any future refinements. Implementation of ICD-10-CM would improve CMS' and the healthcare industry's ability to measure quality, track outcomes, and capture differences in severity of illness. For example, the increased specificity in ICD-10-CM regarding postoperative complications and decubitus ulcers would provide better data for measuring quality of care and assessing patient severity (including improvement or deterioration of a decubitus ulcer). Use of ICD-10-CM would also provide a standardized reporting mechanism for significantly more clinical information than is possible with ICD-9-CM.

AHIMA stands ready to work with CMS and the healthcare industry to see that all these goals, including those of CMS for accurate payment, are met. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS

Submitter : Mr. Pat Laff **Date:** 06/25/2007

Organization : Laff Associates - Consultants in HomeCare & Hospic

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1541-P-69-Attach-1.DOC

#69

Pat Laff, C.P.A.
Lynda Laff, RN, BSN

Via E-Mail cms.hhs.gov/eRulemaking

Centers for Medicare and Medicaid Services
Department of Health & 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

Laff Associates is a consulting firm specializing in providing services to Home Health and Hospice providers and vendors since 1992. Prior to that date and since 1975, both principals have been involved in home health and hospice as providers as the chief clinical, financial administrative and executive officers of their respective organizations as well as on of the principals having served as a Deemed Status Joint Commission surveyor for twelve years. Laff Associates appreciates the opportunity to comment on the proposed rule.

Non-Routine Medical Supplies

Laff Associates has concerns about the proposed model for payment for non-routine medical supplies. While apparently only 10% of claims and cost reports including billing for these supplies, a greater number of providers' cost reports reflect supply costs, but their failure to bill for produced a zero cost to charge ratio and their cost data could not be included in the CMS analysis. The most significant reason was a lack of awareness of the importance of billing for these supplies since payment was not effected in the PPS system.

Additionally, "a number of costly non-routine medical supplies that are not reflected in the medical supply case-mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that made their appearance on the home care scene after the start of PPS are those supplies needed for 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".

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Hilton Head Island, SC 29928
(843) 671-4170
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www.laffassociates.com

While we understand the rationale for the relative weight and payment of $12.96 for severity scores of 0 that CMS estimates will apply to 63% of the episodes, we believe this to be an insignificant payment amount. A review of the proposed severity scores reflect the severity score 4 is designed to accommodate point scores of 60+, yet there is MO450=5 with a point score of 143, or 2.33 times a score of 60, yet the payment amount is the same. There may very well be combinations of items that will create a total score of 100 or more.

"Finally, 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".

Recommendations

The pool of dollars at $12.96 per episode attributed to the proposed Severity Level 0 with a severity score of 0 should be re-distributed to a new Severity Level 5 for point scores of 100+. The proposed Severity Level 4 point score range should be reduced from its presented 60+ to 60 – 99 points. The reduction of the number of episodes in the proposed Severity Level 4 that would be attributed to point scores of 100+ and the elimination of the episodes in the proposed Severity Level 0 could provide a payment amount for Severity Level 5 of approximately $650.00 and leave a surplus for LUPA application.

The case mix model should be adjusted to include supplies needed for closed chest drainage, and supplies for patients with ostomies, other than for bowel elimination at the appropriate severity scores.

LUPA patients should be eligible for non-routine medical supply payments and should not be discriminated against simply because the visits over the episodic period was less than 5. Providers should be allowed to indicate appropriate severity scores and receive the indicated payment amounts for non-routine medical supplies in accordance with the listed diagnosis and MO items, and specifically catheters, ostomies and for wound care. The funding for these payments would come from the elimination of any dollar values attributed to Severity Level 0 and be budget neutral.

Billing for non-routine medical supplies, specifying the type of supply and the quantities, should be made mandatory for all episodes and LUPAs to gather data for future evaluation of diagnosis and rates of payment. Billing for non-routine medical supplies, specifying the type of supply and the quantities, should also be made mandatory for all episodes and LUPAs to support any request for payment based upon severity scores and Severity Levels, or such payment be negated.

Conclusion

Thank you for the opportunity to submit these comments. We believe that the improvements already outlined by CMS in the NPRM issued on April 27th can be further enhanced and more equitable by incorporating the refinements suggested herein.

Respectfully submitted,

Pat Laff, Managing Principal
Laff Associates

Submitter : **Ms. Patricia Thomas** **Date: 06/25/2007**

Organization : **SC DHEC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1541-P-70-Attach-1.TXT

#70

TO: CMS
FROM: Patricia S. Thomas, RN, MN
SC DHEC Home Health Services Administrator

Date: June 27,2007

Please consider the following changes in the Home Health PPS Proposed Rule Changes.

1) Issue: 2.75% Case Mix Creep
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. The reduction of 8.7% is proposed to be taken over
the next three years at 2.75% for each year and will reduce the episode base rate equally.
This across-the-board cut does not consider individual coding practices.
There are several reasons that could 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. Our patients are now more rehab related patients than they were prior to PPS. Prior to PPS, we were
more custodial in nature. Due to this change, our patients have a higher acuity level.
Lastly, there are training issues for staff on all aspects of home health during the early days of PPS.
There was a significant learning curve in the midst of all the changes.

Recommendation: Eliminate or reduce the 2.75% base rate reduction. Changes in patient population and staff
learning curves all play into the increase in the case mix. The original rates were based on a relatively
small sample and the refinement analysis is now too old for appropriate consideration.

2) Issue: LUPA
Section Title: Provisions
Discussion: 15% of all visits were less than 4 during the base year of HH PPS. CMS thought that ¾ of the LUPA
claims would drop after implementation. The most recent data showed national LUPAs at 13% of all visits,
which is contrary to what CMS thought would occur. Our agency rate is higher than the national rate. Our agency is a
"gap filler" in our state. We believe that CMS' proposal to increase the LUPA rate by $92.63 is a good move.
However, what is being proposed is not adequate as it ONLY applies to the first SOC LUPA episode or the sole
LUPA episode. Administrative costs are spread over fewer visits. Those resources are expended in subsequent LUPA EP as well.

Recommendation: Our agency supports CMS' proposed change to increase the LUPA rate by $92.60 for the first
or sole LUPA episode. However, we would encourage CMS to apply the same consideration to all LUPA episodes.

Although LUPA's represent a relatively small number of patients, the administrative costs extend beyond the
first LUPA episode.

Issue: SCIC
Section Title: Provision

Recommendation: Support CMS' plan to eliminate the SCIC.

Issue: Non-Routine Supplies (NRS)
Section Title: Provisions

Recommendation: The concept of the NRS add-on is good. However, it was based on incomplete information
and may inadequately reflect the providers' true costs. Abt Assoc. reported that nearly 40% of the cost
reports where incomplete and unusable and only 10% of the claims data reported any supply charges.
Our agency supports the proposed NRS add-on and encourage CMS to continue to study the supply issue with future data.

Issue: Non-Routine Supplies (NRS)
Section Title: Provisions

Recommendation: We have examples in our agency of high supply costs on long term LUPA patients.
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 and may limit or
negatively impact caring for patients. We would like to encourage CMS to allow a NRS add-on using diagnostic categories.

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. This makes
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. 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. This leaves 2.5-3%
of the allocation on the table.

Recommendation: Use 5 % of the current amount budgeted for outlier payments and allocate the remainder to the
PPS general fund.

Issue: OASIS Changes
Section Title: Provisions
Discussion: The proposed changes on OASIS are positive.

Recommendation: Changes are positive. We would encourage CMS to time all of the OASIS changes at once.

Issue: Therapy Auto-Adjust
Section Title: Provisions
Discussion: CMS is proposing a positive change in the handling of therapy claims. Support change in process.

Recommendation: Our agency 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.
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

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, 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

Recommendation: Support the use of more variations in case mix variables.

Thank you for the opportunity to provide input into the PPS Proposed rule!

Submitter : Mr. Steven Richard **Date:** 06/26/2007

Organization : SUN Home Health Services

Category : Home Health Facility

Issue Areas/Comments

Revising and Rebasing

Revising and Rebasing

There are a number of significant legitimate issues that have been raised by the home health community including the lack of supporting documentation and poor assumptions used to substantiate the creep adjustment, but what is most bothersome is that in addition to the obvious attempt to reduce expenditures with the creep adjustment it is clear that coding case mix deletions and the rebasing of therapy thresholds also have a clear intent of reducing home health reimbursements. The current financial impact analysis is as flawed as it was with PPS implementation and cuts will again be much more severe then estimated. While CMS has provided little time for agencies to analyse the financial results, the analysis performed by providers indicate significantly larger reductions then CMS estimates. If this really is an attempt to improve reimbursement, CMS should be willing to delay the creep adjustment a year to see the effect of other changes. If it is simply a scheme to cut financial outlays without admitting such then CMS will undoubtedly move full steam ahead at the expense of providers and the patients we serve.

Submitter : Mr. Harvey Zuckerberg **Date:** 06/26/2007

Organization : Michigan Home Health Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-72-Attach-1.DOC

#
72

Michigan Home Health Association
2140 University Park Dr. – Suite 220
Okemos, Michigan 48864
Phone: 517/349-8089
FAX: 517/349-8090

June 26, 2007

Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health & Human Services

42 CFR Part 484
File Code: CMS – 1541 – P
Medicare Program; Home Health
Prospective Payment System Refinement
and Rate Update for Calendar Year 2008;
Proposed Rule

Dear Colleagues:

The Michigan Home Health Association (MHHA) is a leader among state home health associations and represents 347 certified, hospice, private duty, home medical equipment and pharmacy/infusion providers in Michigan. As such, MHHA provides information and educational opportunities on regulatory and policy requirements, as well as clinical quality standards for home health agencies. Additionally, on an ongoing basis, we monitor the impact of these requirements on our members and the industry-at-large through dialogue and collaboration with other state associations.

We have reviewed the proposed revisions to the Home Health Prospective Payment System (PPS) and are submitting the following comments for consideration. We appreciate your willingness to gather input and take recommendations prior to final rule implementation.

1. **Diagnosis coding**: The confusion regarding diagnosis coding continues. Although multiple presentations have been performed nationally and at the state level, clinicians find that what is available does not truly reflect the home health patient nor address the multiple services that are invested to provide care in the home. We do, however, appreciate CMS' inclusion of further diagnoses in the case mix that speak to our population. Continued guidance and clarification will still be needed.
   The initial disallowing of V codes as primary diagnoses, then their inclusion, has continually challenged staff who are not educated as professional coders. Their role is to provide the hands on clinical care required by these patients. With the changes that come about from the professional coders association and the revisions mandated by CMS, it is very difficult to educate staff to proficiency.

2. **Therapy Thresholds**: As has been evident with the M0825 up-coding/down-coding adjustments, it is difficult at the initial visit for staff to determine the amount of rehab visits the patient will require. Changes during the course of care that impact progress may alter the initial plan of care and the process that is in place is cumbersome. Therefore, we are happy to read that claims will automatically be adjusted when the final claim is submitted.
However, the proposed breakdown and allotted points do not support reimbursement for additional services, which indicate a higher acuity patient. Removing points when there are documented deficits does not correlate to their service needs.

3. **Medical supplies**: We understand that agencies were not correctly reporting the use of medical supplies in many areas. This is mostly due to misunderstanding on the agencies' part on how to identify them on the claim and believing that since they were bundled, there was no importance to tracking their usage.
Frequently, agencies are providing supplies to patients that are not a component in the plan of care under the current diagnosis; however, since they are bundled during the course of care, i.e. ostomy supplies, the agency is underpaid. This is attributable to various supplies: colostomy, urostomy, tracheostomy, ileostomy, gastrostomy, etc. There has also been an increase in the number of patients being sent home from acute care with pleural drainage systems that are high cost and part of the bundled supply list.
Also, as there will no longer be a SCIC payment adjustment, what will happen if a patient experiences a change in condition which now requires provision of supplies? How will the agency identify and seek additional reimbursement for those supplies?
We ask that CMS further review costs and reimbursement of these products and determine additional reimbursement or unbundling of these supplies by having them reimbursed thru DME suppliers.
An additional concern is the LUPA episode when the majority of these patients are seen for indwelling catheter maintenance and/or wound care. Since the reimbursement is per visit/discipline, the additional cost of the supplies may be a deterrent when agencies are asked to care for these patients.

4. **Case Mix Adjustment**: The proposed changes to the case mix do not reflect the acuity and population characteristics that agencies are experiencing. Acute care facilities discharge quickly with minimal education being provided. Caregivers are not available or willing to provide what they see as 'medical' care in the home setting. Families are mobile and/or employed and not available to meet the needs of family members. Rehab services have increased to promote patient independence and self-sufficiency in order to improve patient outcomes.
The case mix model has been questioned related to its inability to truly capture the correlation between payment and patient needs. We ask that CMS withhold changes to the case mix rates until further analysis can be done.

5. **Wage index:** Staffing in-home health care has become increasingly challenging. Staff are inundated with ever-changing demands regarding documentation, regulations, payor requirements and the increasing acuity of the home care patient. We compete with hospitals in the area for staff, and the limited number of nursing and therapy providers , especially here in Michigan, is creating a crisis. If CMS continues its use of the wage index in its calculation, we request that it be comparable to hospitals in the area. However, we would propose that another method be researched as a more equitable tool.

6. **OASIS assessment changes:** We question the deletion of M0610 as a case mix variable, since there are many instances when a patient's behavior, without benefit of a formal psychiatric diagnosis, may impact the care being provided. For example, the patient who continues to smoke while on oxygen may demonstrate impaired decision-making, which will require increased care from nursing.

We appreciate the opportunity to comment. If you have any questions or wish to discuss our recommendations, we can be reached at (517) 349-8089 or by e-mail at zuckerberg.harvey@mhha.org

Sincerely,

Harvey Zuckerberg
Executive Director

Lynn Zuellig
President

Submitter : **Ms. Susan Dobbelstein** **Date: 06/26/2007**

Organization : **North Country Home Care/Hospice**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

CMS-1541-P-73-Attach-1.TXT

North Country Home Care/Hospice
3515 Pine Ridge Ave. N.W.
Bemidji, MN 56601

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attnetion: CMS – 1541-P
P.O. Box 8012
Baltimore, MD 21244-81012

Re: CMS – 1541-P

This letter is being written on behalf of the North Country Home Care/Hospice's Home Care Program whose purpose is to serve clients in the most cost-effective manner to bring about the most positive client outcomes and functional improvement. North Country provides services to about 700 clients per year in the Skilled Home Care Program.

The Prospective Payment System for Medicare home health is based on the right principles as it facilitates outcomes-oriented patient care planning that is focused on self care and rehabilitation. Our MHCA has strongly supported CCMS efforts to restructure the system and to replace a poorly functioning case mix adjustment model. However, there are areas of serious concern as addressed below:

Concern
Financial Impact – the loss of the Rural Add-On has left our Home Care Program in the **"loss column",** coupled by ongoing necessary training for Coding, OASIS updates and now new training with new PPS System. We are a small agency and do not and cannot afford the support a large agency can have to support these activities.

Concern
CMS comment period is too brief.

Rationale
This lengthy proposal and brief comment period does not allow us as providers the time to understand the changes and the impact the changes will have on the business in order to make informed decisions.

Suggested Solution
Extend the comment period for this change and futuristically, allow enough time for us as providers to evaluate the impact of these significant 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 our agency and the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase reflects the changing demographics of home care's patient population and a need to have a **Certified Coder** in order to appropriately and accurately manage this new component of documentation in home care that does impact our 'bottom line". In addition, accurate coding tells the "story" of the type of patients being effectively served in Home Care. Coding has become a necessity and done in conjunction with the nurse and nurse manager we strive to assure accuracy and not cheat the government or ourselves! In addition, more intense staff training on OASIS has resulted in more accurate OASIS answers.

Today, home care patients are older and more frail, with a significant number of patients being over the age 80. The intensity of service they require has increased significantly due in part to hospital DRG policy changes leading to decreased length of stay and the changes in Inpatient Rehab Facility reimbursement has appropriately steered more, but sicker, patients in home health services. Twenty years ago the population we served was between 65 and 75 and management of chronic disease was far less significant than it is today as we care for 80+ year old patients still living and striving to manage in their own homes.

Over the past 10 years, the Medicare home health benefit has been cut nearly every year. Once comprising 8.7 percent of Medicare spending today it is 3.2 percent 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". Home Care is on of the most cost effective forms of health care we have and can be provided where people want to be – at home. Additionally, in this rapidly changing home care industry, it is unrealistic to plan a three-year reduction. The environment could changes significantly in this short period of time.

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

Concern
Low market basket adjustment for Home Care compared to hospitals and skilled nursing facilities, a lack of rural cost coverage and a higher 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 with 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 percent to match the increase proposed for hospitals and skilled nursing facilities and use the post-rural floor, post reclassified authority wage index for home care as is done for hospitals.

Concern
Supply reimbursement

Rationale
Estimate of supplies is based on inaccurate information. As a Provider, we have not always placed supplies on the claims because the complexity of supplies and getting the right supplies on claims has been not only confusing, but a constant process of re-educating nursing staff; making the accuracy of the cost of supplies nebulous at best. As this is not reimbursable, there are more important issues to focus on: accurate OASIS and accurate coding!

As a provider we already provide LUPA visits at rates far below the cost of care delivery. Failure to provide supply reimbursement for LUPA visits exacerbates this financial loss. This is especially valid for clients with catheters and ostomy supplies (urostomy supplies not covered in any situation). For example, patients with catheters many only require a nurse visit once a month, yet supply costs are significant.

Suggested Solution

Build in reimbursement for supplies under LUPA visits, especially long-term patients who fall under the LUPA visits. Allow inclusion of reimbursement for supplies when there are changes from the initial assessment and from one episode to another. Include variable to also recognize costly Pleurovax and ostomy supplies.

Concern
Estimated financial impact of outliers with a net increase of $140 million set aside by CMS.

Rationale
The financial impact estimate from the "Outlier" patient is unrealistic. Providers historically have not needed outlier reimbursement when we discuss this with other agencies. This agency has yet to have experienced an outlier. These monies will remain on the table and are not useable to help cover care costs under routine PPS.

Suggested Solution
Re-look at the financial impact and adjust the dollars to more accurately reflect the reality of the impact on home care.

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

Rationale
As Providers we must rely on the Common Working File (CWF) 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 has historically not kept up to date. In addition, 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 Solution
Automatically adjust the final claim to accurately reflect early and late episodes of care rather than defaulting to an early episode. And, consider only one agency's episodes of care to determining if an episode is an early or late episode. It seems this would be cost savings to CMS and the providers in the big picture.

Concern
Implementation date of January 1, 2008!

Rationale
These PPS Reform changes are significant! As a provider we must educate all of our employees on these massive changes and work closely with vendors to initiate complex IT changes. As providers we must then implement the changes throughout the organization – clinical and financial. This is no small project to try to implement in two months or less.

Suggested Solution
Push back the implementation date to October 1, 2008 to allow ample time for providers to make all the necessary adjustments. Then, release the long awaited 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 the changes to the Conditions of Participation. Please consider this!

Concern

Known pressure ulcers that are Stage 3 or 4 with eschar coverage.

Rationale

Because providers are currently not allowed to stage pressure ulcers covered with eschar, stage 3 and 4 pressure ulcers that are covered with eschar are not calculated into the case mix. These patients, however, require additional care to address the significant risk of potential further skin breakdown as well as infection. According to WOCN's interpretation, this tissue is always at risk of breakdown due to the underlying permanent damage. Therefore, it does not make sense to omit them from the case mix adjustment.

Suggested Solution

Known stage 3 or 4 pressure ulcers should remain stage 3 or 4 pressure ulcers despite the presence or absence of eschar.

Concern

The OASIS requirement for an OASIS assessment when there is a significant change in client condition.

Rationale

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

Suggested Solution

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

Thank you for taking the time to consider these comments.

Sincerely,

Susan Dobbelstein, Director
North Country Home Care/Hospice

Submitter : **Ms. Landace Woods** **Date: 06/26/2007**

Organization : **Greenville Hosp System Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

Market Basket Index

Market Basket Index

Please maintain at least a 2.9% MBI. Eliminating the MBI for Home Health will negatively impact access to care for Medicare recipients.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Issue: Case Mix Creep: Please eliminate or reduce the 2.75% base rate reduction. The refinement analysis is too old for appropriate consideration. As a hospital based home health agency, the vast majority of our patients have recently experienced acute changes in their condition. Our Medicare patients are admitted to Home Health services sieker than they have been in previous years such as 2000 and 2003. Length of stay has decresed for hospitalization - thus patients are sent home in need of more complex care- Providing home health care is more costly than ever as it is primarily provided by professional staff. Medieare recipients deserve safe and competent care provided by staff who have training in caring for the frail elderly. In order to safely care for these debilitated patients, our home health spends great resources on keeping staff competent and on hiring professional staff. A reduction in the episode base rate would negatively impact access to care for needy Medicare recipients.Our agency may be faeed with not being able to accept patients for care if the episode rate decreases - as a result, length of stay for hosptialization eould increase - thus increasing Medieare expenditures /recipient. Many patients are too sick to go home without Home Health.

Issue: LUPA - Please apply the same proposed increase to the 1st or sole LUPA episode to ALL LUPA episodes. Our agency experiences administrative costs for all LUPA episodes - not just the 1st. Our inability to cover costs may negatively impact access to care for the long term patients such as those with catheters - these patients may have to seek care in more costly alternatives - such as a nursing home. Home Health currently struggles to cover the basic costs required for the hands on care - not to mention the administrative costs - such as visits for the sole purpose of a recertification OASIS.

Issue: SCIC - Eliminate the SCIC

Issue: NRS - Non Routine Supplies - This is an area that warrants additional study as the concept was based on incomplete information and may inadequately reflect the agency's true costs. Abt reports that nearly 40% of cost reports were incomplete and unusable and only 10% of the claims data supported any supply charges. While I support the concept of the add on - additional analysis is needed.

Issue: Outliers - Please allot 3% of the 130 million for outlier payments - this should more than cover the national outlier rate. Our Agency's current rate is less than 2%. Allow the unused 97% allocation to be folded back into the base episode rate.

Issue : OASIS changes - Please make all OASIS changes at once.

Issue: Therapy Auto-Adjust - I support this change.

Issue: Case Mix Refinement - Early/Late Episodes - Eliminate the Early/Late distinction and redistribute the weighting to all the episodes. Simplify the 4-equation model to a 2-equation model with therapy thresholds. Please address the issue of the CWF so that real time data is available. Adding the administrative burden of checking early/late episodes with a inadequate CWF data base only adds to the expenses for agencies . The more non-direct care expenses that are necessary - the less resources agencies have to provide access to hands on care for our frail Medicare population.

Submitter : Mr. Andy Carter **Date:** 06/26/2007

Organization : Visitng Nurse Associations of America

Category : Health Care Provider/Association

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-1541-P-75-Attach-1.DOC

#475

June 25, 2007
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1541-P,
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Kuhn:

I am writing on behalf of the Visiting Nurse Associations of America (VNAA) to comment on: Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P). The VNAA represents over 400 non-profit, community-based home health agencies throughout the United States. We appreciate the opportunity to comment on this proposed rule which, while improving many aspects of the PPS system, will have a negative effect on the ability of our members to provide access to high-quality care to the Medicare population due to the 8.25% payment cut.

At the outset we would like to take this opportunity to thank CMS and its contractor, Abt Associates, for inviting representatives from several Visiting Nurse Associations to participate in the Technical Advisory Group that Abt Associates convened to provide expert advice on many of technical and clinical issues reflected in this rule. We would also like to thank CMS for being responsive to many of the suggestions made by VNAA and its members over the years, which are also reflected in the proposed rule. While there are also suggestions that were not heeded or which have been adopted in what we believe to be a less than an optimal manner (as described in our comments below), we are deeply appreciative of the time and attention the CMS staff has afforded us.

VNAs are disheartened by the unexpected addition of the across-the-board, 3-year cut in payments which has been proposed to account for CMS' estimate of nominal case mix increase since the inception of the PPS program. This adjustment will create tremendous hardship for our membership, compromise their ability to maintain and increase access to cost-effective alternatives to institutional care and, in our view, is totally unjustified. We will be providing detailed comments below which we hope will result in the exclusion of this proposal from the final rule.

Provisions of the Proposed Regulations

VNAA supports, in principle, the refinements to the case mix model as well as many of the specific elements added. We, however, have been frustrated in our ability to analyze

these proposed changes in detail because CMS did not simultaneously publish along with the rule, the detailed software logic to simulate the complex, new HHRG grouper. Nor has it provided the data files and Abt reports which it often references in the rule as the basis upon which its decisions were made. After the 6 years of CMS research that led to these proposed rules it is unrealistic to expect the public to comment fully on that research in 60 days without access to key analytical files and research studies. The delayed and incomplete release of the key information needed to understand this rule certainly frustrated our ability to provide more meaningful public comments. At the closing of the comment period the vendors serving the home health community are still unable to produce consistent impact projections on the proposed PPS changes using the materials provided. Nevertheless, we do appreciate CMS' eventual release of the "toy grouper" and pseudo-code and will comment on specific provisions as competently as possible given the limitations above.

VNAA is pleased with most changes in the case mix scoring methodology but disappointed that two variables important to determining resource use in home health have been deliberately excluded by CMS from the payment algorithm, specifically: Medicaid dual eligibility status and absence of informal caregivers. Our experience shows us again and again that Medicaid/Medicare dual eligibles consume, on average, a disproportionate level of resources. CMS asserts that its data do not support a strong enough relationship to include Medicaid status in the case mix weights. CMS does not offer what its criteria are for a sufficient relationship, nor does it provide a description or access to analytical files that would allow its methodology or conclusion to be reviewed. Absent that, our experience stands at such odds with the CMS conclusion, we can only ask that this issue be revisited and reexamined before the final rule is published since we fear something may be amiss in the analysis. We would point to, for example, the disproportionate share hospital payment methodology that is based on the clear relationship between Medicaid status and higher hospitalization costs under Medicare. We believe it is illogical to conclude that the relationship between increased Medicare costs and Medicaid/Medicare dual eligibility status which has been confirmed by MedPAC in hospital DSH studies suddenly disappears when those same patients are transferred to a home health agency.

CMS also dismisses the suggestion that absence of a caregiver should be included in case mix, not because it does not drive higher costs, but because it "raises policy concerns." CMS specifically cites the fear of negative incentives. We believe excluding this key variable also introduces negative incentives that are far more damaging than inclusion. Specifically, patients who do not have access to an informal caregiver will have increased difficulty gaining access to home health care since, as CMS points out, their care is under-funded by the PPS system. On balance, putting the real concern for beneficiary access ahead of the theoretical and (we believe) mistaken concern that caregivers will cease caring for their relatives or friends, we must conclude that CMS' policy concern should be resolved in favor of including rather than excluding this variable.

CMS also makes reference to certain un-named variables which, while correlated with higher home health cost, were not considered in case mix because of negative treatment

incentives they could create. While we appreciate that concern, it would seem only fair and consistent with the Administrative Procedures Act that alternatives that were not adopted be specified along with the reason for dismissing them so that the public would have the opportunity to understand and comment on them.

We strongly support the elimination of the M0175 variable from case mix for the reasons cited in the proposed rule. However we believe many of those same arguments should have resulted in the elimination of this item from OASIS as well. While it seems simple to obtain reliable prior stay information, we often have difficulty obtaining this information from our oldest and sickest patients. This results in erroneous data and the need to expend limited administrative resources to verify information, which is often frustrating in itself since prior providers may have little interest in responding to our inquiries. We suggest this item be deleted from OASIS if for no other reason than it is often unreliable despite the best efforts of our VNAs' staff. VNAA has made this point directly to OMB in separate comments related to the OASIS PRA notice.

We also support in principle the elimination of the single therapy cap and the substitution of a mechanism that graduates payment related more closely to therapy usage. We are concerned that the size of the dollar increments between the new therapy levels are so modest between 6 and 14 visits that it may create payment deficits. We would urge CMS to reexamine the incremental cost of additional therapy visits to assure that there is a balance between over-compensating and under-compensating therapy usage. We also suggest that the OASIS change requiring projection of a specific number of therapy visits be modified to project visits in the specific ranges included in the new PPS scoring.

We share CMS' concern about coding, both the expanded use of V-codes and the propensity of ICD-9 Coding Directions to identify primary and secondary diagnoses codes that have little relevance to home care costs. We would be supportive of an initiative by CMS to develop and adopt HIPAA coding directions specific to home health within the overall coding conventions. Alternatively, further research might point to linkages between V-codes and secondary numeric codes that are predictive of resource use. The requirement that home health agencies essentially "double code" all home health cases is inefficient and burdensome and should only be considered a short-term expedient.

We are supportive of CMS' adoption of higher case mix weights for third and subsequent episodes of care. VNAs often care for patients whose illnesses are so complex and advanced that their resource needs are great and yet homecare is a more humane and cost-effective alternative to institutional care. The additional Medicare payment on behalf of such patients, although modest, will help VNAs maintain their commitment to caring for such patients.

We also have several technical comments in the form of questions related to case mix which we hope CMS will address in the final rule as outlined below:

- Table 2a "Case-Mix Adjustment Variable and Scores" indicates there are 4 equations. Table 3 "Severity Group Definitions: Four Equation Model" actually has a "fifth equation", the episodes with 20+ therapy visits. How will the episodes with 20+ therapy visits be scored for there is no guidance for this group in table 2a?

- Functional Dimension Equations: We've noted that M0690 transfers and M0700 Ambulation/ Locomotion have been significantly impacted on this rule. Unless the patient requires 13+ therapy visits reimbursement points are not assigned until the patient is unable to transfer. M0700 provides reimbursement points for the patient in equation 2 and 3 only. While the toileting (M0680) is not affected by the equations and bathing (M0 670) and dressing (M0 650/660) continue to receive reimbursement points in all equations at the same level of disability as in the current HHRG methodology. Overall, the standard to receive reimbursement points in the functional dimension for M0690 and M0700 appears to have been set at a higher level than previously. This appears to be another example of adjustments in the payment formula to address "case mix creep." We would propose CMS further study the results of these adjustments before imposing a negative adjustment.

- ICD-9-CM coding will have more an impact on PPS under these rules. However, we noted some inconsistencies with the current practice reported by members. CVA's: The most recent guidance for stroke coding is to use 434.91 for the initial contact after the in- patient stay if the specific reason for the stroke is not known. 434.91 is no longer listed on the case-mix list. However, the code 436, the former and now invalid code for unspecified CVA's, is listed. Was this a mistake or is home health now going to be instructed to use the Late Effects of the CVA code category (438) as is used in other health care facilities (rehabs)?

VNAA is supportive of the change in LUPA payments to allow an additional per-episode payment to reflect the costs of LUPA episodes that had not been previously captured in the LUPA per-visit payment rates. We are concerned, however, that the payment level proposed still understates that cost because CMS only included an estimate of additional minutes of direct service cost for assessment in its computation. LUPA episodes are also underpaid because the entire administrative cost of the agency that was fully recognized in the 60-day episode rate was only partially recognized in the LUPA rates yet the administrative costs incurred in LUPA and full episodes are very similar. Beyond the high cost of initial assessment, the agency has fixed administrative costs for preparing and submitting bills, OASIS transmission, and all the other general and administrative costs of operating an agency. For that reason, we also believe the LUPA add-on should be applied to all LUPA episodes with the exception of those following a full episode payment. When patients have a series of LUPA only episodes, the add-on is justified. We recommend that CMS revisit this issue and increase the LUPA episode amount to account for the full overhead cost for such episodes and apply the add-on to all LUPA episodes except those following a full episode payment. We would also point out that the proposed rule lacks operational clarity in determining what constitutes an "initial" LUPA.

Should the initial LUPA policy be maintained, the method for determining "initial" should be clarified.

During the development of the original PPS rules there was considerable controversy over the amount of the RAP payment. Despite comments made since that time, this proposed rule is silent on the need to increase the RAP. Given the length of the home health episode, it would be more equitable and cost Medicare virtually nothing to increase the RAP percentage and reduce the cash-flow problems of agencies awaiting the processing of final claims. The principal arguments made at the inception of PPS against a higher RAP -- the potential for program abuse of the RAP -- have not materialized. If it had, CMS would have exercised its authority to withhold RAPs. Thus, while there may be a legitimate reason to maintain a low RAP percentage for new providers who have not established a track-record as stable and reliable providers, there is every reason to relieve established providers of the cash flow problems associated with the current low RAP percentage. Therefore, VNAA proposes that the RAP percentage be increased to 80/20 for all providers who have participated in PPS since its inception. CMS would retain the right to reduce this level for abuse of the RAP. Less established providers would operate under current RAP rules until they had a 5-year record of responsible Medicare performance.

VNAA is disappointed that CMS considered but rejected changes in the PEP adjustment that would more accurately allocate costs. While we recognize that the law requires that CMS prorate payment when a patient moves to another agency in the middle of an episode, the current methodology often underpays in the case of PEP transfers. This is particularly troubling when a patient transfers to another agency without notifying the initial agency. These are typically not cases in which the patient is unhappy with care. We are aware of many situations in which a patient who has an intervening hospital stay is advised by the hospital that it is preferable or even required to use its hospital-based home health agency upon discharge, thus generating a PEP. There are also cases in which the patient or family is simply confused and seeks care from another agency believing two agencies are better than one. As the proposed rule points out, visits tend to be front-loaded in episodes. Current QIO advice to agencies reinforces this as a quality improvement mechanism. Thus prorating from first to last billable visit systematically underpays the initiating agency and penalizes agencies who follow QIO advice on front-loading visits to avoid rehospitalization. We believe it is important that the initiating agency receive fair payment under the PEP methodology and believe that there needs to be a change in the ratio used to prorate PEP transfer episodes. We believe, in the case of PEP transfers, it would be more equitable to prorate the initial PEP episode based on the ratio of days between the first billable visit and discharge to the subsequent agency.

We support the changes proposed in this rule to more fairly compensate agencies for non-routine medical supplies. While we recognize that this is a data-driven exercise, the compensation for the highest level supply usage still seems to fall far short of the extraordinary cost that VNAs expend for their most supply-intensive patients. We also note that many conditions that generate high NRS costs are not accounted for in the NRS weights. We would urge CMS to re-examine its analysis prior to the final rule to see if

additional data sources could be mined to assure more complete NRS payments and perhaps a higher category of supply usage or outlier provision could be created for such cases. The decision to exempt LUPA episodes from NRS payment also seems ill-advised since such patients may incur significant supply costs. We also are concerned that the bundling of non-routine medical supplies in what is essentially a budget-neutral system will continue to create a growing payment disparity as new and more expensive technologies are applied to home care. Each year new supplies are added to the PPS bundle that did not exist when the base-line was established for PPS. We would urge CMS to freeze the NRS codes that are currently bundled and unbundle new NRS technology from the PPS as it emerges.

VNAA believes the proposed rule unwisely dismisses the need to adjust the PPS Outlier Threshold simultaneously with the increase in predictive power of the revised PPS system. CMS has systematically over-estimated the cost of the outlier provision resulting in underpayment of the 5% set-aside for this important component of the PPS system. The need to fully utilize this set-aside is made all the more critical by the proposal to reduce payments for case-mix creep. Lowering the fixed dollar loss threshold would provide an important counter-incentive to the propensity to avoid high cost patients in the context of the across-the-board cut that has been proposed.

Finally, as alluded to in our introductory remarks, VNAA and its member agencies are most disappointed and concerned about CMS' intention to cut 2.75% off of PPS payments for each of the next 3-years to adjust payment for nominal case mix growth or case mix "creep." We believe that CMS has not made a strong case for the existence of nominal growth nor has it made a credible estimate of the extent of such growth. We would offer the following points in support of our alternative position.

1. CMS' determination of "nominal" case mix change (case mix creep) is not based on objective, clinical evidence. Rather, it appears to be based on statistical inferences that the change in case mix that happened after PPS was implemented was not legitimate change in the types of patients treated but the result of nurses up-coding patients. Our experience is that the incentives in PPS led many agencies to seek out higher case mix cases and avoid lower case mix cases to maximize reimbursement following PPS implementation. This would create real case mix change vs. nominal change.

2. We believe there are many methodological flaws in the analysis attributing case mix change from 2000-2003 as only nominal case mix change. Key among these is CMS dismissing increases in case mix driven by the therapy variable as indicative of a patient characteristic reflecting real change in case mix. Were it not for the CMS' inclusion of the therapy variable in the home health case mix as a valid marker of real case mix weight, the system would have faltered due to its low predictive power. Thus dismissing this variable as a driver of real case mix change is not supported by the evidence and is fundamentally inconsistent with the case mix system itself. The incentives created by the therapy variable clearly drove case selection but that created real case mix change vs. nominal change.

3. When one recalls that the underlying premise of the PPS system was to control Medicare home health utilization through an episodic payment because CMS had not been able to define appropriate and efficient visit levels, it is particularly inconsistent to use the realization of that expected reduction in visits under PPS to argue that real case mix did not increase during that period. Such a position essentially denies that the PPS system achieved its fundamental goal: increasing the efficiency of care delivery under Medicare home health.

4. It is also our experience and commonly accepted in the health care community that hospitals have been discharging patients "quicker and sicker" as advances in medical technology allowed patients who could previously be served only in hospitals or nursing homes to receive comparable care at home. Advanced wound care and cardiac care are prime examples. During the same period of time for which CMS is deeming case mix change to be nominal rather than real, CMS found it necessary to publish changes to the Medicare Inpatient Payment system to penalize hospitals who had systematically been discharging patients to home health much earlier than the norms of the DRG system. Thus CMS itself recognized the "quicker and sicker" phenomena that resulted in home health agencies receiving higher real case mix cases during the home health PPS period.

5. CMS considers improvement in the accuracy of OASIS patient assessments by home health nurses that increased case mix weight as one of the causes of "case mix creep" even though these changes were mandated by CMS. There is every reason to believe that these changes reflect real change because these patients were under-coded by many typical agencies while correctly coded by demonstration agencies prior to improvements in CMS direction. The measure of whether improvements in coding result in a nominal or real case mix change rests on the resource needs of patients, not the fact that the change was driven by improved coding instructions.

6. CMS' estimate assumes, in part, that all legitimate change in case mix ended with the implementation of PPS because the prior interim payment system (IPS) created sufficient incentives to maximize all real case mix change. However this rationale fails to consider that approximately 20 percent of home health agencies had such high cost limits under IPS that these agencies were not incentivized to create real case mix change until after PPS implementation. Thus the change in real case mix in such agencies only happened when they lost their high IPS Per-Patient Caps and came under PPS. A review by CMS of its data during the IPS period would allow it to document the subset of home health agencies whose case mix was not responsive to the IPS incentives.

7. CMS supports its determination that all post-PPS case mix change was intentional upcoding rather than real change by asserting that OASIS measures that were not used for payment reflected greater stability in patient status than those used to increase PPS payment. However, were these non-payment OASIS measures true

measures of patient severity and thus resource use, they would have been included in the PPS payment formula. Thus the CMS argument is circular. The post PPS OASIS measures that do not predict patient severity naturally remained more stable than those used for payment because they were by definition, not as sensitive to increases in case mix severity as those used for payment. The stability of these measures over time simply reflects the fact that they are inherently more stable regardless of patient resource use.

8. The other PPS payment changes being proposed in this rule reflect the well-documented fact that the original PPS system was no longer accurately measuring the cost of care and that higher case mix cases typically created higher margins than lower case mix cases. This systematic lack of accuracy has been addressed in the proposed rule by the re-weighting of case mix groups to better align actual costs with payments. As a result, average case mix weights should more closely reflect true case mix. CMS acknowledgment that the current PPS system has included incentives for agencies to favor higher case-mix weight patients since PPS implementation contradicts the CMS position that all increases in case mix change since PPS were nominal rather than real. This is particularly true with regard to the single therapy cap. Data suggests that most of the post PPS case mix change was driven by the therapy variable and this incentive has been significantly reduced if not eliminated in the proposed PPS refinements. Adding a case mix creep reduction on top of PPS case mix weight and therapy adjustments designed to eliminate the incentives to over-code creates a double adjustment to the system.

9. Another factor leading to increase in real average case mix change is the growth of Medicare Advantage (MA) enrollment. Many VNAs now serve a substantial number of MA enrollees and such patients are no longer included in PPS case mix statistics because payment is made by the MA plan. We believe that the severity level of MA patients in home health, on average, is lower than that of the traditional Medicare patients and thus the migration of patients to MA plans has increased the average real case mix weight of the remaining Traditional Medicare population served under PPS.

10. Finally, CMS acknowledges and documents the fact many agencies' case mix weight did not rise at the same level during the period under examination. By using the average case mix weight in this period as the measure of case mix creep adjustment, CMS is equally cutting payment to both high and low average case mix agencies. Even if one accepts the premise that case mix creep existed during the study period, the remedy of an across-the-board cut punishes those who did not inflate case mix equally with those whose average case mix was inflated the most. This distributes the negative impact inversely, with the greatest impact hitting those who contributed least to the problem. A more equitable approach would be to reduce proportionally the proposed cut for those agencies whose individual case mix weight was below the mean in the study period.

Thus, VNAA cannot agree with the CMS analysis of nominal case mix change. There were simply too many factors driving change in real case mix during this period and too many flaws in the CMS approach to accept the CMS estimate. We believe it is essentially impossible to create a valid estimate of nominal case mix change on a retrospective basis, using the data available. Moreover, the substantial changes in the PPS system proposed in this rule will alter the incentives in the system, nullifying the assertion that nominal case mix change must be adjusted out of the system through an across-the-board cut. This would argue for the postponement of any cuts to reflect nominal case mix change until after the proposed PPS system changes are implemented and can be evaluated.

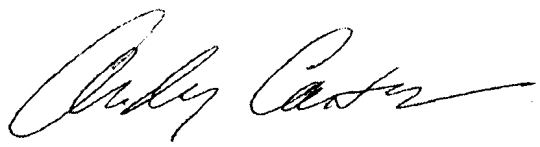
Because VNAA represents non-profit agencies, and CMS' impact analysis would indicate that voluntary non-profit home health agencies will experience an increase in 2008 Medicare payments based on this rule, one might expect that we could be indifferent to the proposed cuts. However, we would point out that the projected impact is an average. Many of our members will see a negative impact on Medicare revenue in 2008. This will force reductions in staffing in certain areas, which compromises patient access to care. It will also force reductions in community services including our ability to care for Medicaid and uninsured patients. Moreover, even those agencies projecting a positive impact generally report a marginal increase versus the level projected in the PPS impact table and would have a much higher, and justifiable, increase were the 2.75 % adjustment not implemented. We have found no agency that projects a positive impact when the 2.75% cut is repeated in 2009 and again in 2010. Because of the reputation VNAs have historically enjoyed in the home health community, CMS and Congressional policy makers have often looked to the impact on VNAs as a measure of policy wisdom. By this measure, the nominal case mix cuts cannot be justified. As cited above, we urge that this cut, if not abandoned entirely, be postponed until the other revisions of the PPS system are implemented and their impacts known. These changes are of such a magnitude that they will change many of the incentives that have driven margins in Medicare home health. Once these changes are in place, CMS would be in a much better position to decide if nominal case mix change continues to exist and if so, at what level.

VNAA and its members are also extremely concerned about possible claims processing delays and errors resulting from the rapid implementation of these PPS changes. We have heard from the billing vendors serving the home health community that there may be too little time to allow for a smooth transition. History teaches that when changes of this magnitude are implemented in a compressed time frame, claims processing delays and errors can be expected among Medicare's contractors. We urge CMS to convene an ongoing series of implementation meetings including Medicare contractors, the home health community and the vendors who support home health to reduce the likelihood of delays and errors. The group should also discuss a viable contingency plan for cash flow in the event of claims payment delays or errors due to rapid systems changes.

Again, thank you for the opportunity to comment on these proposed rules and your responsiveness in these proposals to many of the issues VNAA has raised since the

inception of PPS. I hope you will consider these comments fully in developing the final rule and will feel free to contact me or Bob Wardwell, the VNAA Vice President for Regulatory and Public Affairs, at 240-485-1855 for any clarifications. .

Sincerely,



Andy Carter
Chief Executive Officer

CC: Carol Blackford, CMS

Submitter : Caryn Bommersbach **Date:** 06/26/2007

Organization : Redwood Area Hospital Home Care

Category : Home Health Facility

Issue Areas/Comments

Impact Analysis

Impact Analysis

See Attachment...

CMS-1541-P-76-Attach-1.DOC

#76

Redwood Area Hospital
100 Fallwood Road
Redwood Falls, MN 56283-1828
(507) 637-4500 • FAX (507) 697-6000
www.redwoodareahospital.org

June 26, 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

I am writing this letter on behalf of the Redwood Area Hospital Home Care Service whose purpose is to serve clients in the most cost-effective manner while providing high quality of care to those living in Redwood Falls, MN and surrounding communities. The Redwood Area Hospital Home Care represents approximately 180 non-duplicated clients served per year in our rural area.

The Prospective Payment System for Medicare home health is based on the right principles as if facilitates outcomes-oriented client care planning that is focused on rehabilitation and self care. However, with the proposed changes due for January 2008, I have grave concerns as addressed below:

1. Medicare's proposed changes to PPS incorporate a presumption of case mix creep that I feel is unfounded. CMS has assumed all increases in the average case mix weight is due to providers "gaming" the system. Realistically, the increase reflects the changing demographic of home care's client population and more staff training on OASIS which has resulted in more accurate OASIS answers. In the past 2 years, we have had 3 of our 6 RN's certified in OASIS documentation. That education and certification has directly impacted how we collect and score the OASIS data elements. As a hospital based agency our client population is more older, frail, and sicker than the other providers in our area, who all direct those ill clients to our agency.
    a. Suggestion: CMS should suspend its plan to cut home health payment rates based on unfounded allegations of case mix creep.

2. The proposed PPS reform eliminated payment adjustments for significant change in condition (SCIC). With the elimination of SCIC, there is no process for

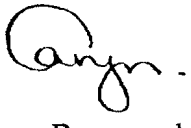
agencies to capture a decrease in client condition that could relate to an increase in episode payment. If a client in relatively good condition at the start of care should suddenly decline due to the disease process and needs additional services, supplies, etc, without the SCIC the provider is "stuck" with the initial episode payment that does not cover the additional costs to provide additional care when the client's condition warrants.

   a. Suggestion: Continue the OASIS requirement at the time of significant change in client condition (SCIC).

3. Many of the Medicaid waiver programs authorize "skilled nursing services" based on their payment terminology, when in reality, the clients are not "skilled" by Medicare's definition. Clients on waiver programs tend to be chronically ill and show no improvement in outcomes, but rather show stabilization in their condition. Under current regulations, these waiver clients are required to have OASIS collection performed (See Minnesota State Operations Manual (SOM) at Section 20202.8C (page 193) 3. Transmission of OASIS data) "...The payer source for services provided a part of a Medicaid waiver or home and community-based waiver program by a Medicare-approved HHA are coded as (3) Medicaid (traditional-fee-for-service) at item MO150". With the inclusion of these waiver clients, there is proof that submitting OASIS data skews provider outcomes as well as aggregate state outcomes.

   a. Suggestion: Eliminate the requirement to complete OASIS assessments on non-Medicare clients. OASIS should be for traditional Medicare only.

Sincerely,



Caryn Bommersbach, RN,C
Home Care Manager
Redwood Area Hospital Home Care
Redwood Falls, MN

Submitter : **Date: 06/26/2007**

Organization : **Stanlex, Inc. dba Home Care of the Carolinas**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment.

CMS-1541-P-77-Attach-1.DOC

Home Care of the Carolinas
Comments on Proposed PPSChanges

Issue ~ 2.9% Market Basket Index (MBI)
We request Congress maintain a 2.9% Market Basket Index to allow us to adequately cover our costs of providing care to Medicare recipients.

Issue ~ 2.75% Case Mix Creep
We feel that the national average case mix rate change is primarily attributable to the following:

(1) Patient characteristics and case mix has changed.
(2) OASIS requirements were implemented during a time of massive change and conflicting CMS instructions on implementing OASIS.
(3) There were training issues for staff for staff on all aspects of home health, especially OASIS, IPS, HH PPS, and ICD-9 coding.

Based on claims submitted to PGBA, Home Care of the Carolinas has actually experienced a decrease in case mix weight since FY 2000. During 10/1/2000 to 9/30/2001, our case mix weight on billed claims equaled 1.53. During 10/1/2005 o 9/30/2006, our case mix rate on billed claims equaled 1.47

We recommend that Congress eliminate or reduce the 2.75% base rate reduction.

Issue ~ LUPA
Home Care of the Carolinas LUPA rate for FY 2006 is 12%, which is close to the national average. We support CMS' proposed change to increase the LUPA rate by $92.60 for the first or sole LUPA episode. We recommend that Congress apply the same consideration to all LUPA episodes. We have found that the administrative costs (i.e. OASIS, billing, etc...) continue in subsequent LUPA episodes. If a LUPA episode is followed by another LUPA episode, your costs are increased due to a longer carrying period of a patient (i.e. 60 day episodes instead of a shorter time period.)

Issue ~ SCIC
We agree with CMS' decision to eliminate the SCIC. Home Care of the Carolinas experienced a tremendous loss of revenue in FY 2006 on SCICs following a software change. The new system automatically billed all SCICS. *Through a revenue recovery program, we recovered some of these funds, less the 30% commission rate. Needless to say, this was quite expensive for our agency.*

Issue ~ Non-Routine Supplies (NRS)
We agree with CMS' concept of the Non-Routine Supplies add-on. However, the NRS add-on amount is based on incomplete information and may inadequately reflect the provider's true cost. *In reviewing our billing history, there were times when supplies*

were omitted from the claims due to internal computer glitches or wound supplies were not coded correctly. We also recall a period of time when PGBA could not process supply line items. PGBA went through a period of time where they asked providers not to submit the supply items. Although PGBA stated that these supplies needed to be added and resubmitted after the problem was rectified, we found this to be an impossible task in our computer system. We recommend that you continue to study the supply issue with future data.

Issue ~ Outlier Issue
Home Care of the Carolinas experienced a 1% outlier rate during FY 2006. We recommend that CMS retain the excess amount of $130 million budgeted for outliers in the Medicare Home Health budget and shift this excess to the base rate. Please maintain the current outlier standard and allow any unused allocation to be folded back into HH PPS.

Issue ~ OASIS Changes
We agree with CMS' plan to exclude M0175 and M0610; and add M0470, M0520, and M0800 are positive changes. We recommend that you time these OASIS changes at once.

Issue ~ Therapy Auto-Adjust
We agree with CMS' proposed change in handling therapy claims.

Issue ~ Case Mix Adjustment Refinement – Early/Late Episodes of Care
The national average for episodes per beneficiary is 1.26 to 1.31. North Carolina averages 1.2 episodes per beneficiary. *Home Care of the Carolinas averages 1.6 episodes per beneficiary.* Clearly there are very few episodes qualifying as "late episodes." Home Care of the Carolinas' late EP cases are typically long-term LUPA patients, such as B12 and catheter care, or Medicaid patients. The feature of Early/Late Episode creates an administrative burden for agencies. We recommend that you eliminate the Early/Late distinction and redistribute the weighting to all the episodes.

We request that you make changes to ensure that the Common Working File provides real-time data based on claims processed. The CWF does not currently provide real-time patient eligibility information. Claims are slow to post 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-Coding
We agree with the use of more variations in case mix variables. We encourage CMS to review the most recent coding guidelines and ensure they are being used in the model.

Submitter : Mr. Joey Spearman **Date:** 06/26/2007

Organization : Gilbert's Home Health & Hospice

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

I believe the timing of implementing these changes is inappropriate. From the problems CMS had with NPI, I suspect that making the computer programming changes to implement these changes will be even more difficult. Software vendors will have only three months to make changes. Home Health agencies will have little time to educate staff that are affected by billing changes.

The complexity of the rule will add great burden to home health agencies. The cost of changing OASIS, educating staff to the changes in OASIS and coding will be significant.

I believe that reducing the home care reimbursement by 2.75% in each of the next three years is a mistake. Fuel price increases combined with the growing problem of shortages of qualified professionals to render care has already taken a toll on increasing the expenses to operate a home health agency in Mississippi and other rural states. Cutting the Medicare reimbursement may threaten the ability to deliver home health services in rural, sparsely populated areas.

Submitter : **Ms. Denise Edgett** **Date: 06/26/2007**

Organization : **Integrated Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-P-79-Attach-1.DOC

#74

HealthPartners
Ramsey Integrated Home Care
475 Etna St. Suite 3, St. Paul, MN 55106
Tel: 651-776-2112

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

This letter is written on behalf of Integrated Home Care, a nonprofit Medicare certified home health care agency in St. Paul Minnesota and a member of the Minnesota HomeCare Association (MHCA). MHCA is a statewide, nonprofit association whose purpose is to promote the delivery of quality health care and supportive services in a variety of home living environments. MHCA represents approximately 220 home care agency members from all types of agencies: county public health nursing services, hospital- and nursing home-based programs, proprietary, and private nonprofit.

The Prospective Payment System for Medicare home health is based on the right principles as it facilitates outcomes-oriented patient care planning that is focused on rehabilitation and self care. MHCA has strongly supported 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.

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 patient assessment to garner higher payment for their agency. More realistically, the increase reflects the changing demographic of home care's patient population, more intense staff training on OASIS which has resulted in more accurate OASIS answers.

Today, home care patients are older and more frail, with a significant number of patients being over age 80. The intensity of service they require has increased significantly due in large part to hospital DRG policy changes leading to decreased length of stay and changes in Inpatient Rehab Facility reimbursement that have appropriately steered more but sicker patients into home health services.

Over the past 10 years, the Medicare home health benefit has been cut nearly every year. Once comprising 8.7 percent of Medicare spending today it is 3.2 percent 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.

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 with for 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 hospitals and skilled nursing facilities and use the post rural-floor, post reclassified authority wage index for home care as you do for hospitals.

Concern
Supply reimbursement.

Rationale
Estimate of supplies is based on inaccurate information. Providers have not always placed supplies on the claims either because they believed it was not required since supplies were bundled or because they did not want to hold up sending claims when working with an outside vendor who did not provide charges in a timely manner. Additionally, the complexity of supplies and getting the right supplies on claims has been confusing, making the accuracy of the cost of supplies nebulous at best.

Providers already provide LUPA visits at rates lower than the cost of care delivery. Failure to provide supply reimbursement for LUPA visits exacerbates this financial loss. This is especially valid for clients with catheters and ostomy supplies. For example, patients with catheters may only require a nurse visit once a month, yet supply costs are significant.

Suggested Solution
Build in reimbursement for supplies under LUPA visits, especially long-term patients who fall under the LUPA visits. Allow inclusion of reimbursement for supplies when there are changes from the initial assessment and from one episode to another. Include variable to recognize costly Pleurovax and ostomy supplies.

Concern
Estimated financial impact with a net increase of $140 million.

Rationale
The financial impact estimate for outliers is unrealistic. Providers historically have not needed outlier reimbursement because they are dissuaded from taking patients needing outlier payments and thus the monies set aside for outliers will remain on the table.

Suggested Solution
Re-look at the financial impact and adjust it to more accurately reflect the reality of the impact on home care.

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 has 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 Solution
Automatically adjust the final claim to accurately reflect early and late episodes of care rather than defaulting it to an early episode. Consider only one agency's episodes of care to determine if an episode is an early or late 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 of 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
Known pressure ulcers that are Stage 3 or 4 with eschar coverage.

Rationale
Because providers are currently not allowed to stage pressure ulcers covered with eschar, stage 3 and 4 pressure ulcers that are covered with eschar are not calculated into the case mix. These patients, however, require additional care to address the significant risk of infection and potential for further skin breakdown. By WOCN's own interpretation, this tissue is always at risk of breakdown due to underlying permanent damage. Therefore, it does not make sense to omit them from the case mix adjustment.

Suggested Solution
Known stage 3 or 4 pressure ulcers are to remain stage 3 or 4 pressure ulcers despite the presence or absence of eschar.

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 reason 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
The PPS reform proposed rule calls for the elimination of M0175 from the case-mix system because of the difficulty encountered by home health agencies in accurately responding to this OASIS item. However, CMS plans to continue to require that home health agencies report this information on the OASIS.

Rationale
Any client discharged from an institution may or may not need additional services and may or may not have experienced an improvement in condition. An institutional stay does not directly correlate to required services for home care.

Suggested Solution
Eliminate the requirement to determine what inpatient facilities patients were discharged from in the past 14 days and accept "NA" as a default response to M0175.

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,

Denise Edgett, PHN
Homecare Manager

Submitter : Mrs. Susan Snow **Date:** 06/26/2007

Organization : Greenville Hospital System Home Health

Category : Home Health Facility

Issue Areas/Comments

Market Basket Index

Market Basket Index

Please maintain at least a 2.9% MBI. Eliminating the MBI for Home Health will negatively impact access to care for Medicare and Medicaid recipients.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

1 - Case Mix Creep: Please eliminate or reduce the 2.75% base rate reduction. Thc refinement analysis is too old for appropriate consideration. As a hospital based home health agency, the vast majority of our patients have recently experienced acute changes in their condition. Our Medicare patients are admitted to Home Health services sicker than they have been in previous years such as 2000 and 2003. Length of stay has decreased for hospitalization - thus patients are sent home in need of more complex care- Providing home health care is more costly than ever as it is primarily provided by professional staff. Medicare recipients deserve safe and competent care provided by staff who have training in caring for the frail elderly. In order to safely care for these debilitated patients, our home health spends great resources on keeping staff competent and on hiring professional staff. A reduction in the episode base rate would negatively impact access to care for needy Medicare recipients. Our agency may be faced with not being able to accept patients for care if the episode rate decreases - as a result, length of stay for hospitalization could increase - thus increasing Medicare expenditures /recipient. Many patients are too sick to go home without Home Health.
2 - LUPA - Please apply the same proposed inerease to the 1st or sole LUPA episode to ALL LUPA episodes. Our agency experiences administrative costs for all LUPA episodes - not just the 1st. Our inability to cover costs may negatively impact access to care for the long term patients such as those with catheters - these patients may have to seek care in more costly alternatives - such as a nursing home. Home Health currently struggles to cover the basic costs required for the hands on care - not to mention the administrative costs - such as visits for the sole purpose of a recertification OASIS.
3 - SCIC - Eliminate the SCIC
4 - NRS - Non Routine Supplies - This is an area that warrants additional study as the concept was based on incomplete information and may inadequately reflect the agency's true eosts. Abt reports that nearly 40% of cost reports were incomplete and unusable and only 10% of the claims data supported any supply charges. While I support the concept of the add on - additional analysis is needed.
5 - Outliers - Please allot 3% of the 130 million for outlier payments - this should more than cover the national outlier rate. Our Ageney's current rate is less than 2%. Allow the unused 97% allocation to be folded back into the base episode rate.
6 - OASIS changes - Please make all OASIS ehanges at once.
7 - Therapy Auto-Adjust - I support this change.
8 - Case Mix Refinement - Early/Late Episodes - Eliminate the Early/Late distinction and redistribute the weighting to all the episodes. Simplify the 4-equation model to a 2-equation model with therapy thresholds. Please address the issue of the CWF so that real time data is available. Adding the administrative burden of ehecking early/late episodes with an inadequate CWF data base only adds to the expenses for agencies. The more non-direct care expenses that are necessary - the less resources agencies have to provide aeeess to hands on care for our frail Medicare population.

Submitter : Marcia Smith **Date:** 06/26/2007

Organization : Albert Lea Medical Center Home Health

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-81-Attach-1.DOC

#81

06/25/07
Deleted:

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

This letter is written on behalf of the Albert Lea Medical Center 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. We represent about 300clients per year

The Prospective Payment System for Medicare home health is based on the right principles as it facilitates outcomes-oriented patient care planning that is focused on rehabilitation and self care. MHCA has strongly supported CMS efforts to restructure the system and to replace a poorly functioning case mix adjustment model. However, we have grave concerns as addressed below:
Deleted:

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.

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 patient assessment to garner higher payment for their agency. More realistically, the increase reflects the changing demographic of home care's patient population, more intense staff training on OASIS which has resulted in more accurate OASIS answers.

Today, home care patients are older and more frail, with a significant number of patients being over age 80. The intensity of service they require has increased significantly due in large part to hospital DRG policy changes leading to decreased length of stay and changes in Inpatient Rehab Facility reimbursement that have appropriately steered more but sicker patients into home health services.

Over the past 10 years, the Medicare home health benefit has been cut nearly every year. Once comprising 8.7 percent of Medicare spending today it is 3.2 percent 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.

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 with for 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 hospitals and skilled nursing facilities and use the post rural-floor, post reclassified authority wage index for home care as you do for hospitals.

Concern
Supply reimbursement.

Rationale
Estimate of supplies is based on inaccurate information. Providers have not always placed supplies on the claims either because they believed it was not required since supplies were bundled or because they did not want to hold up sending claims when working with an outside vendor who did not provide charges in a timely manner.

Additionally, the complexity of supplies and getting the right supplies on claims has been confusing, making the accuracy of the cost of supplies nebulous at best.

Providers already provide LUPA visits at rates lower than the cost of care delivery. Failure to provide supply reimbursement for LUPA visits exacerbates this financial loss. This is especially valid for clients with catheters and ostomy supplies. For example, patients with catheters may only require a nurse visit once a month, yet supply costs are significant.

Suggested Solution
Build in reimbursement for supplies under LUPA visits, especially long-term patients who fall under the LUPA visits. Allow inclusion of reimbursement for supplies when there are changes from the initial assessment and from one episode to another. Include variable to recognize costly Pleurovax and ostomy supplies.

Concern
Estimated financial impact with a net increase of $140 million.

Rationale
The financial impact estimate for outliers is unrealistic. Providers historically have not needed outlier reimbursement because they are dissuaded from taking patients needing outlier payments and thus the monies set aside for outliers will remain on the table.

Suggested Solution
Re-look at the financial impact and adjust it to more accurately reflect the reality of the impact on home care.

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 has 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 Solution
Automatically adjust the final claim to accurately reflect early and late episodes of care rather than defaulting it to an early episode. Consider only one agency's episodes of care to determine if an episode is an early or late 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 of 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
Known pressure ulcers that are Stage 3 or 4 with eschar coverage.

Rationale
Because providers are currently not allowed to stage pressure ulcers covered with eschar, stage 3 and 4 pressure ulcers that are covered with eschar are not calculated into the case mix. These patients, however, require additional care to address the significant risk of infection and potential for further skin breakdown. By WOCN's own interpretation, this tissue is always at risk of breakdown due to underlying permanent damage. Therefore, it does not make sense to omit them from the case mix adjustment.

Suggested Solution
Known stage 3 or 4 pressure ulcers are to remain stage 3 or 4 pressure ulcers despite the presence or absence of eschar.

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 reason 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
The PPS reform proposed rule calls for the elimination of M0175 from the case-mix system because of the difficulty encountered by home health agencies in accurately responding to this OASIS item. However, CMS plans to continue to require that home health agencies report this information on the OASIS.

Rationale
Any client discharged from an institution may or may not need additional services and may or may not have experienced an improvement in condition. An institutional stay does not directly correlate to required services for home care.

Suggested Solution
Eliminate the requirement to determine what inpatient facilities patients were discharged from in the past 14 days and accept "NA" as a default response to M0175.

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,
Marcia Smith, RN
Home Health Director
Albert Lea Medical Center – Mayo Health System
Albert Lea, MN 56007

Deleted: ¶

Submitter : Ms. Rachel Graham **Date:** 06/26/2007

Organization : Floyd Memorial Home Health Care

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Regarding the Case Mix Creep and "manipulation of the system":
Our agency has spent time and money to educate on the proper way to code by teaching our clinical staff and promoting our medical records person as a Certified Homecare Coder.
This is not a "case mix creep". This is finally learning the proper way to code. It's not manipulation. It's education.

Submitter : Mr. Patrick Conole **Date:** 06/26/2007

Organization : Home Care Association of New York State, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1541-P-83-Attach-1.DOC

#83

HOME CARE ASSOCIATION
of New York State, Inc.

June 26, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-P
Post Office Box 8012
Baltimore, MD 21244-8012

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

To Whom It May Concern:

The Home Care Association of New York State, Inc. (HCA), on behalf of its 252 member agencies that serve approximately 188,000 Medicare beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the Medicare Home Health Prospective Payment System (PPS) for Calendar Year (CY) 2008. HCA members serve the majority of Medicare beneficiaries throughout the state, and HCA actively participated in the development of home health PPS.

General Comments

HCA is very appreciative of the consideration that the Centers for Medicare and Medicaid Services (CMS) has given to our questions, concerns and comments which we have submitted throughout the development and refinement of the home health PPS these past seven years. In reviewing the proposed 2008 PPS proposed rule, for HHPPS for CY 2008, we are very pleased that CMS has addressed some of the concerns raised by HCA and others in the home health industry, such as eliminating the Significant Change in Condition (SCIC) policy as well as revising the Outcome and Assessment Information Set (OASIS) so that the MO 175 will not be included in determining providers' reimbursement going forward. HCA believes these types of changes will improve the payment system by allowing home health agencies to devote more of their time and attention to patient care.

However, while we recognize the importance of revising the home health PPS to reflect current patient characteristics and agency practices, we believe that caution is critical when undertaking numerous changes within the same CY. HCA is particularly concerned with CMS' decision to initiate payment reductions at the same time that an enormous revamping is being undertaken in the new PPS case-mix system. Upon conducting a detailed analysis of CMS' CY 2008 proposed rule, HCA offers the following comments as you continue to evaluate refinements and reforms to the home health PPS.

Case Mix "Creep" and Payment Rate Reductions

194 WASHINGTON AVE., 4TH FLOOR, SUITE 400 • ALBANY, NY 12210
PHONE: 518.426.8764 • FAX: 518.426.8788 • E-mail: info@hcanys.org • www.hcanys.org

HCA is extremely concerned with CMS' proposal to reduce the base payment rates by 2.75% for CY's 2008, 2009, and 2010 based on CMS' determination that the increase in the national average case mix weight between 1999 and 2003 in home health was due to factors unrelated to changes in patient characteristics. The original PPS design was based on 1997 patient data and set the average case mix weight at 1.0. According to CMS, by the end of 2003, the average case mix weight nationally for initial episodes was 1.233. CMS concluded that 8.7% (1.0 to 1.23) of the increase had nothing to do with changes in patient characteristics. As a result, CMS proposes to adjust the base payment rate by 2.75% for each of the 3 upcoming years to prevent expenditure increases that are due to factors unrelated to patient characteristics.

HCA believes CMS' proposal to reduce PPS payments by 2.75% for the next three years is based on inaccurate information and a flawed methodology that makes assumptions that are not correlated with patient outcomes. In fact, according to recently released data by Outcome Concept Systems (OCS), the largest provider of data and benchmarking services to home health agencies nationwide, the average 2005 adjusted case-mix weight (on final claims) nationally and in New York was approximately 1.15, not 1.233. This is based on either the provider or regional home health intermediary adjusting (downcoding) final claims upon submission. We believe that if CMS re-examined the most recent adjusted case mix weight data in providers' final claims, the 8.7% increase that supposedly had nothing to do with changes in patient characteristics would become irrelevant.

Furthermore, HCA respectfully requests that CMS consider the following points that help explain why the average case-mix weight for a home health agency has increased from 1.0 at the inception of PPS:

1. CMS failed to consider the utilization of therapy services as a "patient characteristic." The HHPPS uses a case mix adjustment model that incorporates clinical, functional, and services domains in categorizing the characteristics of home health services patients. CMS specifically included a therapy threshold of 10 visits in an episode (MO825) as a means to distinguish patient types. Instead, CMS attempts to invalidate the increase in patient episodes with 10+ therapy visits through evaluation of data from the Clinical and Functional OASIS domains, data that CMS concluded was inadequate to explain therapy service utilization in the original construction of the HHPPS case mix adjustment model.

2. In spite of the weakness set out above, the CMS OASIS data provides a strong indication that the increase in therapy services is directly related to changes in patient characteristics. The OASIS data referenced in the CMS proposal clearly depicts an increase in the clinical severity of patients admitted to home health services from 1999 through 2003. The percentage of patients assessed at C2 and C3 increased in each of these years.

3. The evidence further indicates significant changes in patient characteristics from 1999 to 2003. These include:
    - Home health users grew from 2.1 million to 2.4 million.
    - The number of beneficiaries with a primary diagnosis of diabetes increased by 17%.
    - Patients with abnormality of gait increased by 50%.
    - Patients with wounds increased by 15 percentage points.
    - Patients with urinary incontinence increased by 8 percentage points.
    - Patients showed a substantial decrease in transfer capabilities.
    - There is a demonstrated Increase in cognitive function deficits.
    - Findings of dyspnea increased.

CMS's dismissal of these changes as "modest" ignores the cumulative impact on the need for increased therapy services along with higher clinical and functional scores in the case mix weight. The increase in

patients with ambulation and transfer deficits alone accounts for a significant portion of case mix weight growth from 1999-2003.

4. The growth in enrollment in Medicare Advantage (MA) plans has shifted low acuity patients out of traditional Medicare, as this segment of the Medicare enrollee population has been targeted for enrollment by the plans. Strong evidence exists that the departure of such MA plan enrollees left higher need, higher cost Medicare beneficiaries within the traditional Medicare program.

5. The CMS proposal to reform the case mix adjustment model resolves any concerns regarding inappropriate case mix weights-related increases in the use of therapy services. The purpose of eliminating the single 10-visit threshold for increased payment is to attempt to align payment incentives with patient care needs. Accordingly, the use of a case mix weight creep adjustment that primarily reflects growth in therapy utilization is an unnecessary adjustment that only serves to "double-cut" on rate adjustments.

HCA Recommendation

CMS should withdraw its proposal to reduce base payment rates by 2.75% in 2008, 2009, and 2010. CMS should design and implement an evaluation method to analyze changes in average case mix weights based on adjusted final claims data and that utilizes proper standards related to the home health case mix adjustment model concept of "patient characteristics." Further, CMS should include relevant factors in this analysis such as changes in per patient annual expenditures, patient clinical, functional, and service utilization data, and dynamic factors in the Medicare system that impact on the nature of patients served with home health care.

New Case Mix Adjustment Model & Therapy Threshold Revisions

While HCA supports the concept of replacing the present case mix model of 80 Home Health Resource Groups (HHRGs) with a new 153 HHRG model, we do have some logistical concerns about this major revision as well as some practical concerns. These include making sure providers are given adequate time to train and educate their staff on the new 153 HHRG model and giving providers' software vendors enough time to implement these critical system changes.

An important refinement in CMS' proposed 153 HHRG model is the recognition of the different characteristics of patients and resource utilization in early, versus late episodes of care. HCA supports the delivery of home health services to chronically ill patients as a vital service that enables Medicare beneficiaries to remain in their own homes and reduces overall health care expenditures. HCA believes CMS' proposal to apply different case mix weights depending on whether the patient is receiving an initial episode of care compared to subsequent episodes will result in more appropriate distribution of funds for care of the long term patient. However, CMS' proposed rule did not include instructions for how agencies should differentiate between initial and subsequent patient care episodes. HCA requests that CMS provide specific instructions in the final rule as to how this will be reported and whether this change will require CMS to update the common working file (CWF) in a more expeditious manner.

HCA generally supports the concept of CMS' newly proposed multiple therapy thresholds of 6, 14, and 20 visits and the smoothing effect of the graduated payment methodology; however, we are concerned that the most popular new HHRG scores (those involving first and second episodes with 0-13 therapy visits) will result in agencies' receiving 7% lower Medicare reimbursement on an aggregate basis when compared to the current case mix model with 80 HHRGs (based on industry analysis).

We are pleased that 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 proposal will benefit both the home health providers and the Medicare contractors by ensuring accurate payment of claims.

HCA Recommendation
HCA respectfully requests that CMS issue the 2008 CY PPS Final Rule as early as possible so home health agencies are afforded sufficient time to train and educate their billing and clinical staff as well as to work with their software vendors on implementing the new case mix model.

Non-Routine Medical Supplies
HCA has some concerns with CMS' proposal to update the non-routine supplies conversion factor from $49.62, which is currently part of the national episodic base rate, to a payment amount that would be added to the case mix and wage index adjusted PPS rate in the final claim based on patient characteristics. One of our concerns regards CMS' analysis in the proposed rule, that only 10% of episodes include medical supplies. However, both providers and financial consultants have reported to HCA that medical supplies are delivered to patients in a far greater number of episodes than reported, but home health agencies fail to list non-routine medical supplies on final claims.

Some reasons that agencies fail to report medical supplies are: lack of knowledge as to how to enter them on direct data entry screens (DDE), incomplete or late invoicing by medical suppliers, and lack of awareness of the importance of billing for medical supplies in the PPS systems since payment is not impacted. This could certainly account for a large part of the problems with home health cost reports that could not be used for the PPS reform research.

In addition, the National Association for Home Care and Hospice (NAHC) has identified a number of costly non-routine medical supplies that are not reflected in the medical supply case mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that became prevalent in home care after the start of PPS are those supplies needed for 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.

Finally, HCA is concerned with CMS' proposal to not include the non-routine supply costs to LUPA episodes. HCA provider members have indicated to us that 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 service disincentives and access problems, the end result of which 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 impair the capacity 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.

HCA Recommendation
HCA requests that CMS conduct additional research to identify other diagnoses and patient characteristics before proceeding with a separate case mix adjusted non-routine supply payment based on patient characteristics. HCA is very concerned that only 10% of current home health claims include medical supply data and we believe it would be prudent for CMS to **delay** proceeding with the proposed non-routine supply model until agencies provide more accurate data to CMS about the extent of their supply use. Finally, once a more reliable supply case mix model has been created, CMS should include payment for non-routine medical supplies for all episodes, including LUPA episodes that are not final episodes of care.

Low-Utilization Payment Adjustments (LUPA)

While HCA appreciates CMS' recognition 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 wage adjusted $92.63 LUPA add-on to is a positive step toward ensuring adequate payment for LUPA episodes. However, we believe that this policy should also be extended to adjacent LUPA episodes.

The rationale for the LUPA add-on addresses the fact that time to complete start of care OASIS adds an average of 40 minutes to the typical start of care visit. However, it is unclear how CMS intends to identify and distinguish between initial only and adjacent LUPA episodes. The notice 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. However, it has been reported that CMS plans to program the LUPA add-on payment any time the start of care date matches the "from" date on a claim, in the same manner that the RAP percentage is calculated.

Another major concern we have with the LUPA payment is CMS' prediction that the proportion of LUPA episodes would drop from 15% to 5% with the implementation of PPS. HCA has not found support in either New York or national data for this prediction. In fact, most recent National Government Services (NGS) data for New York (July 2006 – December 2006) showed that 13.54% of the episodes qualify for LUPA reimbursement.

Furthermore, HCA has also been able to review Medicare cost report data submitted by home health agencies in New York from 2001-2004. Those cost reports clearly demonstrate that the revenue on three out of the six LUPA payments falls short of the average cost of those visits. Average cost per visit for the two most utilized home health disciplines (home health aide and nursing) in New York is significantly greater than CMS' proposed LUPA rates for CY 2008. The following chart provides a comparison.

Discipline Type	Proposed CY 2008 LUPA Rate	NYS' Average Cost Per Visit (2004 Cost Report Data)
Home Health Aide	$47.91	$79.12
Skilled Nursing	$105.76	$144.30
Physical Therapy	$115.63	$108.92
Occupational Therapy	$116.42	$103.20
Speech Therapy	$125.55	$121.10
Medical Social Work	$169.53	$183.20

HCA Recommendation

Because of the aforementioned information and the fact that New York's average cost per visit data is from Medicare cost reports submitted for 2004, HCA strongly recommends that there be a review of and increase to the LUPA per visit rates to ensure that they cover the costs of care for these patients and that CMS apply the new LUPA add-on to all LUPA episodes.

Maintaining Current Wage Index

HCA is greatly concerned with CMS' proposal to maintain the current policy of using the pre-rural floor, pre-reclassified hospital wage index to adjust home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next. We also want to inform CMS that its decision two years ago to adopt the Office of Management and Budget's (OMB's) revised definitions of Metropolitan Statistical Areas (MSAs) to the Core-Based Statistical Areas (CBSAs) for the wage index calculation has had serious financial ramifications for home health agencies in New York. While the CY 2006 PPS incorporated a 50/50 blend of MSAs and CBSAs in the wage index calculation, CMS' CY 2007 final rule was based solely on the adoption of the CBSA based labor market definition and its wage index. HCA estimates that this two year wage index shift from using MSAs to CBSAs has resulted in an estimated $28 million cut in Medicare home health reimbursement statewide and over $18 million in cuts for home health agencies in the New York City (NYC) metropolitan area. More disconcerting for home health agencies in the NYC metropolitan area is that their home health wage index has decreased 8.6% since 2004 (1.4414 to 1.3177), which has resulted in cuts of approximately $26 million in Medicare reimbursement to those agencies.

For example, under the 2005 MSA designation for the NYC area, an agency had a wage index of 1.3586, but under the final CBSA wage index in 2007 (which adds Bergen, Hudson and Passaic counties from New Jersey) the value drops to 1.3177, representing an approximate 3% decrease from 2005. As the provision of home health care is a local endeavor, CMS' decision to view the new CBSA area designation in the "aggregate" for a large geographic region like NYC fails to represent the actual impact of the change. CMS' shift to the CBSA wage index designation has resulted in below trend reimbursement for NYC agencies since 2005, due to CMS' policy change implementing the CBSA designation and the Deficit Reduction Act (DRA) legislation which eliminated the entire market basket update in 2006.

In addition, HCA has consistently voiced its concern regarding the lack of parity between different health care sectors, each of which utilizes some form of a hospital wage index yet experiences distinct index values in their specific geographic area. CMS' decision to adopt solely the CBSA-based labor market definition serves to exacerbate that instability.

HCA Recommendation

HCA believes that CMS should consider wholesale revision and reform of the home health wage index. This reform should consider the following:

- The impact on care access and financial stability of home health agencies must be measured at the local level;
- Significant swings in the wage index cause instability and jeopardize access to care; and,
- The use of a hospital wage index with modifications that do not include hospital wage index reclassifications or the application of the rural floor creates an uneven marketplace for healthcare employers seeking to hire and retain comparable staff.

Existing law permits CMS nearly unlimited degree of flexibility to utilize a wage index that recognizes the geographic differences in labor costs in the provision of home health services across the country. Section 1895(b)4(C) of the Social Security Act (SSA) mandates the establishment of area wage index adjustment factors, provides the CMS Secretary discretion to determine which factors to consider, and permits the Secretary to utilize the same wage index adjustment factors that are utilized in composing the hospital wage index. However, despite CMS' ongoing recognition that home health agencies compete in the labor marketplace for the same health care staff utilized within inpatient hospitals, the wage index employed is comparable in name only.

HCA recommends that CMS reform the home health wage index by instituting a proxy that allows home health agencies to receive the same reclassification as hospitals if they provide services in the same service area. HCA believes that making this policy change will result in the important goal of parity in the labor marketplace between hospitals and home health agencies.

Home Health Care Quality Improvement & Pay for Reporting

While HCA is supportive of CMS continuing the pay-for-reporting requirements mandated by the DRA in the proposed rule, we do have one significant concern as CMS eventually considers transitioning to a pay-for-performance environment. In New York we have a 1915 waiver program called the Long Term Home Health Care Program (LTHHCP), which provides an intensive array of Medicaid home and community-based services to nursing home eligible patients. The majority of the patients in the LTHHCP are dually eligible patients (Medicare/Medicaid) but Medicaid is the appropriate payer of services approximately 90% of the time. Patients must also meet the requirements of a mandatory state assessment every 120 days, which is separate from the federal OASIS requirement.

HCA's concern is that CMS does not differentiate between NYS' LTHHCP and our traditional Medicare Certified Home Health Agency (CHHA) providers. CMS simply recognizes both as Medicare certified providers submitting OASIS data. However, the majority of patients being served by our LTHHCP members have long term, chronic needs who are unlikely to improve in the same manner as CHHAs patients with more acute needs and expectations for recovery.

HCA Recommendation

HCA strongly recommends that CMS remove NYS' LTHHCPs and any Special Needs CHHAs from this initiative. This would ensure that, in the future, when CMS begins rewarding home health agencies for their OASIS performance measures, these unique NYS' programs will not be adversely and unfairly effected.

Outlier Payments

HCA is concerned with CMS' decision to continue using the existing outlier payment standards by maintaining the "Fixed Dollar Loss (FDL) ratio at 0.67 percent. Federal law requires that the outlier budget be equivalent to 5% of the total Medicare home health expenditures, a threshold that has never been reached every year that the home PPS has been in place. CMS' estimate that an additional $130 million in outlier payments will be expended in CY 2008 through the use of the same standard in 2007 is without basis.

HCA Recommendation

HCA believes that continued use of the 0.67% FDL will not utilize the 5% outlier budget as required by federal law. CMS should lower the FDL based on historical experiences to a level that ensures full use of the outlier budget.

In conclusion, we thank you for this opportunity to submit comments and appreciate your consideration of our serious concerns and recommendations. We would be pleased to answer any questions or to assist CMS staff in any way going forward.

Sincerely,

Patrick Conole, MHA
Vice President, Regulatory Affairs
Home Care Association of New York State, Inc.

Submitter : Mr. Christopher Attaya **Date:** 06/26/2007

Organization : Partners Home Care

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-84-Attach-1.PDF

#84

Electronically

June 26, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1541-P, Medicare Program: Home Health Prospective Payment System for calendar Year 2008 Proposed Rule (Vol. 72, No. 86), May 4, 2007

Dear Ms. Norwalk:

Partners HealthCare System (PHS), Inc. is pleased to comment on the Proposed Rule for the Medicare Program: Changes to the Home Health Prospective Payment Systems and Calendar Year 2008 Rates, as published in the May 3, 2007 Federal Register, on behalf of the following institution:

Institution	Provider Number
Partners Home Care	22-7207

Partners commends CMS on the payment refinement outlined in the proposed rule. These changes are of the most significant nature since the inception of the home health prospective payment system. We support and appreciate CMS' effort to improve the system to better align payment with actual cost of delivering home health care. In working with the National Association for Home Care & Hospice (NAHC), we have identified areas in which further improvement should be considered. We ask CMS to work closely with NAHC to ensure the most accurate payment for the home health prospective system.

Case Mix Weight Adjustment

CMS proposes a 2.9% market basket update for rate year 2008. CMS also proposes a 2.75% reduction to the update for 3 years, netting an 8.25% total reduction over 3 years, based on "casemix creep" data between 1999 and 2003. CMS asserts that the casemix increase was mostly due to coding improvement based on observed shift of patient distribution from lower to higher weighted groupings without significant change in

patient characteristics. We believe that reduction of such magnitude (8.25%) requires more detailed and robust analysis, especially with the home health patient population both increased and changed significantly since the implementation of home health PPS. Acute hospitals now discharge more patients to home care, and the rehab hospitals divert more therapy intensive patients to home care under the 75% rule. CMS needs to take into consideration of more factors, such as average cost and clinical/resource utilization of each casemix group, before drawing a final conclusion about casemix creep. NAHC, in its comment letter, outlines detailed recommendations to conduct "casemix creep" analysis. We strongly urge CMS to adopt NAHC recommendations and recalculate "casemix creep" analysis. Furthermore, if new analysis, again, supports "casemix creep", ***we emphasize that CMS should phase in the total reduction in a way that its annual reduction does not exceed 50% of market basket update*** so that home health agencies can continue to provide care and ensure access to Medicare beneficiaries.

On behalf of Partners Home Care, I thank you for the opportunity to comment on this proposed rule. Please feel free to contact Anthony Santangelo at (617) 726-5449 or asantangelo@partners.org should you or your staff have any questions or would like more information.

Sincerely,

Christopher Attaya
President and CEO

Submitter : **Date: 06/26/2007**

Organization : **VNA Community Healthcare Inc.**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments regarding proposed PPS regulations

CMS-1541-P-85-Attach-1.DOC

I am submitting this comment letter on the proposed changes to the Prospective Payment System on behalf of my organization, VNA Community Healthcare. The organization is a free standing **not for profit** VNA serving our community for close to a century. Organizations endure this long because of their ability to manage change and this agency is no exception. We have dealt with and persevered through numerous regulatory and reimbursement changes over the years and have continued to be able to serve the residents of our service area. In the service of brevity, I am focusing my comments on the following items of the proposed changes.

Rate Reduction (creep adjustment of 2.75% per year)

The proposed rate cut of 8.25% over the next three years will drastically change our ability to provide the types and quality of services our community has come to expect from us. The proposal is based on a self – serving analysis founded on sweeping assumptions lacking in the substance of logic or proof. The report seems to deliberately omit data which would allow providers to evaluate the reasonableness of the assumption. The proposed cut will **decrease this agency's revenue by one million dollars over the three years.** Since 85% of our costs are related to employees this implies drastic measures will be required to reduce or freeze pay and benefits to employees who are already scarce and difficult to recruit. Once a home care agency loses its ability to attract skilled clinicians and paraprofessionals it begins a downward cycle that negatively impacts on the agency's ability to provide care and seriously reduces the ability to care for the poor.

The rationale for the rate cut was case mix "creep" or upcoding by home health care staff. There are many reasons why this can be disputed but the premise that "all agencies are scamming the system by up-coding" is offensive, untrue and unfair. The report is most disingenuous in the application of the remedy. If some agencies gamed the system, the majority did not. The case mix in our agency **did not rise** at the rate of others but our penalty is the same. The message is clear, we would have been better off to go after only high case mix patients and not admitted those who required only "routine care". Applying the rate cut to all agencies rather than reclaiming overpayments from those who aggressively coded their episodes is dishonest and the easy way out for CMS.

Absence of the Technical Report

With respect to the other details of the proposed PPS refinement, it is ridiculous to ask us to analyze a model in which the research and findings used to develop the model are not accessible. The lack of information regarding the logic and research behind it does not allow for sufficient analysis. Despite the glaring absence of available information these are a few items that I find highly questionable.

The Impact of Medicaid Dually Eligible

CMS states that the data does not support a strong enough relationship between this characteristic and case mix weight. Our experience is directly opposite of this conclusion. The dual eligible patients have dramatically impacted our Home Health Compare numbers, particularly the hospitalization rates so how can they not impact case mix?

Functional Dimension

Another variable where the refinement imposes a negative adjustment is to the functional dimension. MO690 and MO700 relate to functions that are frequently impaired in the geriatric population. Even mild impairments negatively impact the patient's ability to manage safely in their home and yet CMS has made the impairment level extremely high in order to qualify to receive reimbursement points. This is again illogical and we can only infer that CMS is merely looking to decrease reimbursement and is not interested in assessing the true characteristics of patients and their relation to resource consumption.

Non Routine Medical Supplies

There are grave concerns regarding the adjustment to non-routine supplies. Our agency frequently has patients referred to us for drainage of a system called Denver Pleurx. This highly technical procedure requires supplies that cost $500-$600 per month! The diagnosis requiring this procedure is pleural effusion usually caused by congestive heart failure or lung cancer. Under the PPS refinement system, these diagnoses are not eligible for a non-routine supply add-on. If the current proposal remains in place we will be forced to refuse acceptance of these types of patients. Additionally, the concept of no add-on for LUPA clients means patients requiring once a month catheter changes (a standard medical practice) will need to seek care elsewhere as home health agencies will not be in a position to incur those supply costs when LUPA rates barely cover the discipline costs alone.

Summary

These are just a few of the areas that we have identified as problematic in the proposed PPS refinements. The creation of such a negative impact does not seem to be in the best interest of the patients who wish to stay in their homes nor on the industry that can help them attain their wish.

I find it very discouraging to have to write this letter. The Federal government pays lip service to supporting community based and least restrictive services yet it seems reductions in payments to home care providers rears its ugly head at every turn. Not for profit home care is the most cost effective of all health care providers. If we disappear, the only alternative will be higher cost institutional care and continued battle with providers who do game the system by accepting only high case mix patients. I am requesting that CMS rethink its assumption that all providers are gaming the system and rethink it's across the board rate reduction to all providers.

Sincerely,
Susan Faris, Pres. & C.E.O.
VNA Community Healthcare

Submitter : Mr. Javy Gwaltney III **Date:** 06/26/2007

Organization : VNA of Greater Bamberg, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-86-Attach-1.DOC

#86

June 19, 2007

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

RE: Comments to Home Health PPS Proposed Rules – CMS 1541-P

Gentleman,

Included in this letter are my comments to the Home Health Prospective Payment System Proposed Rule Refinement and Rate Update for Calendar Year 2008 that was released on April 27, 2007 and published in the Federal Register on May 4, 20007.

Issue ~ CASE MIX WEIGHT ADJUSTMENT
Section Title ~ PROVISIONS OF THE PROPOSED REGULATIONS
Comments ~ CMS proposes to reduce the base payment rates by 2.75% for the next three years. The rational for this adjustment is that the national average case mix increased between 1999 and 2003 due to factors unrelated in changes in patient characteristics. The original case mix adjustment design was based on 1997 patient data and set average case mix weight to 1.0 based on that data. The current average case mix (2003) is 1.233. CMS has concluded that 8.7% of this increase does not relate to changes in patient characteristics and plans a 2.75% reduction for the next three years to offset this 8.7% increase.

I believe the rate reduction is based on a flawed methodology in examining the patient characteristics. Our patients are significantly sicker than in the 1997 base year. Our percentage of patients which meet the C2 & C3 scoring on their case mix has risen each year. The assessments rely on objective criteria performed by professional staff and are not subject to manipulation. The standards are set in the OASIS document and professional staff score the document based on those standards. The simple facts are that hospitals are discharging patients much quicker than in 1997 and in need more services and scoring worse on the OASIS assessment.

From 1999 to 2003 we are seeing significantly more diabetics, a trend that is continuing into 2007, with approximately 20% more patients being diabetic. We are also seeing significantly more patients in need of wound care and therapy. There are

also increasing percentages of patients with dyspnea, urinary incontinence, abnormality of gait, and diminished transferring and other functional capabilities. These changes in patient characteristics are very significant in comparison to the typical 1999 patient and the case mix scoring accurately reflects this.

One of the likely reasons for the changes in the patient mix since 1999 are program reforms within the Medicare program which are directing patients with more profound needs into home health services. The reforms for Inpatient Rehabilitation Facility services during this time period has had the expected result of having increasing numbers of patient admitted to home health care in need of rehabilitation services. The dramatic increase in the number of patients with abnormality of gait and decline in transfer capabilities all bear witness to this being the primary and substantial reason for the changes in patient case mix scoring, along with the Inpatient Hospital DRG system causing earlier discharges to home health.

Another cause for the increased case mix scoring is very simply that our patient population is getting older. Since 1999, our agency is seeing nearly a 40% increase in the number of patients aged 85 or older. These patients and their characteristics certainly score higher and have more medical needs than in the base year patient population.

The targeting of lower acuity Medicare patients by the Medicare+Choice and Medicare Advantage plans are causing lower acuity patients out of traditional Medicare. This type of marketing activity is leaving the more acute patients in traditional Medicare and is another reason why the characteristics of today's patients are vastly different than in 1999.

Home health agencies have been proactive in meeting the needs of the new type of patient. Their increased need and use of therapy has been improving outcomes and actually saving the Medicare program significant dollars. For example, **from 2001 to 2003, the average annual spending per home health patient decreased from $3,812 to $3,497**, despite the fact that the case mix scoring increased. A quick comparison of that same time period shows inpatient hospital expenditures up from $11,938 to $13,381 and SNF facilities up from $7,517 to $7,965.

The CMS proposal in this rule to adjust the therapy case mix using multiple thresholds instead of the one ten visit threshold should remove all concerns of inappropriate case mix scoring. The increased use of home health therapy services has allowed for quicker patient discharges, and higher quality outcomes at a lower cost to the Medicare program. Cutting the base rate because the vast majority of the "case mix creep" has

come from increased therapy utilization, while saving the Medicare program millions of dollars and achieving better outcomes in the process is inappropriate, and to borrow an old saying, is penny wise and dollar foolish.

Recommendation ~ Eliminate the 2.75% base rate reductions. Changes in patient population, staff learning curves, conflicting OASIS instructions, and greater therapy utilization to achieve faster patient stabilization all play into the increase in case mix. Despite the increased case mix scoring, **the annual dollars spent per patient has been decreasing.**

Issue ~ LUPA
Section Title ~ PROVISIONS OF THE PROPOSED REGULATIONS
Comments ~ I agree with and support CMS' proposal to pay a higher rate for LUPA episodes, thereby giving agencies a chance to recover some of the costs of the initial visit and additional paperwork required for each episode. I do request that CMS consider adding this payment methodology to all LUPA episodes. There are some patients who need medically necessary home care long term and will always be LUPA episodes. A frequent seen example is the catheter patient who may only been seen once a month. This visit volume never lets the agency recover the costs of the admission and recertification visits. Frequently, the skill service is set a very specific intervals and an additional OASIS visit must be performed at a different time just to do the assessment.

Another cause for concern which affects both the LUPA issue and the Early/Late Episode scoring is the new OASIS question asking if this is a new episode. This will be a problematic question very much like the M0170 question which is rightfully being removed from the case mix scoring. The admitting home health agency will not know if the patient has had a recent episode from another provider and will have to refer to the DDE software to determine if another agency has been involved with the patients care. Claims that are not clean can take several months to process and makes it very difficult for the agency to accurately answer this question.

Recommendation ~ My analysis agrees that rates should be increased for a start of care episode that end as a LUPA because home health agencies are never able to absorb the extra costs of the initial visits, paperwork, and instruction time over the course of LUPA episode. While LUPA's represent a fairly small number of episodes, the administrative costs can extend well past the first LUPA episode. Increasing all LUPA episodes to the new model of reimbursement would be appropriate. An agencies inability to cover costs can negatively impact access to care which is medically

necessary for certain groups of long-term patients. For example, someone needing catheter care once or twice a month or B12 shots could be placed in a more costly setting to receive this care.

Issue ~ SCIC
Section Title ~ PROVISIONS OF THE PROPOSED REGULATIONS
Comments ~ The provision to eliminate the SCIC actually represents a reimbursement reduction in the 2.1% of episodes where you actually have a SCIC. However, the difficulty in determining whether a SCIC needs to be claimed and the costs of the associated rebilling make SCIC's a real problem to administer. Given the new proposed methodology of correctly adjusting the case mix factor for therapy utilization on the final claim, I agree with CMS's proposal to eliminate the SCIC.

Recommendation ~ Eliminate the SCIC as proposed.

Issue ~ Non-Routine Supplies (NRS)
Section Title ~ PROVISIONS OF THE PROPOSED REGULATIONS
Comments ~ CMS's data is incomplete in regards to NRS because many agencies have chosen not to bill Medicare for the supplies since they are not reimbursed for them and the additional time and paperwork involved in the billing process is pointless to them. Our agency does collect NRS billing data and bills accordingly. Our average cost of supplies is $231 per Medicare episode. I have ran an analysis of the new system on our data and despite the fact the we see a large number patients requiring wound and ostomy care, the new methodology in the proposed rule is only going to average adding $54 an episode for us based on data from January 1, 2007 through May 31, 2007.

I strongly agree with CMS that a method of allowing additional reimbursement for high supply utilization patients is a needed fix to the PPS reimbursement system. Some complex wound care cases can cost over $1,000 a month. The proposed methodology simply doesn't allow enough resources to cover the costs of such cases.

I also feel that some methodology of including supply costs should be included in LUPA episodes. Many LUPA episodes have high supply costs. A complex wound case that ends up going back to the hospital because of complications, or patients needing urinary catheter changes are common examples of high supply cost LUPA episodes.

Recommendation ~ A better methodology of dealing with NRS has been needed since the implementation of the PPS. I applaud the efforts of CMS in attempting to build a better model; however, with many agencies not billing NRS or capturing them correctly on their cost reports, the model doesn't account for the true costs of NRS and isn't strong enough for intensive cases like decubitus, burns, and trauma wounds which may seriously leave some patients with limited access to medically necessary care that will have to be provided in more expensive settings.

Issue ~ Outlier Issue
Section Title ~ PROVISIONS OF THE PROPOSED REGULATIONS
Comments ~ CMS proposes to maintain the current standard of .67 Fixed Dollar Loss ratio (FDL) in determining outlier payments. The .67 FDL has never come close to utilizing the 5% outlier budget as required by Medicare Law. The CMS estimate that an additional $130 million in outlier payments will be needed for 2008 is without basis and is removing needed dollars which should go back into the base allowing for a better NRS model.

Recommendations ~ Allocate 3% ($3.9 million) of the $130 million for outlier payments. This should more than cover the cost of the outliers and roll back the remaining 97% ($126.1 million) of the proposed outlier allocation to the base rate.

Issue ~ 2.9% Market Basket Index (MBI)
Section Title ~ PROVISIONS OF THE PROPOSED REGULATIONS
Comments ~ Our agency provides services to a geographically large rural area. The recent increases in transportation costs have already made scheduling a difficult task. *The loss of the rural wage index add-on, plus the proposed 8.75% case mix creep reduction proposal, plus the additional possible threat of Congress reducing the MBI will have significant adverse impact on access to medically necessary health care services in rural areas.*

Recommendations ~ Encourage Congress to maintain at least a 2.9% MBI.

Thank you for giving me the opportunity to comment on the proposed regulations. I hope my comments will prove helpful. CMS has made many improvements in the Home Health Prospective Payment System and hopefully will further refine it with the recommendations from these comments.

Sincerely,

J R Gwaltney III,
Chief Financial Officer
VNA of Greater Bamberg, Inc.
PO Box 1048
Bamberg, SC 29003
vnabamberg@yahoo.com

Submitter : Mr. Steve Starke **Date:** 06/26/2007

Organization : Visiting Nurse Association of SW Indiana, Inc.

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

See Attachment

CMS-1541-P-87-Attach-1.DOC

#87

June 26, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1541-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Kuhn:

I am writing on behalf of the Visiting Nurse Association of Southwestern Indiana, Inc. to convey our principle concerns regarding: Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P). As a member agency of the Visiting Nurse Associations of America, we endorse, and also refer you to the extensive comments submitted by Andy Carter, Chief Executive Officer of Visiting Nurse Associations of America.

Recognizing that the proposed PPS revisions include a number of positive changes, we are very concerned that these positives are undermined by the across the board cut in base payment rates contained in this same regulation, resulting in an onerous 8.25% reduction over three years.

CMS's proposed reimbursement cut was included to recoup what is reported to be an unwarranted increase in payments for Medicare home health services between 2000 and 2003. The rationale used to justify the 2.75% reductions in base payment rates for each fiscal year (2008, 2009, 2010) is that home health agencies have inflated their patient assessments (OASIS) to gain higher payment. In our case this is **not true**! In fact, our agency's case mix weight actually dropped – the exact opposite of the CMS assertion. In 2003 VNA's case mix weight was 1.2875. In 2006 it was 1.2182!

We believe that the assertion of intentional "upcoding" on the part of nurses is completely unfounded. The reality is that the condition of patients using home health care continues to become more severe over time. It is already a challenge for our agency to meet the demands of the growing number of older Americans with health care needs who desire to remain in their homes.

This reimbursement cut will hurt Medicare and Medicaid beneficiaries and ultimately will result in increased expenditures by Medicare and Medicaid. I ask you to please give serious consideration to our concerns as well as those expressed by Visiting Nurse Associations of America.

Thank you for the opportunity to comment on these proposed changes, and for the responsiveness to VNAA demonstrated in prior years.

Sincerely,

Steve Starke
Executive Director

CC: Carol Blackford, CMS

Submitter : **Ms. Kathleen Anderson** **Date: 06/26/2007**

Organization : **Ohio Council for Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1541-P-88-Attach-1.DOC

The Voice of Home Care and Hospice

June 26, 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 Calendar Year 2008

On behalf of 332 certified home health agencies serving Ohio's elderly & disabled Medicare beneficiaries, the Ohio Council for Home Care (OCHC) is pleased to submit the following comments on the proposed rule for refinement of the Home Health Prospective Payment System (HHPPS) and the rate update for 2008 that was published as a proposed rule in the *Federal Register* on May 4, 2007.

OCHC appreciates the consideration that the Centers for Medicare & Medicaid Services (CMS) has given to questions and comments we along with the National Association for Home Care (NAHC) have submitted over the years in the proposed revisions to PPS structure and case-mix. We believe that the adoption of many of the recommendations made by NAHC and others, such as elimination of the Significant Change in Condition (SCIC) policy, will improve the payment system by allowing home health agencies to devote more of their time and attention toward the improvement of patient care.

We recognize the importance of refining the home health PPS to reflect current patient characteristics and agency practices. But, we believe that caution is critical when undertaking multiple changes simultaneously. Of particular concern is CMS' plan to impose payment reductions at the same time that a major overhaul is being undertaken in the case-mix system. After in-depth analysis of the proposed refinement regulation and review of opinions from researches, financial and policy experts, and home health providers, OCHC offers the following recommendations.

Case-Mix

Medicaid Eligibility and Caregiver Access

There continues to be great concern about two considerations that were included in the case-mix research, but not in the proposed changes: Medicaid eligibility and caregiver access. Home health agencies continue to report that both of these have a considerable impact on resource use. We realize that CMS conducted an analysis of both Medicaid eligibility and caregiver access and found that Medicaid as reported on OASIS did not have a significant impact on resource use. We also realize that caregiver access was found to have an impact, but CMS believes that adoption of this variable would be a negative incentive.

However, we strongly believe that these findings are questionable since they were based on OASIS data that does not effectively portray reality. Regarding Medicaid eligibility, home health agencies frequently do not record Medicaid numbers in cases where Medicaid is not the payer, resulting in underreporting and loss of valuable data. Also, the OASIS questions for caregivers are invalid for drawing conclusions about the actual nature and time of caregiver availability.

Recommendation

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.

Refine the OASIS items related to caregiver access in order to produce more reliable information about the actual roles caregivers play in meeting the day-to-day needs of home health patients, and the amount of time they are available. Conduct further research on the impact of caregiver access on home health resource use and adjust the case-mix system according to findings.

Diagnosis Codes

We note that CMS plans to revisit the diagnosis codes found in the proposed rule, and consider revising them based on 2005 data. Major changes have occurred in home health diagnosis coding practices since the implementation of Health Insurance Portability and Accountability Act (HIPAA) requiring compliance with official coding guidelines, including ICD-9-CM codes. As a result of HIPAA changes there has been a great deal of confusion on the part of home health agencies about correct diagnosis coding, particularly the proper use of V codes.

According to the Medicare Decision Support Access Facility at CMS, one in one thousand home health patients had a primary diagnosis in the V code category in 2001. However, in 2004 the same source reported over 40% of home health patients with a primary diagnosis in the V code category. We believe that this is the result, in part, of

improper use of V codes. We also believe that the official ICD-9-CM coding guidance does not address the complexity of home health service delivery, resulting in a single aftercare code being selected as a primary diagnosis, when in fact multiple services addressing multiple patient needs are delivered during most home health visits. On another note, home health agencies do not often report all patient diagnoses that impact the plan of care and patient's rehabilitation potential.

In light of the expanded diagnosis list in the proposed rule, we expect home health diagnosis coding practices to change significantly. We believe that diagnosis coding practice changes are long overdue. More thorough and accurate diagnosis coding will produce a wealth of needed information about the home health patients' medical conditions that will lead to better care and more appropriate public policy.

We did note that one case-mix diagnosis was missing. Table 2b does not reflect the changes made to the 2005 official ICD-9-CM coding index, which eliminated 436 (acute but ill-defined cerebrovascular disease) and added 434.91 (cerebral artery occlusion unspecified with cerebral infarction). This is the most appropriate code for many stroke patients.

Recommendation

Proceed with caution before making changes to the proposed PPS diagnosis list. Provide guidance on proper diagnosis coding and support appropriate diagnosis coding practices.

Remove the ICD-9-CM code 436 from the list of case-mix diagnosis codes. Add ICD-9-CM code 434.91 in accordance with current diagnosis coding guidelines.

Early and Late Episodes

Recognition of the different characteristics of patients and resource utilization in early, versus late episodes of care, is an important refinement in the case-mix system. OCHC has long supported the delivery of home health services to chronically ill patients as a vital service that enables Medicare beneficiaries to remain in their own homes and reduces overall health care expenditures. We believe that this proposed change in the case-mix system will result in more appropriate distribution of funds for care of the long-term patient. Therefore, we support this case-mix refinement.

We were especially pleased to learn that CMS plans to have the claims processing system automatically adjust final claims to reflect correct responses to early/late episodes, both upward and downward based on information in the common working file (CWF). This action will alleviate the burden on home health agencies that would otherwise exist if they had to conduct ongoing monitoring of the CWF for adjacent episodes and withdraw and resubmit a revised claim should an error be discovered.

Additional Therapy Thresholds

OCHC supports the concept of multiple therapy thresholds and the smoothing effect of the graduated payment methodology as proposed. We are also pleased that 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. Nor are points allocated for the gait disorder diagnosis in 14 plus therapy visit equations. This proposed point allocation is counterintuitive.

Recommendation

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. Construct the case-mix system in accord with findings.

Low-Utilization Payment Adjustments (LUPA)

We appreciate 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, we believe that this policy should also be extended to adjacent LUPA episodes.

The rationale for the LUPA add-on addresses the fact that time to complete start of care OASIS adds an average of 40 minutes to the typical start of care visit. We believe that there are hidden costs related to LUPA episodes, and that significant information about the time and cost of the conduct of recertification OASIS assessment was not captured in the analysis of adjacent LUPA episode costs. A large percentage of LUPA episodes are for long term care patients that require 2 to 3 nursing visits per episode, many for a specific treatment that must be administered at a prescribed point in time. As a result of treatment timing, home health agency clinicians often must make an additional, non-chargeable visit for the sole purpose of completing an OASIS follow-up assessment in the required 5-day window. The costs for these visits are not captured in the Medicare claims data since agencies are prohibited from billing Medicare for assessment only visits.

Also, it is unclear how CMS intends to identify initial or only, versus adjacent LUPA episodes. The notice 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. However, it has been reported that CMS plans to program the LUPA add-on payment anytime the start of care date matches the "from" date on a claim, in the same manner that the RAP percentage is calculated.

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.

Recommendation

Apply the LUPA add-on to all LUPA episodes. Provide more information as to how the claims processing systems will identify LUPA episodes that are eligible for add-on payments.

Non-routine Medical Supplies

OCHC also has concerns about the proposed model for payment for medical supplies in light of the model's poor performance and R^2 of 13.7%. According to the analysis of home health claims and cost reports, only 10% of episodes include medical supplies. However, it has been reported to OCHC and NAHC by both providers and financial consultants that medical supplies are delivered to patients in a far greater number of episodes than reported, but home health agencies fail to list non-routine medical supplies on final claims.

Some reasons that agencies fail to report medical supplies are: lack of knowledge as to how to enter them on direct data entry screens (DDE), incomplete or late invoicing by medical suppliers, and lack of awareness of the importance of billing for medical supplies in the PPS systems since payment is not impacted. This could certainly account for a large part of the problems with home health cost reports that could not be used for the PPS reform research.

In addition, OCHC has identified a number of costly non-routine medical supplies that are not reflected in the medical supply case-mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that made their appearance on the home care scene after the start of PPS are those supplies needed for 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.

Further, although we agree that elimination of SCICs is a necessary reform, we believe that agencies will be unable to seek reimbursement for medical supplies, as there does not appear to be a mechanism to account for supply needs that surface after the initial start of care assessment has been completed. This could result in grossly inadequate payment.

Finally, 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

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. Do not proceed with the proposed non-routine supply model until more accurate data about the extent of supply use is determined.

In light of the fact that there are no other OASIS items that will lend themselves to predicting non-routine supply use, give consideration to additional diagnosis codes that might meet this need. Consider including secondary (other) diagnoses of V44.0 through V44.9, Artificial Opening Status requiring attention or management, to identify patients needing supplies for other ostomies.

Either add pleural effusion as a supply case-mix diagnosis to capture those episodes during which chest drainage supplies are provided, or reclassify chest drainage catheters and valves as prosthetic devices, thereby capturing the payment for related supplies under that benefit.

Once a more reliable supply case-mix model has been created, include payment for non-routine medical supplies for all episodes, including LUPA episodes that are not final episodes of care.

CASE MIX WEIGHT ADJUSTMENT

PROPOSAL: CMS proposes to reduce the base payment rates by 2.75% for each of 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. CMS concluded that the change in case mix weight between 1997 and 1999 (1.0 to 1.13 (approx.) is due

to changes in patient characteristics. However, CMS further concluded that the change between 1999 and 2003 (1.13 to 1.233) of 8.7% is an increase without any relation to changes in patient characteristics. As a result, CMS proposes to adjust the base payment rate by 2.75% for each of the 3 upcoming years to prevent expenditure increases that are due to factors unrelated to patient characteristics.

OCHC Position: The 2.75% reduction in payment rates is based on an inaccurate calculation that the change in case mix weights is unrelated to changes in patient characteristics. The CMS calculation is based on a fatally flawed methodology, inappropriate standards, and assumptions that are not correlated with outcomes. Uncontroverted data on patient assessment demonstrates that most, if not all, of the increase in case mix weights is directly related to changes in patient characteristics.

OCHC Recommendation: CMS should withdraw its proposal to reduce base payment rates by 2.75% in 2008, 2009, and 2010. CMS should design and implement an evaluation method to analyze changes in case mix weights that utilizes proper standards related to the home health case mix adjustment model concept of "patient characteristics." Further, CMS should include relevant factors in this analysis such as changes in per patient annual expenditures, patient clinical, functional, and service utilization data, and dynamic factors in the Medicare system that impact on the nature of patients served with home health care.

Rationale:

1. CMS failed to consider the utilization of therapy services as a "patient characteristic." The HHPPS uses a case mix adjustment model that incorporates clinical, functional, and services domains in categorizing the characteristics of home health services patients. CMS specifically included a therapy threshold of 10 visits in an episode (MO825) as a means to distinguish patient types. CMS used the volume of therapy visits as a proxy for clinical and functional characteristics that were either unavailable or otherwise inadequately captured through OASIS. Instead, CMS attempts to invalidate the increase in patient episodes with 10+ therapy visits through evaluation of data from the Clinical and Functional OASIS domains, data that CMS itself concluded was inadequate to explain therapy service utilization in the original construction of the HHPPS case mix adjustment model. This internal inconsistency renders the CMS proposal fatally flawed.

2. In spite of the weakness set out above, the CMS OASIS data provides a strong indication that the increase in therapy services is directly related to changes in patient characteristics. The OASIS data referenced in the CMS proposal clearly depicts an increase in the clinical severity of patients admitted to home health services from 1999 through 2003. The percentage of patients assessed at C2 and C3 increased in each of these years. These assessments rely primarily on objective criteria and are not subject to manipulation and/or inaccurate interpretation of standards. Similarly, the period of 1999-2003 shows statistically material increases in the assessment of functional limitations. As with the Clinical domain, the functional assessments domain leaves little room for manipulation or erroneous interpretations. While CMS completely assumed that the

scoring changes in the Clinical and Functional domains are related to policy clarifications, provider training, and other factors unrelated to the patient's home health services, the more logical assumption is that patient characteristics have changed. Corroborative factors for this more reliable assumption are set forth below.

The evidence further indicates significant change in patient characteristics from 1999 to 2003. These include:

- Home health users grew from 2.1 million to 2.4 million.
- The number of beneficiaries with a primary diagnosis of diabetes increased by 17%
- Patients with abnormality of gait increased by 50%
- Patients with wounds increased by 15 percentage points
- Patients with urinary incontinence increased by 8 percentage points
- Patients showed a substantial decrease in transfer capabilities
- There is a demonstrated increase in cognitive function deficits
- Findings of dyspnea increased

CMS's dismissal of these changes as "modest" ignores the cumulative impact on the need for increased therapy services along with higher clinical and functional scores in the case mix weight. The increase in patients with ambulation and transfer deficits alone accounts for a significant portion of case mix weight growth from 1999-2003.

3. Medicare program reforms have changed the nature of patients referred to home health services. Further, Medicare payment changes reflect alterations in patient acuity. First, Medicare initiated claim oversight, tightening of eligibility standards, and payment restrictions for Inpatient Rehabilitation Facility (IRF) services during 1999-2003. As an expected result, the volume of patients admitted to home health care for rehabilitation services significantly increased. The data demonstrates both that the number of patients requiring therapy and the number requiring 10+ visits has increased in a manner corresponding with these program changes.

Second, Medicare has altered Inpatient Hospital services payments to reflect early discharges of patients to home health care. The institution of the Transfer DRG policy is a definite reflection of the increased acuity of patients admitted from hospitals to home health services.

Third, CMS data, cited in the proposed rule, indicates that there has been an increase in patients admitted to home health care from a Skilled Nursing Facility (SNF) stay. The HHPPS case mix adjustment model includes a scoring factor that reflects the CMS finding that patients admitted to home health services from an SNF are different than patients without a recent SNF stay and that such patients require more care.

4. The trends related to patient age indicate the patient characteristics changed between 2000 and 2003. Data shows that the percentage of home health patients age 85 and over increased from 23% to 27%. It can be readily concluded that this change in patient characteristics contributed to the increase in case mix weights.

5. During 2000 to 2003, home health agencies dramatically altered care practices to achieve improved patient outcomes. The onset of HHPPS brought a shift from dependency-oriented care to care designed to achieve self-sufficiency and independence. Indicative of this change is the significant increase in the use of occupational and physical therapy concurrent with the reduction in the use of home health aide services. The average number of home health aide visits in a 60-day episode dropped significantly between 1997 and 2003. Correspondingly, the use of Occupational Therapy and Physical Therapy use increased during that period. The purposes are obvious and the results are undeniable. Patient lengths of stay were reduced and clinical/functional outcomes improved.

The manner in which a patient is served in HHPPS is a "patient characteristic." That is demonstrated by the use of a Service domain in the case mix model as a proxy for patient characteristics that cannot be found in the clinical and function assessment elements of OASIS.

6. The growth in enrollment in Medicare + Choice (M+C) and Medicare Advantage (MA) plans have shifted low acuity patients out of traditional Medicare, as this element of the Medicare enrollee population have been targeted for enrollment by the plans. Strong evidence exists that the nature of M+C and MA plan enrollees left higher need, higher cost Medicare beneficiaries within the traditional Medicare program.

7. The average annual per patient expenditures for home health services do not show that the increase in average case mix weights has increased Medicare expenditures. Instead, between 2001 and 2003, the average annual expenditures actually dropped from $3812 to $3497. This outcome for the Medicare program corresponds with reduced length of stay as triggered by increased use of rehabilitative services. While the increase in therapy led to an increase in case mix weight, Medicare expenditures were controlled and restrained in growth. In contrast, per patient inpatient hospital and SNF expenditures grew during that same period: $11,938 to $13,381 hospital; $7517 to $7965 SNF.

The growth in case mix weights must be viewed in a wider context than used by CMS. The case mix adjustment model sensibly incentivized the use of therapy services to modify care practices, achieving positive outcomes for both patients and Medicare. It is obvious that discouraging the use of therapy services through the proposed 2.75% / 3-year rate reduction would result in increased per patient and overall Medicare expenditures as a return to the dependent-oriented use of home health aide services extends patient lengths of stay.

8. The CMS proposal to reform the case mix adjustment model resolves any concerns regarding inappropriate case mix weights related increases in the use of therapy services. The purpose of eliminating the single 10-visit threshold for increased payment

is to attempt to align payment incentives with patient care needs. Accordingly, the use of a case mix weight creep adjustment that primarily reflects growth in therapy utilization is an unnecessary adjustment that only serves to "double-dip" on rate adjustments.

9. The case mix weight starting point of 1997 is a foundation that is so fundamentally flawed that no meaningful comparison of case mix weight increase is even possible. The case mix adjustment model in use operates with such significant and unending weaknesses that attempting to evaluate scoring changes over time are the equivalent of using a person with a blindfold to judge the color of an object.

First, the model is built on a 1% sample of claims. In many of the case mix groups, insufficient data leads to numerous substituted judgments. Second, the explanatory power (R^2) of the model, originally estimated at 30+%, devolved to 22% by 2003 with it operating at an 11% R^2 in the absence of the therapy adjustment element (MO825). Since the CMS proposal rejects the therapy utilization element as relevant to patient characteristics in the case mix creep analysis, effectively CMS expects to use OASIS data elements that are unable to define patients correctly in 89% of all episodes to explain changes in case mix weights. Third, MedPAC found that the coefficient of variation exceeded 1.0 in over 60 of the 80 case mix groups. Any growth in average case mix weights through 2003 is easily explained by the inherent weaknesses in the model alone.

WAGE INDEX

PROPOSAL: CMS proposes to maintain the current policy of using the pre-rural floor, pre-reclassified hospital wage index to adjust home health services payment rates.

OCHC Position: OCHC and NAHC opposes the continued use of this outdated and inequitable wage index method.

OCHC Recommendation: CMS should replace its home health wage index policy with a method that achieves parity with hospitals in the same geographic market. Further, the wage index should be stabilized through the use of limits on year-to-year changes. This can be accomplished through the use of the rural floor standards and a proxy for hospital reclassifications. Alternatively, the method should be replaced with a BLS/Census Bureau data method as recommended by MedPAC.

Rationale: Home health agencies and hospitals compete for the same staff in a given geographic area. As such, the applicable wage indices should be comparable. Further, the use of a mechanism that limits year-to-year fluctuations in the wage index will offer predictability and stability to annual budgeting.

OUTLIER PAYMENTS

PROPOSAL: CMS proposes to maintain the current standards for applicability of outlier payment. Specifically, CMS proposes to continue use of a .67 Fixed Dollar Loss ratio (FDL).

OCHC Position: OCHC opposes this proposal. Continued use of a .67 FDL will not utilize the 5% outlier budget as required by Medicare law.

OCHC Recommendation: CMS should lower the FDL based on historical experiences to a level that ensures full use of the outlier budget.

Rationale: The CMS standards for outlier payment have failed to fully use the outlier budget in every year that the prospective payment system has been in place. The CMS estimate that an additional $130 million in outlier payment will be expended in 2008 through the use of the same standards as in use in 2007 is without any basis.

CONCLUSION

Thank you for the opportunity to submit these comments. We believe that CMS has made many improvements in HHPPS and look forward to further refinements in line with the comments set out above.

Cordially,

Kathleen Anderson, CAE
Executive Director
Ohio Council for Home Care

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Submitter : **Ms. Ellen Caruso** **Date: 06/26/2007**

Organization : **Home Care Association of Colorado**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment (Non-routine medical supplies.pdf)

CMS-1541-P-89-Attach-1.PDF

#89

Home Care Association of Colorado
Weaving a strong home care industry

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June 26, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn. CMS-1541-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore Maryland

Re: Proposed PPS Changes

To Whom It May Concern:

Following are comments from the Home Care Association of Colorado in a state where home care agencies provide more than three million home care visits to 60,000 plus Coloradans per year and employ more than 10,000 nurses, therapists, home health agencies and personal care providers. Thank you very much for your consideration of our comments:

Addition of Variables *(pg 25361):*

> *We also propose to assign scores to certain secondary diagnoses, used to account for cost-increasing effects of co-morbidities. An example is secondary cancer diagnoses, whose cost-increasing effects are not as large as those for primary cancer diagnoses. However, with most diagnosis groups, we did not make a distinction in the final model between primary placement and secondary placement of a condition in the reported list of diagnoses.*

This sounds reasonable. We have always believed that there were numerous situations that these co-morbidities greatly increased the complexity (cost) of treating the beneficiary but were not readily identified by OASIS. We feel that this will be an improvement to both the OASIS and the resource allocation

thorough PPS. The industry has been awaiting regulatory assistance with the financial recognition for a wider range of diagnoses that has proven to affect resource allocation of home health services. An analysis of the proposed PPS changes shows a devastating change in reimbursement for the home health industry. According to a wide scope analysis conducted by Strategic Health Partners, LLC (SHP) an industrial leader in benchmarking and data mining, the home health industry will see a decline in reimbursement for the majority of the caseloads for home health. After "repricing" a full year (2006) of Medicare PPS episode data using the proposed 2008 regulations the industry will see a decline for specific populations:

CHF	-1.7%	
COPD	-2.5%	
Ulcers	-8.1%	
Diabetes		-9.6%
Orthopedic	-17.7%	
Neurological	-18.5%	

This analysis of the effects of the proposed rule certainly do not allocate the desired increase in reimbursement for the medical patients that the industry was hoping for with this PPS "improvement". The complexities of home health service delivery are not accounted for in the official ICD-9-CM coding guidelines that allows for a margin of error in coding practices. The Health Insurance Portability and Accountability Act (HIPAA) passage has required the home health industry to adopt new coding principles. In response to the required changes the home health industry has undergone a great deal of confusion, which would be reflected in the coding analysis of the earlier HH PPS years. We suggest that CMS implement the scoring of secondary diagnosis to account for the cost-increasing effects of co-morbidities and use current diagnosis data so as not to skew the results based on out of date coding practices prior to 2005.

Non-routine Medical Supplies

A more reliable case-mix model needs to be created and then payment should be included for non-routine medical supplies, including LUPA episodes that are not final episodes of care.

Medical supplies are delivered to patients in far greater numbers than reported because many home health agencies fail to list non- routine supplies on final claims. This is caused by a lack of knowledge as to how to enter supplies as well as a lack of awareness of billing for medical supplies in the PPS system since payment is not impacted. Non-routine supplies are very costly to agencies and some of the highest costs are from patients' wounds and with ostomies including nephrostomy, urethrostomy and ureterostomy as well as supplies for closed chest drainage. Failure to identify patient characteristics that would allow payment for these supplies will result in an

underpayment for home health agencies.

LUPA episodes that are not final episodes often have high supply costs especially for those patients with foley catheters that require monthly catheter changes. Failure to pay for these supplies will result in a disincentive for home health agencies to serve these patients.

Home health patients with wound diagnoses, and their caregivers often use wound care supplies. A LUPA episode would barely cover the visit costs let alone the supplies, so agencies might be inclined to forego teaching of patients and caregivers the wound care and keep the patients on service longer in order to be eligible for full episode payments and coverage of supplies.

LUPA payments

HCAC, although generally supportive of the change in LUPA payments to allow an additional per-episode payment to better reflect the costs of low utilization episodes not currently captured, would like to raise certain issues.

The reasoning for the additional LUPA payment addresses some of the costs. The proposed level still understates the actual agency cost because CMS has only included an estimate of additional time of direct service cost for assessment. This excludes the administrative cost of the agency which is fixed for either a LUPA or a full payment episode: preparing and submitting bills, OASIS transmission, non-billable visits to complete the OASIS within the allotted window of time and all the other general and administrative costs incurred to run the agency. As such, we believe the LUPA add-on payment should be included on <u>all</u> LUPA episodes, not just the initial one. When patients have a series of LUPA only episodes, this cost is maintained.

CMS should also reconsider the amount to account for the full administrative costs for such episodes and apply the add-on to all LUPA episodes. Also, CMS should <u>not</u> exclude LUPA episodes from the medical supply payment

Administrative Burden

HCAC members are extremely concerned with the administrative burden of the rapid implementation schedule of such complex changes to the Prospective Pay System. Software vendors serving the home health community will not have the final rule for PPS refinement until 10/31/07 and must then have final coding of the software completed, tested, and distributed to end users before 1/1/08 for installation. The end users of the software will need to have installation of the software upgrade completed and staff trained by 1/1/08 to ensure a smooth transition in billing. Changes to the OASIS data collection needs to be implemented by providers in November, as changes to significant data elements will affect episodes that lap over into 2008. Changes of this magnitude in the past have not only affected the home health care providers' ability to adapt timely but have also had a significant impact on Medicare's fiscal intermediary contractors' ability

to be ready for the changes. This very tight implementation schedule raises great concern about the potential for claims processing delays and errors. The CMS needs to consider a viable contingency plan for cash flow to home health care providers in the event of claims payment delays or errors due to rapid system changes.

Thank you for reading and for your consideration of our comments.

Sincerely,

Susan Brown, RN
President'

Ellen Caruso
Executive Director

Submitter : Ms. Judy Duhl **Date:** 06/26/2007

Organization : Visiting Nurse Service of New York

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-P-90-Attach-1.DOC

#90

Visiting Nurse Service Of New York
We Bring The Caring Home

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June 25, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1541-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore Md. 21244-1850

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

On behalf of the Visiting Nurse Service of New York (VNSNY) we welcome this opportunity to submit comments on the Medicare Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P). VNSNY is the largest not-for-profit home health agency in the nation. In 2006, our more than 12,000 employees provided 2.4 million home and community based visits to 94,000 patients, of whom 43,000 were Medicare beneficiaries.

VNSNY acknowledges that the current Prospective Payment System (PPS) case mix methodology required updating, and we are generally pleased with many of the improvements proposed by CMS, such as the elimination of MO 175 from case mix calculation and the addition of reimbursement for patients requiring extensive periods of skilled services. Based on our extensive clinical and research experience serving our large patient base, we do have comments and specific recommendations that we urge you to consider incorporating into the final rule.

PROVISIONS OF THE PROPOSED REGULATIONS

Case Mix Coding Changes under PPS:

Proposal: CMS proposes to reduce the base payment rates by 2.75% for each of the next three years beginning in 2008 to recoup what CMS says was an unwarranted increase in payments for home health (HH) services since the early years of the Medicare HH PPS. CMS asserts that the increased payments were the result of inaccurate patient assessments performed by home health nurses.

Comments: VNSNY believes this adjustment is unjustified and is flawed for two basic reasons: actual changes in the home health population and improvements in the accuracy of OASIS coding

1. **Home health population**

   a. **Impact of In-patient PPS:** In our experience, patients today are in fact sicker, more functionally impaired, and require more medically-intensive services than they did at the beginning of the HH PPS. We believe that the average increase in patients' clinical needs is largely due to an inpatient hospital payment system that has created incentives for early discharge of patients who require more care. CMS itself recognized the "quicker and sicker" phenomenon that was resulting in HH agencies receiving higher real case

mix cases in its published changes to the Medicare Inpatient Payment System in which it penalized hospitals who had systematically been discharging patients to HH much earlier than the norms of the DRG system. While advances in medical technology allowed patients who could previously be served only in hospitals or nursing homes to receive comparable care at home, the result is a HH population with higher acuity and more intense resource needs.

b. **Growth of Managed Care:** Another factor leading to increase in real average case mix change is the growth of Medicare Advantage (MA) enrollment. VNSNY now serves a substantial number of MA enrollees, most of who have a severity level that is lower than that of fee-for-service (FFS) Medicare patients. Since MA enrollees are no longer included in PPS case mix statistics, we believe that the remaining FFS Medicare population served under PPS has increased the average real case mix weight of the remaining FFS Medicare population served under PPS.

2. **OASIS Accuracy:**

VNSNY believes that the accuracy of OASIS coding by nurses and therapists has improved dramatically since the inception of PPS. The language and definitions in the OASIS tool are not intuitive and field staff needed to be trained to improve their accuracy in OASIS completion. In the analysis of the case mix coding changes under PPS, CMS cited some alternate reasons for the change in the case mix. It is our belief that many of these factors impacted the change and not improper OASIS coding. They include:

a. **Improved support from CMS** including instructional aides and revisions to the guidance in Chapter 8: Chapter 8 has been revised with updated guidance as to how to assess accurately. An OASIS training site was provided to foster improved OASIS accuracy. These updates and revisions would not have been necessary if the OASIS was being completed accurately under IPS and from PPS's inception in October 2000.

b. **Educational initiatives** led to improved understanding of the accurate completion of the OASIS. This is especially pertinent to the change in functional scoring. The concept of 'safe performance' and the definition of 'prior' and 'current' were clarified. The data also reflects that certain IADLs experienced a shift. Since these are not case mix items, this finding supports the premise that changes in coding were a result of improved assessment accuracy. In addition, CMS's educational initiatives were directed to many of the other M0 items cited in the analysis. They include: the number of stage 3&4 pressure ulcers, the status of surgical wounds, the presence of pain interfering with activity, the incidence and frequency of incontinence, and behaviors exhibited at least weekly.

c. **A shift in the scoring of M0175** to a more highly reimbursed level is also cited. It is well known that this M0 item was problematic because the data needed to accurately complete the item was not easily available to the clinician. It has now been removed from the HHRG.

d. **ICD-9-CM coding**: The document cites the overuse of Abnormality of Gait as an issue when correlated with therapy use. However, it further states that the burns/ trauma assignment was also overused initially. This second issue was corrected by an educational effort. Why was the same educational effort not applied to all diagnostic codes that appeared to be assigned inappropriately? The severity rating of diagnoses was also poorly understood initially. Other issues in the proposal related to coding will be discussed in more depth later. However, it is well known that diagnostic coding in HH prior to and under IPS was questionably accurate. Accuracy has improved under PPS. The validity of citing diagnostic coding issues in support of the concept of case mix creep appears questionable in light of the comparison population.

In summary, many of the OASIS coding changes can be attributed to an increased acuity in the FFS Medicare population and educational initiatives of staff. The findings of the analysis also support CMS's original decision in choosing which M0 items to use for the HHRG: the HHRG M0 items were chosen because they were predictors of cost in home care.

Recommendation: Since the proposed new HH PPS rule addresses many of the areas that CMS and the technical expert panel found to be problematic in the data studied, we recommend that CMS study the data after these changes are implemented for a period of at least one year. If the proposed changes in the case mix construction do not correct the "case mix creep" an adjustment may then be warranted. Imposing an adjustment at this point, in addition to the corrections in the case mix calculation would seem to over-correct the finding. If any payment adjustment is warranted after a study period, such adjustment should not be across-the-board affecting all agencies; adjustment should instead be based on the actual incidence of the behavior of the staff in the completion of the OASIS.

Additional Case Mix Factors: Both Medicaid eligibility and caregiver access have a considerable impact on resource use and should be included in the reimbursement calculation.

Impact of the dually eligible population: In 2006 VNSNY completed 22,909 Medicare non-LUPA episodes for patients that were dually eligible. This represented 42% of all episodes completed that year. As a result, VNSNY believes it is important that we comment on CMS's decision to exclude the impact of this population in the reimbursement methodology. Our experience indicates that the non-LUPA episodes of the dual eligibles have a 7 percent lower CMI while requiring 46 percent more visits per HHRG. These patients consistently have longer lengths of stay and have complex needs due to their multiple co-morbidities. While VNSNY has a long history of providing care to this population with significant special, high cost needs, we are concerned that other agencies are unable or not willing to, thus creating an access problem for this population. It remains to be seen whether the addition of the other diagnoses into the HHRG calculation and the concept of early vs. late episodes will sufficiently reimburse the care for this population.

Caregiver Impact: In our experience, the lack of an available, willing and able caregiver to participate in the patient's care **does** affect the cost of care. This is particularly seen in patients with the need for high frequency care. The case mix creep data does not reflect that family and friends did not offer support. However, it does reflect that patients without a primary caregiver declined. This may indicate a barrier in access to home health for this population due to an agency's concern related to the cost of this patient's care. Exclusion of this variable may eventually result in an increase in institutional care.

Recommendation:

We recommend that CMS re-evaluate its position on excluding the impact of dual eligibles and caregiver availability into the reimbursement process. In both situations, we feel the exclusion of these variables will place patients with these characteristics at risk for encountering barriers to home care services.

Non-Routine Supplies (NRS) Reimbursement:

Proposal: CMS has proposed to unbundle NRS reimbursement from the HHRG calculation and to provide a separate payment for NRS based on five severity levels specified in table 11. The severity designation will be based on selected OASIS responses as outlined in table 12 a & b. It is acknowledged that this model only accounts for 13% of costs. LUPA episodes will not receive any NRS adjustment. An outlier adjustment was considered but not included due to issues with administrative feasibility and the lack of an infrastructure and a basis for assigning allowable cost.

Comments:

- The amounts listed for wound supplies are inadequate in light of the cost of many of the advanced wound products. They should be updated to more accurately reflect the cost of wound products currently in use. The anticipated effect on VNSNY's reimbursement for supply cost is a negative 15 percent (–15%).
- Table 12a&b should include the cost of all pressure ulcers and ostomies. As stated earlier, the cost of these cases is also not captured in the HHRG or in the NRS calculation.
- We strongly feel an outlier adjustment for NRS is indicated in light of the high cost of advanced wound products. We will continue to provide our supply costs on claims and in our cost reports as requested so further study can be performed.
- The exclusion of LUPAs from the NRS adjustment is also not supported by our experience. It would seem more appropriate to apply the same adjustment to these cases, for supplies may be ordered for a particular case, especially in cases of wound care, with the intent to provide care for the entire episode and the episode becomes a LUPA due to an intervening hospital stay. Some cases, due to the infrequent nature of the service ordered, become LUPAs but they do require supplies. An example of such a case is one where the only service provided is the changing of a urinary catheter. Supplies are required and this variable is listed in table 12a. Our agency's data for 2006 indicates a supply cost of $14.21 for LUPA episodes and the cost for 2007YTD is only slightly less.

  Recommendations:
  - We recommend that the costs indicated in table 12a be re-examined in light of the cost of current wound products.
  - We further propose that adding the following diagnostic code to table 12b to include the costs of all ostomies: V55.x (x= 0 to 9) and that M0450 selection "e" be included on table 12a so the cost of all pressure ulcer supplies will be included in the NRS adjustment.
  - LUPA episodes should receive the same NRS adjustment as HHRG-based episodes if the OASIS data supports the need for supplies as in table 12a.

Refinements of the Case Mix Model:

Proposal: CMS has proposed significant change in the calculation of the HHRG, including:

1. Concept of early and late episodes
2. Changes in the allocation of reimbursement points as listed in table 2a, including additional diagnostic variables,
3. Payment of non-routine supplies (NRS)

Comments:

1. **Concept of early and late episodes**: The concept of providing additional reimbursement for patients requiring extensive periods of skilled services is supported by VNSNY. Many of our patients have complex situations that require an extensive, coordinated effort to maintain them safely in the community. We applaud CMS's intent to adjust the classification of these episodes using the CWF. However, there are still operational issues related to the initial coding of the episode that could reduce adjustments at the final claim. In addition, the scoring of the episodes with 20 + therapy visits appears convoluted and should be a separate equation.

   Recommendation: The 20+ therapy cases should either be considered a separate equation or be coded under one equation for the purposes of the clinical and functional dimension.

2. **Table 2a "Case-Mix Adjustment Variable and Scores:**

   a. **Diagnostic variables**: We applaud the inclusion of additional diagnostic categories and the inclusion of co-morbidities in the reimbursement formula, for these often impact the patient's ability to function safely at home. The inclusion of the categories of heart, hypertension and the expansion of diagnoses related to wounds are particularly appropriate. However, upon review of the case mix list we did note several issues and

inconsistencies that will impact the implementation in light of ICD-9-CM coding changes since 2003:

i. The major change was the requirement to **use "V" codes** where appropriate, beginning in 2003. This requirement was due to HIPAA regulations that require that appropriate ICD-9-CM coding guidelines be followed to protect the accuracy of patients' protected health information. Due to the fact that in home care we are often providing care to a resolving illness or injury, the prevalence of such codes should not be suspect. This is the very definition of the term "aftercare", one of the most frequently used "V" codes in home care. In addition, the increase in post-surgical care and cases involving rehab further supports the incidence of this type of code, for "V" codes are often used in coding such cases.

The CMS addition of M0245 and now the proposed M0246 is fraught with opportunities for error and lost revenue. It is particularly an issue with codes used for the "aftercare following surgery..." Due to coding guidelines and the need to code the case mix diagnosis in M0246, redundant coding may occur. A diagnosis may be listed in M0246 for a "V" code and M0240 if the diagnosis is still a pertinent diagnosis. This will result in redundant coding and the proposed rule indicates that reimbursement will only be applied once. The inclusion of a select group of "V" codes, rather than the requirement to code under two systems would reduce the incidence of such redundancy and improve the data. Furthermore, the need to code under two systems is unnecessarily complex and costly to HHAs from the perspective of training and systems to monitor compliance with the inclusion of the case mix diagnosis in M0246.

Recommendation: Select "V" codes should be included in the case mix list since they are appropriately prevalent in home care due to ICD-9-CM coding guidelines required by HIPAA. They could be added as interactions with related MO items.

ii. The **Neuro 3 code case mix list** includes the outdated code for stroke (436) and does not include the most prevalent code used in HH for strokes i.e., 434.91. This change occurred in 2004. The case mix list includes stroke codes where the specific cause of the CVA is known but not the code which is assigned when the cause is not known. This is often the case in HH and accounts for the frequent use of 434.91. The use of the acute stroke code was an exception granted to HH because the late effects codes were not included on the original case mix list. In other post acute settings the late effects codes are used in accordance with coding guidelines. It is not clear if under PPS Refinement HH will now be directed to follow standard coding practice and assign the late effects stroke codes since they are now included in the neuro 3 group.

Recommendation: CMS needs to clarify its position on the coding of strokes under this new proposal. The code 434.91 needs to be added to the neuro 3 case mix list and it is questionable whether code 436 should be included.

b. **M0 responses**: We have several concerns about the point allocation:

i. **M0488 Status of Most Problematic Surgical Wound**: The patient with a surgical wound with a status of early/ partial granulation in M0488 does not receive reimbursement points until equations 3&4. Under the new proposal the post-surgical patient in an early episode will receive reimbursement points under 3 circumstances:

- Their surgery was due to one of the case mix diagnoses.
- The primary diagnosis is one of the complications of surgery on the case mix list.
- The wound is scored with the status of "not healing".

Recommendation: The increased incidence of the early/partial granulation response reported in the discussion on case mix creep should not be considered an example of up-coding only. Rather, since it is related in large part to an increased understanding of how to appropriately assess wounds as per OASIS guidelines, we recommend that CMS reevaluate the scoring of MO488.

ii. **M0450 Current Number of Pressure Ulcers**: We noted the significant weight given to these wounds and agree with this allocation. However, we are concerned about the continued lack of reimbursement for the pressure ulcer that cannot be observed (M0450 #e). This is most often due to eschar or slough covering the wound. If debridement is done while the patient is at home it is more likely to be done using chemical, mechanical or autolytic agents. This process is costly due to the supply cost and the clinician hours required for the process.

Another issue for this M0 item is the OASIS definition of the staging of pressure ulcers. The guidance provided by the National Pressure Ulcer Advisory Panel (NPUAP) in January 2007 is much clearer and more clinically appropriate than the 2006 WOCN statement and the most current CMS responses to Q&As in July 2006.

Recommendation: We strongly recommend that the 2007 NPUAP guidance be accepted so the most clinically appropriate guidelines for scoring pressure ulcers are used and that some point allocation be assigned to the care of ulcers that cannot be observed in both table 21and in the NRS calculation. The scoring of pressure ulcers that cannot be staged should be re-evaluated in light of the cost to care for these wounds.

iii. **Ostomy Care**: The calculation of the HHRG has again excluded ostomies other than bowel ostomies. In home care we provide care to a variety of ostomies, including nephrostomies, ureterostomies, gastrostomies and tracheostomies. These patients require the same instruction on the management of their ostomy and their supplies are often just as costly as the bowel ostomy.

Recommendation: Reimbursement points should be allocated to all ostomies, not just bowel ostomies.

iv. **Functional Dimension Equations (M0650-700)**: We've noted that impact of M0690 transfers and M0700 Ambulation/Locomotion has been significantly impacted in this proposed rule. Unless the patient requires 13+ therapy visits, reimbursement points are not assigned until the patient is unable to transfer. M0700 provides reimbursement points for the patient only in equation 2 and 3, while the toileting (M0680) is not affected by the equations and bathing (M0670) and dressing (M0650/660) continue to receive reimbursement points in all equations at the same level of disability as in the current HHRG methodology. Ambulation and transfer is a focus area for physical therapy and the scoring impact of these items is limited across the equations. Overall, the standard to receive reimbursement points in the functional dimension for M0690 and M0700 appears to have been set at a higher level than previously.

Recommendation: The allocation of reimbursement points to the transfer and ambulation in the functional dimensions appears to have been impacted by the study on case mix creep and is further evidence that the HHRG calculation should address this issue without a negative adjustment.

RAPs: Current practice guidelines promote the front-loading of services in an episode in order to promote positive outcomes. The current payment percentages of RAPs (60/40 for initial episodes and 50/50 for episodes that are recertified) are not consistent with this practice.

Recommendation: CMS should increase the initial RAP payment and this percentage should be the same for initial and recertified episodes.

Collection of Information Requirements

Proposal: The final rule will be released after the comment period and implementation of the rule will be required for episodes beginning January 2008.

Comments: VNSNY is concerned about the short time period between publication of the final PPS rule and the proposed implementation date. In addition, we are concerned that the rapid implementation plan would open the industry to a cash flow problem due to claims processing delays related to systems issues. We feel that a transitional period may be indicated to allow sufficient time to design and test the necessary systems needed to implement this rule. We recommend that such a transitional phase be incorporated into the rule for the first year and that claims be reconciled at year's end when adjustments are needed.

Recommendation:
A transitional phase should be incorporated into PPS refinement to allow agencies sufficient time to implement the necessary systems changes without encountering cash flow issues.

In conclusion, VNSNY believes that the PPS system was in need of refinement and the case mix calculation proposed will address many of the inadequacies of the present system. CMS has been responsive to the industry in its elimination of certain items. As an agency with a long history of providing care to a complex urban population we support the inclusion of the early and late episode as a variable to more appropriately reimburse the population that requires prolonged support in the community. We are also encouraged by CMS's intent to provide automatic adjustments of the HHRG for the proposed new M0 item needed to identify the early and late episodes. We likewise applaud the CMS decision to adjust upward and downward at the final claim for the therapy services provided.

However, the inclusion of a negative adjustment for the alleged "case mix creep" appears to be premature. Although we have raised concerns related to some of theses changes, the case mix calculation proposed appears to address many of the issues cited. We strongly recommend that CMS postpone any further reimbursement adjustments so the true impact of the HHRG calculation can be assessed. Imposing both the calculation change and a negative adjustment may result in an over-correction and hamper the ability to assess the true impact on the case mix calculation and whether it is truly addressing the care needs of the home health population.

We thank you for this opportunity to comment on these proposed revisions to the Home Health Prospective Payment System. We would be pleased to respond to any follow-up questions you have.

Sincerely,

Joan Marren
Chief Operating Officer