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June 25, 2007

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Department of Health and Human Services
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Dear Sirs:

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

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

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

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

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

We disagree with the proposal to reduce rates by 8.7 percent because of a "nominal" change in case mix. First, it is unclear from Table 7 what "Average Resource Cost" is and what data source was used. Second, the separation of "real" vs. "nominal" seems arbitrary as do the dates chosen (HH IPS baseline and most recent data available from 2003). We

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June 21, 2007

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

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

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

Issue ~ 2.75% Case Mix Adjustment

- **Section Title** ~ Provisions
- **Discussion** ~ 8.7% of the 23.3% change in the average case-mix is purported to be due to coding behavior, rather than real changes in the patient's condition. SCHCA believe that there has been real changes in the patient's condition. There are improtant reasons to explains that explain this increase in the average case mix rate as a real change. First, patient characteristics and case mix has changed. Patients now are different than those in 2000, 2003, and 2006. It is readily apparent that the age of the Medicare home health patient has increased, with a growth in the percentage of patients over 85 increasing from 17 to 23 percent nationally. At the same time, it also is apparent that the home health modality of care has dramatically changed with a shift to rehabilitative services and shorter lengths of stay. Therapy has greatly reduced the need for need for aide services by improving functioning and patient self-care. Second, although OASIS began prior to HH PPS, it is was implemented during a time of massive changes and conflicting instructions. Lastly, there are training issues for staff on all aspects of home health especially on OASIS, IPS (during that period), HH PPS, and ICD-9 coding. There was a significant learning curve in the midst of all the changes and clarification.
- **Recommendation** ~ SCHCA recommends the elimination of the case mix adjustment of 2.75% in the base rate for 2008, 2009, and 2010. Changes in patient population, conflicting CMS instructions, and staff learning curves all play into the increase in the case mix. Further, the original rates were based on a relatively small sample and the

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

Issue ~ LUPA

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

Issue ~ SCIC

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

Issue ~ Non-Routine Supplies (NRS)

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

Issue ~ Non-Routine Supplies (NRS)

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

Issue ~ Outlier Issue

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

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

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

Issue ~ OASIS Changes

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

Issue ~ Therapy Auto-Adjust

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

Issue ~ Case Mix Refinement

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

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

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

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

Issue ~ ICD-9 Coding

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

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

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

Issue ~ ICD-9 Coding - Updated Guidelines

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

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

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

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

Sincerely,

Sherry Thomas

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

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June 25, 2007

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

Re: CMS –1541-P

This letter is written on behalf of the Minnesota HomeCare Association (MHCA) whose purpose is to represent agencies which serve clients in the most cost-effective manner to bring about the most positive client outcomes and functional improvement. MHCA represents *250 member* agencies 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:

Financial impact –

Concern
CMS comment period is too brief.

Rationale
The brief comment does not allow providers time to understand the changes and the impact the changes will have on the business and make informed decisions.

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

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

Rationale
CMS proposal assumes all increases in average case mix weight are entirely due to provider "gaming." To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase reflects the changing demographic of home care's

patient population, more intense staff training on OASIS which has resulted in more accurate OASIS answers.

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

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

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

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

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

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

Concern
Supply reimbursement.

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

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

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

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

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

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

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

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

Suggested Solution
Automatically adjust the final claim to accurately reflect early and late episodes of care rather than defaulting it to an early episode. Consider only one agency's episodes of care to determine if an episode is an early or late episode.

Concern
Implementation date of January 1, 2008

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Neil Johnson
Executive Director
Minnesota HomeCare Association

BEACON HEALTH®

JUN 26 2007

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June 25, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
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7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1541-P, Home Health Prospective Payment System Refinements and Rate Update for CY 2008

To Whom It May Concern:

My comments reflect the concerns and interests of over 650 Medicare-certified agencies that are members of our Beacon Institute™.

Nonroutine supplies

The Centers for Medicare and Medicaid Services (CMS) proposes a new system for determining payment for supplies, based on five severity levels and a national conversion factor. This system offers many positives over the current method of adding a set dollar amount to an episode, without regard to supply utilization; however, there are concerns the CMS must address.

- The CMS proposes removing the supply allowance from low utilization-payment adjustment (LUPA) episodes so as not to encourage agencies to take on LUPA cases. Many LUPA cases, however, are by nature supply intensive, e.g., patients with catheters.

  Suggestion to the CMS: Restore a supply allowance to LUPA cases. Failure to do so may encourage agencies not to take on these patients.

- There do not appear to be variables to recognize some of the most expensive supply cases, e.g., Pleurex® drainage supplies, or certain supply needs, such as patients with urinary ostomies. Also the maximum dollar amount possible is $367, far from adequate to cover the costs of patients with costly supplies. We have heard from several Beacon Institute members that they will not be able to admit patients who need Pleurex supplies because of the excessive costs.

  Suggestion to the CMS: Reevaluate the needs of patients with expensive supplies and proposed payment.

- The start and follow-up (recertification) assessments determine the payment for supplies. There is no mention of an adjustment in payment if a patient's need for supplies develops or significantly changes after the assessment establishing payment for the episode. *Example: The patient who had no need for supplies at start of care develops a Stage 4 pressure ulcer during the fourth week of service.*

  Suggestion to the CMS: Without recreating the nightmares associated with the significant changes in condition (SCIC) adjustment, develop a way to recognize the additional payment these changes in supply utilization will create.

Partial episode payment (PEP) adjustment

The CMS reports that almost half (42%) of PEP-adjusted episodes result from a patient-elected transfer. Beacon Institute members report that they incur PEPs for patients they have discharged with goals met, only to start services again with another agency in a day or two. There seems to be little evaluation of whether this resumption was medically necessary. There have also been reports of agencies being surprised to receive PEPs, which means the receiving agency did not contact the initial agency on the day of the patient's transfer, as instructed to do in CMS Publication 100-4.

Suggestion to the CMS: Direct intermediaries to review patient-elected transfers to verify that the receiving agency followed protocol and that the transfer was medically necessary.

SCIC adjustment

The CMS proposes to eliminate the SCIC adjustment. While a good thing, the Conditions of Participation require an update of the assessment whenever the patient experiences a major deterioration or improvement in health status. Since data from this follow-up assessment have never contributed to outcomes and now it won't be used for payment, why is it necessary for agencies to complete this assessment?

Suggestion to the CMS: Eliminate the requirement in §484.55(d) to update the assessment for a major change in status. The Conditions of Participation require clinicians to reevaluate patients' needs and they can accomplish that without collecting OASIS data, which will serve no purpose.

OASIS and outcomes

The CMS proposes adding two measures to the list of publicly reported outcomes.

- Improvement in the status of a surgical wound: This is a descriptive, not risk-adjusted, outcome. According to the Medicare Payment Advisory Commission (MedPAC), publicly reported outcomes must be properly risk-adjusted.

  Suggestion to the CMS: Do not add this outcome to the list of publicly reported outcomes until it is properly risk-adjusted.

- Emergent care for wound infections, deteriorating wound status: This data element (M0830, emergent care) also captures a new lesion/ulcer, which the proposed rule seems to ignore.

  Suggestion to the CMS: Clarify the intent of this measure before publicly reporting data. If the focus is only on infections or deteriorating status, then it will be necessary to revise the wording of the data element.

There is a more serious problem with the emergent care adverse event outcomes, in general. This data element asks whether the patient has utilized any emergent services. An assessment strategy, revised in August 2006, reads, "Clarify that a doctor's office visit which is scheduled less than 24 hours in advance is considered an emergent care visit." This revision implies that any visit scheduled less than 24 hours in advance, no matter the reason, is emergent care.

One example in a list of questions and answers published by the CMS: *A clinic does not schedule appointments in advance. The receptionist calls and tells the patient when to come in.* If this call occurs less than 24 hours in advance of the visit, this would be emergent care. Another example: *The patient is due to see the physician for a blood pressure check and prescription renewal in two weeks. When she calls to make an appointment, the receptionist informs her that the physician will be on vacation at that time but there is an opening tomorrow.* Under the revised language, both of these examples would constitute emergent care. There is no way that these two examples are comparable to the true examples of emergent care, including improper medication administration, dehydration, wound infection, and GI bleeding, to name a few, described in M0840, emergent care reason. To continue with this revised assessment strategy makes statistics about emergent care almost meaningless.

Suggestion to the CMS: Revise the instructions so only visits to an emergency room or an outpatient emergency clinic constitute emergent care is. Do not consider visits to physician offices, no matter when scheduled, as emergent care.

Thank you for considering these suggestions.

Sincerely,

Diane J. Omdahl, RN, MS
President

PROVIDENCE
Health & Services

June 26, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
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REF: CMS-1541-P

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

Dear Ms. Norwalk:

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide our comments on the changes proposed by the Centers for Medicare and Medicaid Services (CMS) to the Home Health Prospective Payment System (HH PPS). CMS published these changes as part of its Notice of Proposed Rule Making (NPRM) in the *Federal Register* on May 4, 2007. Providence Health & Services is a faith-based, non-profit health system that includes 26 hospitals, more than 34 non-acute facilities, physician clinics, a health plan, a liberal arts university, a high school, approximately 45,000 employees and numerous other health, housing and educational services in Alaska, Washington, Montana, Oregon, and California.

As a Catholic health care system striving to meet the health needs of people as they journey through life, Providence is pleased to submit comments on several areas related to the proposed changes to the HH PPS which were published in the *Federal Register* (Vol. 72, No. 86, pages 25356-25481) on May 4, 2007.

We applaud the efforts of CMS to refine the HH PPS to improve both the performance and appropriateness of payments. The NPRM contains the first major revisions to the HH PPS since its implementation in October of 2000 and Providence supports many of the changes being proposed:

- Creation of three therapy thresholds;
- Elimination of the Significant Change in Condition (SCIC) provision;
- Expansion of quality measure data collection and public reporting; and
- Rebasing and revising the Home Health Market Basket

Other provisions in the Proposed Rule are welcome changes; however, Providence has some specific concerns with several as outlined below.

Provisions of the Proposed Regulation

Refinements to the HH PPS – Case-Mix Weights:

Based on analysis of trends and data, CMS estimates that the average case-mix index (CMI) has risen over 23% since 1997. Comparing CMI from a time period of October 1997-April 1998 to the 12 months ending September 30, 2000 (the HH IPS time period), CMS calculated that CMI rose 13.4%. This entire increase is attributed to real change in case mix because there was no incentive for home health agencies (HHAs) to alter any coding or documentation practices since reimbursement during this time was not related to a patient's case mix. However, from the HH IPS time period until 2003 (the HH PPS time period), CMI rose 8.7% from 1.134 to 1.233. Unlike the previous CMI increase, CMS attributes this to nominal case-mix change related entirely to changes in coding and documentation practices.

CMS concludes that only nominal case-mix change accounts for the difference in resource use when comparing the CMI during HH IPS and HH PPS. Resource use decreased between the end of HH IPS and the start of HH PPS while CMI increased, thus CMS determined that the increase in CMI was solely related to coding and documentation practices. However, the data show that while in the initial phases of HH PPS the average amount of resource use did decrease, since that time the resource use has gradually increased in conjunction with the gradual increase in CMI. The only evidence of nominal case-mix related change occurred during the initial implementation of PPS; since that time, resource use and case mix increases have occurred simultaneously and indicate the real case mix has increased over time. CMS should refrain from penalizing HHAs for the full 8.7% increase in CMI because this increase cannot be solely attributed to coding and documentation behaviors.

Additionally, HHAs are admitting a higher number of post-acute care patients in attempts to have patients return to their homes from the hospital sooner while using fewer resources than while in an acute setting. The average case-mix in hospitals has been increasing over the years while the length of stay for these patients has decreased. The types of patients being admitted to HHAs require a higher intensity of care and spend less amount of time in the hospital. The increases seen in CMI in the home health arena can be directly attributed, at least in part, to the higher acuity of patients being discharged from hospitals.

Recommendation – Case-Mix Weights:

Providence recognizes that some of the CMI increases seen since the implementation of HH PPS are reflective of nominal changes in case-mix as would be expected with the introduction of any prospective payment system. However, we urge CMS to reevaluate the premise that the entire increase in CMI since the beginning of PPS is solely related to behavior changes associated with coding and documentation practices. **Providence strongly opposes the inclusion of an 8.7% behavioral offset over the next three years when the CMI increase cannot be completely attributed to**

nominal case-mix change and we urge CMS to eliminate part or all of this proposed payment reduction.

Refinements to the HH PPS – Early and Later Episodes:
CMS is proposing to introduce a variable in the case-mix system to account for whether the 60-day episode reflects an "early" or "later" episode. Early episodes will include not only the initial episode in a sequence of adjacent episodes, but also the next adjacent episode, if any, that follows the initial episode. Later episodes will include all adjacent episodes beyond the second episode. While we appreciate CMS attempting to refine the payment system adequately capture the higher resource use per episode and the different relationship between clinical conditions and resource use, we have concerns related to the ability of HHAs to accurately capture the information required for this variable. Most providers will rely on the Common Working File for determining whether a patient is in an early or later episode. Unfortunately, this data source is often incorrect or does not contain the information in a timely manner in order for HHAs to accurately respond to a question on the OASIS. CMS is proposing to default to identify episodes as an early episode in situations where the HHA is uncertain of the status. This default may significantly alter the accuracy of a HHA's reimbursement by incorrectly identifying later episodes as early episodes.

Recommendations – Early and Later Episodes:
Providence Health & Services urges CMS to reconsider implementing a default conclusion that an episode be classified as early when the HHA is uncertain as to whether it is an early or later episode.

Refinements to the HH PPS – Low-Utilizing Payment Adjustment (LUPA):
CMS is proposing an increase of $92.63 for LUPA episodes that occur as the only episode or the initial episode during a sequence of adjacent episodes. While Providence Health & Services applauds this attempt by CMS to more accurately pay HHAs for LUPA episodes, we are concerned that the payment adjustment is not yet at a level to avoid unanticipated consequences. Because providers are not fully capturing the costs associated with low utilization, an incentive exists for HHAs to provide at least five visits when actually only a few are needed.

Recommendation – LUPA:
Providence Health & Services urges CMS to continue to review and adjust the LUPA to adequately compensate HHAs for these types of episodes.

Refinements to the HH PPS – Behavioral Problems:
CMS has proposed to eliminate M0610 (behavioral problems) as a case-mix variable because this item "did not perform well in" studies and the addition of two groups of psychiatric diagnoses will "account for the contribution of behavioral problems to resource cost variation." *Federal Register*, Vol. 72, No. 86 page 25365. No additional justification or analysis for the removal of M0610 was provided in the Proposed Rule and Providence is concerned that the additional psychiatric diagnosis groups will not accurately reflect a patient's case mix. Patients with behavioral problems, many without formal psychiatric diagnoses, consume large amounts of resources including

staff time. Without this variable included, patients with behavior problems may not be accurately represented by their case-mix.

Recommendation – Behavioral Problems:
Providence Health & Services requests that CMS provide further data, analysis and explanation regarding the proposal to remove item M0610 as a case-mix variable.

As CMS continues the process of refining the HH PPS, we would like to encourage CMS to consider the significant changes that must be made to operationalize such changes. Not only will HHAs need to provide extensive education to staff members, providers will also be relying on third parties such as software vendors to update products and services to align with the Final Rule requirements. The extensive changes proposed by CMS, while for the most part welcome and necessary, should only be implemented after sufficient preparation and planning.

In closing, thank you for the opportunity to review and comment on the Medicare Program Proposed Changes to the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 NPRM. Please contact Beth Schultz, System Manager, Regulatory Affairs, at (206) 464-4738 or via e-mail at Elizabeth.Schultz@providence.org if you have questions about any of the material in this letter.

Sincerely,

John Koster MD

John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services

VNA OF Medical Park

58 Sixteenth Street 5th Flr, Wheeling WV 26003 (304) 243-4663

June 21, 2007

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

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

To Whom It May Concern:

I am writing to provide feedback on the proposed changes to the Medicare Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008. I would like to express my support for the refining of the PPS system to reflect the true needs of our patients. However there are also areas of concern with regard to the approach to these changes.

Diagnosis Codes:

It is good that CMS plans to revisit diagnosis codes and is considering revising them. Major changes have occurred in diagnosis coding practices since the implementation of HIPPA and the need to comply with official coding guidelines for ICD-9 coding. For the past several years, CMS itself, through its fiscal intermediaries has been guiding how home health agencies code, particularly as relates to the use of V-codes. At least yearly, supervisory staff in our agency attend ICD-9 coding training, which includes the latest changes and updates. In light of the expanded diagnosis list in the proposed rule, it is expected that home health coding will again change and change significantly. Although I do agree with the need for more thorough and accurate diagnosis coding, it is also important for CMS to recognize that the more specific the home health codes, the more likely a complete picture of the medical condition of the patient will emerge as well as the need for increased resources to meet those needs. I am hoping that this will not be viewed as agencies attempting to increase their reimbursement versus the fact that more resources may be needed to meet the medical needs of the patient.

Comment: Before making changes to the PPS diagnosis list, provide guidance on proper diagnosis coding and support appropriate diagnosis coding practices.

Early and Late Episodes:

I am pleased that CMS is planning to have the claims processing system automatically adjust final claims to reflect correct responses to early/late episodes, both upward and downward. For agencies to have to conduct ongoing monitoring of the Common Working File for adjacent episodes, and withdraw and resubmit a revised claim should an error be found, would be a burden they should not have to assume.

Additional Therapy Thresholds:

Both the National Association for Home Care and Hospice and the Visiting Nurse Associations of America support the concept of multiple therapy thresholds and a graduated payment process. It is also good to know that CMS is planning to have the claims for therapy visits adjusted automatically, both upward and downward, according to the number of therapy visits on the final claim. One concern expressed focuses on 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 MO700 (ambulation) deficits. However the proposed system allocates "0" points for ambulation deficits in two of the three equations, including both equations for the 14 plus therapy visits. In addition there are no points allocated for the gait disorder diagnosis in the 14 plus therapy visit equation. This does not make sense.

In addition VNAA expressed concern about the size of the dollar increases between the new therapy levels since they are so modest between 6 and 14 visits that the result could be a payment deficit. I agree with VNAA that CMS should reexamine the incremental cost of additional therapy visits to ensure that they balance over compensating and under compensating therapy use.

Comments: Please further analyze the impact of MO700 (ambulation) on service utilization for episodes with 14 plus therapy visits, or provide a rationale for eliminating points for this functional variable in the 14 plus therapy episodes. Then base the case mix system on these findings. In addition, please further examine the incremental cost of additional therapy visits to ensure that there is a balance between over compensating and under compensating therapy usage.

Low Utilization Payment Adjustments (LUPA):

Since the implementation of the LUPA, home health agencies have not had the opportunity to spread the cost of the admission visit across an episode of care, thus resulting in a financial loss for every LUPA admitted. Thus CMS's proposal to apply a LUPA add-on is a very positive step towards achieving adequate payment for LUPA episodes. However, CMS needs to extend this policy to all LUPA episodes, not just the first one.

In addition to the fact that the time to complete an admission/start of care OASIS adds an average of 40 minutes to the typical admission visit, a large percentage of LUPA episodes are for long term care patients who require limited nursing visits per episode such as a patient on service for foley catheter changes every six weeks, or a tracheostomy

patient who requires trach changes monthly. Many of these interventions are ordered for a specific point in time which can result in the OASIS followup assessment, which has to be completed in the required 5-day window, occurring as a non-chargeable visit. These types of costs are not captured in the Medicare claims data since agencies are prohibited from billing Medicare for assessment visits only.

It is also not clear how Medicare plans to determine whether a LUPA episode is an initial episode or an adjacent episode, which is important because the additional reimbursement of $92.63 will only apply to the initial episode. LUPA episodes should not be excluded from the medical supply payment since a significant portion require supplies i.e. foley catheter, tracheostomy supplies.
Comment: The LUPA add-on should be applied to all LUPA episodes and medical supply payment should also be included. In addition, please provide additional information as to how claims processing systems will identify LUPA episodes that are eligible for add-on payments.

Non-Routine Medical Supplies:

Due to the fact that only 10% of providers actually list medical supply utilization, I have concerns that this is the basis for the determination of medical supply usage. VNA of Medical Park has always listed medical supplies on their claims because we recognize the importance of CMS being aware of how much an episode of care is actually costing. It is also my understanding after reviewing information from NAHC and VNAA that a number of costly non-routine medical supplies are not reflected in the medical supply case model. Among these are patients with ostomies, other than for bowel elimination such as tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). There are also supplies ordered for chest drainage that are not included. Failure to identify patient characteristics that would allow for payment of such supplies, and others that are not yet identified, will result in home health agencies being underpaid.

Another problematic area is that agencies will have no way to seek reimbursement for medical supplies once the SCIC is eliminated because there is no way to account for supply needs that come up after the admission is completed. Thus there could be significantly inadequate payment for these supplies. It is agreed that elimination of the SCIC is a necessary reform, but there needs to be another way for agencies to be able to report additional medical supply costs.

Comment: I agree with NAHC that additional research needs to be conducted to identify other diagnosis and patient characteristics before proceeding with a separate case-mix adjusted non-routine supply payment based on patient characteristics. More accurate data is needed about the extent of medical supply usage.

It is suggested that additional diagnosis codes be considered as a way of determining medical supply usage, with particular focus on the secondary diagnoses categories

(V-codes). For example, it was suggested that diagnoses such as V44.0 through V44.9, Artificial Opening Status requiring attention or management be used to identify patients needing supplies for other ostomies.

Once a more reliable supply case-mix model is developed, include payment for non-routine medical supplies for all episodes and include LUPA episodes that are not final episodes of care.

Case Mix Weight Adjustment:

CMS has proposed a reduction in base payments by 2.75% for each of 2008, 2009 and 2010. This 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 that are not related to changes in patient characteristics. It is my understanding that the original model for the case mix weight was based on 1997 patient data and that is when the case mix weight was set at 1.0. Between 1999 and 2003 there was a change in the average case mix weight to 1.233. This was an 8.7% increase. As a result of this change, and the (erroneous) conclusion that it has nothing to do with actual changes in patient characteristics, CMS proposes the 2.75% adjustment over a three year period to prevent increases that are due to factors not related to patient characteristics.

I support the position of NAHC and VNAA that states that the 2.75% reduction in payment rates is based on an inaccurate calculation that the changes in case mix weights are unrelated to changes in patient characteristics. The methodology used by CMS is flawed and assumptions are not correlated to outcomes. CMS should withdraw this proposal and should design and implement an evaluation method that will analyze case mix weights using proper standards related to the home health case mix adjustment model concept of "patient 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."

NAHC cited evidence that there has been a significant change in patient characteristics from 1999 until 2003. Some of these include:

- The increase in home health utilization from 2.1 to 2.4 million people
- Diabetes diagnoses increased by 17%
- Patients with abnormal gait increased by 50%
- Patient with wounds increased by 15%
- Patients with urinary incontinence increased by 8%
- Patients had substantial decrease in their transfer abilities
- There was an increase in cognitive deficits
- Dyspnea increased

All of these types of changes call for additional services, particularly therapy services, which increase clinical and functional scores. In addition, we are now in 2007 and moving toward 2008. Length of hospital stays continue to decrease, average patient ages are increasing and identification of patient co-morbidities is improving yearly with the

adjustments to ICD-9 coding. Case mix weight has increased not only because patient characteristics are changing, but also because there has been a continual revision of our ICD-9 codes to identify as specifically as possible the medical condition of the patient. It is not due to "case mix creep"!

NAHC has done an excellent job of helping to identify why the rationale of "case mix creep" as an explanation for the change in case mix weight is not correct. In addition, it is pointed out that the actual annual expenditure by Medicare for home health patients, even given the increase in average case mix weights, has not increased but instead, between 2001 and 2003, it decreased from $3812 to $3497. This is due to more patients having increased rehabilitative services prior to admission to home health. On the other hand, per patient hospital and SNF expenditures grew during the same period from $11,938 to $13,381 for hospitals and $7517 to $7965 for SNFs.

Comment: I agree with NAHC's statement that using 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." It is built on a 1% sample of claims, CMS is rejecting the therapy utilization element as relevant to patient characteristics in the case mix creep analysis, and is asking that OASIS items be used, when OASIS is unable to define patients correctly in 89% of all episodes to explain case mix weights. CMS needs to withdraw this proposal which is based on a flawed model and false assumptions concerning home health case mix weights. As a non-profit home health provider that has always tried to deliver patient care of the highest quality and in the most cost effective manner, I found the explanation of "case mix creep" unfounded and an affront to the integrity of ethical home health agencies.

Wage Index:

VNA of Medical Park is located in Ohio County, West Virginia, a county which has one of the lowest, if not the lowest, wage index in the country. CMS is proposing that the current policy of using the pre-rural floor, pre-reclassified hospital wage-index to adjust home health service payment rates be continued. I join with NAHC and VNAA in opposing the use of such an outdated and inequitable model for calculating the wage index.

Comment: I support NAHC's position that CMS should replace its home health wage index policy with a method that achieves parity with hospitals in the same geographic market. For example, Ohio County, West Virginia, serves the same populations as Belmont County in Ohio, however our wage index is significantly lower. There is no rational explanation for why this situation should exist in this area. It has produced extreme hardship on home health providers in West Virginia and resulted in the loss of providers who are moving across the river to obtain the higher wage index. The population and areas we serve are the same. I further agree with NAHC that the wage index should be stabilized through the use of limits on year-to-year changes. NAHC states this can be accomplished through the use of

the rural floor standards and a proxy for hospital reclassifications. They also recommend that the method should be replaced with a BLS/Census Bureau data method as recommended by MedPac. All organizations, whether home health agencies or hospitals/hospital based home health are competing for the same staff resources in the same geographic area. Thus wage indices should be comparable.

Elimination of MO175:

Comment: Elimination of the MO175 variable from the case mix is strongly supported, however it is recommended that MO175 be removed from OASIS as well. It is extremely difficult for home health agencies to accurately determine prior stay, particularly if they are not hospital-based. There is no point in keeping a question that cannot be answered reliably.

Finally I would like to agree with the concerns of the VNAA with regard to claims processing delays and errors resulting if PPS reforms are implemented too rapidly. Billing vendors are reporting that there may be too little time for a smooth transition and based on past experience we know that major changes have resulted in claims process delays and errors among Medicare's contractors. It is recommended that once the PPS Reform proposals are refined and decided upon, that CMS provides educational meetings that include home health providers, vendors and Medicare contractors in order to prevent as many delays and errors as possible.

I thank you for providing the opportunity to comment on the PPS Reform proposal. As a provider of home health services for many years, I have seen the impact of major change, both positive and negative, and know the importance of considering all feedback, particularly since the changes are of such magnitude. I hope that all of the comments and input by providers and representatives of the home health community, particularly concerning the case mix weight adjustment, will be seriously reviewed and considered in the development and refinement of the final rule.

Sincerely,

Paula M. Singer

Paula M. Singer
Director
VNA of Medical Park, a Division of Wheeling Hospital

Centers for Medicare and 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 Indiana Association for Home & Hospice Care (IAHHC) is the trade association for the majority of home health providers in Indiana. For the last thirty years, IAHHC has represented providers 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 (PPS) and the rate update for 2008 that was published on May 4, 2007.

IAHHC understands the Centers for Medicare and Medicaid Services (CMS) mandate to refine the current system. However, IAHHC believes that CMS has placed unnecessary emphasis on making changes because "providers have gamed the system." CMS has included such wording as "case-mix creep," "severity has increased", "incentives to manipulate care plans", and "inhibit a future decline in model performance." Such proclamations, can lead policy makers and the public to believe that all home health providers are disreputable businesses.

Another concern is that PPS was a major clinical and reimbursement change for providers. Learning OASIS, HHRG, appropriate ICD-9 coding, submission of data, etc. did not happen overnight. During the first years of PPS, providers spent hours and money to train staff on the new processes to ensure clinical accuracy and meet reimbursement guidelines. However, IAHHC is alarmed that CMS is using data from 2000 to 2003 (the learning phase of PPS) to compare with current data (proficiency phase) and make major changes in PPS.

When PPS was originally proposed, the changes in the payment system were to incentivize providers to provide high quality, cost effective care. Providers were to provide all services under an episodic payment. However, CMS is now stating this improvement in practices is bad. Even though outcome scores from OASIS data have consistently shown that patient outcomes have improved. Home health agencies have been diligent to make PPS work and now are getting slammed for improving the care received by the Medicare home health recipient.

Early-Late Episode

During discussions on early and late episodes, IAHHC members expressed concern that data used by Abt and Associate did not correlate with providers own data. All providers stated that the first episode is more costly than subsequent episodes. This is due to the burden of Medicare required paperwork, the patient's and family's acute care needs, appropriate care plan development, front loading of services, and more frequent

communication between the health care team including the physician and discharge planners, during the start of care process. Members further stressed that data from 2000-2003 does not reflect home health agency (HHA) current practice of front loading which increase the cost of the initial episode.

Also, since the original data was collected, hospitals are discharging patients sooner. Since these patients have had little education about their disease or post-surgery care, plans of care reflect the need for more services during the initial episode. Hospitals, especially critical access hospitals, are discharging patients with serious health conditions. One IAHHC member stated that they had no referral from critical access hospitals in 2005 but 30% of 2007 referral are from critical access hospitals. Thus, the acuity of their patients is higher. Some joint replacement patients are discharged the day after surgery. CMS's own statements "the case-mix of the population of home health beneficiaries clearly shifted towards more post-surgical patients" and "the number of surgical wounds increased due entirely to the increased numbers of post surgical patients." IAHHC questions why CMS does not equate this data as one reason home health patients are more acutely ill. CMS can use hospital length of stay (LOS) data from 2000-2003 and presently to determine if home health providers are correct that hospital LOS is less.

Also, during, IAHHC members' discussion, the data alluding to a 7% increase in late episodes brought further discussion. Members wondered if this 7% reflects the last episode in a patient's life. Thus this is truly, end-of-life care not provided by a hospice. Many Medicare recipients do not wish hospice services. This may be the reason the costs are higher. IAHHC is encouraging CMS to further research this issue.

Providers are skeptical that late episodes with the higher reimbursement will trigger focused medical reviews from the Regional Fiscal Intermediary. It seems that an increase in payment eventually means providers are criticized unfairly.

It should be noted that CMS has determined that late episodes cost 7% more, but has chosen not to differentiate early and late LUPA episodes. IAHHC questions data that increases payment for one payment type and does not do the same for another payment type.

Case Mix

IAHHC members believe that the CMS determination that Medicaid eligibility and presence of or absence of a caregiver has no affect on case-mix is not based on reality. Medicaid recipients usually have many more social needs including financial instability, housing, education, caregiver support. These recipients require more resource allocation.

CMS should compare the impact of Medicaid eligibility by studying a sample of home health patient who are and are not Medicaid eligible before making assumptions that affect provider reimbursement. Not being reimbursed for patients that require more services, can adversely affect agency admission of this type of patient.

Since the inception of PPS, HHAs have reiterated that the lack of a caregiver in the home requires more intense services. These patients require more frequent contact, more aide visits, more clinical oversight. It appears that CMS in making changes without validated data. The presence of a caregiver improves patient's quality of care. As an example:

I thought of an example that I thought might demonstrate how important caregiver status is for PPS home care.

Mrs. H was released from a long term care facility with abdominal fistulas, ostomy, Foley cath, NPO, on TPN and all meds IV push. She had a recent CVA was aphasic and bedridden. Her husband was an extremely supportive caregiver and was very involved in her care. He learned how to administer her IV meds and provide wound care, ostomy care, etc. This lady was very sick! She was on service for a long time and was in and out of the hospital quite a bit which was unavoidable because she was literally developing new fistulas in the form of "holes" spontaneously opening up on her abdomen. She required extensive therapy and nursing visits because of the severity of her illness, but in the end was discharged walking, talking, eating and without wounds! There is no way that this lady would have done so well if she did not have such excellent caregiver support at home. I also do not believe she would have been able to leave the facility without this. This is a prime example of the impact of the caregiver on home care visits. Without him we would have done many more visits. I think this is also an example of the complexity of home care patients that all agencies are now working with and the challenges associated with providing the best quality care and not over utilizing.

IAHHC requests that CMS refine the OASIS items related to caregiver access in order to produce more reliable information about actual roles caregivers play in meeting the needs of home health patients. Also it is hoped that CMS will conduct further research on the impact of caregiver access on home health resource allocation and adjust the case-mix accordingly.

IAHHC wants to adamantly disagree with the CMS proclamation that "case-mix creep" is due to providers' manipulation of the system. The following information delineates some of the legitimate reasons for the so called "creep."

- Agencies have spent thousands of non-reimbursable dollars to educate staff on proper OASIS coding. IAHHC annually holds an OASIS coding workshop and certification. OASIS accuracy better reflects the current home health patient.
- More physical therapists are doing start of care and follow up comprehensive assessments. Studies have shown that PTs tend to more accurately code the patient's functional status.
- Agencies have spent thousands of non-reimbursable dollars on ICD-9 coding classes. IAHHC holds an annual coding and certification workshop.
- CMS is basing changes on data collected before home health staff became competent in OASIS data collection and ICD-9 coding.
- Hospitals, especially critical access hospitals, are discharging patients with serious health conditions. Some joint replacement patients are discharged the day after surgery. CMS's own statements "the case-mix of the population of home health beneficiaries clearly shifted towards more post-surgical patients" and "the number of surgical wounds increased due entirely to the increased numbers of

post surgical patients." IAHHC questions why CMS does not equate this data as one reason home health patients are more acutely ill.

Therapy Thresholds

IAHHC member voiced some concern about the complexity of the therapy thresholds, but believe that as with all of PPS, understanding will improve with time and education. There is one major concern, however. IAHHC believes that the impact of changes made to the point allocation for OASIS functional variables in relationship to therapy will have a negative impact on care. The current case-mix system allocated "6-9" points for MO700 (ambulation) deficits. The proposed system allocated "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 equation. If ambulation deficits or gait disturbances are not worth any points, how can a HHA justify physical therapy fore gait disturbance or ambulation deficits? With CMS's emphasis on decreasing hospital readmissions, HHAs are diligently adding more therapy to prevent patient falls. This "0" worth seem counterintuitive to the CMS goals.

Low Utilization Payment Adjustment (LUPA)

IAHHC appreciates CMS understand that the initial LUPA visit in an episode, which includes the initial assessment and the comprehensive assessment, is more time consuming and, thus, more costly. Members commented that CMS is not considering the cost of the reassessment visit for the next episode. In many instances, completely out of the control of the HHA, the assessment "5 day window' required by the Medicare Conditions of Participation does not correlate with the skilled visit. As a result, many of these visits are done by the provider as a non-billable administrative cost visit and thus are not captured in the CMS data. Many chronic patients with Foley catheters remain LUPAs for every episode and regularly require this un-captured comprehensive assessment visit. Failure to add any payment to these episodes continues the current disincentive to maintain these particular patients. IAHHC encourages CMS to add the $92.63 to every LUPA episode to cover the cost of the comprehensive assessment.

Members also have concerns about medical supplies during a LUPA episode and this will be discussed under the medical supply section.

Non-routine Medical Supplies

A critical access hospital stated, "We have been including our supplies for the past year." This is typical of home health providers. The National Association for Home Care & Hospice and IAHHC's home health CPAs both state that providers have been negligent in documentation of supply costs. To base payment on non-valid data will create financial problems for providers. Potential financial problems will result in HHAs being more cautious about admitting patients with high non-routine medical supply (NRS) costs.

IAHHC is very concerned that NRS reimbursement is excluded for LUPAs. These patients are usually require long term Foley catheter replacement, PICC care, Vitamin B12 injection, closed chest drainage, etc. Provider can not absorb the cost of these supplies and may have to decide to not admit long tern LUPA patients. Through medical review, CMS should be able to determine the medical supplies required by LUPA patients and adjust payment accordingly.

IAHHC encourages CMS to conduct additional research before proceeding.

MO175

IAHHC appreciates the elimination of MO175. Not only was it difficult to determine hospitalization within the last 14days, but providers found recently hospitalized patients to have more acute needs.

SCIC

Though SCICs have been problematic for providers, elimination has posed additional questions.

- How will providers document the addition of therapy after the RAP is sent?
- The Conditions of Participation require a reassessment at the time of a change in condition, will this OASIS data collection time point continue?

Rural Providers

Indiana is a rural state. IAHHC has great concerns about the impact of a decrease in the standard payment rate, coupled with a change in the amount of the standard rate subject to the wage index adjustment and the inability of rural agencies to seek the same reclassification that the hospitals in their communities are allowed. Rural providers must compete with these reclassified hospitals for skilled labor that is in increasing shortage of supply and at the same time have higher costs than their urban counterparts in mileage reimbursement for staff in an environment where gasoline costs are escalating at an unprecedented rate. The current proposed methodology has the potential to smooth out some highly profitable providers at the expense of decimating rural providers. This proves will result in further loss in beneficiary access to home care in rural areas.

IAHHC's final comments on the proposed changes to the home health prospective payment system relate to our belief that instead of rewarding providers for caring for an increasing number of very sick Medicare recipients while at the same time improving patient outcomes, CMS has chosen to punish for making positive changes. Punishment is based on an inaccurate data calculation that the change in case-mix weights is unrelated to changes in patient characteristics. During the last five years, HHA have been dedicated to improving patient care. At the same time, the cost of salaries, employee health plans, travel reimbursement, liability insurance, etc. has continued to escalate. CMS should withdraw its proposal to reduce base payment rates by 2.75% each of the next three years until CMS can design and implement an evaluation method to analyze changes in case-

mix weights that utilizes proper standards related to home health care mix adjustment model concepts of patient characteristics.

The Indiana Association for Home & Hospice Care is a member of the National Association for Home Care & Hospice. IAHHC fully supports NAHC's written comments on CMS-1541-P which contain more specific data.

Thank you for the opportunity to submit comments. IAHHC trusts that the Centers for Medicare and Medicaid will be cognizant of providers concerns as further refinements are made.

Submitted by:

N. Jean Macdonald, RN, BSN, MS
Director of Public Policy
Indiana Association for Home & Hospice Care

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Catholic Healthcare West
CHW

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June 22, 2007

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

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

Catholic Healthcare West (CHW) is a large not-for-profit hospital system on the West coast, headquartered in San Francisco, California. CHW has a total of 42 hospitals and medical centers in California, Arizona and Nevada and a total of 17 Medicare certified Home Health Agencies including affiliates. All but one of these HHAs is considered hospital-based. We provide home health services to approximately 15,000 Medicare beneficiaries each year primarily within urban areas. In general, we typically find our patient outcomes are better than average, visit utilization lower, shorter LOS, non-routine medical supply utilization higher, LUPA percentage higher and Outlier percentage lower than the national average. 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 understand the importance of refining the home health PPS to reflect accurate resource utilization and concur with many of the proposed changes. We are currently in the midst of evaluating the financial affects of all proposed changes to our Medicare reimbursement. With the review to date, we offer the following comments and recommendations.

Case-Mix

Diagnosis Codes

We recognize the need to expand the ICD-9-CM diagnostic Categories for case-mix adjustment variables. The Table 2B within the FR seems to be a comprehensive list of codes which can lead to predictive utilization and resource use results. Our quick review has shown, however, that possibly code 434.91 had been inadvertently left off. This code is currently a case-mix adjustment variable and is the common code used for stroke patients.

In as much as we understand the need for the OASIS assessment tool we continue to be concerned over the increased administrative burden its completion has on our clinical staff. It is common knowledge there is a large shortage of available and qualified clinical home health staff. The OASIS assessment along with other "paperwork" burdens has over time resulted in additional difficulty in recruiting and retaining clinical staff. The new OASIS assessment tool, OASIS-B1 (1/2008) Draft 4/19/2007, would have an increased burden for question M0246, the optional section where this would be completed if a V code is used within M0230 and or M0240. We believe this added burden along with other changes in the OASIS tool will require development of new training programs as well as several hours of training for every clinician completing the OASIS assessments. We suggest CMS should consider a one-time expense add-on for the training and a permanent add-on to the national PPS base rate and LUPA rates for this increased administrative expense.

Early and Late Episodes

While we understand that there needs to be recognition of the different characteristics of patients and resource utilization we question the practicality in adding another complex level of reimbursement formulas for early versus late episodes of care. The proposed FR indicates that a large random sample was used in determining a 7 percent difference in the average resource cost between early and late episodes of care. This does not seem to be a large enough differential to make such a large complex method change. Our own analysis indicates that early episodes are more costly than later episodes. We believe it is individual care practices will dictate the variation of resource costs between early and late episodes. We see this difference within our own system of HHAs. Our average length of stay ranges from 25.9 days to 62.9 days per HHA at a weighted average of 37.8. Our average number of episodes per Medicare beneficiary for each HHA ranges from 1.01 to a high of 1.78 with an average of 1.36. The recent MedPac Report to the Congress (March 2007) reported the national average of episodes/patient per for 2005 was 1.7, 25% higher than our weighted average. Our care practices are such that patient outcomes are achieved efficiently and effectively much sooner than is typical among all HHAs.

We believe that this proposed change in the case-mix system will result in a shift of longer length of stays resulting in a greater number of 3+ episodes per patient when this may not be required for the proper care of patients. We encourage CMS to review this element further and properly redistribute the reimbursement dollars equitably among all episodes. Elimination would also mean dropping the added OASIS question, M0110, saving time for home health clinicians as well as avoiding the complexity of adjusting reimbursement when the M0110 question was not answered correctly, saving time and resources at the clerical/administrative level.

Low-Utilization Payment Adjustments (LUPA)

We agree with the CMS proposal to apply a LUPA add-on payment to recognize the added cost of such episodes. We believe, however, that the method should be extended to all 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.

We would recommend that all LUPA episodes include an add-on payment to cover the administrative cost burden of such episodes. We believe a simple add-on which would be labor adjusted would also simplify the reimbursement method by eliminating the requirement to identify those LUPA episodes which are the initial or only episode for Medicare beneficiaries.

Non-routine Medical Supplies

CHW has various monitoring systems in place to ensure proper planning of patient's care for visits and non-routine medical supplies. All services and medical supplies are documented and associated charges included on final billing claims. Our current average cost of non-routine medical supplies is $36 per episode. We welcome the new methodology of adding a non-routine medical supply add-on payment to episode payments on the basis of the severity levels as outlined in the proposed method.

In noting the CMS solicitation for comments on alternative approaches for NRS payments on LUPA episodes we offer the following suggestions:

- Eliminate the $1.94 per visit add-on for all LUPA visits but add the accumulated amount to the pool of NRS payments thereby possibly increasing the amount to the NRS conversion factor
- Make all episodes eligible for the NRS payment amount without regard to adjustment type but based on the proposed severity level determination

- Require that non-routine medical supplies be charged on the final claim or the determined NRS add-on payment will not be paid. No charges for non-routine medical supplies indicates that non-routine medical supplies were not provided to the patient for that episode and therefore justifies non-payment.

We believe this method will provide the proper incentives for provision and billing of all non-routine medical supplies irrespective of the type of episode.

CASE MIX WEIGHT ADJUSTMENT

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.

CHW agrees with the National Association for Home Care & Hospice (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 utilize 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 did not 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. 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.

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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 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 enhanced 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.

OUTLIER PAYMENTS

CHW recognizes that the proposed increases in the standardized costs and the lowered national episodic rate will increase outlier payments. We do not believe, however, that this change will result in an additional $130 million in outlier payments in 2008 as estimated by CMS. In order to realize total outlier payments to reach the 5% portion of the HHA budget expenditures, we believe the .67 Fixed Dollar Loss ratio would need to be adjusted according to current reimbursement practices. Not adjusting this ratio would result in undistributed funds set for the Home Health budget as has been occurring in the past.

While we are continuing to study the probable financial impact of all proposed changes, our preliminary findings to date are that reimbursement would be decreased by approximately 5% compared with current 2007 rates.

We at Catholic Healthcare West (CHW) thank you for the opportunity to submit these comments. We believe that CMS has made many improvements in HHPPS and look forward to further refinements in line with the comments set out above.

Sincerely,

Paul Giles
Director of Home Health Finance
Catholic Healthcare West

Visiting Nurse Service Of New York
We Bring The Caring Home

June 25, 2007

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

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

On behalf of the Visiting Nurse Service of New York (VNSNY) we welcome this opportunity to submit comments on the Medicare Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (CMS-1541-P). VNSNY is the largest not-for-profit home health agency in the nation. In 2006, our more than 12,000 employees provided 2.4 million home and community based visits to 94,000 patients, of whom 43,000 were Medicare beneficiaries.

VNSNY acknowledges that the current Prospective Payment System (PPS) case mix methodology required updating, and we are generally pleased with many of the improvements proposed by CMS, such as the elimination of MO 175 from case mix calculation and the addition of reimbursement for patients requiring extensive periods of skilled services. Based on our extensive clinical and research experience serving our large patient base, we do have comments and specific recommendations that we urge you to consider incorporating into the final rule.

PROVISIONS OF THE PROPOSED REGULATIONS

Case Mix Coding Changes under PPS:

Proposal: CMS proposes to reduce the base payment rates by 2.75% for each of the next three years beginning in 2008 to recoup what CMS says was an unwarranted increase in payments for home health (HH) services since the early years of the Medicare HH PPS. CMS asserts that the increased payments were the result of inaccurate patient assessments performed by home health nurses.

Comments: VNSNY believes this adjustment is unjustified and is flawed for two basic reasons: actual changes in the home health population and improvements in the accuracy of OASIS coding

1. **Home health population**

   a. **Impact of In-patient PPS:** In our experience, patients today are in fact sicker, more functionally impaired, and require more medically-intensive services than they did at the beginning of the HH PPS. We believe that the average increase in patients' clinical needs is largely due to an inpatient hospital payment system that has created incentives for early discharge of patients who require more care. CMS itself recognized the "quicker and sicker" phenomenon that was resulting in HH agencies receiving higher real case mix cases in its published changes to the Medicare Inpatient Payment System in which it penalized hospitals who had systematically been discharging patients to HH much earlier than the norms of the DRG system. While advances in medical technology allowed patients who could previously be served only in hospitals or nursing homes to receive comparable care at home, the result is a HH population with higher acuity and more intense resource needs.

b. **Growth of Managed Care:** Another factor leading to increase in real average case mix change is the growth of Medicare Advantage (MA) enrollment. VNSNY now serves a substantial number of MA enrollees, most of who have a severity level that is lower than that of fee-for-service (FFS) Medicare patients. Since MA enrollees are no longer included in PPS case mix statistics, we believe that the remaining FFS Medicare population served under PPS has increased the average real case mix weight of the remaining FFS Medicare population served under PPS.

2. **OASIS Accuracy:**

VNSNY believes that the accuracy of OASIS coding by nurses and therapists has improved dramatically since the inception of PPS. The language and definitions in the OASIS tool are not intuitive and field staff needed to be trained to improve their accuracy in OASIS completion. In the analysis of the case mix coding changes under PPS, CMS cited some alternate reasons for the change in the case mix. It is our belief that many of these factors impacted the change and not improper OASIS coding. They include:

a. **Improved support from CMS** including instructional aides and revisions to the guidance in Chapter 8: Chapter 8 has been revised with updated guidance as to how to assess accurately. An OASIS training site was provided to foster improved OASIS accuracy. These updates and revisions would not have been necessary if the OASIS was being completed accurately under IPS and from PPS's inception in October 2000.

b. **Educational initiatives** led to improved understanding of the accurate completion of the OASIS. This is especially pertinent to the change in functional scoring. The concept of 'safe performance' and the definition of 'prior' and 'current' were clarified. The data also reflects that certain IADLs experienced a shift. Since these are not case mix items, this finding supports the premise that changes in coding were a result of improved assessment accuracy. In addition, CMS's educational initiatives were directed to many of the other M0 items cited in the analysis. They include: the number of stage 3&4 pressure ulcers, the status of surgical wounds, the presence of pain interfering with activity, the incidence and frequency of incontinence, and behaviors exhibited at least weekly.

c. **A shift in the scoring of M0175** to a more highly reimbursed level is also cited. It is well known that this M0 item was problematic because the data needed to accurately complete the item was not easily available to the clinician. It has now been removed from the HHRG.

d. **ICD-9-CM coding**: The document cites the overuse of Abnormality of Gait as an issue when correlated with therapy use. However, it further states that the burns/ trauma assignment was also overused initially. This second issue was corrected by an educational effort. Why was the same educational effort not applied to all diagnostic codes that appeared to be assigned inappropriately? The severity rating of diagnoses was also poorly understood initially. Other issues in the proposal related to coding will be discussed in more depth later. However, it is well known that diagnostic coding in HH prior to and under IPS was questionably accurate. Accuracy has improved under PPS. The validity of citing diagnostic coding issues in support of the concept of case mix creep appears questionable in light of the comparison population.

In summary, many of the OASIS coding changes can be attributed to an increased acuity in the FFS Medicare population and educational initiatives of staff. The findings of the analysis also support CMS's original decision in choosing which M0 items to use for the HHRG: the HHRG M0 items were chosen because they were predictors of cost in home care.

Recommendation: Since the proposed new HH PPS rule addresses many of the areas that CMS and the technical expert panel found to be problematic in the data studied, we recommend that CMS study the data after these changes are implemented for a period of at least one year. If the proposed changes in the case mix construction do not correct the "case mix creep" an adjustment may then be warranted. Imposing an adjustment at this point, in addition to the corrections in the case mix calculation would seem to over-correct the finding. If any payment adjustment is warranted after a study period, such adjustment should not be across-the-board affecting all agencies; adjustment should instead be based on the actual incidence of the behavior of the staff in the completion of the OASIS.

Additional Case Mix Factors: Both Medicaid eligibility and caregiver access have a considerable impact on resource use and should be included in the reimbursement calculation.

Impact of the dually eligible population: In 2006 VNSNY completed 22,909 Medicare non-LUPA episodes for patients that were dually eligible. This represented 42% of all episodes completed that year. As a result, VNSNY believes it is important that we comment on CMS's decision to exclude the impact of this population in the reimbursement methodology. Our experience indicates that the non-LUPA episodes of the dual eligibles have a 7 percent lower CMI while requiring 46 percent more visits per HHRG. These patients consistently have longer lengths of stay and have complex needs due to their multiple co-morbidities. While VNSNY has a long history of providing care to this population with significant special, high cost needs, we are concerned that other agencies are unable or not willing to, thus creating an access problem for this population. It remains to be seen whether the addition of the other diagnoses into the HHRG calculation and the concept of early vs. late episodes will sufficiently reimburse the care for this population.

Caregiver Impact: In our experience, the lack of an available, willing and able caregiver to participate in the patient's care **does** affect the cost of care. This is particularly seen in patients with the need for high frequency care. The case mix creep data does not reflect that family and friends did not offer support. However, it does reflect that patients without a primary caregiver declined. This may indicate a barrier in access to home health for this population due to an agency's concern related to the cost of this patient's care. Exclusion of this variable may eventually result in an increase in institutional care.

Recommendation:

We recommend that CMS re-evaluate its position on excluding the impact of dual eligibles and caregiver availability into the reimbursement process. In both situations, we feel the exclusion of these variables will place patients with these characteristics at risk for encountering barriers to home care services.

Non-Routine Supplies (NRS) Reimbursement:

Proposal: CMS has proposed to unbundle NRS reimbursement from the HHRG calculation and to provide a separate payment for NRS based on five severity levels specified in table 11. The severity designation will be based on selected OASIS responses as outlined in table 12 a & b. It is acknowledged that this model only accounts for 13% of costs. LUPA episodes will not receive any NRS adjustment. An outlier adjustment was considered but not included due to issues with administrative feasibility and the lack of an infrastructure and a basis for assigning allowable cost.

Comments:

- The amounts listed for wound supplies are inadequate in light of the cost of many of the advanced wound products. They should be updated to more accurately reflect the cost of wound products currently in use. The anticipated effect on VNSNY's reimbursement for supply cost is a negative 15 percent (–15%).
- Table 12a&b should include the cost of all pressure ulcers and ostomies. As stated earlier, the cost of these cases is also not captured in the HHRG or in the NRS calculation.
- We strongly feel an outlier adjustment for NRS is indicated in light of the high cost of advanced wound products. We will continue to provide our supply costs on claims and in our cost reports as requested so further study can be performed.
- The exclusion of LUPAs from the NRS adjustment is also not supported by our experience. It would seem more appropriate to apply the same adjustment to these cases, for supplies may be ordered for a particular case, especially in cases of wound care, with the intent to provide care for the entire episode and the episode becomes a LUPA due to an intervening hospital stay. Some cases, due to the infrequent nature of the service ordered, become LUPAs but they do require supplies. An example of such a case is one where the only service provided is the changing of a urinary catheter. Supplies are required and this variable is listed in table 12a. Our agency's data for 2006 indicates a supply cost of $14.21 for LUPA episodes and the cost for 2007YTD is only slightly less.

  Recommendations:
  - We recommend that the costs indicated in table 12a be re-examined in light of the cost of current wound products.
  - We further propose that adding the following diagnostic code to table 12b to include the costs of all ostomies: V55.x (x= 0 to 9) and that M0450 selection "e" be included on table 12a so the cost of all pressure ulcer supplies will be included in the NRS adjustment.
  - LUPA episodes should receive the same NRS adjustment as HHRG-based episodes if the OASIS data supports the need for supplies as in table 12a.

Refinements of the Case Mix Model:

Proposal: CMS has proposed significant change in the calculation of the HHRG, including:

1. Concept of early and late episodes
2. Changes in the allocation of reimbursement points as listed in table 2a, including additional diagnostic variables,
3. Payment of non-routine supplies (NRS)

Comments:

1. **Concept of early and late episodes**: The concept of providing additional reimbursement for patients requiring extensive periods of skilled services is supported by VNSNY. Many of our patients have complex situations that require an extensive, coordinated effort to maintain them safely in the community. We applaud CMS's intent to adjust the classification of these episodes using the CWF. However, there are still operational issues related to the initial coding of the episode that could reduce adjustments at the final claim. In addition, the scoring of the episodes with 20 + therapy visits appears convoluted and should be a separate equation.

   Recommendation: The 20+ therapy cases should either be considered a separate equation or be coded under one equation for the purposes of the clinical and functional dimension.

2. **Table 2a "Case-Mix Adjustment Variable and Scores:**

   a. **Diagnostic variables**: We applaud the inclusion of additional diagnostic categories and the inclusion of co-morbidities in the reimbursement formula, for these often impact the patient's ability to function safely at home. The inclusion of the categories of heart, hypertension and the expansion of diagnoses related to wounds are particularly appropriate. However, upon review of the case mix list we did note several issues and

inconsistencies that will impact the implementation in light of ICD-9-CM coding changes since 2003:

i. The major change was the requirement to **use "V" codes** where appropriate, beginning in 2003. This requirement was due to HIPAA regulations that require that appropriate ICD-9-CM coding guidelines be followed to protect the accuracy of patients' protected health information. Due to the fact that in home care we are often providing care to a resolving illness or injury, the prevalence of such codes should not be suspect. This is the very definition of the term "aftercare", one of the most frequently used "V" codes in home care. In addition, the increase in post-surgical care and cases involving rehab further supports the incidence of this type of code, for "V" codes are often used in coding such cases.

   The CMS addition of M0245 and now the proposed M0246 is fraught with opportunities for error and lost revenue. It is particularly an issue with codes used for the "aftercare following surgery..." Due to coding guidelines and the need to code the case mix diagnosis in M0246, redundant coding may occur. A diagnosis may be listed in M0246 for a "V" code and M0240 if the diagnosis is still a pertinent diagnosis. This will result in redundant coding and the proposed rule indicates that reimbursement will only be applied once. The inclusion of a select group of "V" codes, rather than the requirement to code under two systems would reduce the incidence of such redundancy and improve the data. Furthermore, the need to code under two systems is unnecessarily complex and costly to HHAs from the perspective of training and systems to monitor compliance with the inclusion of the case mix diagnosis in M0246.

   Recommendation: Select "V" codes should be included in the case mix list since they are appropriately prevalent in home care due to ICD-9-CM coding guidelines required by HIPAA. They could be added as interactions with related MO items.

ii. The **Neuro 3 code case mix list** includes the outdated code for stroke (436) and does not include the most prevalent code used in HH for strokes i.e., 434.91. This change occurred in 2004. The case mix list includes stroke codes where the specific cause of the CVA is known but not the code which is assigned when the cause is not known. This is often the case in HH and accounts for the frequent use of 434.91. The use of the acute stroke code was an exception granted to HH because the late effects codes were not included on the original case mix list. In other post acute settings the late effects codes are used in accordance with coding guidelines. It is not clear if under PPS Refinement HH will now be directed to follow standard coding practice and assign the late effects stroke codes since they are now included in the neuro 3 group.

   Recommendation: CMS needs to clarify its position on the coding of strokes under this new proposal. The code 434.91 needs to be added to the neuro 3 case mix list and it is questionable whether code 436 should be included.

b. **M0 responses**: We have several concerns about the point allocation:

   i. **M0488 Status of Most Problematic Surgical Wound**: The patient with a surgical wound with a status of early/ partial granulation in M0488 does not receive reimbursement points until equations 3&4. Under the new proposal the post-surgical patient in an early episode will receive reimbursement points under 3 circumstances:

      - Their surgery was due to one of the case mix diagnoses.
      - The primary diagnosis is one of the complications of surgery on the case mix list.
      - The wound is scored with the status of "not healing".

Recommendation: The increased incidence of the early/partial granulation response reported in the discussion on case mix creep should not be considered an example of up-coding only. Rather, since it is related in large part to an increased understanding of how to appropriately assess wounds as per OASIS guidelines, we recommend that CMS reevaluate the scoring of MO488.

ii. **M0450 Current Number of Pressure Ulcers**: We noted the significant weight given to these wounds and agree with this allocation. However, we are concerned about the continued lack of reimbursement for the pressure ulcer that cannot be observed (M0450 #e). This is most often due to eschar or slough covering the wound. If debridement is done while the patient is at home it is more likely to be done using chemical, mechanical or autolytic agents. This process is costly due to the supply cost and the clinician hours required for the process.

Another issue for this M0 item is the OASIS definition of the staging of pressure ulcers. The guidance provided by the National Pressure Ulcer Advisory Panel (NPUAP) in January 2007 is much clearer and more clinically appropriate than the 2006 WOCN statement and the most current CMS responses to Q&As in July 2006.

Recommendation: We strongly recommend that the 2007 NPUAP guidance be accepted so the most clinically appropriate guidelines for scoring pressure ulcers are used and that some point allocation be assigned to the care of ulcers that cannot be observed in both table 21and in the NRS calculation. The scoring of pressure ulcers that cannot be staged should be re-evaluated in light of the cost to care for these wounds.

iii. **Ostomy Care**: The calculation of the HHRG has again excluded ostomies other than bowel ostomies. In home care we provide care to a variety of ostomies, including nephrostomies, ureterostomies, gastrostomies and tracheostomies. These patients require the same instruction on the management of their ostomy and their supplies are often just as costly as the bowel ostomy.

Recommendation: Reimbursement points should be allocated to all ostomies, not just bowel ostomies.

iv. **Functional Dimension Equations (M0650-700)**: We've noted that impact of M0690 transfers and M0700 Ambulation/Locomotion has been significantly impacted in this proposed rule. Unless the patient requires 13+ therapy visits, reimbursement points are not assigned until the patient is unable to transfer. M0700 provides reimbursement points for the patient only in equation 2 and 3, while the toileting (M0680) is not affected by the equations and bathing (M0670) and dressing (M0650/660) continue to receive reimbursement points in all equations at the same level of disability as in the current HHRG methodology. Ambulation and transfer is a focus area for physical therapy and the scoring impact of these items is limited across the equations. Overall, the standard to receive reimbursement points in the functional dimension for M0690 and M0700 appears to have been set at a higher level than previously.

Recommendation: The allocation of reimbursement points to the transfer and ambulation in the functional dimensions appears to have been impacted by the study on case mix creep and is further evidence that the HHRG calculation should address this issue without a negative adjustment.

RAPs: Current practice guidelines promote the front-loading of services in an episode in order to promote positive outcomes. The current payment percentages of RAPs (60/40 for initial episodes and 50/50 for episodes that are recertified) are not consistent with this practice.

Recommendation: CMS should increase the initial RAP payment and this percentage should be the same for initial and recertified episodes.

Collection of Information Requirements

Proposal: The final rule will be released after the comment period and implementation of the rule will be required for episodes beginning January 2008.

Comments: VNSNY is concerned about the short time period between publication of the final PPS rule and the proposed implementation date. In addition, we are concerned that the rapid implementation plan would open the industry to a cash flow problem due to claims processing delays related to systems issues. We feel that a transitional period may be indicated to allow sufficient time to design and test the necessary systems needed to implement this rule. We recommend that such a transitional phase be incorporated into the rule for the first year and that claims be reconciled at year's end when adjustments are needed.

Recommendation:
A transitional phase should be incorporated into PPS refinement to allow agencies sufficient time to implement the necessary systems changes without encountering cash flow issues.

In conclusion, VNSNY believes that the PPS system was in need of refinement and the case mix calculation proposed will address many of the inadequacies of the present system. CMS has been responsive to the industry in its elimination of certain items. As an agency with a long history of providing care to a complex urban population we support the inclusion of the early and late episode as a variable to more appropriately reimburse the population that requires prolonged support in the community. We are also encouraged by CMS's intent to provide automatic adjustments of the HHRG for the proposed new M0 item needed to identify the early and late episodes. We likewise applaud the CMS decision to adjust upward and downward at the final claim for the therapy services provided.

However, the inclusion of a negative adjustment for the alleged "case mix creep" appears to be premature. Although we have raised concerns related to some of theses changes, the case mix calculation proposed appears to address many of the issues cited. We strongly recommend that CMS postpone any further reimbursement adjustments so the true impact of the HHRG calculation can be assessed. Imposing both the calculation change and a negative adjustment may result in an over-correction and hamper the ability to assess the true impact on the case mix calculation and whether it is truly addressing the care needs of the home health population.

We thank you for this opportunity to comment on these proposed revisions to the Home Health Prospective Payment System. We would be pleased to respond to any follow-up questions you have.

Sincerely,

Joan M. Marren

Joan Marren
Chief Operating Officer

VNAA Visiting Nurse Associations of America®

the voice of home healthcare

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

Dear Mr. Kuhn:

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

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

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

Provisions of the Proposed Regulations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

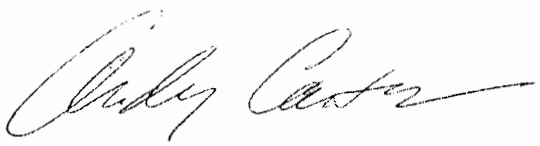
Because VNAA represents non-profit agencies, and CMS' impact analysis would indicate that voluntary non-profit home health agencies will experience an increase in 2008 Medicare payments based on this rule, one might expect that we could be indifferent to the proposed cuts. However, we would point out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

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

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

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

Sincerely,



Andy Carter
Chief Executive Officer

CC: Carol Blackford, CMS