

Submitter : Ms. Nancy McCarthy

Date: 06/26/2007

Organization : Hackley Visiting Nurse Services and Hospice

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Although I applaud your efforts to implement some positive changes in PPS, the proposal to reduce base payment rates by 2.75% for the next three years is very troubling. Home health is being penalized for a case mix creep that has everything to do with changes in the type of patients under our care and nothing to do with clinician error in scoring. 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. Therefore, CMS should withdraw its proposal to reduce base payment rates by 2.75% in 2008,2009 and 2010. Two additional recommendations are that 1. you apply the LUPA add-on to all episodes (to allow agencies to recoup the up-front costs that go into an admission). It is more economical to the Medicare system for a patient to have several LUPA episodes than to have a full episode. And two, that in terms of non-routine supplies, you take into account the number of costly non-routine supplies that are not reflected in the medical supply case-mix model, such as trach supplies, gastrostomy and nephrostomy supplies and closed chest drainage, which are very expensive to provide. Thank you.

Submitter : Mr. Scott Amrhein
Organization : Continuing Care Leadership Association
Category : Health Care Provider/Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-92-Attach-1.DOC

#92

CONTINUING CARE LEADERSHIP COALITION



June 26, 2007

VIA E-MAIL

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Dear Ms. Norwalk:

The Continuing Care Leadership Coalition (CCLC) represents over 100 not-for-profit and public long term care providers in the New York metropolitan area. The members of CCLC provide services across the continuum of long term care to older and disabled individuals. CCLC's members are leaders in the delivery of home care, skilled nursing care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. CCLC's members have also had a significant impact on the development of innovative solutions to long term care financing and service delivery in the U.S., with several of its members having played pioneering roles in the development of managed long term care programs in New York and Social HMO and PACE programs at the national level.

On behalf of the long term care providers in the CCLC membership, I appreciate this opportunity to comment upon the Center for Medicare and Medicaid Services' (CMS's) proposed rule (CMS-1541-P) regarding the Home Health Prospective Payment System (PPS) for Calendar Year (CY) 2008.

Key Changes to the Home Health PPS

CMS has proposed the following three key changes to the home health PPS:

- Refining the PPS by increasing the number of HHRGS in the case mix classification system from the present 80 groups to 153 groups, providing an add-on to certain LUPA episodes, eliminating the SCIC adjustment, and using a revised approach to pay for non routine supplies (NRS).
- Revising and rebasing the home health market basket and providing a full market basket increase of 2.9% for 2008.
- Reducing the nationalized base rate by 2.75%, for 3 consecutive years, commencing in 2008, for "case mix creep".

CCLC Comments

CCLC appreciates, and is supportive of, CMS's proposal to provide a full market basket increase of 2.9% in 2008. This measure provides relief to urban home health agencies that were slated to receive a 2.8% increase in 2006, but instead were subject to a 0% inflation update under Section 5201 of the Deficit Reduction Act of 2005 (DRA). This was on top of a 0.8% point reduction in the market basket for 2005 and 2004 (July to December).

CCLC also supports CMS's proposal to adjust the case-mix system to reflect whether the episode of care was rendered "early" or "late" in the sequence of episodes. This provision will better align payments with the resources expended to render care during different intervals of time.

CCLC also backs CMS's proposal to eliminate the Significant Change in Condition (SCIC) provision. We anticipate this measure will reduce paperwork, person-hours, and will help avoid confusion in appropriate billing for care, while ensuring that resources are better directed to serving patients.

We also support the CMS proposal to provide an add-on payment to Low Utilization Payment Adjustment (LUPA) episodes - whether this occurs as the only episode, or the first in a series of episodes. This proposal recognizes that in LUPA cases, costs are front-loaded and agencies have little opportunity to spread the costs of initial visits over a full episode.

While supporting the initiatives outlined above, CCLC does, however, have serious concerns with regard to other CMS proposals as noted below:

Reduction in Rates to Account for Case Mix Creep

CMS is proposing to phase in an annual reduction of 2.75% in nationalized rates over a 3 year period commencing in 2008 as a means of adjusting for what the agency is suggesting has been an 8.7% increase in case mix from 1999 through 2003 due to "case mix creep," i.e., factors other than those related to changes in the underlying condition of patients.

CCLC strongly opposes the reduction in payments associated with this assumed case mix creep. The existing system, under which every home health agency's OASIS submissions are subject to rigorous audit, possesses adequate checks and balances to ensure appropriate case mix coding. Further, CCLC takes exception to the shifting of the burden of the costs of the perceived case mix creep to providers across the country. CCLC holds that if CMS contends that there are instances of case mix creep, CMS should identify those specific instances and apply the appropriate payment adjustment only to those specific providers. This approach would ensure that the entire home health sector is not penalized by an across-the-board reduction in rates.

CCLC also objects to CMS' assumption that scoring changes in the clinical and functional dimensions were primarily due to clarifications in policy, provider training, etc., and that the therapy service increases were not related to the underlying patient severity. This assumption is inconsistent with CMS' own data presented in the PPS, which clearly indicates that the percentage of patients accessed at clinical severity levels C2 and C3 increased in each of the years from 1999 to 2003. During this same period there were also material increases in the assessment of functional limitations. Furthermore, scoring on the clinical and functional areas is

based on objective criteria that leave little room for subjectivity. CMS should recognize that the underlying severity increases resulted in an increase in the need for therapy services.

A further concern about CMS' case mix creep proposal relates to the fact that the agency is concurrently proposing a PPS refinement proposal to eliminate a single 10 visit therapy threshold and replace it with multiple thresholds and payment gradations in an attempt to better align payments with therapy utilization. CCLC contends that the proposed reduction in payments to account for case mix creep, which is asserted to be primarily related to growth in therapy utilization, would over-adjust rates related to therapy services in a manner that would unfairly curtail payments to agencies across the U.S.

CCLC contends that the case mix creep computed by CMS is based on a weak and flawed methodology. The initial base, which set the CMI at 1.00, was based on a sample of 1% of claims. We believe that this sample is too small to fully capture the characteristics of every case mix group. Further, the sample was only based on initial episodes, which is far from representative of all claims. Other PPS refinements recognize this distinction by providing different payments based on whether the episode is "early" or "late". Furthermore, the r-squared, or the explanatory power, of the model is relatively low. Therefore, the proposal to cut payments for case mix creep over 3 years, with the first year phase-in alone resulting in cuts of \$400 million to providers, is untenable. As a result of all of the concerns noted above, CCLC strongly recommends that the case mix creep adjustment proposal be withdrawn.

Revised Approach to Payment for Non-Routine Supplies (NRS)

CMS has proposed to carve-out the payment for non-routine supplies (NRS) from the nationalized 60-day episode payment and route the payment towards instances of NRS usage based on five severity levels. While CCLC understands that CMS would like to tie NRS payments to usage, we have concerns regarding the model for determining such payments. First, CMS's own statements indicate that they do not have adequate data to make accurate NRS payments, and the proposed model for NRS payment has a weak r-squared of 13.7%. Second, CCLC members report that it is quite common for some home health agencies to fail to list non-routine medical supplies on final claims, so the CMS analysis further understates the extent of the cost of non-routine supplies. Third, the proposed medical supply case mix model does not reflect costly NRS costs for closed chest drainage, and for patients with ostomies (tracheotomy, urethrostomy, etc.). Finally, the NRS amount in the proposed model is not based on a study of recent NRS costs but instead is based on a study of average NRS costs per episode in 1997 which are subsequently inflated by the annual market basket updates.

CCLC members also contend that the proposed rate for NRS does not reflect its true cost. The proposed new system of carving out the NRS amount imbedded in the nationalized rate and apportioning it based on NRS severity level is only a nominal fix to the underlying problem of inadequate NRS reimbursement, and hence does not make providers whole. Further, CCLC takes strong exception to CMS's continued use of NRS cost data that is almost 10 years in the past.

CCLC also objects to the CMS proposal to exclude LUPA episodes from NRS payments. LUPA episodes have high supply costs such as costs for urinary catheter changes and wound care supplies. Failure to compensate providers in these instances would result in access barriers for patients requiring these supplies.

CCLC therefore recommends that CMS commission a study to determine the adequacy of NRS payments, and, to quantify the shortfall, so that appropriate additional resources are added to

the system to fairly compensate providers. CCLC also strongly recommends that the base year for determining NRS costs be updated to 2005 or later. CCLC also calls for the annual updates to any proposed NRS rates to be tied to a medical supply inflation index (rather than the home health market basket) to reflect a more representative cost increase in NRS.

Dual-Eligible Population Ignored in Refinement Proposals

The payment rates make no distinction between dual eligible and non dual eligible persons, even though our member providers report that the health care needs of the former exceed the average needs due to the health status and utilization differences associated with low income populations. Dually eligible patients also carry a higher risk for providers because they adversely affect the outcome measures for providers because of their higher rates of hospitalizations, higher rates for urgent and unplanned medical care, etc. CCLC is therefore concerned that this presents a serious access issue for dual-eligibles as providers may tend to favor treating non-dual eligibles. Further, not-for-profit providers that are mission driven and who provide care for the dual-eligibles would unfairly be penalized for serving a disadvantaged population without payments explicitly recognizing their higher costs. CCLC therefore strongly suggests that the proposed refinement include an additional frailty-factor or risk adjustment payment to compensate providers for treating such patients.

CCLC also contends that the CMS study, which found the presence of Medicaid coverage to be a marginal predictor of costs, is distorted as the study relied exclusively on the presence of a Medicaid number on the OASIS record to determine Medicaid eligibility. CCLC contends that home health agencies often do not report Medicaid numbers in instances where Medicaid is not the payer, and, therefore the underreporting of such cases has negatively influenced the outcome of the CMS study.

Lack of Contingency Payment Arrangements

The PPS refinements require substantial changes to the software needed to support the OASIS instrument and related billing functionality. For home health agencies that have in-house software development teams, this presents an even greater challenge of dealing with the tight timeline of a January 1, 2008 effective date. We would therefore appreciate CMS's understanding of the complexity and time involved with deciphering the proposed refinements, making changes to the software code, testing the software, and training staff on the updated software and the new PPS case mix classification system. CCLC is therefore requesting that effective January 1, 2008, CMS institute a contingency payment plan to facilitate interim payments to home health agencies that are unable to bill Medicare under the new PPS system. The contingency payment arrangement would ensure that no provider is presented with a significant cash flow problem because of the tight timeframe involved.

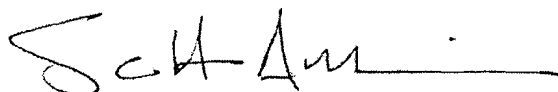
Lack of Training and Health Information Technology Resources

The 2008 home health PPS is the first major refinement of the PPS since it was introduced in October 2000. The revisions are substantial as the underlying case mix methodology is proposed to be thoroughly revamped, resulting in 153 HHRGs compared to the existing 80 HHRGs. The proposed changes will have to be communicated across functional staff such as professional and medical staff, persons completing the OASIS instrument, medical billing staff, etc. We anticipate that the time involved in training these staff will amount to tens of thousands of hours nationwide. Further, for home health agencies that have their own in-house software,

development costs of updated software, to reflect the proposed changes, will amount to hundreds of thousands of dollars nationwide. CCLC therefore is concerned that CMS has not provided additional resources to help providers cope with this major change. Further, CCLC is disappointed that the first major revision in the PPS does not include additional resources to encourage investments in telemedicine, remote care, and other information technology initiatives that would steer the home health sector towards providing more reliable and efficient services to its patients.

On behalf of CCLC and its members, I want to reiterate my appreciation for the opportunity to comment on this proposed rule. We strongly urge CMS in particular to withdraw the proposed reduction in payments of 2.75% in 2008, 2009, and 2010. We stand ready to work with you and your staff in addressing these issues, and we encourage you to contact Desmond D'sa, CCLC's Associate Vice President for Finance and Reimbursement, at 212-506-5458 if you have any questions about these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Amrhein", with a long horizontal line extending to the right.

Scott C. Amrhein
President

cc: The Honorable Hillary Rodham Clinton
The Honorable Charles E. Schumer

Submitter : Ms. Anne-Marie Dockins
Organization : VNA of Care New England
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

Market Basket Index

Market Basket Index

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

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

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

The VNA of Care New England, in Warwick, Rhode Island, appreciates 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 agency to provide access to high-quality care to the Medicare population due to the 8.25% payment cut.

The VNA of Care New England is discouraged 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 agency, compromise our ability to maintain and increase access to cost-effective alternatives to institutional care and, in our view, is totally unjustified.

M0175

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 its 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. We believe that information regarding the patient's recent history of healthcare is obtained at the time of the referral, answers to MO 180, MO 200 and MO210. This information is also collected again by the clinician at the start of care visit.

Our concern is the excessive administrative burden of resources needed to verify this information. We suggest this item be deleted from OASIS if for no other reason than it is often unreliable despite the best efforts of our VNA staff

2.75% cut

Our agency is likely to see a negative impact on Medicare revenue in 2008. This will force reductions in staffing and service areas which compromise patient access to care. It will also force reductions in community services including our ability to care for Medicaid and uninsured patients. We are not projecting a positive impact when the 2.75 cut is repeated in 2009 and again in 2010.

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.

Implementation

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.

Thank you for the opportunity to submit these comments. We believe that CMS has made many improvements in HHPPS and hope you will consider these comments fully in developing the final rule.

Sincerely,

Anne-Marie Dockins
Director of Quality
VNA of Care New England

Submitter : Mrs. Phyllis Wang

Date: 06/26/2007

Organization : New York State Assn. of Health Care Providers, Inc

Category : Home Health Facility

Issue Areas/Comments

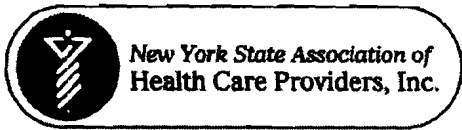
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See Attachment

CMS-1541-P-94-Attach-1.PDF

#94.



New York State Association of Health Care Providers, Inc.

Representing home and community-based care

Phyllis A. Wang, President

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Re: Medicare Program; Prospective Payment System for Home Health Agencies; Proposed Rule

June 26, 2007

On behalf of the members of the New York State Association of Health Care Providers, Inc. (HCP), I am writing to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed regulations relating to the Prospective Payment System for Medicare Home Health Agencies as published in the May 4, 2007 issue of the *Federal Register*. The New York State Association of Health Care Providers, Inc. (HCP) is a statewide trade association representing home care and community-based providers through advocacy, information and education. Founded in 1974, HCP represents approximately 500 offices of Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Hospices and related health organizations throughout New York State. Through a strong network of regional chapters and an active state office in Albany, HCP is a primary authority of the health care industry.

HCP has long supported moving the Medicare home health system from cost-based reimbursement to a Prospective Payment System (PPS) and believes that refinements to the system are needed. As with most detailed systems such as PPS, there are often ways to make the payment system more efficient and effective. Refinements to this system are long overdue, as it had not been re-visited since it first began in 2000. We appreciate CMS efforts to update the payment system and look forward to assisting in future updates.

The following comments address our thoughts, concerns and recommendations on the proposed refinements to PPS.

Base Payment Reduction

While there are some welcome and positive changes to certain structural elements of the proposed PPS refinement, they are largely overshadowed by a misguided reduction in the PPS base payment. CMS reported that over 1/3 of changes in the average case-mix are "believed" to be due to providers taking advantage of the system by reporting a higher case-mix weight than a patient actually needs in order to receive an increased Medicare reimbursement. The result of this unproven assumption is over \$7 billion in the next five years being siphoned away from home health.

CMS must put more thought into the changes that have taken place in the home health marketplace over the past six years. Providing home care services has not become a place to scam the system. Instead the home care landscape has grown and matured. Patients no longer



New York State Association of
Health Care Providers, Inc.

Representing home and community-based care

Phyllis A. Wang, *President*

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**Re: Medicare Program; Prospective
Payment System for Home Health
Agencies; Proposed Rule**

June 26, 2007

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CMS must put more thought into the changes that have taken place in the home health marketplace over the past six years. Providing home care services has not become a place to scam the system. Instead the home care landscape has grown and matured. Patients no longer

just receive personal care support for an extended period. Instead they are moved out of the health care system faster with the use of physical and occupational therapy, resulting in patients becoming more independent and using fewer home care resources.

The average 150 day stay in home care from the period prior to PPS is now less than 90 days. The result is that home health costs are below 1997 levels. During the first year of PPS, spending on each home health Medicare beneficiary averaged \$3,812. In 2003 the average dropped to \$3,497. While there might be positive increases in the actual case mix weight for that period, home health agencies were providing a different type of care that actually resulted in reduced Medicare expenditures.

In addition, patient demographics have changed. Data shows that home health patients age 85 and older increased 4% between 2000 and 2003, from 23% to 27%. Patients are now often older, frailer and have many illnesses and conditions that must be addressed and controlled. In addition, increased enrollment in Medicare + Choice and Medicare Advantage has left traditional Medicare with higher need patients, resulting in elevated costs.

The so-called "case mix creep" is also likely due to providers more accurately determining a patient's needs. When PPS was first instituted in October 2000, there was a very steep learning curve that providers had to overcome during the 1½ to 2 hour patient assessment process. Six years later, providers have gradually learned the assessment process and are more skilled at accurately assessing patients.

Finally, CMS did not consider therapy services as a patient characteristic. Increased therapy usage has added to the case mix weight, but is due to a change in mind set from making patients dependent on home care to increasing their independence. Therapy use is a product of patients requiring such care and agencies working to increase a patients' independence.

Again, home health patient characteristics have changed greatly since the inception of PPS, resulting in a higher case mix weight. It would be irresponsible, however, to assume that none of the case mix increase has been due to some agencies inaccurately scoring a patient in order to receive a higher reimbursement. HCP does not condone scoring for profit and appropriate action should be taken.

Unfortunately, the approach taken by CMS to address inaccurate scoring penalizes all providers. In the new system, agencies providing a good-faith effort to score patients accurately will unfairly receive less reimbursement while agencies scoring for profit will continue to do so, resulting in additional and inaccurate reimbursement. HCP believes there is a better solution to case-mix creep than slashing access to cost-efficient home care services through severe payment reductions.

- **Recommendation** - HCP urges CMS to refrain from cutting home health payment rates. As mentioned, there are parts of the proposed PPS refinement that have merit. HCP is pleased with some changes to the structure of the PPS, but has concerns that the positive results of those changes will not be fully realized due to the base payment reduction. The reduction in overall reimbursement will offset the positive changes and could ultimately mask weaknesses in the system. The cut is a rash and unfair action aimed at all agencies and affecting all patients, while the stated intent is to address inappropriate coding.

Wage index

HCP objects to the use of the pre-floor, pre-reclassified hospital wage index to determine geographically relevant wages for home health workers. Hospitals are given the opportunity to reclassify as a means for moving into a geographical area with a higher wage index. Home health agencies are not given this option under the proposed continuation of using the pre-reclassified hospital wage index to determine reimbursement, putting them at a distinct disadvantage in attracting and retaining employees.

- **Recommendation** - There are two reforms that are needed to achieve parity and stability. 1) To achieve parity, home health agencies should have the benefit of both the rural floor and the geographic area reclassification authority. Home health agencies often compete for the same workforce as hospitals, the identical wage index should be used. 2) Limits should be established on the allowable annual changes in the index values from one year to the next to achieve wage index stability.

Time frame - software implementation and training

Many of the changes to the Outcome and Assessment information set (OASIS) will eliminate confusing questions and assist with collecting more accurate patient data. The main concern regarding such major changes is the time frame CMS has laid out for full implementation of the final PPS rule. The rule is slated to be fully operational on January 1, 2008, with the final rule not expected to be released until late September/early October. This provides less than three months to train staff on the new assessment and become familiar with revised software. It also imposes an additional training expense on agencies. Because HCP members strive for excellence in coding patients, a three month transition period to ensure full understanding of OASIS changes is too short and could jeopardize the integrity of new assessments.

In addition to a limited amount of time for agencies to learn the new system, there is concern that vendors designing the software to submit claims will either not be ready for the changes or the software will not be fully de-bugged, possibly generating inaccurate reports. This will create enormous unrest in the industry and additional administrative costs.

- **Recommendation** - HCP urges CMS to delay implementation of the refined PPS until government and vendor software is free of bugs and until the industry has had sufficient additional time to train staff and make other needed adjustment to the coding and billing process. While there is a need for a timely implementation of the final rule, expediency should not trump quality and accuracy.

Outlier Payment

In past years total spending on outlier funds have been far below the funding set aside for outlier payments. The proposed outlier budget should better reflect the amount that has actually been spent in past years on outliers.

- **Recommendations** - The remaining outlier funds should be used to increase the base payment.

Automatic placement in early episode if actual episode is unknown

Under the new four equation model, HHAs must denote whether a patient's episode is an early episode or late episode. While the stated intent of more accurately reimbursing home health agencies for services provided is appreciated, HCP is concerned about the ability to answer this question accurately and the automatic placement into an early episode if "UK" is entered because the answer is unknown.

- **Recommendation** - Permit the claims processing system to adjust final claims automatically to reflect correct responses to early/late episodes, both upward and downward based on information in the common working file.

LUPA Payment Increase

HCP is pleased with changes to the Low Utilization Payment Adjustment (LUPA). LUPA visits prevent agencies from spreading the higher cost of the first few visits across the entire episode. The LUPA add-on for first or only LUPA episodes will assist in absorbing the additional costs of an episode with few visits.

Elimination of SCIC

HCP applauds the removal of the Significant Change in Condition (SCIC) adjustment. The SCIC was only used in 2.1% of episodes and was difficult to apply to cases accurately.

Non-Routine Supplies

The change in billing for Non-Routine Supplies (NRS) will assist in better understanding of what types of patients are using NRS. HCP urges CMS to continue looking at the issue of NRS in order to provide more accurate payment.

Unfortunately, the NRS payment proposal does not include LUPA episodes which can often generate high supply costs. This could serve as a disincentive to home health agencies to serve these types of patients

- **Recommendation** - Include NRS payment for all LUPA episodes.

Thank you in advance for your consideration of our comments. We look forward to working with you throughout the implementation process.

Sincerely,



Phyllis A. Wang
President

Submitter : Mr. Lawrence Leahy
Organization : Foundation Management Services
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-95-Attach-1.DOC

#95

June 26, 2007,

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

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

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Foundation Management Services assists home care providers by offering consulting, management, billing, coding, educational services and home health and hospice products. We appreciate the opportunity to provide comments on the proposed rule for refinement of the Home Health Prospective Payment System (PPS) and the rate update for 2008 that was published on May 4, 2007 in the Federal Register. While we appreciate the Centers for Medicare and Medicaid Services' (CMS) efforts to update PPS, we have strong concerns over CMS' ambitious time frame for implementation of a very complicated revision at the same time proposing major changes in case-mix and the wage index. We believe that more time, at least 90 days, should be allowed for implementing such a major over haul of Home Health PPS. That said, we offer the following recommendations for your consideration:

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'PROVISIONS OF THE PROPOSED RULE'

1. Issue: The proposed rule identifies seven areas of refinement all of which will require major changes in operating procedures, major software changes, intensive staff education and in some cases significant financial setbacks. At the same time that agencies are increasing their costs to implement HHPPS Refinement with its 2.75% reduction in episode payment, home care agencies will also be implementing a new wage-index system that will reduce payments to some agencies and is in jeopardy of being passed by Congress. Thus, there is a potential reduction in funding of approximately 5.65%.

Recommendation: That CMS not implement the 2.75% reduction as scheduled.

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2. Issue: We have major concerns over the elimination and lack of consideration of other variables during Abt Associates' research. We question the validity of disregarding Medicaid eligibility and caregiver access and feel that the researchers did not spend adequate time in evaluating these two variables. Also, we are disappointed that the researchers did not evaluate the impact on case-mix of two other variables; the over 85 population and the diabetic population. It is our opinion that the growth in these two populations has had significant impact on the increase in case-mix and to ignore these other variables questions the validity of the Abt Associates' study. When one looks at patient characteristics associated with these two populations as listed below, it is more than apparent that the study group's dismissal of these characteristics as modest ignores the true impact of these population groups on the case-mix index.

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Significant changes in patient characteristics:

- 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% points
- Patients with urinary incontinence increased by 8% points
- Patients showed a substantial decrease in transfer capabilities
- There is a demonstrated increase in cognitive function deficits
- Findings of dyspnea increased

In addition, we have concerns that the proposed HH PPS reduces the reimbursement for those agencies located in the Southern states. When the age adjusted prevalence of diabetes in 2005 is over 8% for most states, and many of the providers in the Southern States serve a larger population of two high diabetes risk groups (black and Hispanic), we believe that the lower reimbursement will decrease home care services to these high risk groups and increase the overall cost of the Medicare Program.

Recommendation: Conduct further research on the impact of the over 85 and diabetic population groups on home health resource use and adjust the case-mix based on the studies results. CMS should not propose any reduction in the base payment rate until such time a more thorough analysis is performed.

3. Issue: The modeling for the proposed rule utilized new or revised diagnosis groups for inclusions in the case-mix models. In reviewing the new or revised diagnosis codes, we have the following comments to offer:

- a. The proposed rule states that 781.2 'abnormality of gait' provides case mix adjustment only when MO460 = 1,2,3,4. In effect, the patient must have a pressure ulcer to receive a case mix adjustment for the diagnosis of abnormality of gait. The official guideline for using this code currently is that the patient must have at least one of the following: 1.) Neuro diagnosis; i.e. Parkinson's, Alzheimer's, multiple sclerosis, etc., 2.) Surgically corrected orthopedic problem: i.e. joint replacement, 3.) Fracture, 4.) Amputation. None of these underlying criteria indicate a person experiencing bed confinement but rather typically a surgical condition that is resolving with therapy. The reasoning for linking the case mix adjustment for this code to pressure ulcers is unclear.
- b. The proposed rule states that the dementia codes 290.0 series have been designated as manifestation codes and can only be placed as secondary diagnoses. However, the proposed rule offers case mix adjustment only when placed as a primary code but

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because of their designation as a manifestation code they will never be a primary code due to coding guidelines.

c. The proposed rule states that 434.91 'CVA' will not offer case mix adjustment. This code is the most common code used in home health. The two CVA codes that will offer case mix adjustment requires information that home health agencies typically do not have access to, i.e. was the clot causing the injury a thrombosis or an embolism.

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d. The proposed rule states that some surgical complication codes have been added for case mix adjustment however, key surgical complication codes have not been added and therefore encourages incorrect coding to capture case mix points. Complicated surgical codes that have been omitted from the case mix list are the 996 and 997 series which include joint prosthesis complications, amputation complications, skin graft complications, transplanted organ complications etc.

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e. Currently 728.87 'muscle weakness' offers 11 points towards case mix adjustment. The proposed rule eliminates muscle weakness from the case mix list. It is unclear why this condition no longer meets criteria for case mix adjustment.

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f. Currently 781.3 'ataxia' offers 11 points towards case mix adjustment. The proposed rule eliminates ataxia from the case mix list. It is unclear why this condition no longer meets criteria for case mix adjustment.

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g. The proposed rule does not offer case mix adjustment for pressure ulcers. It is unclear why this condition does not meet criteria for case mix adjustment when arterial, venous, and diabetic ulcers have been added as well as cellulites and abscesses.

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h. The proposed rule does not offer case mix adjustment for coronary artery disease 414 series. It is unclear why this condition does not meet criteria for case mix adjustment when the 410, and 411 series has been added.

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Also, the proposed rule indicates that the final rule will become effective January 2008. All ICD-9 coding manuals are updated and must be used beginning October 1, 2007. In effect because of the two different dates all coding manuals will be incorrect 60 days after their publication and required use.

Recommendation: That CMS not implement the proposed rule until FY 2009. This would allow CMS to evaluate the above listed coding concerns as well as link the new rule with 2009 coding manuals update.

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4. Issue: CMS states that the proposed reduction in HH PPS national standardized payment rate is done to offset a change in coding practice that has resulted in significant growth in CMI not related to "real" changes in the case mix. We find this assumption to be invalid and believe that the more reasonable assumption is change in patient characteristics as stated above and major changes in Medicare programs especially changes in Inpatient Hospital services and Inpatient Rehabilitation Facilities. These Medicare reforms significantly increased the number of patients admitted to home care for rehabilitation and significantly increased the patient acuity.

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Recommendation: CMS should design and implement a case-mix evaluation method that utilizes a true evaluation of "patient characteristics" and changes in the Medicare system that impact on the home care patient.

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5. Issue: CMS proposes removing the supply allowance from low utilization adjustment episodes (LUPA). However, LUPA cases are more supply intensive over the length of episode.

Recommendation: Maintain the supply adjustment for LUPA episodes.

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6. Nonroutine supplies: CMS proposal for determining payment for supplies is a creative approach over the current method of adding a set dollar amount to an episode regardless of supply utilization. However, we do have some concerns. First is the five severity levels approach does not recognize supply episodes with supply costs exceeding the maximum dollar amount of \$367.00. Second is the issue of supply payment adjustments if the patient's supply needs change. An example of this is a patient who on admission had no supply needs but develops a need for wound care and associated supplies during the episode.

Recommendation: That CMS reevaluate the need for a additional severity level to reflect the need for more expensive supplies and that CMS develop a way to recognize the change in supply utilization during the episode.

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7. Issue: CMS proposes a new OASIS data element, M0110, episode timing that depends on accurate data in the Common Working File (CWF). Because the CWF data is not always current, the agency does not always know which episode the patient is in and as proposed the system will default to "early" and reduce the reimbursement.

Recommendation: CMS consider up coding an agency's response automatically.

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8. Issue: The propose change to eliminate the SCIC adjustment seem to be in conflict with the Conditions of Participation that require an update of the assessment whenever the patient experiences either a deterioration or improvement in health status.

Recommendation: Eliminate the requirement within the CoPs (484.55(d)) to update the assessment for a major change in condition.

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9. Issue: The proposed rule still incorporates a pre-floor, pre-reclassified hospital wage index that places home care agencies at a competitive disadvantage to hospitals and other health care facilities. Also, while we can not determine the real exact impact of the changes, we do feel that the propose change in the labor portion of rates subject to wage index will penalize those agencies located in Southern States. This has the potential to compromise the availability of home care services within the Southern States.

Recommendation: That CMS reconsider the propose change to the labor portion of rates

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CONCLUSION

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We extend our thanks and appreciation to CMS for allowing us to comment on the proposed HHPPS rule. We believe that CMS has made significant improvement in HHPPS and hope that our comments will assist CMS in its efforts to further improve HHPPS.

Sincerely,

Lawrence Leahy
Vice President Finance
Foundation Management Services, Inc.
Denton, TX

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Submitter : Marilyn Evans

Date: 06/26/2007

Organization : Arkansas Department of Health

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Comments are in the form of an attachment

CMS-1541-P-96-Attach-1.DOC



Arkansas Department of Health
 5800 West 10th, Suite 300
 Little Rock, AR 72204

Medicare Provider Number: 047000

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service.

Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely
Marilyn Evans
Home Health Director

Submitter : Ms. GERI WAGNER

Date: 06/26/2007

Organization : LAKEVIEW HOMECARE AND HOSPICE

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHEMNT

CMS-1541-P-97-Attach-1.RTF

#97

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 Lakeview Homecare and Hospice whose purpose is to serve clients in the most cost-effective manner to bring about the most positive client outcomes and functional improvement. Lakeview represents 1300 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 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 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.

Rational

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.

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

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 M017s.

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,

Geri Wagner
Director of Homecare & Hospice

Submitter : Fran Naylor
Organization : CareSouth Homecare Professionals
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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 : Fran Naylor
Organization : CareSouth Homecare Professionals
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-99-Attach-1.DOC



June 26, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1541-P

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

To Whom It May Concern:

Caresouth Home Care Professionals consists of 13 separate home health providers. We appreciate the opportunity to provide comments on the proposed rule for refinement of the HHPPS and the rate update for 2008 that was published on May 4, 2007 in the Federal Register.

Inflation Update

We feel that the proposed Home health inflation update of 2.9% versus the 3.3% for hospitals and skilled nursing facilities is unfair. We have the cost of maintaining an agency building as do hospitals and the SNF. In addition, we have increased costs for gas consumption in traveling to our patients as well as the cost of providing more education for staff due to their autonomous environment. Additionally, all OASIS forms will need to be replaced when the revisions are implemented at a substantial cost to agencies.

Case-Mix

1. We feel more research needs to occur regarding a patient's Medicaid eligibility and their access to caregivers. Medicaid eligible patients are under-reported because they are not listed as a payer in M0150 when Medicare is the payment source for home care. CMS found caregiver access to have an impact on resource use but also believes that adoption of this variable would be a negative incentive. We feel strongly that both of these have a significant impact on home health resource use and CMS needs to conduct further research and adjust the case-mix system according to findings.

2. "Creep Adjustment" and proposed 2.75% reduction in the base payment rates in 2008, 2009, 2010 due to CMS conclusion that an 8.7% increase in case mix between 1999 and 2003 was due to factors unrelated to patient characteristics. CMS concluded that the growth in the national average CMI reflected coding practice changes against a background of new financial incentives. We disagree for a number of reasons:

- a. Clinicians underwent a learning curve in answering OASIS MOItems. We believe that clinicians underscored their patients inappropriately by not understanding the question completely and reading the specific instructions related to the MOItem. As clinicians became more educated and CMS released more OASIS FAQs related to more patient situations and scenarios, HHRG scores gradually increased.
- b. Major changes have occurred in home health diagnosis coding practices since the implementation of HIPAA. 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. 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. Additionally, home health agencies often do not report all patient diagnoses that impact the plan of care and patient's rehabilitation potential. Because of the complexity of home health coding, agencies have also incurred the additional expense of hiring and certifying staff in home health coding in order to submit appropriately coded claims.
- c. 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.
- d. 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.
- e. 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.

- f. 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.
- g. 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.

Early and Late Episodes

We are encouraged to find out 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), but question the validity of the information available in the CWF. The CWF is notorious for having outdated insurance information. Another agency can submit their claim previous to us after our episode of care. What steps will be put in place to ensure the CWF information will be current so the episodes will be adjusted timely and correctly?

There is still confusion over early and late episodes and the definition of "contiguous" episodes. This must be clearly defined to avoid any penalties by identifying an early or late episode incorrectly. We suggest the elimination of early and late episodes because they create a burden for the provider and the FI in ensuring accuracy for payment purposes and ultimately is an administrative headache.

Outliers

The current outlier payment standards are continued with the FDL (Fixed Dollar Loss) maintained at 0.67. CMS estimates that this standard will result in achieving an expenditure of the 5% of total expenditures budgeted for outliers. If that actually occurs, 2008 expenditures would increase by \$130 million over 2007. This increase is in real dollars only if it occurs. CMS is able to estimate an increase in expenditures for outliers because it set the outlier eligibility standards too high for 2007, thereby leaving a portion of the outlier budget unspent.

While maintaining the FDL ratio of .67 may provide incentive for an adequate number of episodes, loss sharing methodologies provide substandard reimbursement, which in most cases do not cover the direct cost of the visit much less a fully loaded cost per visit. Therefore, the lowering of the threshold via the FDL does little to relieve the ultimate burden on the agency, and increasing the overall Outlier percentage accelerates the erosion of already dwindling operating revenue.

Considering the fact that there is a 2.9% inflation update (\$410 million) less the 2.75% coding creep adjustment (\$400 million) for a net increase of \$10 million, CMS is using the stability of the Outlier FDL to derive a net increase of \$140 million. The inclusion of the supposed increase in Outlier payments may increase revenues, but unduly shifts the burden of the cost to the provider and to advertise it as a part of an overall increase seems rather disingenuous to even the causal observer.

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. 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.

Non-routine Medical Supplies

A number of costly non-routine medical supplies 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, urethroscopy, 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.

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.

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.

SCIC

We are very happy with the elimination of the SCIC adjustment. We also propose the elimination of the requirement to collect OASIS RFA 05 – Other follow-up for a patient's significant change in condition. Since we no longer need to establish a HHRG score for payment purposes, we can simply document the patient's change in condition in the medical record to decrease our paperwork burden.

Implementation Date

We do not believe the proposed January 1, 2008 implementation date is realistic. This date leaves very little time for software vendors to implement and test the revisions to ensure agencies will be able to submit claims successfully, have all new OASIS forms printed, and provide the necessary education to staff.

Thank you for your kind consideration of our comments.

Respectfully submitted,

Fran Naylor.

Fran Naylor, RN, COS-C
Manager Regulatory Services

Submitter : Ms. Jeanie Stoker
Organization : AnMed Health
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

Consolidated Billing

Consolidated Billing

Issue ~ Non-Routine Supplies (NRS)

" Section Title ~ Provisions

" Discussion ~ CMS has proposed developing non-routine supply (NRS) diagnostic categories.

" Evaluation ~

o We continue to bill for all non-routine supplies as we feel it is critical that CMS see the cost of supplies we utilize while providing patient care. Unfortunately, our data was not included in the evaluation of the NRS.

o In light of the chronic care and wound care services we provide we often see our allowable supply reimbursement fall short of our actual cost.

" Recommendation ~ We support 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

" Discussion ~ The previous allocation in the LUPA rate of \$1.96 assigned to NRS did not adequately cover the costs of a medically necessary NRS.

" Evaluation ~

o As previously noted, we have a 16% LUPA rate and many of these patients require catheter care.

o Our catheter supply charges for routine catheter replacement is \$11.88. Our cost for these supplies exceed the \$1.96 rate by 396%!

" Recommendation ~ The previous allocation in the LUPA rate of \$1.96 assigned to NRS does not adequately cover the costs of a medically necessary NRS. We would ask CMS to allow a NRS add-on using diagnostic categories.

Market Basket Index

Market Basket Index

Issue ~ 2.9% Market Basket Index (MBI)

" Section Title ~ Provisions

" Discussion ~ we are aware that Congress is looking for funding for the ESCHIP (Medicaid Program for children) as well as other important programs. There is a strong possibility that this funding could come from home health by cutting our MBI, and while this is not related to PPS refinement it could have a serious impact to our agency.

" Evaluation ~ When we analyzed this impact of losing the MBI we became very concerned that this could eliminate any margin we could have for recruitment. AnMed Health home care has been struggling to provide timely nursing and therapy services due to our staffing shortage and this would compound the problem.

" Recommendation ~ While we know you are not in charge of the MBI we will be asking Congress to maintain at least a 2.9% MBI and would solicit your support

Provisions of the Proposed Regulation

Provisions of the Proposed Regulation

Issue ~ LUPA

" Section Title ~ Provisions

" Discussion ~ CMS has proposed to increase the LUPA rates for the first SOC episode.

" Evaluation ~ AHHA has consistently seen between 14-18% (with an average of 16%) of LUPA episodes since the inception of PPS. We have a higher volume of chronic long term catheter care that consistently needs fewer visits, thus we see more LUPAs. The cost is the same as we are providing the same service over a longer period of time.

" Recommendation ~ We support CMS' proposed change to increase the LUPA rate by \$92.60 for the first or sole LUPA episode. We would like 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. Our inability to cover costs may negatively impact access to medically necessary care for those long-term care patients, i.e., catheter care or B12, who would otherwise be placed in a more costly alternative.

Issue ~ SCIC

" Section Title ~ Provisions

" Discussion ~ CMS proposes to eliminate SCICs.

" Evaluation ~ This has been an area that has created additional work for professional staff with minimal positive outcomes

" Recommendation ~ We strongly support CMS' plan to eliminate the SCIC.

Issue ~ OASIS Changes

" Section Title ~ Provisions

" Discussion ~ The proposed changes on OASIS are positive. CMS wants to exclude M0175 & M0610; added M0470, M0520, and M0800 to the mix for payment purposes.

" Evaluation ~ We support the proposed change.

" Recommendation ~ We would like to thank CMS for evaluating and making these recommended OASIS changes.

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

" Section Title ~ Provisions

" Discussion ~ CMS proposes additional payments for later episodes (3rd or greater)

" Recommendation ~ We would recommend to CMS that they eliminate the Early / Late distinction and redistribute the weighting to all the episodes. The expense of providing home care remains consistent over all episodes of care. Additionally, OASIS continues to remain complex and increases administrative time for clinicians, adding an additional early / late episode factor would add even more. We would also suggest that CMS spend time addressing the problems with 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.

Revising and Rebasing

Revising and Rebasing

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 of diverse agencies.

" Evaluation ~

1- Over the last 6 years AnMcd Health Home Health (AHHH) has seen a shift in patients as well

as needs. Many agencies have become more selective in their acceptance of patients, and being a hospital based agency, we have been compelled to meet all patient's needs within our scope and ability. We have seen an increase in chronic care needs, such as CHF and to this we have implemented telmonitoring.

While there is not reimbursement for this model of care we have been able to care for more patients with minimal resources.

The other patient types we have seen an increase in are those with poor healing chronic wounds. This has taxed our staff and supplies at times but we have often been the only provider available to care for these patients. Our highly competent wound care team has allowed us to successfully care for these patients in spite of the obstacles.

2- Over the last 3 years (AHHH) has actually experienced a reduction in our average case weight mix by almost 6%. While we feel we have educational opportunities we feel very strongly that there has not been case mix creep in our organization and the reduction will again, compromise the care we are trying to provide.

3- When data was collected to determine the PPS changes, hospital based agencies were excluded. As noted by this brief example, many hospital based agencies have seen minimal margins with an increase in services to those needing home care.

" Recommendation ~ Eliminate or reduce the 2.75% base rate reduction. Changes in patient population, growing chronic care needs, 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. We would also like hospital agencies to be included in future data collection.

Submitter : Mr. Glenn Hackbarth
Organization : MedPAC
Category : Federal Government

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1541-P-101-Attach-1.PDF

#101



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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

June 26, 2007

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

Re: file Code CMS-1541-P

Dear Ms Norwalk:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program: Proposed Changes to the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008*, Federal Register Vol. 72, No. 86, pages 25356-25481 (May 4, 2007). We appreciate your staff's ongoing efforts to administer and improve the payment system for home health services, particularly considering the agency's competing demands.

In this letter, we comment on the categories the new resource groups, the variation within resource groups, payments for non-routine supplies, adjustment for changes in case-mix, and other miscellaneous issues.

General comments

The Commission appreciates that CMS has recognized the need for significant refinement of the home health prospective payment system (PPS). In prior reports we have discussed several issues that suggest the current system needs improvement, such as the dated case-mix weights and the variation in service use within the home health resource groups (HHRGs). These issues, in addition to the reduction in the average number of visits in a home health episode, suggest that the system may not reflect the current relationship between patient characteristics and episode costs for many patients.

CMS's intent with the proposed changes is to refine the accuracy of the home health PPS. The home health benefit has changed significantly since the advent of PPS, but the payment system's resource groups and relative weights are based on data from 1997 and 1998. This rule provides an important opportunity to revise the system based on more recent data about resource use.

New episode categories (the four equation model)

Under the new system a patient's clinical characteristics, functional limitations, therapy visits, and episode timing would determine payment. The rule would establish a new system of HHRGs that sort

episodes into 5 categories based on therapy use and an episode's timing in a sequence of consecutive episodes. The five category system provides higher payments for third and subsequent episodes in a sequence of consecutive episodes, and it would provide a graduated increase in payment for additional therapy visits.

The new system would retain the clinical, functional and service domains established in the current PPS, but would significantly restructure them. Under the current system there are 4 clinical, 5 functional, and 4 service groups, and the unique combinations of each of these groups comprise the current 80 home health resource groups. In the proposed system, there would be 3 clinical, 3 functional groups, and the number of service groups would vary based on the number of therapy visits in an episode. For patients with 13 or fewer therapy visits, there would be 5 service groups, and patients with 14-19 visits there are 3 severity groups. Patients with 20 or more therapy visits are included in one single group. The unique combinations of severity groups comprise the 153 resource groups in the proposed system.

The proposed changes include the establishment of separate clinical and functional severity scales for each category of HHRGs, and it also expands the number of clinical conditions that affect a patient's case-mix. For example, the new system will assign a cancer patient who is in a first or a second episode and uses little therapy to the lowest clinical severity category, while in later episodes a patient with that diagnosis would be assigned to a higher clinical severity category. As CMS notes, the separate severity scales reflect the finding that the relationship between clinical and functional characteristics and resource use varies among the categories. The addition of more clinical conditions to the case-mix allow for the effects of some secondary diagnosis and interactions between clinical conditions in the determination of the case-mix. The modifications should permit a more accurate measurement of patient resource use.

However, MedPAC is concerned about any payment system that ties payments explicitly to the level of services provided. Under the proposed payment system HHAs could potentially seek higher payments by providing more therapy or providing later episodes of home care. MedPAC will be analyzing the impact of changes in payments and utilization.

Payment accuracy in the new system

MedPAC analyzed the accuracy of the home health payment systems two ways: by examining the ratio of payments to cost, and by examining the variation in the amount of services used by patients in the same HHRG. Payment to cost ratios that are close or equal 1.0 are ideal, as they indicate that payments for an episode are near costs. However, we note that payment to cost ratios for home health are much higher because, as MedPAC has noted in several reports, home health payments substantially exceed costs. For this analysis, we will compare the range from the highest to the lowest payment to cost ratios across HHRGs.

Reviewing variation in the service use among the episodes within an HHRG allows us to determine if episodes are appropriately grouped. The episodes assigned to an HHRG should have similar levels of resource use, in the case of home health they should be similar in the number of visits provided. In prior reports, the Commission has noted that there is broad variation in service use within the HHRGs. The Commission has expressed concern that the within group variation suggests the payment system is inappropriately grouping dissimilar episodes in the same resource group, and creates the potential for agencies to favor profitable patients within a group. For this analysis, we will be comparing the coefficient of variation for the number of visits per episode, a measure of how episodes in an HHRG differ from the average episode. A lower coefficient is indicative that the episodes within an HHRG are internally homogenous, or are relatively similar in the number of visits provided.

Our payment to cost analysis found that the proposed changes would result in a more even distribution of payments relative to costs. We compared the payments for episodes with similar therapy visits and episode timing. MedPAC computed the average payments under the current and proposed payment systems for each group of episodes, and computed the payment to cost under the current HHRG-80 and the proposed HHRG-153 system. Under the current system, the payment to cost ratios for episodes with similar service use range from 1.02 to 1.73. Under the new system, the range between the ratios is narrowed, and range from 1.14 to 1.40. More uniform ratios reduce the differences in financial returns among different type of patients, and reduce the provider's preference for some patients. However, we note that margins will increase with the number of therapy visits. For example, patients that need 0-5 visits will average a margin of 12 percent, while those who need 20 or more visits will average 29 percent.

The coefficient of variation analysis found that the new system establishes a more internally homogenous set of HHRGs. The new system has more resource groups and uses two dimensions of service use, the number of visits provided and episode sequence, to classify episodes. Consequently, it has less within-group variation in the number of visits provided. The average coefficient of variation for visits has fallen from .81 in the current system to .75 for the proposed system of HHRGs. The reduction in variation means that the new resource groups are better at identifying episodes with similar resource use than the current system. The reduction in within-group variation reduces the potential for providers to select the least costly patients in a resource group.

This analysis suggests that the proposed changes will make a modest improvement in the accuracy of the system. However, the magnitude of the improvements will not obviate the need to continue to refine the payment system. MedPAC will explore other alternatives to improving the accuracy of the HHRGs, and urges CMS to continue efforts to refine the PPS.

Replacement of the therapy threshold

MedPAC has expressed concerns about the current threshold, which increases payments for episodes that have 10 or more therapy visits. The increase can be as much as \$2,700 per episode. As MedPAC has noted in the past, and the analysis included in the rule suggests, having a single threshold that provides a significant incentive for providers to deliver just enough visits to meet the threshold. The proposed adjustment will make gradual payment increases with more therapy visits. The new system split the range of therapy visits from 0-20 visits into 9 thresholds, and provides smaller increases \$273 to \$646 dollars among the thresholds. The proposed changes also set lower payments for episodes that are very profitable under the current system, those in the 10-13 visit range, and raise payments for episodes that are not as profitable under the current system. The redistribution from episodes with the highest margins to less profitable episodes permits more appropriate payments for a broader range of episodes.

The experience with the current therapy threshold suggests that providers are sensitive to the financial incentives associated with therapy visits. It is difficult to anticipate how utilization may change under the new system. Agencies could respond by lowering or raising the number of visits provided, and it is unclear that guidelines exist to determine if these changes represent an improvement in care or an effort to maximize payment. Because of this uncertainty, and the likelihood that the change will vary among providers, analysis of the changes in therapy under the new system should be a key priority for future research. MedPAC will be assessing the changes in therapy patterns and home health outcomes that result from this rule, to follow how any changes in therapy volume affect beneficiaries and program spending.

Increased payments for 3rd and subsequent episodes

Medicare bundles payments for home health into 60 day episodes; beneficiaries can have multiply episodes if needed. CMS's found that the service use of third and subsequent episodes are greater than the average of first and second episodes. Based on this finding, CMS proposes to make higher payments for third and subsequent episodes. Similar to CMS's finding, MedPAC found that the average number of visits was greater in later stays. This variation indicates that the change proposed by CMS is reasonable.

MedPAC notes that the proposed rule is a refinement of the PPS, and is not changing home health coverage policy. The higher payments for later episodes reflect the higher service use compared to earlier episodes. The nature of third and subsequent stays deserves further research. MedPAC plans to assess the service these patients receive, to better understand how they differ from short-stay patients and if alternative forms of payment are warranted.

Non-routine supplies

CMS's analysis of the cost of non-routine supplies (NRS) found that they varied substantially among episodes, and suggested that a more targeted payment method is need for NRS. Currently, the system provides a uniform payment of \$54 per episode, regardless of patient severity. Since NRS use varies widely, this overpays some agencies. For example, in 2003 MedPAC estimates that more than half of all episodes had costs below the amount included in the base payment in 2003, while the top quarter exceeded double the amount provided.

To explore alternatives to the current system, CMS developed a statistical model that measured the relationship between clinical characteristics and NRS cost. In its model CMS relied on the limited information about NRS charges and costs on the home health cost report. Cost to charge ratios were computed for each agency, and the NRS charges on each agency's claim were used to estimate episode-level NRS costs. Based on the results from this model, CMS developed a severity scale for NRS. Episodes would be assigned to one of five severity levels based on the clinical conditions of a beneficiary, and payments would be adjusted by a case-mix score that represents the mean NRS costs for each severity group. The explanatory power of the model was low, with an r-square of 13 percent.

This approach yields a small improvement in the targeting of payments for NRS. The analysis presented by CMS demonstrates that the current method pays too much for most episodes, and too little for episodes with moderate to high NRS use. The proposed change will better target NRS payments, but we also note that the low explanatory power of the NRS model indicates that CMS should continue efforts to refine the model.

The rule does not propose an outlier policy for NRS. CMS cites the lack of an administrative infrastructure for recording NRS cost and use, and also indicates that current reporting may not capture all NRS use. The low power of the NRS model suggests that including NRS in the home health outlier policy would help improve payment accuracy. NRS, like visits, are a covered service reimbursed through the home health PPS. The system already pays for outlier costs related to home health visits, and we see no reason to exclude NRS from this policy.

Wage index

MedPAC is proposing a new approach to the hospital wage index in our June 2007 report, as mandated by Congress in the Tax Relief and Health Care Act of 2006. MedPAC also recommends that CMS adopt our proposed method for home health agencies. Under this system home health agencies and hospitals in the same market would have the same wage index. The new methodology would utilize data that is

available for all labor areas, eliminating the need for imputing an index for agencies in areas with no hospital wage index. We urge CMS to begin implementing the new wage index recommended by the Commission for home health in the 2009 payment year.

Adjustment for changes in case mix

CMS has proposed an adjustment for case-mix changes related to changes in coding practices of 8.25 percent. The reduction is based on a review of changes in case-mix and patient characteristics between 2000 and 2003. CMS's review found that, adjusted for changes in the types of agencies participating in Medicare, case-mix increased from 1.13 to 1.23, a growth of 8.7 percent. CMS compares this with information about patient severity from the OASIS assessments, the reduction in the average visits per episode, other changes in the characteristics of home health patients and trends in resource cost. It concludes that this other data does not suggest a real increase in patient severity. Based on this, the rule posits that the 8.7 percent increase in case-mix is not related to severity. CMS proposes to recover the increase through an annual reduction of 2.75 percent to the payments in 2008-2010.

MedPAC did not independently assess the case-mix and patient data included in CMS's analysis, the findings are consistent with the prior experience with other prospective payment systems. Case-mix increases attributable to coding improvements are common when new payment systems are implemented. For example, an adjustment occurred at the inception of the inpatient hospital PPS. A second adjustment had to be made when the first proved inadequate. Other post-acute PPSs, such as the inpatient rehabilitation facility and long-term acute care hospital PPSs, have also been adjusted for case-mix increases. An adjustment for home health is consistent with the experience in other systems.

The review of patient severity and resource use presented by CMS suggests that coding improvements have occurred in the home health PPS. The analysis makes the best use of currently available data, but for the future it would be beneficial to have a more systematic approach to measuring changes to in coding practices. For example, CMS should consider efforts such as the collection of OASIS from independent entities for comparison to agency assessments or on-site visits to check agency coding practices. Better data would allow CMS to continually assess impact of coding adjustments, and enable to act swiftly when it occurs in the future.

The need for better data is particularly acute because this rule will present another opportunity for case-mix increases due to coding improvement, so there should be a prospective adjustment as well. The new rule expands the diagnosis codes and functional limitations that affect payment, and CMS should be wary of unwarranted increases in case-mix. CMS should consider a combined (retrospective and prospective) adjustment for this rule that would be taken over a longer period of time. In addition, CMS should continue to evaluate coding changes in future years to determine if additional coding improvement is occurring. If so, the agency should move promptly to reflect this additional change in home health payments.

Measurement of home health service use

The rule follows the methodology established at the implementation of the home health PPS to measure the resource costs of episodes and update the case-mix index (CMI). This method uses visit length and BLS wage data to compute the labor cost of a visit.

This is the first time CMS has updated the CMI since the inception of the PPS. Considering the rapid pace of change that can occur in health care delivery, CMS should consider updating the CMI with greater frequency to ensure payments accurately reflect the relative resource use of the different kinds of patients.

CMS should consider using the information on the cost report for measuring resource use. CMS currently uses salary information to estimate the costs of a visit, and does not include overhead costs. This method assumes indirect costs are proportional to direct costs, and it is not clear that this assumption is correct. MedPAC plans to examine the cost report data to see if provides better data on overhead costs. We suggest that CMS should assess its utility.

This information could be combined with claims information about home health charges to better assess labor costs. The current methodology assumes labor costs are constant across the continuum of patient severity. The charges recorded on a home health claim have the potential to reveal more information about the variation in labor costs across episode types. This information, combined with the cost report information on costs and charges, could be used to compute the per-visit discipline costs for different types of episodes. MedPAC plans to explore the use of this data for this purpose, and again we suggest CMS should assess the feasibility of using this data as well.

Information from the Medicare home health cost report is critical to these efforts. We encourage CMS and the home health industry to make every effort to ensure these reports are complete and accurate.

Revisions to the market basket

The rule proposes to update the market basket with new weights and prices proxies based on more recent data about the cost and prices of inputs. Using more recent data should ensure that the market basket reflects the input price changes faced by home health agencies.

New quality measures

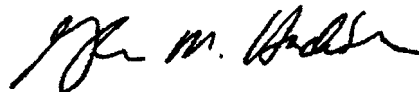
The rule proposes to add two new home health quality measures for wound care. The new measures would track the status for the healing of a wound, and would measure emergency room visits that result from wound infections. MedPAC commends CMS for adding these measures, which we note are consistent with our comments for the 2006 home health payment rule. In these comments, we also suggested that CMS develop measures for fall prevention. We understand that CMS has an effort underway in this area, and we look forward to reviewing this effort.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

Submitter : Ms. Cindy Susienka
Organization : AseraCare Home Health and Hospice
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#102

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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 : Mr. David McClure
Organization : Tennessee Hospital Association
Category : Health Care Provider/Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-103-Attach-1.DOC

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 the hospitals and health systems which operate home health services in Tennessee, the Tennessee Hospital Association Home Care Alliance appreciates this opportunity to comment on the Center for Medicare and Medicaid Services' (CMS) calendar year 2008 proposed rule for refinement of the home health prospective payment system (PPS).

Overall

There are several welcome changes in the proposed rule that we are pleased to support, including the elimination of OASIS question M0175, the elimination of the significant change in condition (SCIC) adjustment, the automatic adjustment of rates based on common working file and final claims data, and increased payments for patients with fewer than five visits in an episode (LUPA payments).

We also support the proposed refinements to better align Medicare payment with the actual cost of delivering home health services, such as the inclusion of secondary diagnoses to more accurately reflect patient acuity. However, we have significant concerns about the complexity of the new system and the additional, unreimbursed administrative burden that will be placed upon home care providers.

Additionally, we have concerns and/or recommendations about the following provisions of the proposed rule:

1. 2.75% reduction in payment from the CMS-imposed behavioral offset
2. Late episode payments
3. Lack of inclusion of Medicaid eligibility in case-mix calculation
4. LUPA add-on for start of care
5. Lack of payment for non-routine supplies in LUPA visits
6. Computation of non-routine medical supplies in typical episodes
7. Reporting of quality data and information
8. Timing and administrative burden of the rule

2.75% reduction in payment from the behavioral offset

CMS proposes to apply a 2.75% payment reduction in each of the next three years to offset historic coding changes. We disagree with the methodology used to determine the offset and, ***instead of making these dramatic cuts, we urge CMS to further analyze the increase in case mix.*** We recommend consideration of at least the following additional factors that we feel have resulted in actual changes in patient characteristics:

- Declining hospital length of stay. The acuity of patients entering home health continues to increase as hospitals in Tennessee discharge patients earlier.
- Changes in reimbursement and admission criteria for inpatient rehabilitation facilities (IRFs) resulting in more complex knee and hip replacement cases being referred to home health
- Incentives in the home health PPS system to treat higher acuity patients
- An intense focus by home health providers to assess patients and code more *accurately* since the inception of PPS
- Trends in patient demographics, such as aging. Our membership reports treating many more patients in the 85+ category.

Late episode payments

While we appreciate CMS' identification of the costs associated with subsequent "late" episodes, we are concerned about the timing of the information in the common working file to enable agencies to properly identify previous episodes of care. The proposed policy would result in yet another opportunity for providers to have payments unexpectedly adjusted after the submission of the final claim, all of which make it very difficult for providers to effectively manage their businesses. Additionally, we are concerned that this policy will incentivise providers to keep patients longer than may be necessary.

Therefore, we recommend that CMS ***take the total anticipated payments for the late episodes and increase the base amount for all episodes, creating a single, higher rate for all episodes.***

Lack of inclusion of Medicaid eligibility in case-mix calculation

CMS's conclusion that Medicaid eligible patients are not more resource intensive is counterintuitive to what providers experience in the delivery of care. We feel that CMS' findings in this area are based on incomplete data, since home health agencies typically do not record Medicaid numbers when Medicaid is not the payer source. We recommend that CMS ***conduct a more thorough comparison of Medicaid and non-Medicaid patients and reconsider a payment adjustment for these higher-cost, dually-eligible Medicaid/Medicare beneficiaries.***

LUPA add-on for start of care

We applaud CMS' recognition of the high costs associated with the start of care and support the add-on. However, ***we suggest that this add-on be included for all subsequent episodes as well,*** given that the home health personnel complete the full OASIS assessment in each episode of care. As explained more fully in the next section, many LUPA episodes result in financial losses to our providers. This results in many agencies choosing to not treat them, so our hospital-based providers have to care for a disproportionate number of these cases.

Lack of payment for non-routine supplies in LUPA visits

The primary reason for LUPAs in most agencies is catheter changes once a month or once every two weeks. Many times, these patients also have ostomies and require expensive colostomy supplies. Compounded by the need to complete the full OASIS assessments, the cost per LUPA episode often exceeds reimbursement, creating significant disincentives for agencies to care for many of these patients. Some supply reimbursement would be a great assistance in helping to offset these losses, so we recommend that CMS ***include a supply add-on for LUPA visits.***

Computation of non-routine medical supplies in typical episodes

While we agree that there should be payment recognition for non-routine medical supplies, we have concerns about the methodology CMS used to determine the supply add-on. Specifically, your findings indicate that only 10% of episodes actually include medical supplies. This is clearly a gross understatement and the result of agencies simply not understanding the importance of billing for supplies since PPS payments have not been impacted until this point. Informally, our agencies state that the percentage is at least 25, 40, 50%...or more. Therefore we urge CMS to ***recalculate the add-on using more accurate data.***

Additionally, we request CMS to ***make agencies responsible ONLY for those supplies that are directly tied to the patient's plan of care.*** Under the current system, agencies provide all necessary patient supplies regardless of whether or not they are part of the disease or condition for which home care services are being ordered by a physician and delivered by the home care team.

Re: CMS' request for input on enteral nutrition

Enteral nutrition is most often associated with very complex patient care. These patients develop diarrhea, require frequent monitoring of electrolytes, may require continuous feeding with a pump or extensive teaching of family members for bolus feeding. Excluding enteral feedings from the scoring system is a step in the wrong direction and unfairly penalizes agencies providing quality care, so we recommend that ***enteral supplies be included in the scoring system for supplies.***

Reporting of quality data and information

We support CMS' efforts to improve the quality of care delivered in all settings through the collection and reporting of outcomes measures. However, it is important that CMS recognize the major differences in care delivery between the various payer sources currently included in the CMS Compare data and monitor and report the information accordingly.

Under traditional Medicare, home care agencies working with the physician, patient and family manage and direct the care of the patient in an episode of care lasting up to 60 days. The agencies have the ability to respond quickly to changing patient needs and are able to help the physician provide all necessary care during that time.

Conversely, many Medicare Advantage plans, state Medicaid programs and Medicaid managed care plans use case managers to direct the care of the patient. Home care agencies are often authorized by the plans to provide no more than one or two visits (often after waiting for many days for initial approval) and approval for additional visits can take as long as several days to a week. Under the current system, agencies are effectively held responsible for outcomes of patients that they no longer manage.

Therefore, we recommend that CMS:

- stratify the CMS Compare information into at least three separate categories: traditional Medicare, Medicare Advantage, and Medicaid.
- use the information to monitor the outcomes from the Medicare Advantage plans as compared to traditional Medicare and/or require Medicare Advantage plans to pay home health agencies according to the PPS rule (effectively putting the physician and the agency back in control of managing the patient)
- remove long-term "private duty" Medicaid patients (such as ventilator-dependent patients) from the CMS Compare data, since these patients have (relatively) little improvement in their outcomes

Timing and administrative burden of the rule

We are greatly concerned about the timing of the rule given the magnitude of the changes and the effects they will have on providers and their staff, software vendors, billing companies, fiscal intermediaries and others. The need for the delay becomes even more apparent when you consider holiday schedules as well as uncontrollable factors such as the flu season, which can have a devastating effect on staffing. A significant amount of agency training and in-service will be necessary to implement these changes at even the most basic levels. Therefore, ***we strongly urge CMS to delay the implementation of the final rule well beyond the proposed January 2008 deadline to give all parties ample time to implement adequate operational policies and processes.***

Finally, as mentioned previously in this document, it is evident that this new rule will significantly increase administrative costs for providers due to its complexity. The development of new therapy thresholds is, in itself, a positive move. But when it is combined with new stratification for supplies, case mix, early and late episodes, etc, it becomes very difficult to manage in a cost-effective manor.

Several of our agencies have modeled the new rule using the data they operate with in the current system and found that reimbursement is significantly decreased. If all of the proposed data elements are also entered in the models, reimbursement effectively remains flat, yet significant additional personnel time is needed to accomplish this task. This comes at a time when all other costs including, salaries, gas/mileage reimbursement, supplies, recruitment, retention, and training are growing daily. There is no respite from the paperwork, the need to supervise care or maintain the quality of the staff through training, yet reimbursement continues to shrink.

Therefore, ***we urge CMS to eliminate the behavioral offset reduction as an explicit recognition of these increased administrative costs.***

Thank you for your consideration of these comments and suggestions.

Sincerely,

Mike Dietrich
Vice President
Tennessee Hospital Association

Submitter : Jeanette Mefford

Date: 06/26/2007

Organization : Crystal Care HHome Health Services, INC.

Category : Home Health Facility

Issue Areas/Comments

Consolidated Billing

Consolidated Billing

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.

Market Basket Index

Market Basket Index

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.

Revising and Rebasing

Revising and Rebasing

Concern
Medicare's recently proposed changes to PPS incorporate a presumption of case mix creep that I 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-1541-P-104

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

Submitter : Mr. Gary Hjelmstad
Organization : Guardian Angels Elim Home Care
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-105-Attach-1.DOC

Guardian Angels † Elim Home Care
400 Evans Ave.
Elk River, MN 55330

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 Guardian Angels † Elim Home Care, Inc. whose purpose is to serve clients in the most cost-effective manner to bring about the most positive client outcomes and functional improvement. Guardian Angels † Elim Home Care represents 950 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 concerns as addressed below:

Financial impact – A review of 19 episodes in our agency comparing current PPS OASIS to the PPS Reform changes are significant. Comparing both early and late for our 19 episodes we would have reduced payouts of 9.58%. While I realize that 19 episodes are a small percentage it still gives us a disturbing pattern that gives us grave concern. We will continue to review how these changes affect us but there is not much chance with the time frame given. These changes will take an enormous amount of Nurse training for us to evaluate and make informed decisions. Our profit from last year was 2.8% and we are using that to help fund a new telehealth program. This type of change will not allow us access to telehealth.

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

Our agency cannot compete with hospitals or hospital based home care agencies for Registered Nurses. They are \$9 to \$11 an hour higher on their pay scale for like positions, so the rationale for a lesser market basket adjustment makes no sense. When you start putting all of these changes together and reducing payments 2.75% for the next 3 years you are putting our Home Care Agency where it was 7-years ago with the Interim Payment System. Our agency is still trying to recoup from the massive losses during that time. Because of these IPS changes we still owe our parent companies \$442,000.00. Our 2.8% profit does not come close to paying this amount back during those huge losses. I am tired of having my Health Insurance premiums increase double digits and have the same company reduce our dual eligible payments to us as a provider for Minnesota Senior Health Options (MSHO), managed care.

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

Estimate 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 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 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 conditions (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 requirements to complete OASIS assessments on non-Medicare clients.

Sincerely,

Gary Hjelmstad
President/CEO
Guardian Angels † Elim Home Care

Submitter : Mrs. Kay Smith
Organization : State of Arkansas Home Health
Category : Nurse

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-106-Attach-1.DOC



Cleburne County Health Unit
 600 South 11th , Heber Springs, Ark.

Medicare Provider Number: 047809

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service.

Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely

Kay Smith, RN
In-Home Services Administrator

Submitter : Ms. Nancy Elphingstone
Organization : HomeCare Association of Arkansas
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-107-Attach-1.DOC

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 CY 2008

On behalf of 175 certified home health agencies serving over 80,586 elderly and disabled Medicare beneficiaries annually, the Home Care Association of Arkansas (HCAA) is pleased to submit the following comments on the proposed rule for refinement of the Home Health Prospective Payment System (PPS) and the rate update for 2008 that was published as a proposed rule in the *Federal Register* on May 4, 2007.

The most significant is the recognition of different characteristics of patients and resource utilization in early versus late episodes. HCAA 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.

After in depth analysis of the proposed refinement regulation and review of NAHC's research and comments we would like to offer the following recommendations in priority order:

1. Case Mix Weight Adjustment
2. Non-Routine Medical Supplies
3. Low-Utilization Payment Adjustments (LUPA)
4. Additional Therapy Thresholds
5. Wage Index
6. Outlier Payments
7. Timing and Administrative Burden

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.

HCAA 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.

HCAA 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.

HCAA 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 service domains in categorizing the characteristics of home health services patients. CMS specifically included a therapy threshold of 10 visits in an episode (M0825) 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.

NON-ROUTINE MEDICAL SUPPLIES

HCAA also has concerns about the proposed model for payment for medical supplies in light of the model's poor performance and R² 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 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, 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.

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. 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.

LOW-UTILIZATION PAYMENT ADJUSTMENTS (LUPA)

We appreciated 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 a 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

HCAA Position: HCAA opposes the continued use of this outdated and inequitable wage index method.

HCAA 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).

HCAA Position: NAHC opposes this proposal. Continued use of a .67 FDL will not utilize the 5% outlier budget as required by Medicare law.

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

HCAA 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.

TIMING AND ADMINISTRATIVE BURDEN

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

Recommendation: CMS needs to explicitly recognize these transition cost. HCAA suggests eliminating the balance of the coding creep adjustment as a reasonable first step.

Also, home health agencies need to offset grossly under recognized administrative cost from the CMS Paperwork Reduction Act (PRA).

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.

Submitter : Ms. Melissa Dehoff

Date: 06/26/2007

Organization : The Hospital & Healthsystem Association of PA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-108-Attach-1.DOC



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

June 26, 2007

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

Re: 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. Nowalk:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 250 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the state, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2008 proposed rule on the home health prospective payment system (HH PPS). We recognize the importance of refining the HH PPS to reflect patient characteristics and agency practices; however, we do have concern over the amount of multiple changes simultaneously, such as payment reductions, in conjunction with major revisions to the case-mix system.

Case-Mix Changes

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

HAP supports the concept of multiple therapy thresholds and the "smoothing effect" of the graduated payment methodology as proposed. We were also pleased that CMS plans to have the claims processing system automatically adjust the therapy visits, both up and down, according to the number of therapy visits on the final claim. This action will

benefit the home health providers, as well as their contractors, by ensuring accurate payment and reducing administrative burden.

Market Basket Update for CY 2008

CMS proposes a 2.9 percent update for calendar year CY 2008, which equates to a payment rate of \$2339.00. While this amount seems acceptable upon first glance, the impact on the base rate is significantly reduced after factoring in each of CMS' proposed policies, such as the Low-Utilization Payment Adjustment (LUPA), Non-Routine Supplies, Significant Change in Condition (SCIC), Outliers, and Case Mix. Based on sample calculations, the final adjusted rate less the total impact changes equated to lowering of the final rate by over \$200.

One of HAP's hospital-based agencies conducted an assessment of the impact and estimates the agency will experience a \$500,000 loss even with the 2.9 percent market basket update. Without this market basket update, the loss would be more significant at close to \$1,000,000. This is significant to home health agencies and could impact their ability to provide care to those that truly need it.

SCICs, M0175s and LUPAs

HAP commends CMS for their proposed elimination of the SCIC adjustment policy, as well as the M0175 adjustments. As cited in the proposed rule, this policy has been confusing to agencies and interpreted differently by many as well. In addition, the policy produced additional administrative burdens to agencies.

We also support CMS' proposal to exclude OASIS item M0175 from the case-mix model, which has proved to increase the administrative burden on agencies. Most of this administrative burden was associated with difficulties encountered with ascertaining precise information about patients' admission locations during the initial assessment. We concur that agencies must continue to establish the patient's recent history of health care before determining the plan of care. An accurate and effective plan of care cannot be established for a patient without accounting for this information as part of the record.

HAP appreciates that CMS has recognized that in LUPA episodes, agencies do not have the ability and opportunity to "spread" the costs of lengthy initial visits over a full episode. CMS' proposal to apply a LUPA add-on of \$92.63 is a positive step toward ensuring adequate payment for these episodes. We would like CMS to consider extending this policy to adjacent LUPA episodes as well. Also, it is unclear how CMS intends to identify initial or only, versus adjacent LUPA episodes. The proposed rule 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 Request for Anticipated Payments (RAP) percentage is calculated.

The rationale for the LUPA add-on addresses the fact that time to complete a 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 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.

Case-Mix Weight Adjustment

CMS proposes to apply a 2.75 percent reduction in payment for 2008, 2009, and 2010 to offset historic coding changes. According to CMS, this adjustment is based on 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 was based on 1997 patient data. The average case mix has been 1.233 (as of 2003), based on the most recent available data. This proposal reduces the base rate by 2.75 percent each year through 2010 to compensate for this "case-mix creep," as CMS refers to it. The CMS calculation is based on a flawed methodology, inappropriate standards and assumptions that are not correlated with outcomes. We urge CMS to further analyze the increase in case-mix due to the implementation of the home health PPS. Case mix has increased due to several factors, including earlier discharges from general acute care hospitals, PPS changes that provided incentives to treat higher acuity patients, and other post-acute regulations which divert more medically complex patients to the home health setting. While coding changes do account for part of the increase, we urge CMS to more adequately account for these concurrent factors.

An outcome data analysis was conducted by one of HAP's hospital-based home health agencies that provide evidence that further indicates significant change in patient characteristics from 1996 to 2006. Some of the findings from this analysis include:

- Patients with wounds increased 19 percent
- Patients with urinary incontinence increased 6.8 percentage points
- An increase in cognitive function deficits from 13 to 19 percent
- The average length of stay increased from 25.7 days to 27.25 days; with an all-time high of 34.14 days in 2004

Leslie Norwalk, Esq.

June 26, 2007

Page 4

This particular agency was selected as an OASIS demonstration agency, meaning they were specially trained and began using OASIS starting in 1996. This fact and their findings contradict CMS' position that agencies did not accurately know how to use OASIS.


CMS should consider withdrawal of this proposal and 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." Additionally, 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.

Outlier Payments

Within the proposed rule, CMS indicates their intention to maintain the current standards for outlier payments, which uses a .67 Fixed Dollar Loss (FDL) ratio. HAP opposes this proposal and feels CMS should lower the FDL based on historical data to a level that ensures the full use of the outlier budget, which is 5 percent, as required by Medicare law.

HAP appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about our comments, please contact Melissa Dehoff, director, health care continuum finance policy, at (717) 561-5318, or by email at mdehoff@haponline.org.

Sincerely,



PAULA A. BUSSARD
Senior Vice President
Policy and Regulatory Services

/dd

Submitter : Mrs. Kay Smith
Organization : State of Arkansas Home Health
Category : Health Care Professional or Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1541-P-109-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health

Keeping Your Hometown Healthy

White County Health Unit
Searcy, Ark. 72143

Medicare Provider Number: 047862

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service.

Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely

Kay Smith, RN
In-Home Services Administrator

Submitter : Mr. C. Steven Guenther

Date: 06/26/2007

Organization : Almost Family, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-110-Attach-1.PDF

June 26, 2007

**Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

RE: Comments regarding proposed Medicare Home Health PPS reimbursement for 2008 [CMS-1541-P]

Dear Sir or Madam:

Almost Family, Inc. is a multi-state provider of home health services that has participated in the Medicare program since 1981. We operate 47 Medicare-certified locations and 21 in-home personal care locations. In 2006 we provided over 770,000 patient days of care for the elderly and disabled. We greatly appreciate the opportunity to submit our comments in response to CMS' request for comments on the proposed rule.

Elimination of SCIC

We concur with the proposed change.

Labor Portion of Home Health Market Basket

We concur with the proposed change.

Quality Reporting

We concur with the proposed change.

Non-Routine Supplies

While we do not object to the proposed change we do question the relative value given the small dollar amounts involved. Additionally, we would prefer to see the change implemented within the determination of the case mix number to be applied to the national payment amount rather than as a separate calculation outside the case mix and in an amount separated from the national payment amount. Case mix is a useful tool in monitoring reimbursement and resource utilization patterns and the current 2008 proposal tends to dilute (albeit slightly) the utility of the case mix measurement.

We believe that significant supply utilization is common among large categories of LUPA episodes as well. Accordingly, we believe LUPA episodes should not be excluded from the NRS reimbursement.

LUPA Adjustment

We have long believed that the reimbursement for LUPA episodes is well below the cost of such episodes. Accordingly, we agree with the concept of establishing a lump sum reimbursement amount to which a rate per visit is added for LUPA episodes. Although the CMS proposal is directionally sound, we believe it still does not provide reimbursement in line with resource utilization (cost). The fixed costs associated with patient acceptance, admission or recertification assessment, patient chart setup and maintenance, acquiring appropriate physician orders and completion of billing and other requirements are well above the reimbursement being proposed in the 2008 regulations. Accordingly, we respectfully request that CMS increase the fixed component of reimbursement on all LUPA episodes to better match the fixed costs.

Case Mix Increase from Coding Behavior

We respectfully object to the view of CMS (and the resulting proposed reduction in the national payment rate) regarding case mix on the following bases:

- 1) Any finding of inappropriate coding of patients should be made on a provider specific basis following appropriate medical review of such individual patients. We do not believe it is appropriate to form a generalized perspective of such behavior based on such a high level macro-analysis.
- 2) We echo and reiterate the comments made by LHC Group in their (CMS-1541-P) comment letter dated June 22, 2007 regarding the implications of:
 - a) Increased age of beneficiaries receiving home care
 - b) Influx of higher case mix patients into home health care from skilled nursing facilities and inpatient rehabilitation facilities (largely in response to CMS incentives); and
 - c) Increased average severity of traditional Medicare patients as Medicare Advantage plans focus their marketing and enrollment activities on healthier, more profitable segments of the Medicare-eligible population.
- 3) Finally, we are concerned that CMS has ignored in its case mix creep argument the tremendous impact that the existing therapy threshold adjustment has on the case mix. This is clearly articulated by CMS in its discussion of the therapy problem on pages 39-40 of the proposed regulations:

“Our data analysis revealed evidence of undesirable incentives from the 10-visit therapy threshold. Our analysis suggested that the 10-visit therapy threshold might have distorted service delivery patterns. In our analysis sample, of all episodes at or above the threshold, half were concentrated in the range of 10 to 13 therapy visits. This range had the highest concentration of therapy episodes among episodes with at least one therapy visit. In contrast, a large analysis sample from the period immediately preceding the HH PPS indicated that the highest concentration of therapy episodes was in a range below the 10-visit threshold – approximately 5 to 7 therapy visits.”

Accepting this assessment at face value, combined with the great weight given in the case mix as a result of the 10th visit, leads one to the conclusion that this change in behavior must be a substantial contributor to the case mix creep CMS seeks to address with the proposed adjustment to the national payment rate.

- 4) Because CMS has already proposed to refine the reimbursement system to more appropriately align reimbursement with resource utilization across four therapy break-points rather than just one, we believe CMS proposes to fix the same “problem” twice and thus is over-compensating by proposing to also make the payment adjustment for perceived case-mix “creep”.
- 5) We believe that CMS has not appropriately measured and removed from its “coding creep” argument that amount of increase in case mix that has resulted directly from an increase in the percentage of patients receiving therapy visits numbers 10 to 13. We believe that the increase in the percentage of patients receiving from 10 to 13 therapy visits would be mathematically certain to create the perception that case mix has increased disproportionate to the increase in resource utilization. This would be particularly true when combined with the influx of higher acuity patients from upstream providers (SNF’s and IRF’s). Because the 10th therapy visit has such a tremendous impact on case mix (either 0.95 or 1.02 incrementally) in comparison to a national average case mix of 1.2601, a significant change in the percentage of patients moving past the 9th visit can have a disproportionate impact on case mix as compared to resource utilization.
- 6) Because CMS already proposes to refine reimbursement for therapy creating multiple break-points instead of only one at 10 visits, a change with which we concur, it is not necessary, and in fact is duplicative to attempt to solve the same problem again by adjusting the national payment rate. At an absolute minimum, if CMS persists in adjusting the payment rate to address perceived case mix creep, CMS should reassess the amount of perceived creep after removing the effect of therapy utilization on case mix.

Case Mix Regression Model and Case Mix Model Variables

As noted above we concur with the concept of eliminating the single therapy threshold of 10 visits and replacing it with multiple thresholds. Additionally, we concur with the concept of recognizing the increased costs associated with later episodes. We also concur with the proposed changes to the case-mix model variables eliminating M0175 and M0610 and adding M0470, M0520, and M0800.

We applaud the directional efforts of CMS to recognize the increased resource utilization associated with certain diagnoses and in particular co-morbidities. We believe additional attention should be given to further identify high cost combinations of diagnoses reflective of medically complex high resource utilizing cases and place additional reimbursement value on those cases.

However we take exception with what we believe is the unnecessarily complex approach to the implementation of the four equation model. Specifically, we believe that the equations can be greatly simplified so that the assessment can drive Clinical and Functional Dimension scores that are the same without regard to the number of therapy visits and which episode number is involved. We strongly believe that the clinical and functional scores of an assessed patient should be useful to a provider (and to caregivers) in correlating to the number of visits (and thus the resource utilization) on a given patient to the Clinical and Functional Dimensions. We believe the proposed approach is too confusing in that two patients with exactly the same clinical assessment can wind up with a different number of clinical points and/or placed in different Clinical Dimensions based on either the number of therapy visits they receive or the sequential number of the episode. This is evidenced by the different Clinical points scales used across the different equations in Table 3 of the proposed regulations.

We respectfully submit that providers and their employees will complete assessments and billing documents more accurately and in better compliance with regulations if this confusion is eliminated by first calculating the Clinical Dimension and the Functional Dimension scores and classifications and adding subsequent factors into case mix for the sequential number of the episode and the number of therapy visits.

The Role of Home Health Care in Managing the Dually Eligible Population

While we understand the comments of CMS with regard to its inability to find a relationship between dual eligibility status and resource utilization, we suggest that results more from the quality of available data sources than from the lack of existence of such a relationship. In our view, meeting the health care needs of the dually eligible population is one of the larger fiscal challenges facing CMS. We must conclude that if the Centers for Medicare and Medicaid Services does not itself have the ability to cross-match Medicare and Medicaid eligibility, it is being denied the ability to determine the best way to manage overall expenditures for this population. We believe that dually eligible individuals are higher utilizers of inpatient and outpatient hospital care, physician services, emergency room services and likely many other Medicare covered services as well.

We believe that if cross-match data were available it would support a conclusion that additional Medicare home health reimbursement should be provided for dually eligible patients. (At a minimum, we know from our own data that dually eligible home health patients are higher utilizers of home health aid visits than those Medicare patients that are not dually eligible.) Increasing reimbursement for the dually eligible home health recipient would serve to both a) better match resource requirements and b) provide incentives to providers to develop strategies to move these patients from higher cost settings into lower cost home health settings. We strongly encourage CMS to evaluate its administrative procedures and put in place the capability to track Medicare and Medicaid eligibility in support of developing the expanded role of home health care in constraining the overall rate of growth in health care spending for this population.

Centers for Medicare and Medicaid Services
June 26, 2007
Page 5 of 5

Thank you for the opportunity to submit our comments. We look forward to working with CMS while the provisions of the proposed rule are being finalized. Please do not hesitate to contact us if you have any questions or concerns.

Sincerely,

Almost Family, Inc.

/s/ C. Steven Guentner
C. Steven Guentner
Senior Vice President and
Chief Financial Officer

Submitter : Mrs. Kay Smith

Date: 06/26/2007

Organization : State of Arkansas Home Health

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-111-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health*Keeping Your Hometown Healthy*

Cross County Health Unit

714 Canal, Wynn, Ark.

Medicare Provider Number: 047874

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service.

Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely

Kay Smith, RN
In-Home Services Administrator

CMS-1541-P-112

Submitter : Mrs. Mary St.Pierre

Date: 06/26/2007

Organization : NAHC

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1541-P-112-Attach-1.PDF



Elaine D. Stephens, RN, MPH,
Chairman of the Board

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamanakis, JD
President

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

The National Association for Home Care & Hospice (NAHC) is the largest trade association in the United States representing providers of home health care and the patients they serve. We appreciate the opportunity to provide comments on the proposed rule for refinement of the Home Health Prospective Payment System (HHPPS) and the rate update for 2008 that was published on May 4, 2007 in the Federal Register.

NAHC appreciates the consideration that the Centers for Medicare & Medicaid Services (CMS) has given to questions and comments we 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. However, 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 researchers, financial and policy experts, and home health providers, NAHC offers the following recommendations.

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.

NAHC 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.

NAHC 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.

The original HHPPS rulemaking clearly establishes that the number of therapy visits in a patient's episode is the equivalent of a "patient characteristic" for purposes of analyzing increases in average case mix weights. In the Final Rule, CMS stated that a therapy threshold was used in the case mix adjustment model [t]o ensure that patients who require therapy would maintain their access to appropriate services... " 65 FR. 41128, 41148 (July 3, 2000). The inclusion of a therapy threshold was proposed to be "based on a clinical judgment about the level of therapy that reflects a clear need for rehabilitation services and that would reasonably be

expected to result in meaningful treatment over the course of 60 days.) Id. Further, CMS stated that:

The rationale for recognizing a therapy utilization factor is to ensure that agencies will be adequately compensated for delivering this high cost service, thus preserving access for patients with therapy needs. It is the same rationale that underlies case-mix adjustment itself. Payment weights for groups containing patients whose therapy utilization is spread over multiple episodes reflect the resource costs of those patients per 60-day episode.” 65 FR at 41149.

This description of the purpose behind the therapy utilization threshold directly establishes that it is an element used to describe a patient characteristic in the case mix adjustment model. The “same rationale” that is the basis for applying the Clinical and Functional domains in the case mix adjustment model underlies the use of the Service domain. Each of the components of these domains, including the therapy threshold” reflects the characteristics of patients necessary to estimate resource costs.

In its original rulemaking, CMS also states that the therapy utilization element is necessary in the case mix adjustment model because, “we cannot achieve the preferred level of payment accuracy” without it. Ibid. As such, the therapy factor is not only a “patient characteristic” in the model, it may be the most important one in its operation.

It also is notable that CMS indicates that it uses the measure of treatment planned or received in other Medicare case-mix systems while CMS has never disregarded these measures in evaluating case-mix weight changes in those other systems.

Most telling that CMS has always properly considered therapy utilization as a “patient characteristic” is the discussion of the case-mix model in the original proposed rule where CMS unambiguously describes the three dimensional model (Clinical, Functional, and Service domains) as the elements of patient characteristics. CMS specifically refers to the Service domain and the therapy utilization component as a “patient characteristic” in the context of the case-mix model. In the original proposed rule, it states:

Ideally, the case-mix system should rely on data elements that do not depend on treatments planned or received; however, the case-mix research project found that a measure of therapy received is extremely powerful in explaining resource use, even after all other predictive patient characteristics are used in the system. Consequently, we decided to incorporate a measure of therapy. 64 FR 58134, 58142 (October 28, 1999)(emphasis added).

Further, CMS stated that:

“The development of case-mix groups requires identifying groups of patients with similar resource cost and similar clinical and functional characteristics. To do this, data analyses studied the statistical association between clinical and

functional characteristics, as measured by the assessments, and resource cost, as measured by the standardized resource cost. In choosing patient characteristics for inclusion in the case-mix adjuster, and in arranging those characteristics into a system of groups, the system's developers gave considerable weight to the clinical diagnostic process. We sought data elements and an overall system that reflected a clinician's perspective when confronted with a patient with care needs to be assessed. We also gave considerable weight to simplicity in the system's overall structure, and thus opted for a straightforward three-dimensional approach. Under this approach, a patient's case-mix classification is found by assessing the patient on each of the three dimensions, and then combining the results from the three dimensions." 64 FR 58134, 58179 (October 28, 1999)

This description of the case-mix model unqualifiedly lists the Service domain as one of the three dimensions used in the model to depict patient characteristics. In fact, the case-mix model predominately depends on the therapy service component to achieve any respectable level of performance. NAHC understands that the R squared of the existing model drops to 11% in the absence of the therapy component. Similar impact occurs in the proposed model in the absence of the three threshold element. In other words, the level of therapy service is the prime factor in characterizing patients for payment purposes.

The current CMS proposal to evaluate case mix weight changes by disregarding the therapy threshold as an element of change in patient characteristics is wholly inconsistent with this standard. The illogic of the method used is further highlighted in CMS' recognition that there has been an increase in patients admitted to home health services from Skilled Nursing Facilities (SNF). The case-mix model includes such patient care history as a patient characteristic for obvious reasons—patients who have had an SNF stay prior to home health admission are different than those who have not had such a stay. The same can be said about patients who receive therapy—they are different from those that do not.

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 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 home health services patients, the more logical assumption is that patient characteristics have changed. Corroborative factors for this more reliable assumption are set forth below.

The evidence 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.

In the formation of the case-mix model, CMS concluded that a therapy related service domain was necessary because the clinical and functional domain inputs available did not adequately explain patient resource needs. Further, CMS contractor Abt Associates found that there were no other patient characteristics available through OASIS data that could explain therapy needs and use. Nevertheless, CMS attempts to determine that any increase in therapy (and the resulting case mix weight increase) is inappropriate by examining changes in the OASIS data. That contradictory approach is unacceptable as a method of evaluating changes in case mix weights. However, even with the obvious flaws in that method, the clinical and functional domain inputs from OASIS data definitively demonstrate that patients have changed and that the therapy increases are warranted.

The result of these changes is that more patients have been admitted to home health services with rehabilitation care needs that lead to the provision of therapy services. The proportion of patients receiving some therapy services has grown since 1999. Correspondingly, the proportion of patients receiving 10 or more therapy visits also has grown while the ratio of those patients to the universe of patients receiving some therapy has remained reasonably constant. The result in terms of average case mix weight change is a natural increase because the proportion of patients with any therapy need grew. This does not demonstrate "creep" as the ratio of patients above and below the 10 visit threshold has barely changed.

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. In a recent issuance by CMS regarding IRF utilization, data shows that since 2000 there has been an increase in IRF discharges to home health services for patients with total knee

replacements, total hip replacements, hip fractures, and strokes. CMS letter p.10, Figure 7 (June 8, 2007). This is a clear indication that there have been more admissions of rehabilitation-type patients to home health. When the proportion of rehabilitation patients in home health services increases, the natural mathematical result is an increase in the average case mix weights.

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 and Medicare Advantage 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 is 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 lead 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.

10. CMS' rejection of therapy services increases in the case-mix weight change has the character of a retroactive claim denial without a claim review. It is an assumption-based conclusion rather than one founded in evidence.

The essence of the CMS finding of inappropriate increases in case mix weight since 1999 is a conclusion that the therapy services increase that drives the weight increase is due to therapy services that were not reasonable and necessary. CMS is not authorized to reject service claims without utilizing the claim determination process. No such process was employed in this rulemaking for any individual HHA or for the universe of HHAs affected by the CMS action. Instead, CMS employed a system that simply evaluated the increase in therapy use against a sample of statistical findings regarding limited OASIS data elements that had previously been considered unrelated to therapy needs.

To objectively evaluate the case mix creep assessment methodology employed by CMS, NAHC contracted with the highly respected research firm, The Lewin Group. In its report, The Lewin Group, concludes that the methodology is severely flawed and that a strong evidentiary base exists demonstrating that significant changes in the patient characteristics of home health services patients have occurred between 1999 and 2003. These changes more than support the increase in case mix weights. Rather, than offering a digest of the report, NAHC incorporates the report into these comments wholesale as Attachment A.

CASE-MIX MODEL

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 inadequate 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 any decision about the inclusion of Medicaid eligibility as a variable in the case-mix system on the results of this 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: General

We note that CMS plans to revisit the diagnosis codes found in the proposed rule, and to 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) which requires 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 45.2% 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 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 found 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 very important information about home health patients' medical conditions that will lead to improved 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 appropriate code for many stroke patients.

Also, we've received comments from professional coders expressing concern about the limited number of available slots (five) at OASIS M0240 for reporting "other" diagnoses. In light of coding sequence guidance based on severity ranking, there will be many instances where case-mix diagnoses that impact the plan of care and resource utilization will not be captured for patients with multiple co-morbidities, leading to underpayment for some of the sickest of patients if coding rules are followed. It would also make sense to address the OASIS diagnoses spaces in preparation for ICD-10, which will significantly increase the number of required diagnoses codes.

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.

Thoroughly analyze the impact of V codes on the case-mix system and resource utilization.

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.

Expand the number of available coding slots on OASIS at M0240.

Diagnosis Codes: Specific

1. The proposed rule states that 781.2 "abnormality of gait" provides case mix adjustment only when MO460 =1,2,3,4. In effect, the patient must have a pressure ulcer to receive a case mix adjustment for the diagnosis of abnormality of gait. Patients in need of therapy services for gait training often are coded as "abnormality of gait." Persons receiving therapy for gait training are not typically bed or chair bound. Therefore, they do not typically have pressure ulcers. The reasoning for linking the case mix adjustment for this code to pressure ulcers is unclear.

Recommendation

Reevaluate the impact of the combination of abnormality of gait and pressure ulcers on resource utilization, or provide the rationale for the linking.

2. The proposed rule states that the dementia codes 290.0 series have been designated as manifestation codes and can only be placed as secondary diagnoses. The proposed rule offers case mix points only when Psych 2 conditions are primary diagnoses. However, since they are manifestation codes they will never be primary codes based on coding guidelines.

Recommendation

Allow for case-mix points for manifestation codes as secondary diagnoses in the same manner that manifestation codes are assigned case-mix points in the current system.

3. The proposed rule includes some surgical complication codes in the case mix. However, key surgical complication codes have not been included. Complicated surgical codes that have been omitted from the case mix list are the 996 and 997 series. This series includes joint prosthesis complications, amputation complications, skin graft complications, transplanted organ complications etc.

Recommendation

Add ICD-9-CM 996 and 997 series to surgical complication codes.

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. NAHC has long supported the delivery of home health services to chronically ill patients as a vital to enabling Medicare beneficiaries to remain in their own homes and reduce 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 revised claims should errors be discovered.

Additional Therapy Thresholds

NAHC 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 the 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 found in the notice addresses the fact that the completion of a 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 assessments was not captured in the analysis of adjacent LUPA episode costs.

A significant 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 must often 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.

We also have concern 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.

Non-routine Medical Supplies

NAHC 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 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, 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 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 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 that will increase the accuracy of case-mix adjusted non-routine supply payment based on patient characteristics.

In light of the fact that there are no other OASIS items that will lend themselves to predicting non-routine supply use, consider including secondary (other) diagnoses of V44.0 through V44.9 (Artificial opening status) and V55.0 through V55.9 (Attention to artificial openings) for patients needing supplies for ostomies other than bowel ostomies.

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.

Establish a methodology for ensuring payment for medical supplies in cases where supply needs arise after a start of care.

Provide payment for non-routine medical supplies for all episodes, including LUPA episodes.

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.

NAHC Position: NAHC opposes the continued use of this outdated and inequitable wage index method.

NAHC 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 in its *Report to Congress :Promoting Greater Efficiency in Medicare*, Ch. 6 (June 2007)..

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).

NAHC Position: NAHC opposes this proposal. Continued use of a .67 FDL will not utilize the 5% outlier budget as required by Medicare law.

NAHC Recommendation: CMS should lower the FDL based on historical experiences to a level that ensures full use of the outlier budget. NAHC further recommends that CMS empanel a Technical Expert Panel to comprehensively assess the outlier policy and implementing standards. That Panel should be charged with the responsibility to evaluate the strengths and weaknesses of the existing model and to offer proposals for alternative models that will improve performance in terms of expending the full budgeted amount on outliers.

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. The consistent record of "short spending" on outliers has discouraged the admission of high cost patients into home health services and severely penalized those HHAs that serve such patients. NAHC estimates that since the inception of HHPPS, over \$1.5 billion in outlier budgeted allowance has not been expended.

In 2005, approximately 2.8% of all episodes met the outlier qualifications. These episodes resulted in spending of merely 60% of the "budgeted" outlier payments. In a review of over 6000 cost reports from that time period, we estimate that of the \$11.7 billion in expenditures, only \$291 million of outlier payments were made, far short of the \$584 million budgeted.

CMS itself estimates that the FDL would need to drop to .42 in order to expend the full 5% outlier budget. Nevertheless, the proposal by CMS is to maintain the FDL at .67. There is no basis for a conclusion that there will be a sudden influx of outlier eligible episodes when nearly seven years of HHPPS history indicates otherwise.

SYSTEM TRANSITION

Over the years the home health industry has been subjected to disruptions in payment as a result of problems with software changes undertaken by CMS and its contractors. The establishment of a new case-mix, and other structural changes and payment adjustments

necessary to implement the proposed PPS reform, raise serious concerns about the ability of CMS, its contractors, and home health software vendors to meet a January 1, 2008 transition timeline. Any significant disruption in payment to home health agencies could be disastrous in light of the fact that the majority of them are small businesses that do not have cash reserves.

Recommendation

Ensure a minimum of 90 days between publication of the final rule and implementation of the new PPS to enable CMS and software vendors sufficient time to make necessary program changes. Increase that time to 120 days if the final rule is significantly different than the proposed rule.

Share billing instructions and coding details with the home health industry promptly.

Provide detailed technical specifications and grouper software with issuance of the final rule.

Establish a contingency plan to ensure timely payment to providers that will be implemented by CMS and its contractors immediately upon discovery of "glitches" in they system.

Establish procedures for alternate means for providers to submit claims and receive accelerated payment in cases of major vendor failures.

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.

Very truly yours,

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The LEWIN GROUP

The Lewin Group

**Evaluation of the Proposed Coding
Adjustment for CY 2008 for Home
Health Prospective Payment
Systems**

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June 26, 2007

I. Purpose

The Lewin Group was commissioned by National Association of Home Health and Hospice to address the appropriateness of the proposed additional adjustment to the home health (HH) prospective payment system (PPS) for calendar year (CY) 2008 to account for case mix upcoding that is not due to changes in the underlying health status of home health users.

Section 1895(b)(3)(B)(iv) of the Balanced Budget Act of 1997 specifically provides the Secretary of Department of Health and Human Services with the authority to adjust the standard payment amount if the Secretary determines that the case mix adjustments resulted 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 index (CMI). The Centers for Medicare and Medicaid Services (CMS) proposes to implement a 3-year phase-in of the coding adjustment for changes in case mix by reducing the national standardized 60-day episode rate by 2.75 percent each year up to and including CY 2010. This annual reduction percent is based on CMS' current estimate of the nominal change in case mix index of 8.7 percent that has occurred between 1999 and 2003.

In evaluating the proposed coding adjustment of 2.75 percent annually for CY 2008, The Lewin Group conducted three sets of analyses.

- (1) Analysis of the health characteristics as reported in OASIS as the basis for coding adjustment.
- (2) Therapy visits as a component of case mix index

In this analysis, we investigate the degree to which Abt Associates' analyses produces convincing arguments that any change in CMI from 1999 to 2003 can only be attributed to HH PPS upcoding.

In this analysis, we attempt to quantify the effects of the change in home health pattern of care on CMI, particularly the change in therapy visits. In this analysis, we attempt to quantify the effects of the change in home health pattern of care on CMI, particularly the change in therapy visits.

- (3) Recent Trends and Implications of the Coding Adjustment

The first section of this report describes CMS' rationale for the coding adjustment. Next, we critique the logic used by CMS to support the proposed coding adjustment. In the third section, we provide the results of our analyses on health characteristics as it relates to CMI and as reported in OASIS. Finally, we provide a discussion of relationship between CMS logic and our analyses of the case mix issues.

Background of Home Health Prospective Payment system

Medicare pays for beneficiaries' home health service in 60-day units called episodes. Home Health agencies (HHA) receive one payment per episode for home health services. Medicare adjusts this payment based on measures of patients' clinical and functional severity, the use of certain health services preceding the home health episode, and the use of therapy during the episode. Payment also is adjusted for differences in local wages with the prefloor, prereclassification hospital wage index. Medicare makes additional adjustments to some episodes under special circumstances including a low utilization payment adjustment (LUPA), an outlier payment, a significant change in condition adjustment and a partial episode payment.

In the early 1990s, both the number of users and the amount of service they used grew rapidly. At the same time, the home health benefit increasingly began to resemble long-term care and to look less like the medical services of Medicare's other post-acute care benefit.¹ In addition to the stricter enforcement of integrity standards and refinements to eligibility standards by Medicare, HHA's payment system switched from cost-based payment system to a prospective payment system (PPS) in the mid-1990s.

CMS' Rationale for the coding adjustment

Along with the transition from the old case-mix system to the new case mix system, CMS proposes an adjustment to the HH PPS national standardized rate to account for changes in case-mix not due to change in the underlying health status of home health users, but rather due to changes in upcoding.

In order to change in CMI due to upcoding, CMS considers the change in the average case-mix of a 1 percent sample of episodes from 1999-2000 under the HH IPS in comparison to that of 2003 HH PPS data. They find an 8.7 percent case-mix difference between these two time periods. Also during this time period, CMS shows resource use remains fairly stable or even decreases, while the case mix index consistently increases. This relationship is counterintuitive leading CMS to believe that the case-mix growth is due to upcoding rather than a reflection of the true severity of illness increases of the underlying patient population.

Therefore, CMS considers the 8.7 percent case mix change due to upcoding and not reflective of "real" change in case mix. CMS does not consider the 8.7 percent increase in the CMI between HH IPS baseline and CY 2003 to be a real increase in case mix index based on the following supporting evidence between 1999 and 2003.

¹ MedPac 2005 March Report, pg 142

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf

- The number of total home health visits declined
- Average resource cost per episode declined
- Improved coding
- A higher proportion of HH population assigned to the higher severity levels for each of the three domains of clinical, functional and service utilization
- Reduction in the population assigned to 40 smallest HHRGs relative to increase in the population assigned to 40 highest HHRGs

CMS also claims past experience with other prospective payment systems, where “Medicare payments were almost invariably found to be affected by nominal case-mix change,” as justification for an upcoding adjustment.

CMS has not finalized a proposal for incorporating the adjustment. They are considering phasing the 8.7 percent for up to 3 years in recognition that full implementation in the first year may have potentially significant impacts for certain providers.

Critique of the CMS Rationale for the Coding Adjustment

CMS raises a number of arguments as evidence of “upcoding” and the subsequent coding adjustment for CY 2008.

Sampling Issues

CMS uses a mere 1 percent sample of initial episodes from the 1999 – 2000 data based on only 90 out of 7,000 home health agencies under the HH IPS and compares it to 20 percent sample from HH PPS. The CMI derived from the initial episodes from HH IPS period does not capture the severity of the patient population with two or more episodes. Furthermore, the Abt case mix dataset that was used to determine current set of case mix weights i.e. the baseline, is based on a sample comprising of volunteers for the study and could not be considered a perfectly, unbiased sample. As the baseline CMI is based on this sample, there could be several potential issues with the measurement of the CMI. Hence, the apparent increase in the CMI by 8.7 percent needs to be examined carefully.

Critique of the Analyses of Health Characteristics as Measured by OASIS Items

In the proposed rule, CMS states that the HH PPS population changed in a numbers of ways.

- More post-acute and more post-surgical patients
- More patients that had a recent history of post-acute institutional care
- More patients in the orthopedic diagnosis group defined under the PPS system’s clinical dimension.

- More patients assessed with dependencies in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as of 14 days before the assessment.
- The proportion of patients using at least 10 therapy visits also increased.

The above mentioned changes might be reflective of home health population with a higher proportion of orthopedic conditions. A recent CMS memorandum on the 75 percent rule states that hospital discharges related to knee replacement (major musculoskeletal surgery) has increased by 10 percent between 1999 and 2005. Hence, the proportion of patients with musculoskeletal conditions has increased substantially for all post acute care providers. The presence of a higher proportion of patients with musculoskeletal conditions is evident of the patient mix of short term acute care hospitals and not “upcoding”.

The increase in the proportion of orthopedic conditions is highly associated with the increase in the number of therapy visits and higher ADLs. Increase in orthopedic cases might have changed the pattern of care leading to more therapy visits. Therapy visits are typically linked to an outcome of rehabilitation whereas nursing visits are associated with more dependence oriented care. The decline in the number of visits concurrent with an increase in the number of therapy visits reflects the rehabilitation oriented goals of therapy visits. These orthopedic cases are not associated with physiologic measures such as urinary tract infection or depressive symptoms.

With the phase in of the implementation of the 75 percent rule for inpatient rehabilitation PPS, the number of orthopedic episodes, particularly joint replacements, is likely to increase over time, leading to further increases in the number of therapy visits and subsequent case mix index.

The proposed rule also states that the case mix of the home health PPS population clearly shifted towards more post-surgical patients with a possible indication that the average patient’s healing status worsened. CMS analyses also showed that there was a six percentage point increase in the probability that the most problematic surgical wound’s healing status would be in an early stage of healing. And yet, the average length of stay for surgical patients in the short term acute care hospital has declined substantially in the past few years. Consequently, there might be a higher number of surgical patients in early “wound” stage and this phenomenon might not be evident of provider “upcoding”.

CMS also includes arguments whereby minimal changes in person’s ADL ratings could result in changes in functional severity away from the two lowest severity groups towards the middle severity group. A higher proportion of patients coded in the middle severity group does not necessarily imply “upcoding”. Despite an increase in the number of Medicare skilled nursing facility stays, the average nursing facility census declined between 1999 and 2004, indicating a shift from custodial nursing facility use to

alternative settings.² Residents in these alternative settings, whether their own home or assisted living, consequently have higher functional needs. This could provide a possible explanation to the higher proportion of Medicare home health patients with within the middle functional severity group.

Therapy Visits as a Component of the Case Mix Index

A major factor in the increase in the home health case mix index since the advent of PPS appears to be the result of an increase in the number of episodes with at least 10 therapy visits. Table 10 in the Federal Register announcement indicates that the number of episode with 10 or more therapy visits (M0825) went from 27 percent under IPS to 35 percent under PPS – an eight percentage point increase. In the current case mix index, exceeding 9 therapy visits means an additional four points added to the Service Utilization component and movement into at least a Moderate category for this component. Holding the other case mix components constant, moving from the low to the moderate category for the service utilization component means a 52 percent to 144 percent increase in payment for the episode, depending upon the rating for the other case mix domains. Upward movement between categories for the clinical and functional components results in payment changes of generally less than 30 percent.

The Service Utilization component of the Home Health PPS Case Mix was included in the case mix because the traditional clinical and functional component portions explained a relatively small amount of the variation in resource use ($r^2=0.1$ without the service utilization component compared to $r^2=0.3$ with it). This implies that the Service Utilization Component accounts for two thirds of the explained variation (Goldberg et. al, 1999). The inclusion of services results in a portion of payments not based on patient need, but on patient use of services.

The substantial increase in payment that results from the provision of additional therapy visits suggests that home health agencies would have a strong incentive to provide more therapy visits. In addition, the lack of rigid standards for practice in home health means that home health agencies and physicians have a fair degree of latitude in determining the appropriate number and type of visits. CMS cites the decline in the overall number of visits and average resource levels between IPS to PPS at the same time the case mix increased as evidence that the increase in case mix was the result of upcoding by providers and not actual changes in the patient mix or their requirements.

However, many of the changes in patient characteristics noted in Table 10 of the Federal Register Notice are indicative of a greater need for therapy visits. In particular, the seven percentage point increase in the Orthopedic Diagnosis Group (M0230) coincident with a ten percent increase in the number of hospital discharges for knee replacement surgeries³

² Lisa Alecxih, (2006) "Nursing Home Use by "Oldest Old" Sharply Declines," <http://www.lewin.com/NR/rdonlyres/9A0A92A2-4D76-4397-A0A2-04EB20700795/0/NursingHomeUseTrendsPaper.pdf>

³ Centers for Medicare and Medicaid Services, "Inpatient Rehabilitation Facility PPS and the 75 Percent Rule," June 8, 2007.

indicates a greater need for physical and occupational therapy. Also, the greater proportion of cases needing assistance with transferring and ambulation are also suggestive of a greater need for physical and occupational therapy.

Although not evident from the data provided in the Federal Register Notice, the increase in therapy visits appears to be related to adding therapy disciplines resulting in an overall increase in therapy visits per person, as opposed to increasing the average number of therapy visits provided to users among those receiving that particular therapy discipline. ***Exhibit 1*** presents information on use of home health services by discipline during a calendar year (not episodes) for 2000 and 2004 based on data provided in the Medicare and Medicaid Statistical Supplement (CMS, 2002 and 2006).

Exhibit 1. Home Health Use, Calendar Year 2000 and 2004

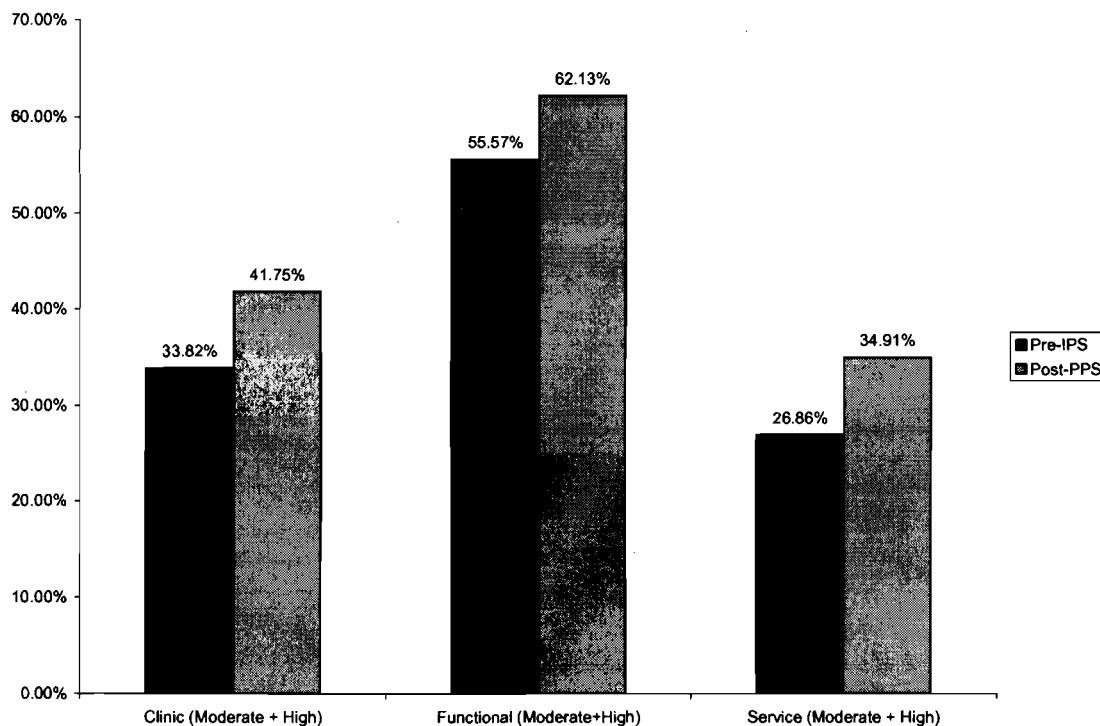
	2000	2004	2000-2004
Persons Served	2,461	2,836	15.2%
Nursing Care	2,194	2,599	18.5%
Home Health Aide	847	754	-11.0%
Physical Therapy	1,288	1,864	44.7%
Speech Therapy	82	96	17.1%
Occupational Therapy	392	651	66.1%
Other	409	419	2.4%
% of HH Users with			
Nursing Care	89.2%	91.6%	2.8%
Home Health Aide	34.4%	26.6%	-22.8%
Physical Therapy	52.3%	65.7%	25.6%
Speech Therapy	3.3%	3.4%	1.6%
Occupational Therapy	15.9%	23.0%	44.1%
Other	16.6%	14.8%	-11.1%
# of Visits	90,566	89,130	-1.6%
Nursing Care	44,593	45,383	1.8%
Home Health Aide	27,652	18,797	-32.0%
Physical Therapy	14,106	19,786	40.3%
Speech Therapy	657	637	-3.0%
Occupational Therapy	2,632	3,747	42.4%
Other	926	780	-15.8%
All therapies	17,395	24,170	38.9%
Percent of Total Visits			
Nursing Care	49.2%	50.9%	
Home Health Aide	30.5%	21.1%	
Physical Therapy	15.6%	22.2%	
Speech Therapy	0.7%	0.7%	
Occupational Therapy	2.9%	4.2%	
Other	1.0%	0.9%	
Visits per Person Overall	36.8	31.4	-14.6%
Nursing Care	18.1	16.0	-11.7%
Home Health Aide	11.2	6.6	-41.0%
Physical Therapy	5.7	7.0	21.7%
Speech Therapy	0.3	0.2	-15.9%
Occupational Therapy	1.1	1.3	23.5%
Other	0.4	0.3	-26.9%
All therapies	7.1	8.5	20.6%
Visits per Person Using Each	37	31	-14.6%
Nursing Care	20	17	-14.1%
Home Health Aide	33	25	-23.6%
Physical Therapy	11	11	-3.1%
Speech Therapy	8	7	-17.2%
Occupational Therapy	7	6	-14.3%
Other	2	2	-17.8%

Source: CMS, Medicare and Medicaid Statistical Supplement, 2002 and 2006.

More home health users received physical and occupational therapy, however, the average number of visit per person receiving each of these therapies declined slightly – physical therapy remained about the same with 11 visits on average and occupational therapy going from seven to six visits. This is consistent with accepted practice standards for therapies that indicate certain minimum number of visits for those requiring therapy, depending upon the goals of the therapy. The increase in the overall number of therapy visits per user appears to result from a greater number of home health users receiving more than one type of therapy. As discussed earlier, the increase in the number of orthopedic diagnoses would suggest more home health users that would need both physical and occupational therapy.

Exhibit 2 shows the growth of the two highest severity levels of case mix systems’ three domains (clinical, functional and service). Moderate and high severity level of clinical domain increased by 23.4 percent. Growth of the moderate and high severity level of the functional domain totaled about 12 percent and that of the service domain totaled 30 percent. The similarity and magnitude of the growth in severity along the three domains might imply a change in patient acuity as opposed to purposeful upcoding.

Exhibit 2. Patients’ severity level prevalence changed after the prospective payment system



Source: 42 CFR Part 484, Table 8.

Recent Trends and Implications of the Coding Adjustment

The most recent MedPAC report shows that since 2003, the CMI has not changed significantly, rising by 1.24 percent annually to 2005. However, as shown in *Exhibit 3*, the number of beneficiaries using home health care grew 3.5 times more than the growth rate in the number of Medicare beneficiaries (a 5.6 percent growth in home health users compared to a 3.2 percent increase in beneficiaries). Over the same period, the number of episodes rose from 4.5 million to 4.9 million. The increase in the case mix index in the initial years of the HH PPS with the stabilization of the CMI growth rate in the subsequent years does not support the alleged “upcoding” by HH providers. If the providers were invested in “upcoding” then the increase in the CMI would have continued unabated in the recent past. Home health agencies serve patients with both short term and long term care needs and their practice patterns continue to evolve.

Exhibit 3. Trend in the provision of home health care

	1997	2000	2002	2003	2004	2005
Beneficiaries (in million)	3.5	2.4	2.4	2.6	2.7	2.9
Visits (in thousands)	258,168	90,566	83,460	88,620	94,050	101,920
Per Person Served Visits	73	37	35	34	35	35
Average case mix	1.0	1.13	1.18	1.2	1.22	1.23
Average visits per episode	36	21.6	21.4	21.1	20.9	20.8

Discussion

Health characteristics reflected in OASIS indicate a shift in the care of home health patients since the advent of PPS. CMS’ conclusion that the total change in the CMI of 8.7 percent between 2000 and 2003 does not reflect a change in “real CMI” is not based on valid reasoning. CMS uses the 2.75 percent annual increase in CMI from 2000 to 2003 to justify the proposed coding adjustment. More recent CMI data from the 2006 MedPAC report indicates that the change in average annual CMI from 2003 to 2005 is much lower at 1.2 percent. The MedPAC report also states that the HHA’s average CMI had only a small relationship to HHA margins, implying that HHAs are not “gaming” by “upcoding”. In addition, individuals discharged from hospitals have had increasing acuity levels, so greater acuity levels of home health patients would be expected. The CMI of hospital discharges to post acute care has increased by approximately 2.0 percent annually between 2003 and 2005.

In conclusion, the elements of PPS payment classification are usually oriented toward the intrinsic characteristics of the patient population. The inclusion of a service component (visits) as a PPS element allows CMS the opportunity to allege “upcoding” practices among the providers. For instance, the number and type of therapy is likely to change in

the future given changes in home health practice and the impact of the 75 percent rule. The implementation of the HH PPS refinement along with the above mentioned changes might result in further changes to the HH CMI.

Unfortunately, the data available would not allow an estimate of the proportion of the 8.7 percent increase in CMI that may be due to upcoding versus a real change in case mix index. Given the lack of recent data analyses by CMS to support this coding adjustment, we would strongly recommend CMS to analyze recent data and provide public access to the analysis files. We would also recommend that CMS develop an analytical plan to identify “upcoding” by using more complete information. CMS could also build a longitudinal database linking home health claims and OASIS data to pre-HH care to post HH care that will allow them to determine precursors to the increase in therapy visits and its effect on outcomes and utilization of other Medicare services, such as inpatient hospitalization and ER use.

Submitter : Mrs. Betsy Case
Organization : Arkansas Department of Health and Human Services
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : Ms. Pam Angell

Date: 06/26/2007

Organization : Miller County Health Dept.

Category : Health Care Professional or Association

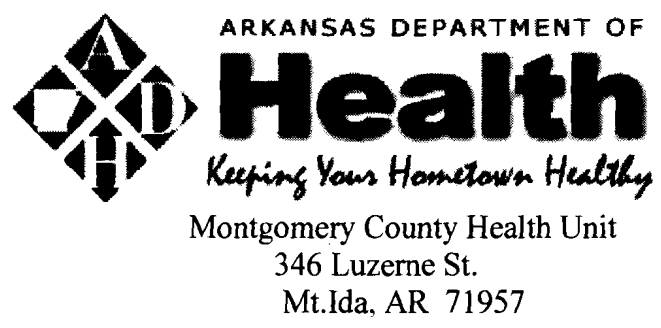
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-114-Attach-1.DOC



Medicare Provider Number: 047841

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service.

Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely

Echo Donahou, RN
In-Home Services Administrator

CMS-1541-P-116

Submitter : Ms. Pam Angell

Date: 06/26/2007

Organization : Lafayette County Health Dept.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an Attachment

CMS-1541-P-116-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health

Keeping Your Hometown Healthy

County Health Unit

Medicare Provider Number: 047831
Lafayette Co. Health Department
P.O.Box 367
Lewisville, AR 71845

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

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Sincerely
Pam Angell, RN, IHS ADM.

In-Home Services Administrator

Submitter : Jean Duck
Organization : DHHS/Division of Health
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-117-Attach-1.DOC

CMS-1541-P-117-Attach-2.DOC



ARKANSAS DEPARTMENT OF

Health*Keeping Your Hometown Healthy*

Hot Spring County Health Unit
2204 East Sullenberger
Malvern, AR 72014

Medicare Provider Number:

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

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Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment

at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely

Jean Duck, RN
In-Home Services Administrator

CMS-1541-P-118

Submitter : Mr. Stephen Harwell

Date: 06/26/2007

Organization : Healthcare Association of New York State

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-P-118-Attach-1.DOC



Healthcare Association
of New York State

June 26, 2007

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

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

Dear Ms. Norwalk:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the Medicare Home Health Prospective Payment System (HH PPS).

The Centers for Medicare and Medicaid Services proposes to apply a 2.75% reduction in payment in each of the next three years to adjust for case mix increases that CMS assumes are due to coding changes and not to "real" changes in patient acuity. Instead of making these dramatic cuts, we urge CMS to further analyze the increase in case mix due to the implementation of the home health PPS.

The proposed adjustment is based on an analysis of the change in the national average case mix from 1997 to 2003. CMS looked at the trend in case mix change during this period and concludes that "the change in the case-mix index between the Abt case-mix sample (a cohort admitted between October 1997 and April 1998) and the HH IPS period (the 12 months ending September 30, 2000) is due to real case-mix change. This change from these two periods is from 1.00 to 1.134, an increase of 13.4%. However, we are not proposing to adjust for case-mix change based on this change in values. However, we are proposing that the 8.7 percent of case-mix change that occurred between the 12 months ending September 30, 2000 (HH IPS baseline, CMI=1.134), and the most recent available data from 2003 (CMI=1.233), be considered a nominal change in the CMI that does not reflect a "real" change in case-mix."

It is not reasonable to assume that the full 8.7% change in case mix subsequent to September 2000 is due to coding improvement and other nominal changes and that none of the change is

Leslie Norwalk
June 26, 2007

Page 2

attributable to changes in patient acuity. The fact that case mix increased by 13.4% from 1997 to 2000 (prior to the implementation of the HH PPS) demonstrates the substantial effect that changes in patient characteristics can produce. CMS' own conclusion is that the change in case mix during this period reflected "substantial change in real case-mix" and 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." If "real" case mix could increase by 13.4% prior to the implementation of the HH PPS, it is unreasonable to assume that none of the change after that point is real.

Case mix has increased due to several factors, including earlier discharges from general acute hospitals, PPS changes that provided incentives to treat higher-acuity patients, and other post-acute regulations such as the inpatient rehabilitation "75% Rule," which divert more medically complex patients to the home health setting. We urge CMS to defer any adjustment for case mix change and to perform an analysis that accounts for these factors.

HANYS appreciates having the opportunity to comment on the proposed rule. If you have any questions regarding our comments, please contact me at (518) 431-7777 or sharwell@hanys.org.

Sincerely,

Stephen Harwell
Vice President
Economics, Finance, and Information

Submitter : Mrs. Betsy Case

Date: 06/26/2007

Organization : Arkansas Department of Health and Human Services

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-119-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health

Keeping Your Hometown Healthy

Yell County Health Unit

Medicare Provider Number: 047880

Yell County In-Home Services
P. O. Box 628
Danville, AR 72833

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the

RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

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Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

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Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely,

Betsy Case, RN
In-Home Services Administrator

Submitter : Mr. Richard Snyder
Organization : Oklahoma Hospital Association
Category : Hospital

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-120-Attach-1.DOC



4000 Lincoln Boulevard
Oklahoma City, OK 73105
(405) 427-9537
www.okoha.com

Craig W. Jones, FACHE
President

June 26, 2007

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

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

Dear Ms. Norwalk:

On behalf of our nearly 150 member hospitals, health systems and other health care organizations, the Oklahoma Hospital Association (OHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the home health prospective payment system (PPS). We think most elements of the proposed home health PPS refinement regulation are appropriate, but would like to call your attention to some areas that deserve further examination.

Case-Mix

Providers are certain that Medicaid eligibility is strongly correlated with the cost of care. Your analysis downplayed the Medicaid factor. It seems very likely that incomplete patient data could be causing this conclusion. Because the home health benefit does not carry a coinsurance obligation, providers have little reason to record Medicaid dual eligibility. If this is true, the patient demographic database would not accurately identify Medicaid-eligible patients. This is a significant issue worth further study with more reliable data.

Research commissioned by CMS showed that a "caregiver access" variable improved the ability of the model to explain resource costs, despite reliance on a rather limited OASIS question that does not fully measure the quantity or quality of caregiving available to the patient. But the proposed changes do not add this factor to the case-

mix definition. It appears this reflects a philosophical preference in favor of family caregivers taking priority over an opportunity to improve the case-mix model. Please reconsider the exclusion of the caregiver access factor from the calculation of case-mix.

Case Mix Weight Adjustment

We strongly object to the proposal to reduce base payment rates by 2.75% per year in 2008, 2009, and 2010. CMS has incorrectly downplayed significant changes in the patients served by home health between 1999 and 2003, and the types of care they received.

- Changes in the Inpatient Prospective System, the Skilled Nursing Facility Prospective Payment System, and the Inpatient Rehabilitation Facility system have all contributed to an increase in acuity, particularly regarding rehabilitation, in the home health setting.
- The percentage of patients assessed at C2 and C3 increased each year from 1999 to 2003, as did the assessment of functional limitations.
- The percentage of home health patients age 85 and over increased from 23% to 27% between 2000 and 2003.
- The increased enrollment in Medicare + Choice and Medicare Advantage plans have removed low-acuity patients from the traditional Medicare program, increasing the acuity and cost of traditional Medicare patients.

While we agree with the intent of improving the accuracy of case-mix weights, this arbitrary reduction pretends there have been no legitimate changes in the nature of services needed by beneficiaries, nor changes in the beneficiary pool.

Outlier payments

The current Fixed Dollar Loss (FDL) ratio of .67 does not utilize the 5% outlier budget as required by Medicare law. CMS should lower the FDL to a level that utilizes the entire outlier budget.

Thank you for the opportunity to submit these comments. If you have any questions, please feel free to contact me at rsnyder@okoha.com or (405) 427-9537.

Sincerely,

OKLAHOMA HOSPITAL ASSOCIATION



Richard K. Snyder
CFO & VP Finance and Information Services

Submitter : Mrs. Echo Donahou
Organization : Arkansas Department of Health
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-121-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health*Keeping Your Hometown Healthy*Polk County Health Unit
702 Hornbeck
Mena, AR 71953

Medicare Provider Number: 047849

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**

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment

at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

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Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

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

Thank you for the opportunity to submit these comments.

Sincerely
Echo Donahou
In-Home Services Administrator

Submitter : Mrs. Barbara Lites
Organization : Pike County Health Unit
Category : Health Care Professional or Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

COMMENTS IN THE FORM OF AN ATTACHEMENT

CMS-1541-P-122-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health

Keeping Your Hometown Healthy

Medicare Provider Number: 040782
Pike County Health Unit
PO Box 413
Murfreesboro, Arkansas 71958

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

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

Thank you for the opportunity to submit these comments.

Sincerely:

Barbara Lites, RN
In-Home Services Administrator

Submitter : Mrs. Barbara Lites
Organization : Sevier County Health Unit
Category : Health Care Professional or Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

COMMENTS IN THE FORM OF AN ATTACHMENT

CMS-1541-P-123-Attach-1.DOC



Medicare Provider Number: 040782
Pike County Health Unit
PO Box 413
Murfreesboro, Arkansas 71958

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

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

Thank you for the opportunity to submit these comments.

Sincerely:

Barbara Lites, RN
In-Home Services Administrator

Submitter : Ms. Joanne Kramer
Organization : VNA Care Network
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

June 26, 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

Re: File Code CMS-1541-P

Dear Sirs:

I am writing on behalf of the VNA Care Network, Inc. (Provider # 22-7098) to comment on the Medicare Program Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P). 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 our ability to provide access to high-quality care to the Medicare population in our service area due to the 8.25% payment cut.

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. 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 inpatient stays. We somewhat 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 SCIC claims has proven to far outweigh the small benefit that agencies receive from the occasional increase in reimbursement.

The following are our specific comments on certain proposed changes.

Change in LUPA Payments

VNA Care Network 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 currently 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, our agency has fixed administrative costs for preparing and submitting bills, OASIS transmission, and all the other general and administrative costs of operating our agency. For that reason, we also believe the LUPA add-on should be applied to all LUPA episodes. Even when patients have a series of LUPA only episodes, the add-on is justified for each period. 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.

Submitter : Ms. Jill Arvidson
Organization : Integrated Home Care
Category : Individual

Date: 06/26/2007

Issue Areas/Comments

Impact Analysis

Impact Analysis

Thank you for continuously evaluating the payment of healthcare services. I have worked in rehab for SNFs and now Home Care. I am concerned about the proposed inflation rates of 2.9% in addition to the -2.75% coding creep adjustments. There is a nationally documented shortage of qualified rehab professionals (PT/OT/ST). This is creating extremely competitive markets for any agency/facility to hire. The upward adjustment of 2.9% compared to the SNF and Hospital rates of 3.3% must be reassessed. It is just as expensive to hire a rehab professional in a SNF as it is in Home Care. Please consider this. The -2.75 coding creep is just wrong. The initiative has been to learn correct coding. As agencies have put forth resources and efforts to ensure clinicians are coding correctly, the notion is that now there is abuse. Perhaps results in the training/education can be found in different coding trends. I believe, as in any system, there are individuals who will take advantage of the system. Please focus your efforts to audit and recover resources from those individuals and agencies. The Oasis has its pluses and minuses for sure, but there must be the understanding that coding trends will change as people are better trained and confident with coding. These coding trend changes should be considered better data. I would also like to respond to increased therapy utilization. Over the past 4-5 years there has been a marked trend for Home Care agencies to provide rehabilitation programs for their clients. There is an obvious benefit to the client to provide this service to ensure they are meeting their goals in the home. It is a win situation for the client. These rehabilitation programs must be supported and recognized further in the Home Care reimbursement. Please consider all of these comments as the final rule is prepared.

Thank you.

Sincerely,

Jill M. Arvidson, M.S.T. CCC-SLP

#128



ARKANSAS DEPARTMENT OF
Health
Keeping Your Hometown Healthy

Medicare Provider Number: 047876
Little River Health Unit
150 Keller
Ashdown, Arkansas 71822

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the

RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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.

Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely:

Janet Dunn, RN
In-Home Services Administrator

Submitter : Ms. Joan Taylor
Organization : Trinity Home Health Services
Category : Health Care Provider/Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attached"

CMS-1541-P-127-Attach-1.DOC

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

Trinity Home Health Services, a home care and hospice holding company in Novi, Michigan, appreciates the opportunity to provide our comments on the proposed rule for refinement of the Home Health Prospective Payment System (PPS) and the rate update for 2008 that was published on May 4, 2007 in the Federal Register. In addition to three Medicare certified hospice agencies, Trinity Home Health Services has seven home health agency providers in two states:

- | | |
|-------------------------------|--------------|
| • Mercy Home Care, Grayling | CCN # 237223 |
| • Mercy Home Care, Cadillac | CCN # 237191 |
| • Mercy Home Care, Oakland | CCN # 237192 |
| • Mercy Home Care, Port Huron | CCN # 237422 |
| • Saint Mary's Home Care | CCN # 237217 |
| • Mercy Home Care Muskegon | CCN # 237198 |
| • Saint Agnes Home Health | CCN # 057135 |

As a non-profit organization, we share the Centers for Medicare & Medicaid Services' (CMS) desire to provide realistic, appropriate reimbursement for home health services while maintaining Medicare beneficiaries access to high quality cost-effective care. We recognize the importance of refining the home health PPS to reflect current patient characteristics and agency practices. However, we believe that undertaking all of the proposed changes simultaneously will be detrimental to patient access. 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 which will require home health agencies to increase clinician and administrative training, upgrade information systems and modify budgetary structures.

We respectfully ask you to review and adopt the recommendations listed below as well as those already included in the National Association for Home Care and Hospice (NAHC) comment letter. We believe that the adoption of these recommendations and those proposed by NAHC will improve the payment system by allowing our home health agencies to devote more of their time and attention toward the improvement of patient care.

Diagnosis Codes

The home health Conditions of Participation (COPs) state that all pertinent diagnosis codes should be listed on the beneficiary's plan of care. Other CMS instructions state that there must be congruency among the OASIS, 485 and UB-04

documents. As our coders continue to follow the coding conventions and guidelines as mandated by the Health Insurance Portability and Accountability Act (HIPAA), we find that the limited number of diagnoses coding slots (6) on the OASIS documents forces clinicians to judge which top 5 co-morbid conditions will most likely impact the 60 day episode of care, instead of allowing all pertinent co-morbid conditions to be listed on the OASIS. We believe that expanding the number of OASIS diagnosis slots to correspond to the number of diagnosis codes that are currently available on the new UB-04 will improve the quality and accuracy of home health diagnosis data. In addition, this improved data will be available to CMS for any future PPS revisions and will prepare home health documents for the implementation of ICD-10 diagnosis codes.

Recommendation

- Expand the number of diagnosis spaces on the OASIS to reflect the number allowed on the new UB-04.
- Implement the revisions recommended by NAHC.

Early and Late Episodes

- We support this case-mix refinement and are especially pleased that CMS plans to have the system automatically adjust final claims to reflect the early/late episode status based on the common working file (CWF).

Additional Therapy Thresholds

Like NAHC, we support 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 alleviate some of the administrative burden associated with the unlocking and correcting the OASIS when the patient's therapy needs were not accurately predicted at the start of care.

We also share NAHC's concern 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

- Prior to implementing changes, we recommend conducting 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. The OASIS time requirements are only slightly modified when performing a recertification OASIS. 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, our 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 we are prohibited from billing Medicare for assessment only visits.

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.

Non-routine Medical Supplies

We completely agree with the comments under this section as identified by NAHC. Of particular concern to our agencies is the bundling of new higher cost chest and abdominal drainages devices into the home health benefit. Patients are being discharged from hospital with orders to change these drainage devices every 2-3 days. It costs our agency \$560 per case of 10 for Chest Pleurx Drainage Systems and \$590 per case of 10 for Abdominal Pleurx Drainage Systems. The highest severity level payment of \$367.34 would not even begin to cover the costs of these supplies.

Recommendations

- 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 and ascites as a supply case-mix diagnosis to capture those episodes during which chest drainage supplies are provided, or reclassify chest and abdominal drainage systems as prosthetic devices, thereby capturing the payment for related supplies under that Part B 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.

HHRG and HIPPS codes

The proposed rule offers multiple values for each HHRG score based on early/late episode status and therapy provision. However the proposed rule does not address the HIPPS correlation to each of the 153 HHRG variations.

Recommendation:

Each case weight should have a distinct HHRG and HIPPS code that can be attached to a discrete reimbursement level allowing for comparison of financial data.

Case-Mix Wage Adjustment

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. Following this assumption, the general home health population has not aged, technology has remained stagnant and the needs of someone discharged from the hospital 2 days earlier than the average length of stay are the same as the person who remains hospitalized through the average length of stay per DRG rendering the Transfer DRG rule unnecessary. In addition, saying that the home health patient characteristics ignores the impact of the enforcement of the "75% Rule" for Inpatient Rehabilitation Facilities.

We concur with the following comments and recommendations from NAHC:

1. CMS failed to consider the utilization of therapy services as a "patient characteristic." The HPPS 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 HPPS 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 home health services patients, 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 and Medicare Advantage 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 \$3,812 to \$3,497. 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; \$7,517 to \$7,965 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 is 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 lead to numerous substituted judgments. Second, the explanatory power (R2) of the model, originally estimated at 30+%, devolved to 22% by 2003 with it operating at an 11% R2 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.

Recommendations:

- 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.

Wage Index

We agree with the following NAHC comments and recommendations:

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.

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.

Outlier Payments

We agree with the following NAHC comments and recommendations:

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. 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).

Recommendation:

- CMS should lower the FDL based on historical experiences to a level that ensures full use of the outlier budget. Continued use of a .67 FDL will not utilize the 5% outlier budget as required by Medicare law.

Conclusion

Thank you for the opportunity to submit these comments. We hope you will consider these comments to refine the HHPPS. We believe that CMS has made many improvements in HHPPS in the past and we look forward to further working together collaboratively to improve home health care to Medicare beneficiaries.

Submitter : Mrs. Barbara Lites
Organization : Sevier County Health Unit
Category : Health Care Professional or Association

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

COMMENTS IN THE FORM OF AN ATTACHMENT

CMS-1541-P-128-Attach-1.DOC



Medicare Provider Number: 047875
Sevier County Health Unit
304 North 4th Street
Dequeen, Arkansas 71832

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

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that processes, then rebill the final. This cumbersome process delays the correct payment at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

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

Thank you for the opportunity to submit these comments.

Sincerely:

Barbara Lites, RN
In-Home Services Administrator

Submitter : Ms. Joanne Kramer
Organization : VNA Care Network, Inc.
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-P-129-Attach-1.RTF

June 26, 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

Re: File Code CMS-1541-P

Dear Sirs:

I am writing on behalf of the VNA Care Network, Inc. (Provider # 22-7098) to comment on the Medicare Program Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P). 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 our ability to provide access to high-quality care to the Medicare population in our service area due to the 8.25% payment cut.

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. 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 somewhat 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 SCIC claims has proven to far outweigh the small benefit that agencies receive from the occasional increase in reimbursement.

The following are our specific comments on certain proposed changes.

Change in LUPA Payments

VNA Care Network 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 currently 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, our agency has fixed administrative costs for preparing and submitting bills, OASIS transmission, and all the other general and administrative costs of operating our agency. For that reason, we also believe

the LUPA add-on should be applied to all LUPA episodes. Even when patients have a series of LUPA only episodes, the add-on is justified for each period. 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.

VNA Care Network Continued

Non-Routine Medical Supplies

We somewhat support the changes proposed in this rule to more fairly compensate for non-routine medical supplies. We appreciate the 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 would urge CMS to re-examine its analysis prior to the final rule to see if additional data sources could be used to assure more complete NRS payments.

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 our VNA incurs 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 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 or by implementing an outlier provision.

The decision to exempt LUPA episodes from NRS payments also seems inequitable since such patients may incur significant supply costs. In 2006 our agency provided \$16,200 in supplies to patients with LUPA episodes. With a total of 2,518 total LUPA episodes that year, our supply costs averaged \$6.43 per LUPA episode.

Case Mix Creep Adjustment

VNA Care Network is 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. We are 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." 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. This adjustment will create tremendous hardship for our organization and, in our view, it is totally unjustified. We hope these comments will result in the exclusion of this proposal from the final rule.

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 "up-coding" 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 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.

Data suggests that most of the post PPS case mix change was driven by the 10-visit therapy threshold adjustment which is the only case mix item over which agencies have direct control and this incentive has been significantly reduced if not 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. Adding a case mix creep reduction on top of PPS case mix weight and therapy adjustments creates a double adjustment to the system. The 2.75% case mix weight creep adjustment that primarily reflects growth in therapy utilization is unnecessary and punitive. The VNA Care Network did not incur case mix creep in relation to the 10-visit therapy threshold. Our statistics when benchmarked against regional and national statistics show that we consistently fall below the average percentage of episodes receiving the therapy add-on for having 10 or more therapy visits. We did not game the system to create a higher case mix but yet based on this proposed change we will be penalized as if we did.

Our agency’s 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 payments to both high and low average case mix agencies. The remedy of an across-the-board cut punishes those of us 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, VNA Care Network 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 data 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. We strongly recommend that CMS eliminate the 2.75% reduction to base rates for the next three years or at least prorate the adjustment based on individual agency case mix creep instead of an across the board cut.

Cash Flow Concerns

We use Delta Health Technologies as our billing vendor and we were one of the agencies which had extreme difficulty with processing delays and errors resulting from the original implementation of the PPS system. We are extremely concerned about possible claims processing delays and errors resulting from the rapid implementation of these PPS changes. We are concerned that there may be too little time to allow for a smooth transition. This could cause us to repeat the cash flow nightmares we experienced in the year 2000. 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.

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

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. We also feel that Home Health Agencies should have the same appeal rules for reclassification to a neighboring CBSA allowed by the hospitals.

Thank you for this opportunity to comment.

Sincerely,

Joanne Kramer
VP of Finance/CFO
VNA Care Network, Inc.

Submitter : Mr. Rickey Mattiace
Organization : Quality Home Health Care of the Gulf Coast, Inc.
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1541-P-130-Attach-1.DOC

CMS-1541-P-130-Attach-2.DOC

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to
(800) 743-3951.

Submitter : Ms. Nelma Bennett
Organization : North Logan County In Home Service
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-131-Attach-1.DOC



North Logan In Home Service
 150 South Lowder Street
 Paris AR 72855

Medicare Provider Number: 104312514

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

The Arkansas Department of Health (ADH) is a governmental Medicare certified home health agency.

We recognize that refinements to the Home Health Prospective Payment System are needed. It is really difficult for us to complete review all of the changes because of their complexity. There are many positives within the HHPPS refinements, but in an effort to be brief the significant issues only are addressed.

Issue: The creation of a new OASIS item (M0110 Episode Timing) to capture whether a particular assessment, is for an episode considered to be an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes. We agree with the change in considering early or later episode in payment. However, to answer this question correctly a crystal ball or a private investigator is required. Medicare only knows the answer when all home health agencies involved in providing care to this patient are billed. If the billing is current, we can obtain this information from the common working file. If it is not current, we must try to obtain correct information from a sick and sometimes confused patient. If we answer M0110 wrong we can be penalized with decreased reimbursement. It is my understanding that Medicare will automatically down code but will not automatically up code. If the agency answers it as a (1 early) and it should have been a (2 later), the correction to receive appropriate payment involves a very cumbersome process: Cancel the final; cancel the RAP; have the OASIS author correct M0110; recycle our billing; bill the RAP, wait until that processes, then rebill the final. This cumbersome process delays the correct payment

at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

Leave the new OASIS item M0110 but **Auto Adjust it**. Please do not remove the burden of M0175 and M0825 and replace it with a M0110 nightmare.

Issue: The Procedures for making data submitted available to the public and the use of the Home Health Compare. This reporting includes both Medicare and Medicaid patient data. When used in outcome reporting the inclusion of the Medicaid patient information can significantly skew the data. Medicaid and Medicare admission criteria are not the same. Often patients that no longer meet Medicare criteria still meet Medicaid criteria and Medicaid becomes the payor and Medicaid (3 or 4) only is selected in M0150. Many Medicaid patients are seen in lieu of more costly nursing home placement; therefore, at discharge, their outcomes especially related to activities of daily living (ADLs) have deteriorated. Home Health agencies with a high Medicaid caseload will most likely be damaged in the public reporting process because these patients are less likely to show marked improvement due to their chronic conditions. The public reporting does not give an accurate picture of the agency's performance or outcomes. We are a governmental agency and have a high population of Medicaid patients and believe we are punished in caring for Medicaid patients in the reporting of the outcome data merged together. When pay for performance begins this negative impact could create issues of access to care for Medicaid patients.

Recommendation

Only include the Medicare patients in the public reported data and Home Health Compare. DO NOT include patients in Home Health Compare that has M0150 marked as Medicaid only.

Issue: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010.

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 after implementation of the other PPS changes. The proposed decrease in the base payment rates could result in a negative impact on the nature of patients served with home health care and their access to home health

Issue: 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.

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Issue: 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).

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

Thank you for the opportunity to submit these comments.

Sincerely

Nelma Bennett
In-Home Services Administrator

Submitter : Mrs. Johnette Bearden
Organization : Arkansas Department of Health
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachemnts

CMS-1541-P-132-Attach-1.DOC



ARKANSAS DEPARTMENT OF
Health
Keeping Your Hometown Healthy

Ouachita County Health Unit
740 California
Camden, AR 71701

Medicare Provider Number: 047844

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

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Johnette Bearden
In-Home Services Administrator

Submitter : Ms. Nelma Bennett
Organization : South Logan County In Home Service
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-133-Attach-1.DOC

#133



ARKANSAS DEPARTMENT OF
Health
Keeping Your Hometown Healthy

South Logan In Home Service
721 West First Street
Booneville AR 72927

Medicare Provider Number: 104312514

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

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Nelma Bennett
In-Home Services Administrator

Submitter : Mrs. Johnette Bearden
Organization : Arkansas Department of Health
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-134-Attach-1.DOC

#134



ARKANSAS DEPARTMENT OF

Health

Keeping Your Hometown Healthy

Calhoun County Health Unit

1119 Prestess Drive

Hampton, AR 71744

Medicare Provider Number: 047844

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

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Sincerely
Johnette Bearden
In-Home Services Administrator

Submitter : Mrs. Lora Forst

Date: 06/26/2007

Organization : Scott County In Home Service

Category : Home Health Facility

Issue Areas/Comments

GENERAL

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Comments in the form of an attachment

CMS-1541-P-135-Attach-1.DOC



Scott County In Home Service
487 West 6th Street
Waldron AR 72958

Medicare Provider Number: 104312514

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

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at least 3 or weeks or longer plus it has added administrative cost to provide the service. Also the OASIS must be retransmitted to the CMS state agency. (Doesn't this sound like the old M0175 and M0825?)

Recommendation

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

Thank you for the opportunity to submit these comments.

Sincerely

Lora Forst
In-Home Services Administrator

Submitter : Ms. Jo C Rowbotham
Organization : Conway County
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment

CMS-1541-P-136-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health*Keeping Your Hometown Healthy*

County Health Unit

104312514
Conway County
100 Hospital Drive
Morrilton, Arkansas 72110

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

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Sincerely

Jo C Rowbotham, RN I.H.S Administrator

In-Home Services Administrator

Submitter : Ms. Judi DeVore

Date: 06/26/2007

Organization : Home Care of the Grand Valley

Category : Individual

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule
REGULATORY IMPACT ANALYSIS

Home Care of the Grand Valley
1131 N. 21st St.
Grand Junction, CO 81501

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

See Attachment

CMS-1541-P-137-Attach-1.DOC

REGULATORY IMPACT ANALYSIS

Home Care of the Grand Valley
1131 N. 21st St.
Grand Junction, CO 81501

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

We appreciate the opportunity to provide comments on the proposed rule for refinement of the Home Health Prospective Payment System (PPS) and the rate update for 2008 that was published on May 4, 2007 in the Federal Register.

We are the only non-profit home health agency serving a rural county of western Colorado. Our agency during the past year was rated in the top 100 agencies across the country for quality in both care and financial performance by the OCS Home Care Elite SP. Our agency's acute care hospitalization rate is half of the national average, which given an average hospitalization rate of even 4 days, has saved on average \$40,000 per patient not accessing the hospital to the Medicare system. We have significant concerns to the proposed rule and the ability for our agency to survive.

Here are our comments related to the proposed rule:

1. We support the elimination of the Significant Change in Condition (SCIC) policy. Elimination will have a positive effect on our agency, since there was seldom any financial benefit for reporting a SCIC and it will allow us to focus our efforts on more important matters of patient care.
2. We believe the adjustments being made to impose payment reductions prior to testing a massively changed payment structure is premature and should be put on hold until the total impact of the revised payment structure has been evaluated. With the short time period we have had to evaluate our patient population and the impact of the new case mix structure and rate reductions, we are looking at a 15% cut in revenue. That is before adding on the administrative burden of training staff to new forms and new OASIS methodology changes.

Cutting our payment rates so drastically will seriously threaten our agency's ability to survive. Given the cost savings we have demonstrated in preventing re-hospitalization and more expensive care, to impose home care payment reductions at the same time that a major overhaul is being undertaken in the case-mix system may be a method for Medicare to cut off its nose to spite its face.

We support changes in the case mix structure recognizing 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, and believe the additional 8.7% payment reduction is heavy handed, given the lack of statistics to identify the impact of the PPS payment revision.

Basing the “case-mix creep” on a comparison of data retrieved from the beginning of PPS to 2003, is basing data on faulty information. The complexity of the OASIS tool was extremely difficult to learn and most of 2000-2001 was spent training staff to work with the tool to yield an accurate and consistent reflection of patient status. The learning curve on the OASIS tool has a huge bearing on the increase in case mix identified from 2000-2003.

Additionally, the case mix system as it currently is designed puts a higher value on the intense rehab patient, giving agencies more of an incentive to target their marketing to SNF patients. Our data shows an increase of 84% in SNF referrals from 2004 to 2005 alone. This increase in therapy episodes has significant bearing on the increase in our case weight, which is reflective of true patient characteristics and not “case-mix creep” as described.

Recommendation: Put the 8.7% payment cut on hold until the full impact of the change in the new PPS payment structure can be evaluated. Further study of data from 2002 to 2004 (after the initial training period on OASIS) is needed to evaluate any valid changes in case-mix before drawing conclusions on faulty data. A revisit of more current data will yield a more accurate reflection of case-mix changes and subsequent payment adjustments.

3. We note that CMS plans to revisit the diagnosis codes found in the proposed rule, and consider revising them based on 2005 data. We applaud the change to include all reported diagnosis including multiple secondary diagnoses as a means to better capture a picture of the complexity of the average home care patient today.

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 about correct diagnosis coding, particularly the proper use of V codes.

Currently in order to be in compliance with the HIPAA act and code appropriately, there are a number of patients being served who require the use of aftercare codes, since the original fracture or orthopedic diagnosis no longer applies, having been corrected by a surgical procedure. According to correct coding practice, once the fracture has been repaired surgically, it should not longer be reported as a diagnostic code. The current payment codes do not allow for the use of aftercare codes. Therefore, with the elimination of MO245, agencies will no longer be able to get credit for caring for a patient with a fracture code, since the aftercare code is the appropriate code to use and is not listed as a payment code. These patients are often very resource intensive generally needing multiple therapies and nursing and aide visits.

Recommendation: The aftercare codes for fractures and for correction of orthopedic conditions (v54.01-v54.9) should be included in the payment codes.

4. 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: 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. Proceed with caution before making changes to the proposed PPS diagnosis list. Provide guidance on proper diagnosis coding and support appropriate diagnosis coding practices.

5. We are also 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.

6. 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.

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.

7. We also have concerns about the proposal to exclude LUPA episodes from the medical supply payment. LUPA patients often are high supply users—generally needing expensive catheter equipment. Long term catheter patients often require silver-coated catheters to prevent UTI's, which is more costly than the standard supply. It is a disincentive to an agency to care for these patients correctly and may create access to care problems that result in more costly urgent care visits to care for them without proper supply reimbursement.

Our agency did not begin accurately reporting the use of supplies until the end of 2003, since it did not change our reimbursement, so our cost reports are not reflective of supply use before 2004.

Recommendations:

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

Continued study of actual supply use is warranted to get a better figure of actual agency cost as many agencies were not accurately reporting supplies since there was no additional reimbursement or incentive to do so with the original PPS system.

Submitter : Mr. John Beard

Date: 06/26/2007

Organization : Alacare Home Health Services, Inc.

Category : Home Health Facility

Issue Areas/Comments

Market Basket Index

Market Basket Index

This comment is strictly devoted to the proposed adjustment for case mix changes which CMS suggests are unrelated to corresponding changes in the characteristics of Medicare beneficiaries from October 1, 2000 through CY2003. Despite legitimate concerns about the subjective elements of OASIS, Sta-home respectfully submits that CMS has failed to satisfy the statutory condition for making such adjustments because (1) no rational mathematical conclusion can be drawn from fundamentally flawed calculations, and (2) there is no rational basis to conclude that patients who were admittedly excluded from home health under IPS experienced similar access barriers under PPS.

**COMMENT ON PROPOSED ADJUSTMENT FOR
CASE MIX CHANGES UNRELATED TO PATIENT CONDITIONS**

Section 1895 (b)(3)(B)(iv) of the Social Security Act authorizes the Secretary to adjust payments if the Secretary determines that case mix adjustments resulted in a change in aggregate payments due to coding practices that do not reflect real changes in case mix. 2008 PPS Proposed Rule F.R. Vol. 72 No. 86 p. 25392 (emphasis added). In order to make any adjustment at all, CMS must show that from some baseline time frame through 2003 (the year of the sample) case mix changed without any correlating change in patient characteristics.

The springboard of the entire analysis starts is the premise that the average case mix weight of the original Abt model was 1.0 for a sample of beneficiaries receiving home health from October of 1997 through April of 1998. Id. p. 25392. That assumed baseline was compared to the average case mix weight of 1.233 for CY2003 to justify a conclusion that average case mix weight had increased 23.3% since October of 1997. Id. However, the analysis rejects 1997 as a proper year of comparison primarily because IPS began on January 1, 1998 and ended on October 1, 2000 and CMS admits that case mix was in real flux throughout IPS: [C]hange in case mix between the Abt Associates study and the end of the HH IPS reflected substantial change in real case mix. Id. (emphasis added).

Despite the admission that real case mix change occurred throughout IPS, the analysis selects the last full year of IPS from September 30, 1999 through September 30, 2000 as its baseline of comparison to average case mix weight in CY2003. Id. Based on an analysis of a one percent sample of initial episodes from the 1999-2000 data under IPS, the analysis calculates a standardized average case mix of 1.134 relative to the assumed starting point of 1.0 in October of 1997. Id. The increase from 1.134 to 1.233 in 2003 reflected an 8.7 percent change that has been dubbed coding changes unrelated to changes in patient characteristics. Id.

The information provided about the calculation of the 1.134 figure is insufficient to determine whether the Secretary complied with the statutory condition precedent to making any adjustments. If 1.134 is the case mix weight that existed on September 30, 2000, then it includes all of the real case mix change that admittedly occurred during the previous year. However if the 1.134 is an average case mix weight for the entire last year of IPS, it impermissibly includes real case mix change that occurred from the beginning to the end of the year for which no adjustments are allowed by the statute.

The second premise of the analysis is the assertion that from the advent of PPS on October 1, 2000 through CY2003 patient characteristics stayed the same as they were at the end of IPS. Neither premise can be reconciled with known facts which negate the Secretary's authority to make any adjustment for coding changes from October 1, 2000 through CY2003.

Submitter : Mrs. Diana McGuire
Organization : Arkansas Department of Health
Category : Home Health Facility

Date: 06/26/2007

Issue Areas/Comments

GENERAL

GENERAL

Comments in the form of an attachment.

CMS-1541-P-139-Attach-1.DOC



ARKANSAS DEPARTMENT OF

Health

Keeping Your Hometown Healthy

County Health Unit

Medicare Provider Number: 047850

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

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Sincerely
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In-Home Services Administrator