Submitter : Ann Reynolds **Date:** 06/14/2007

Organization : CMC-Home Care

Category : Other Health Care Professional

Issue Areas/Comments

Provisions of the Prosposed Rule

Provisions of the Prosposed Rule

* Maintain at least a 2.9% market basket increase. * Eliminate or reduce the 2.75% base rate reduction. Changes to patient population, conflicting CMS instructions, and staff learning curves all play into the increase in the case mix. The original rates were based on a relatively small sample and the refinement analysis is too old for appropriate consideration. * The proposed change to increase the LUPA rate by $92.60 for the first or sole LUPA episode is good, but could there be consideration to an increase for all LUPA episodes? Our LUPAs are 15% of our episodes and the administrative costs extend beyond the first LUPA episc Our inability to cover costs may negatively impact access to medically necessary care for those long term patients, i.e. catheter care or B12, who would otherw e be placed in a more costly alternative. * We agree with the plan to eliminate the SCIC. * CMS' concept of the NRS add-on is good. However, it was based on incomplete information and may inadequately reflect the provider's true costs. Abt Associates reorted that nearly 40% of the cost reports were incomplete and unusable and only 10% of the claims data reported any supply charges. It would be more meaningful if CMS would continue to study the supply issue with more current and complete data. * The previous allocation in the LUPA rate of $1.06 assigned to NRS did not adequately cover the costs of a medically necessary NRS. This refinement excluded any update to NRS and may limit or negatively impact caring for patients. CMS should consider allowing a NRS add-on using diagnostic categories. * Outlier issue - CMS should maintain the current outlier standard and allow any unused allocation to be folded back into HH PPS. * CMS' plan to exclude M0175 and M0610; and add M0470, M0520, and M0800 are positive changes. Please make all the OASIS changes at once. * 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. If the Early/Late provision is kept, CMS needs 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 to clearly determine status and access to care. Adding the Early/Late EP distinction would magnify the complications and may delay appropriate access to care. *

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

Dear Mr. Kuhn:

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

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

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

Provisions of the Proposed Regulations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

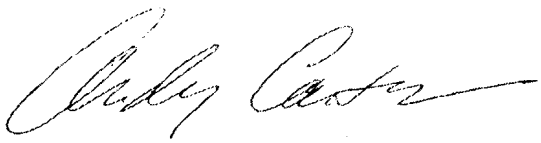
Because VNAA represents non-profit agencies, and CMS' impact analysis would indicate that voluntary non-profit home health agencies will experience an increase in 2008 Medicare payments based on this rule, one might expect that we could be indifferent to the proposed cuts. However, we would point out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

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

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

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

Sincerely,



Andy Carter
Chief Executive Officer

CC: Carol Blackford, CMS

Docket Management Comment Form

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

Temporary Comment Number: 185590

Submitter: Mr. Timothy R. Rogers **Date:** 06/22/07

Organization: Association for Home & Hospice Care of NC

Category: Health Care Provider/Association

Issue Areas/Comments

General

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

Attachments

CMS-1541-P-T185590-Attach-1.pdf

Print | Comment on Another Docket | Exit

Print - Print the comment
Exit - Leave the application

Association for
Home & Hospice Care
of North Carolina

6-1

3101 Industrial Drive
Suite 204
Raleigh
North Carolina
27609

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

June 21, 2007

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

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

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

Issue ~ 2.75% Case Mix Adjustment

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

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

Issue ~ LUPA

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

Issue ~ SCIC

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

Issue ~ Non-Routine Supplies (NRS)

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

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

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

Issue ~ Non-Routine Supplies (NRS)

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

Issue ~ Outlier Issue

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

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

Issue ~ OASIS Changes

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

Issue ~ Therapy Auto-Adjust

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

Issue ~ Case Mix Refinement

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

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

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

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

Issue ~ ICD-9 Coding

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

Issue ~ ICD-9 Coding - Updated Guidelines

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

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

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

Sincerely,

Timothy R. Rogers

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

California Association for Health Services at Home

3780 Rosin Court, Suite 190, Sacramento, CA 95834
(916) 641-5795
fax (916) 641-5881
www.cahsah.org

JUN 26 2007

June 20, 2007

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

Dear Sirs:

The California Association for Health Services at Home (CAHSAH) is one of the largest state home care associations in the United States representing providers of home health care and the patients they serve.

We are writing to comment on the proposed rule published on May 4, 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 approximately double the complexity of the system.

Provisions of the Proposed Regulations

We support the proposal to eliminate MO175 from the case-mix model. It has always been difficult for providers to code this item accurately. We also recommend that CMS stop the retrospective MO175 audits for the same reason.

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

penalize providers by eliminating almost all of the market basket increase by offsetting it with the case-mix creep adjustment when the nominal change in case-mix is so speculative.

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

PEP Adjustments

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

LUPA Adjustments

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

SCICs

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

Non-Routine Medical Supplies

We support the proposal to provide additional payments for non-routine medical supplies based on the severity level. CMS should note that estimated medical supply costs may be significantly understated due to providers failure to include these costs on final claims. As stated above, we believe the NRS payment should also be applied to LUPAs since these frequently involve the use of NRS.

Outlier Payments

According to the notice "Under HH PPS, outlier payments have thus far not exceeded 5 percent of total HH PPS payments." If this is the case, we do not believe it is appropriate for CMS to state that maintaining outlier payments will increase payments by $130 million.

Home Health Care Quality Improvement

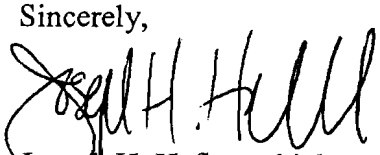
The regulation proposes that two additional quality measures be added to the ten already required. In order to reduce the regulatory burden, we recommend that if CMS adds two new measures, you delete two of the existing measures to keep the total number of quality measures at ten.

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

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

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

Sincerely,



Joseph H. Hafkenschiel
President

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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June 20, 2007

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

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

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 35,000 individual members, including 1,385 hospital-based home health agencies, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year 2008 proposed rule for the home health prospective payment system (PPS). We applaud the proposed refinements to increase the number of payment categories to improve accuracy in payment and make other appropriate improvements.

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

CMS proposes to apply a 2.75 percent reduction in payment in each of the next three years to offset historic coding changes. Instead of making these dramatic cuts, we urge CMS to further analyze the increase in case mix due to the implementation of the home health PPS. Case mix has increased due to several factors, including earlier discharges from general acute hospitals, PPS changes that provided incentives to treat higher-acuity patients, and other post-acute

regulations such as the inpatient rehabilitation "75% Rule," which divert more medically complex patients to the home health setting. While coding changes do account for part of the increase, we urge CMS to more adequately account for these concurrent factors.

The proposed coding cut would be particularly severe for hospital-based home health providers that often treat medically complex, post-acute patients not admitted by community-based home health agencies. Hospital-based home health agencies face additional vulnerability because they already lose money serving Medicare patients, as reflected in their negative Medicare margins. In addition, many hospital-based agencies are rural providers. We encourage CMS to implement measures to improve access and payments to rural home health agencies.

We thank CMS for the opportunity to comment on this proposed rule. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

vna
More than a century of caring ...since 1885

Visiting Nursing Association of WNY, Inc.

VNA Home Care Services

June 21, 2007

Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

On behalf of the Visiting Nursing Association of Western New York, our 850 employees, and the 13,000 Medicare beneficiaries we serve, I appreciate the opportunity to comment on CMS-1541-P.

Because of the complexity and magnitude of the changes, we are still in the process of performing a financial impact analysis of the reform proposal. My comments are therefore more conceptual in nature rather than analytical. Our analysis should be complete in a few weeks beyond your stated comment period.

In sum, I believe that the new proposal will solve many of the existing problems with the current system. However, the positives are mitigated by the proposed 8.25% reduction in payment rates due to CMS' contention that case mix increases are not due to changes in patient acuity. Our experience and outcomes categorically refute that position.

Case Mix Adjustment

I would submit the following reasons for an increase in case mix from 2000 to 2003:

(1) **Agencies increased their understanding of the original model, and caregivers became more comfortable with completing the OASIS assessment according to CMS guidelines**. At the start of PPS, the industry was naturally confused over the total revamping of patient assessment and reimbursement. This was compounded by the nature of home care assessment. Unlike hospitals, where case mix weight is assigned in a central records review area by technical experts, home care assessments and the resulting case mix score are completed in a decentralized manner. The VNA of Western New York has a staff of over 400 different nurses and therapists completing assessments. There are over 100 questions and observations a caregiver must complete in this process. Through constant training and retraining of CMS' own guidelines, we have improved the consistency and accuracy of our assessments.

2100 Wehrle Drive
Williamsville, NY 14221

Tel: 716.630.8000
Fax: 716.630.8660

www.vna-wny.com

Based on our experience, we believe we were undercoding cases in the early years of PPS. Increased training and familiarity resulted in more accurate adherence to CMS guidelines.

(2) **The original system contained substantial incentives to focus on rehab-intensive cases.** By CMS's admission, the current system did not match agency expenses in over 75% of Medicare episodes. One area where payment was too high was in episodes with more than 10 rehab visits. Agencies – especially for profits – focused marketing efforts in the area. Rehab intense cases have higher case mix, and case mix rose as a result. CMS has already addressed this issue in the new model, and we support the changes in valuing various rehab thresholds. **There is no reason to "double-adjust" the rehab issue through the 8.25% reduction.**

(3) **The population of Traditional Medicare beneficiaries is gradually being supplanted by Medicare HMO patients.** Newly retired seniors are choosing Medicare HMO plans in greater numbers, resulting in an older, sicker Traditional Medicare pool. From 2000 to 2003, the VNA of Western New York's unduplicated Medicare census fell by 15% and our Medicare HMO census grew proportionately.

Newly retired seniors are generally healthier, and the remaining pool of Traditional Medicare patients can be expected to have higher case mix.

(4) **Hospitals are under extreme pressure to reduce length of stay and are consequently discharging patients earlier.** CMS acknowledged this trend with the introduction of the transfer DRG penalty. There is no question that we are seeing patients earlier in their recovery process, and those patients have higher case mix.

(5) **The average cost per patient in home care dropped from 2001-2003, from $3812 to $3497.** Despite an increase in case mix, per patient costs decreased. Over the same period, inpatient costs rose from $11,938 to $13,381 and Skilled Nursing Facility expenses rose from $7517 to $7965. **The Home Health industry is seeing more patients (from 2.1 Million in 1999 to 2.4 Million in 2003) at a lower per patient cost, while alternative care providers' cost are rising.**

For these reasons, I believe that CMS's proposed 2.75% cut in payments in 2008-2010 is based on unreliable assumptions at best about the increase in case-mix weight from 2000 to 2003. The harsh reality is that VNAs in 2004 (year of most recently available data) had an average total operating margin of negative 2.3% accounting for all payer sources. Charity contributions to VNAs brought that average up to 3%. Since that time, costs have only increased – not decreased – because of the stiff competition for clinicians, gas price increases, and purchase of telehealth systems to better manage patient caseloads by thinly stretched clinical staffs.

Last year, the Moran Company produced data for VNAA that demonstrated that 66% of VNA providers have total operating margins of less than 5% and that 39% of VNA providers have negative total operating margins. If CMS includes the combined 8.25% cut in its final rule for PPS refinement, the vast majority of VNAs would be in serious financial jeopardy. The real tragedy though, would be the impact that any VNA closures would have on Medicare beneficiaries' access to a safety net home health provider in their community. Following the implementation of the BBA'97 and the devastating Interim Payment System (IPS), 26 VNAs were forced to close their doors. All of us are concerned what any repetition of the past would have on communities nationwide.

LUPA Changes

Another area where proposed changes are problematic is in the treatment of Low Utilization Payment Adjustment (LUPA) cases. While the proposed LUPA add-on rate is a positive start, we will continue to lose significant money serving these patients. The add-on covers additional assessment minutes, but ignores supply costs, and agency overhead (origination, documentation, physician orders, billing) that are present regardless of the number of visits. **We would recommend that the add-on rate be increased to reflect supplies and overhead.**

Positives

The proposal contains many positives that we support, including the supply adjustments, the rehab multiple thresholds, the elimination of MO175, and higher case mix for the third recertification episode.

In closing, I implore that you not mitigate these positive changes with an unwarranted and ill-advised case mix reduction.

Thank you for the opportunity to comment.

Sincerely,

Lawrence J. Zielinski
President, VNA of WNY

Park Ridge Hospital
HOME HEALTH

10

June 20, 2007

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

CMS 1541-P
Submitter: Cynthia Dobias, Administrator
Organization: Park Ridge Home Health
Category: Home Health Facility
Area/Issue of comment: Analysis of Early/Later Episodes

In reading through the section addressed "Analysis of Later episodes" it is the intent that nationwide Home health agencies would be able to obtain their information regarding recent HH episodes by going to the Common Working File. In a perfect world where all Agencies are timely in closing their cases and getting their information into the system, this might work. It has been my experience that the CWF is not updated timely and the information coming off that system is not current. This proposed plan would put many agencies in harms way financially as they would assume that the information IS correct and timely. Many elderly patients do not know their dates of service with a HHA. While information is left in a patients home for the family to read and refer to, it is not always put in a place where that information is be readily available ,or the patients move it to an inaccessible place. Asking agencies to "keep record" of other HHA is neither practical nor in their best interest. The demand for timely and accurate information collection along with agency participation in Quality Initiative campaigns is already stretching resources while providing quality patient care. Please give reconsideration to this proposal.

It is also noted that while reading through the Federal Registry that statistical information is taken from years 2003 or earlier. That data is old and the acuity of many HH patients has changed dramatically. Many agencies that were providing services in the home are no longer operating. Patients are now in and out of many systems that provide in home care. Timely date from even 2005 would have given the authors of the Proposals a much clearer picture of the elderly now living in the USA.

Park Ridge Home Health has a high LUPA ratio as the agency services a number of Assisted Living Facilities. Thank you for acknowledging the length of time that even

a LUPA visit takes. Especially doing a Start of Care. Increasing the reimbursement of the first visit will be a great help. These services to the ALF's assists them in providing a better quality of care, but at times does financial harm to the HHA providing the care. The Agency is the 24/7 service for them where nursing care is concerned. Please note that many of these LUPA visits involve changing foley catheters, suprapubic catheters and other ostomy appliances. These are costly supplies and reimbursement is not always adequate to cover the patient needs.

Comments respectfully submitted by: Cynthia Dobias 

"Excellence in Care Since 1976"

June 21, 2007

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

Sta-home Health Agency is a Mississippi corporation that provides home health services to a daily census of 4000 Medicare beneficiaries in 44 counties across the State of Mississippi. Sta-home appreciates CMS's efforts to refine PPS to more accurately allocated resources to meet patient needs.

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

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

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

The springboard of the entire analysis starts is the premise that the average case mix weight of the original Abt model was 1.0 for a sample of beneficiaries receiving home health from October of 1997 through April of 1998. Id. p. 25392. That assumed baseline was compared to the average case mix

406 Briarwood Dr., Bldg. 200 • Jackson, MS 39206
Telephone: 601-956-5100 • Fax: 601-956-3003 • 1-800-STA-HOME

Website: http://www.sta-home.com

weight of 1.233 for CY2003 to justify a conclusion that average case mix weight had increased 23.3% since October of 1997. Id. However, the analysis rejects 1997 as a proper year of comparison primarily because IPS began on January 1, 1998 and ended on October 1, 2000 and CMS admits that case mix was in real flux throughout IPS: "[C]hange in case mix between the Abt Associates study and the end of the HH IPS reflected substantial change in real case mix." Id. (emphasis added).

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

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

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

THE AVERAGE CASE MIX WEIGHT OF THE ORIGINAL Abt MODEL WAS NOT 1.0

Accordingly to both HCFA and Abt, it was not possible to calculate an average case mix of 1.0 in the original model because the database of 19,449 simulated episodes was too small to place a reliable number of episodes into each of the 80 HHRGs:

> "If a large national data set that linked resource utilization and HHRG classifications for 60-day episodes of care were available, we would have computed the relative weights in the following manner: First, we would have calculated the mean cost per episode for each HHRG, as well as the mean cost for all episodes.

Then, each mean cost would have been divided by the mean cost of all episodes. Calculating the relative weights in this manner ensures that the relative weight of the average episode is 1.0.

However, since only a sample data set is available, it was necessary to modify this method in order to obtain reliable relative weights. The Abt data set is large enough to establish the case-mix groups and to calculate average resource use for many of the HHRG categories. However, there are also many HHRGs with relatively small numbers of episodes for which reliable estimates cannot be made. As a result, it was necessary to make full use of the information contained in the sample." 1999 PPS Proposed Rule p. 84 of 151.

As described by Abt:

"Finding relative case-mix weights. Information from the case-mix groups is required in determining the case-mix relative weights. A straightforward method of calculating the relative weights is to divide each group's mean per-episode resource cost by the overall mean per-episode cost. This set of rations comprises a set of case-mix relative weights whose average value is 1.0 as long as the means are volume-weighted. However, the very small sample sizes in some groups (Appendix C) suggest that the raw group mean may not be a reliable measure of the population mean. Regression analysis can be used to estimate group and overall means using data from observations in the broader sample. The population weights discussed above would be used in estimating the group mean and overall mean resource cost before forming the ratios." Abt Second Interim Report p. 72 (September 24, 1999).

Thus weighted regression analysis was used to estimate group and overall means to arrive at relative weights. 1999 PPS Proposed Rule p. 84 of 151.

"All episodes at each level of the clinical, functional, and service domains were employed to estimate the resource use for specific combinations of clinical, functional and service levels. For example, in estimating the average cost of HHRG C3F4S1, we used data for all C3 episodes, all F4 episodes, and all S1 episodes. The method involved computing an average cost for each clinical level (C0, C1, C2, and C3), each functional level (F0, F1, F2, F3, and F4), and each service level (S0, S1, S2, and S3). Then the average additional cost of each level above the C0F0S0 base cost was computed: C2-C0, C2-C0, C3-C0; F1-F0,

> F2-F0, Fe-F0, F4-F0; S1-S0, S2-S0, S3-S0. Finally, these average additional cost amounts were added to the base cost (C0F0S0) to obtain the average cost of each HHRG.... In more precise statistical terms, the mean cost estimates described above were obtained using multiple regression analysis. To account for the stratification of the sample, weighted regression was used. We regressed the dependent variable (the Abt resource cost) on categorical variables C1-C3, F1-F4 and S1-D3. By omitting C0, F0, and S0 from the regression, the intercept term measures the mean cost of the C0F0S0 group. The regression coefficients of each of the clinical, functional, and service levels measure the mean difference in cost between the given level and the base cost (C0F0S0)." 1999 PPS Proposed Rule p. 84 of 151.

So what we know for certain is that the average case mix weight of the original model was not 1.0 because an insufficient number of episodes in many HHRGs rendered unreliable a calculation that would have ensured an average case mix weight of 1.0. The current case mix weights calculate the mean difference in cost between any given domain and C0F0S0.

Since the real average case mix weight of the original model is unknown, mathematical calculations based on an assumed value of 1.0 are inherently inaccurate to an unknown degree and fundamentally unsound. Given the huge amount of error built into the original model (R^2 = .219) it is highly probable that the difference between the calculated means and the assumed average of 1.0 exceeds the entire proposed adjustment.

There are other indications that the original average case mix weight was not 1.0. The revised 2008 case mix model was developed from a database of 1,656,551 sample episodes. 2008 PPS Proposed Rule F.R. Vol. 72 No. 86 p. 25392. Presumably[1], this database was sufficiently large to ensure an average case mix of 1.0 in the revised model. Id.

To achieve a true average case mix weight of 1.0, the revised model had to be adjusted **upward** by 19.4% in order to ensure budget neutrality. Id. p. 25392.

> "The budget neutrality adjustment restores the average case mix weight that results from the revision process to the average level observed before implementing the proposed new case mix system." Id.

[1] Abt has indicated that no report was issued to describe methodologies used to create the revised model.

Therefore the average case mix for the year 2007 was in fact 1.194 relative to a true average case mix of 1.0. Id. If y = the number of dollars spent in 2007 under the original model and in 2008 under the revised model and x = the unknown average case mix in 2007, then

$$xy = 1.194\ y$$
$$x = 1.194.$$

It is difficult to reconcile 1.233 in 2003 relative to a supposed starting point of 1.0 in 1997 with a true average case mix of 1.194 in 2007 relative to a known starting point of 1.0. These numbers strongly suggest that the average case mix weight in 1997 was much higher than 1.0.

Another indication that the original average case mix was not 1.0 is the actual performance of the model under IPS. As established infra., patients under IPS tended to need short-term, low cost care. Patients in need of substantial resources were discharged from or denied access to the benefit. Nevertheless "real" case mix rose during IPS. One logical explanation is that case mix weight was rising to an actual average value that exceeded 1.0.

Since the springboard for the entire quantification analysis is based on the false assumption that the original average case mix weight was 1.0, there is no rational basis for a finding that case mix weight changed 8.7% from 2000 to CY2003. That number is pure guesswork. Moreover, there is no rational basis to conclude that any amount of case mix change from 2000 for CY2003 was based on anything other than a correlating change in patient characteristics and a brand new focus on therapy utilization as a means to maximize patient self-sufficiency.

PATIENT CHARACTERISTICS FROM OCTOBER 1, 2000 THROUGH CY2003 WERE NOT STABLE

The second premise of the Proposed Rule is that from October 1, 2000 through CY2003 patient characteristics were essentially stable. Id. It is important to view this premise from an historical perspective. During the years of the demonstration project preceding IPS (1995-1997) the home health benefit experienced "a time of large volume growth and an increasing proportion of more acutely ill patients." 1999 PPS Proposed Rule p. 11 of 151. Beginning January 1, 1998, IPS dramatically reversed this pattern of growth with (1) huge fiscal cuts that drove over 3000 agencies out of business, and (2) with per beneficiary caps that created access barriers to expensive long-term patients.

The data that Abt used to simulate episodes and develop the case mix adjuster included industry experience under the first four months of IPS. CMS described patient characteristics under IPS as follows:

> Dramatic changes in the home health benefit also became Evident under the HH IPS as a result of provisions of the Balanced Budget Act of 1997. Venipuncture patients were suddenly no longer eligible; members of this group often had multiple comorbidities and commonly used substantial amounts of personal care. In addition, according to a study in the literature, beneficiaries age 85 and older, as well as beneficiaries dually eligible for Medicare and Medicaid, were slightly less likely to be admitted to home care (McCall *et al*, 2003). Both of these groups are associated with high needs for personal care services, suggesting that long-term care patients were less likely to be admitted under the HH IPS. The agency closure rates in States associated with high utilization (for example, Louisiana, Oklahoma, and Texas) also suggests that admissions among long-term care patients experienced decline. The OASIS data comparing the case-mix sample and the HH IPS period exhibit some consistency with these ideas, in that they indicate substantial decline in admission of the kinds of patients likely to be long-term home-bound beneficiaries with chronic medical care needs-patients with diabetes, impaired vision, parenteral nutrition, bowel and urinary incontinence, behavioral problems, toileting dependency, and more-severe transferring dependency. 20080 PPS Proposed Rule F.R. Vol. 72 No. 86 p. 25393.

Beneficiaries aged 85 or older suffered particularly large declines in access. Health Affairs, Vol. 22 No. 5, p. 186 (2003), Murtaugh et. al.

Various studies cited by CMS as well as OASIS data indicate "that patients with intensive or lengthy needs for nursing and personal care services as opposed to short term or rehabilitative needs were less likely to be found in the national home care caseload as a result of HH IPS" and its per beneficiary cost cap. 2008 PPS Proposed Final Rule F.R. Vol. 72 No. 86 p. 25393 citing (MedPac, 1999; GAO 1998; GAO 1999; Smith et. al., 1999). In fact, in 1999 there were 877,998 fewer home health beneficiaries than in 1997. (HCIS 1999). Agencies simply refused to admit or actually discharged long-term expensive chronic care patients. MedPac (June 1999).

These facts establish that the case mix model developed from pre-IPS and IPS data (September of 1997 through October of 1998) contained little if any meaningful information about patient characteristics or resource needs of long-term, expensive chronically ill patients. Moreover, the baseline year chosen by CMS for comparison to 2003 was a full blown IPS year with an ongoing shrinkage in the volume of expensive long-term patients.

PPS put an end to these IPS trends. By statutory directive PPS was crafted to ensure quality access to all eligible beneficiaries. Section 1895(b)(2). By regulatory design, case mix adjustment was engineered to remove incentives for providers to ostracize expensive patients. 1999 PPS Proposed Rule p. 17 of 151. As described by MedPac:

> Under IPS "The number of beneficiaries using home health services fell by about 1 million, and one-third of agencies providing services left the program. Spending decreased by about half. In the current decade, the trends have changed direction. The total number of beneficiaries using the benefit grew for the first time in several years between 2001 and 2002 and has continued to grow. MedPac (March 2007)

The underlying hypothesis of the model "was that patients who had the greatest degree of Clinical Severity, the most severe functional impairment, and the greatest need for rehabilitation and other services would yield the most home health resources." Abt Second Interim Report p. 32.

In an effort to design a system that would appropriately compensate providers for care and services rendered to all eligible patients, the PPS case mix adjuster assigned weights to all of the patient characteristics that CMS identified as neglected under IPS: Diabetes (17 points); impaired vision (6 points); parenteral nutrition (20 points); urinary incontinence (6 points); bowel incontinence (9 points); behavioral problems (3 points); toileting dependency (3 points); and transferring dependency (6 points). A huge amount of energy was devoted to the creation of an outlier system to mitigate the impact of super-expensive patients. Policies were adopted to allow unlimited episodes for all patients and to measure improved outcomes with the OBQI tool. **FOR THE FIRST TIME EVER**, the industry devoted significant resources to maximize the rehabilitation of the frail and elderly and achieve improved outcomes. From 2000 to 2003 there was a 17% increase in the number of home health beneficiaries with a primary diagnosis of diabetes. Health Affairs Vol. 22 No. 5 p. 146-155 (2003), Murtaugh et. al. The percentage of patients 85 years and older increased from 23% to 27%. This shift in patient population with emphasis on outcomes is the real driver of case mix weight change from 2000-2003.

The problem has been the case mix adjuster's inability to cope with therapy utilization by long term users, not the absence of these patients from the system. GAO reported that PPS was based on incomplete knowledge and that it had been difficult to develop a case mix adjustment method that adequately described resource use, PARTICULARLY FOR LONG-TERM USERS. (GAO April 2000) p. 19. "[P]rior research has demonstrated that the health status and patterns of care of long-term users of home health care, as described by functional limitations, differ substantially from those of short-term users. Id. p. 20.

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June 22, 2007

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

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

Dear Sir or Madam:

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

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

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

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

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

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

I. Introduction

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

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

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

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

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

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

Rule.

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

A. CMS' Position

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

B. Unsubstantiated Assumptions Underlying CMS' Position

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

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

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

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

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

C. Evidence Rebutting CMS' Position

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Adverse Effects of CMS' Position

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

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

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

III. Home Health Wage Adjustment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. Conclusions: Recommendations to CMS

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

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

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

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

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

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

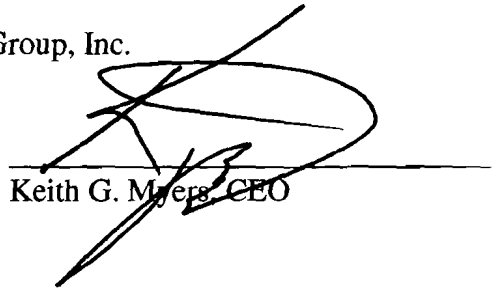
2. CMS should withdraw its proposal to increase the labor-related share of the base payment rate. This proposal in particular would severely harm home health agencies serving rural areas and, thus, threaten access for rural beneficiaries.

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

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

Sincerely,

LHC Group, Inc.

BY: 

Keith G. Myers, CEO

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

12-1

John Ilcyn, Controller
UPMC/Jefferson Regional Home Health, L.P.
1370 Beulah Road
Pittsburgh, Pa 15235

June 21, 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

UPMC/Jefferson Regional Home Health appreciates 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 recognize the importance of refining the home health PPS to reflect current patient characteristics and agency practices. But, we believe that caution is critical when undertaking multiple changes simultaneously. Of particular concern is CMS' plan to impose payment reductions at the same time that a major overhaul is being undertaken in the case-mix system. After reviewing the changes we offer the following recommendations.

Case-Mix

Medicaid Eligibility and Caregiver Access

There continues to be great concern about two considerations that were included in the case-mix research, but not in the proposed changes: Medicaid eligibility and caregiver access. We believe that both of these have a considerable impact on resource use. We realize that CMS conducted an analysis of both Medicaid eligibility and caregiver access and found that Medicaid as reported on OASIS did not have a significant impact on resource use. We also realize that caregiver access was found to have an impact, but CMS believes that adoption of this variable would be a negative incentive.

However, we strongly believe that these findings are questionable since they were based on OASIS data that does not effectively portray reality. OASIS questions for

caregivers are invalid for drawing conclusions about the actual nature and time of caregiver availability.

Recommendation

Compare the impact of Medicaid eligibility by studying resource use of a sample of home health patients enrolled in a Medicaid program from Medicaid files, against patients without Medicaid. Base the inclusion of Medicaid eligibility in the case-mix system on the results of further study.

Refine the OASIS items related to caregiver access in order to produce more reliable information about the actual roles caregivers play in meeting the day-to-day needs of home health patients, and the amount of time they are available. Conduct further research on the impact of caregiver access on home health resource use and adjust the case-mix system according to findings.

Diagnosis Codes

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

According to the Medicare Decision Support Access Facility at CMS, one in one thousand home health patients had a primary diagnosis in the V code category in 2001. However, in 2004 the same source reported over 40% of home health patients with a primary diagnosis in the V code category. We believe that this is the result, in part, of improper use of V codes. We also believe that the official ICD-9-CM coding guidance does not address the complexity of home health service delivery, resulting in a single aftercare code being selected as a primary diagnosis, when in fact multiple services addressing multiple patient needs are delivered during most home health visits. On another note, home health agencies do not often report all patient diagnoses that impact the plan of care and patient's rehabilitation potential.

In light of the expanded diagnosis list in the proposed rule, we expect home health diagnosis coding practices to change significantly. We believe that diagnosis coding practice changes are long overdue. More thorough and accurate diagnosis coding will produce a wealth of needed information about the home health patients' medical conditions that will lead to better care and more appropriate public policy.

We did note that one case-mix diagnosis was missing. Table 2b does not reflect the changes made to the 2005 official ICD-9-CM coding index which eliminated 436 (acute but ill-defined cerebrovascular disease) and added 434.91 (cerebral artery

occlusion unspecified with cerebral infarction). This is the most appropriate code for many stroke patients.

Recommendation

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

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

Early and Late Episodes

Recognition of the different characteristics of patients and resource utilization in early, versus late episodes of care, is an important refinement in the case-mix system. We have supported the delivery of home health services to chronically ill patients as a vital service that enables Medicare beneficiaries to remain in their own homes and reduces overall health care expenditures. We believe that this proposed change in the case-mix system will result in more appropriate distribution of funds for care of the long term patient. Therefore, we support this case-mix refinement.

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

Additional Therapy Thresholds

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

However, we are concerned about the impact of changes made to the point allocation for OASIS functional variables in relationship to therapy. The current case-mix system allocates "6-9" points for M0700 (ambulation) deficits. However, the proposed system allocates "0" points for ambulation deficits in two of the three equations, including both equations for 14 plus therapy visits. Nor are points allocated for the gait disorder diagnosis in 14 plus therapy visit equations. This proposed point allocation is counterintuitive.

Recommendation

Conduct further analysis of the impact of M0700 (ambulation) on service utilization in episodes with 14 plus therapy visits, or provide the rationale for eliminating points for this functional variable in 14 plus therapy episodes. Construct the case-mix system in accord with findings.

Low-Utilization Payment Adjustments (LUPA)

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

The rationale for the LUPA add-on addresses the fact that time to complete start of care OASIS adds an average of 40 minutes to the typical start of care visit. We believe that there are hidden costs related to LUPA episodes, and that significant information about the time and cost of the conduct of recertification OASIS assessment was not captured in the analysis of adjacent LUPA episode costs. A large percentage of LUPA episodes are for long term care patients that require 2 to 3 nursing visits per episode, many for a specific treatment that must be administered at a prescribed point in time. As a result of treatment timing, home health agency clinicians often must make an additional, non-chargeable visit for the sole purpose of completing an OASIS follow-up assessment in the required 5-day window. The costs for these visits are not captured in the Medicare claims data since agencies are prohibited from billing Medicare for assessment only visits.

Also, it is unclear how CMS intends to identify initial or only, versus adjacent LUPA episodes. The notice states that payments for LUPA episodes will be increased by $92.63 for initial or only episodes during a series of adjacent episodes, with adjacent defined as a series of claims with no more than 60 days between the end of one episode and the beginning of the next episode. However, it has been reported that CMS plans to program the LUPA add-on payment anytime the start of care date matches the "from" date on a claim, in the same manner that the RAP percentage is calculated.

We also have concerns about the proposal to exclude LUPA episodes from the medical supply payment. This will be discussed under the Medical Supply section.

Recommendation

Apply the LUPA add-on to all LUPA episodes. Provide more information as to how the claims processing systems will identify LUPA episodes that are eligible for add-on payments.

Non-routine Medical Supplies

We also have concerns about the proposed model for payment for medical supplies in light of the model's poor performance and R^2 of 13.7%. According to the analysis of home health claims and cost reports, only 10% of episodes include medical supplies. However, medical supplies are delivered to patients in a far greater number of episodes than reported, but many home health agencies fail to list non-routine medical supplies on final claims.

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

In addition, a number of costly non-routine medical supplies are not reflected in the medical supply case-mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that made their appearance on the home care scene after the start of PPS are those supplies needed for closed chest drainage. Failure to identify patient characteristics that would allow for payment for these, and other supplies not yet identified, will result in an underpayment of home health agencies.

Further, although we agree that elimination of SCICs is a necessary reform, we believe that agencies will be unable to seek reimbursement for medical supplies as there does not appear to be a mechanism to account for supply needs that surface after the initial start of care assessment has been completed. This could result in grossly inadequate payment.

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

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

Recommendation

Conduct additional research to identify other diagnosis and patient characteristics before proceeding with a separate case-mix adjusted non-routine supply payment based on patient characteristics. Do not proceed with the proposed non-routine supply model until more accurate data about the extent of supply use is determined.

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

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

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

CASE MIX WEIGHT ADJUSTMENT

PROPOSAL: CMS proposes to reduce the base payment rates by 2.75% for each of 2008, 2009, and 2010. The adjustment is based on the CMS conclusion that the increase in the national average case mix weight between 1999 and 2003 is due to factors unrelated to changes in patient characteristics. The original design of the case mix adjustment model set the average case mix weight at 1.0. That design is based on 1997 patient data. At the end of 2003, the average case mix weight is 1.233. CMS concluded that the change in case mix weight between 1997 and 1999 (1.0 to 1.13 (approx.)) is due to changes in patient characteristics. However, CMS further concluded that the change between 1999 and 2003 (1.13 to 1.233) of 8.7% is an increase without any relation to changes in patient characteristics. As a result, CMS proposes to adjust the base payment rate by 2.75% for each of the 3 upcoming years to prevent expenditure increases that are due to factors unrelated to patient characteristics.

Our 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.

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

Rationale:

1. CMS failed to consider the utilization of therapy services as a "patient characteristic." The HHPPS uses a case mix adjustment model that incorporates clinical, functional, and services domains in categorizing the characteristics of home health services patients. CMS specifically included a therapy threshold of 10 visits in an episode (MO825) as a means to distinguish patient types. CMS used the volume of therapy visits as a proxy for clinical and functional characteristics that were either unavailable or otherwise inadequately captured through OASIS. Instead, CMS attempts to invalidate the increase in patient episodes with 10+ therapy visits through evaluation of data from the Clinical and Functional OASIS domains, data that CMS itself concluded was inadequate to explain therapy service utilization in the original construction of the HHPPS case mix adjustment model. This internal inconsistency renders the CMS proposal fatally flawed.

2. In spite of the weakness set out above, the CMS OASIS data provides a strong indication that the increase in therapy services is directly related to changes in patient characteristics. The OASIS data referenced in the CMS proposal clearly depicts an increase in the clinical severity of patients admitted to home health services from 1999 through 2003. The percentage of patients assessed at C2 and C3 increased in each of these years. These assessments rely primarily on objective criteria and are not subject to manipulation and/or inaccurate interpretation of standards. Similarly, the period of 1999-2003 shows statistically material increases in the assessment of functional limitations. As with the Clinical domain, the functional assessments domain leaves little room for manipulation or erroneous interpretations. While CMS completely assumed that the scoring changes in the Clinical and Functional domains are related to policy clarifications, provider training, and other factors unrelated to home health services patients, the more logical assumption is that patient characteristics have changed. Corroborative factors for this more reliable assumption are set forth below.

The evidence further indicates significant change in patient characteristics from 1999 to 2003. These include:

- Home health users grew from 2.1 million to 2.4 million.
- The number of beneficiaries with a primary diagnosis of diabetes increased by 17%
- Patients with abnormality of gait increased by 50%
- Patients with wounds increased by 15 percentage points
- Patients with urinary incontinence increased by 8 percentage points
- Patients showed a substantial decrease in transfer capabilities
- There is a demonstrated Increase in cognitive function deficits
- Findings of dyspnea increased

CMS's dismissal of these changes as "modest" ignores the cumulative impact on the need for increased therapy services along with higher clinical and functional scores in the case mix weight. The increase in patients with ambulation and transfer deficits alone accounts for a significant portion of case mix weight growth from 1999-2003.

3. Medicare program reforms have changed the nature of patients referred to home health services. Further, Medicare payment changes reflect alterations in patient acuity. First, Medicare initiated claim oversight, tightening of eligibility standards, and payment restrictions for Inpatient Rehabilitation Facility (IRF) services during 1999-2003. As an expected result, the volume of patients admitted to home health care for rehabilitation services significantly increased. The data demonstrates both that the number of patients requiring therapy and the number requiring 10+ visits has increased in a manner corresponding with these program changes.

Second, Medicare has altered Inpatient Hospital services payments to reflect early discharges of patients to home health care. The institution of the Transfer DRG policy is a definite reflection of the increased acuity of patients admitted from hospitals to home health services.

Third, CMS data, cited in the proposed rule, indicates that there has been an increase in patients admitted to home health care from a Skilled Nursing Facility (SNF) stay. The HHPPS case mix adjustment model includes a scoring factor that reflects the CMS finding that patients admitted to home health services from an SNF are different than patients without a recent SNF stay and that such patients require more care.

4. The trends related to patient age indicate the patient characteristics changed between 2000 and 2003. Data shows that the percentage of home health patients age 85

and over increased from 23% to 27%. It can be readily concluded that this change in patient characteristics contributed to the increase in case mix weights.

5. During 2000 to 2003, home health agencies dramatically altered care practices to achieve improved patient outcomes. The onset of HHPPS brought a shift from dependency-oriented care to care designed to achieve self-sufficiency and independence. Indicative of this change is the significant increase in the use of occupational and physical therapy concurrent with the reduction in the use of home health aide services. The average number of home health aide visits in a 60-day episode dropped significantly between 1997 and 2003. Correspondingly, the use of Occupational Therapy and Physical Therapy use increased during that period. The purposes are obvious and the results are undeniable. Patient lengths of stay were reduced and clinical/functional outcomes improved.

The manner in which a patient is served in HHPPS is a "patient characteristic." That is demonstrated by the use of a Service domain in the case mix model as a proxy for patient characteristics that cannot be found in the clinical and function assessment elements of OASIS.

6. The growth in enrollment in Medicare + Choice and Medicare Advantage plans have shifted low acuity patients out of traditional Medicare, as this element of the Medicare enrollee population have been targeted for enrollment by the plans. Strong evidence exists that the nature of M+C and MA plan enrollees left higher need, higher cost Medicare beneficiaries within the traditional Medicare program.

7. The average annual per patient expenditures for home health services do not show that the increase in average case mix weights has increased Medicare expenditures. Instead, between 2001 and 2003, the average annual expenditures actually dropped from $3812 to $3497. This outcome for the Medicare program corresponds with reduced length of stay as triggered by increased use of rehabilitative services. While the increase in therapy led to an increase in case mix weight, Medicare expenditures were controlled and restrained in growth. In contrast, per patient inpatient hospital and SNF expenditures grew during that same period: $11,938 to $13,381 hospital; $7517 to $7965 SNF.

The growth in case mix weights must be viewed in a wider context than used by CMS. The case mix adjustment model sensibly incentivized the use of therapy services to modify care practices, achieving positive outcomes for both patients and Medicare. It is obvious that discouraging the use of therapy services through the proposed 2.75% / 3-year rate reduction would result in increased per patient and overall Medicare expenditures as a return to the dependent-oriented use of home health aide services extends patient lengths of stay.

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

9. The case mix weight starting point of 1997 is a foundation that is so fundamentally flawed that no meaningful comparison of case mix weight increase is even possible. The case mix adjustment model in use operates with such significant and unending weaknesses that attempting to evaluate scoring changes over time is the equivalent of using a person with a blindfold to judge the color of an object.

First, the model is built on a 1% sample of claims. In many of the case mix groups, insufficient data lead to numerous substituted judgments. Second, the explanatory power (R^2) of the model, originally estimated at 30+%, devolved to 22% by 2003 with it operating at an 11% R^2 in the absence of the therapy adjustment element (MO825). Since the CMS proposal rejects the therapy utilization element as relevant to patient characteristics in the case mix creep analysis, effectively CMS expects to use OASIS data elements that are unable to define patients correctly in 89% of all episodes to explain changes in case mix weights. Third, MedPAC found that the coefficient of variation exceeded 1.0 in over 60 of the 80 case mix groups. Any growth in average case mix weights through 2003 is easily explained by the inherent weaknesses in the model alone.

WAGE INDEX

PROPOSAL: CMS proposes to maintain the current policy of using the pre-rural floor, pre-reclassified hospital wage index to adjust home health services payment rates.

Our Position: We oppose the continued use of this outdated and inequitable wage index method.

Our Recommendation: CMS should replace its home health wage index policy with a method that achieves parity with hospitals in the same geographic market. Further, the wage index should be stabilized through the use of limits on year-to-year changes. This can be accomplished through the use of the rural floor standards and a proxy for hospital reclassifications. Alternatively, the method should be replaced with a BLS/Census Bureau data method as recommended by MedPAC.

Rationale: Home health agencies and hospitals compete for the same staff in a given geographic area. As such, the applicable wage indices should be comparable. Further, the use of a mechanism that limits year-to-year fluctuations in the wage index will offer predictability and stability to annual budgeting.

OUTLIER PAYMENTS

PROPOSAL: CMS proposes to maintain the current standards for applicability of outlier payment. Specifically, CMS proposes to continue use of a .67 Fixed Dollar Loss ratio (FDL).

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

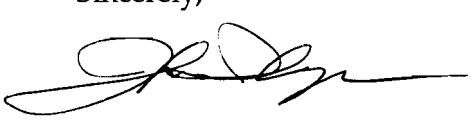
Our Recommendation: CMS should lower the FDL based on historical experiences to a level that ensures full use of the outlier budget.

Rationale: The CMS standards for outlier payment have failed to fully use the outlier budget in every year that the prospective payment system has been in place. The CMS estimate that an additional $130 million in outlier payment will be expended in 2008 through the use of the same standards as in use in 2007 is without any basis.

Conclusion

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

Sincerely,



John Ilcyn, Controller

The Home Care Network
Jefferson Health System

June 25, 2007

Extended Home Care
Home Health
Home Infusion Service
Hospice and Palliative Care
Rehab Equipment Services
Respiratory and Home Medical Equipment

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

RE: File Code CMS-1541-P

To all concerned:

Attached are our comments on this important proposal, along with two attachments. This proposal could set the stage for the on-going growth in the least costly, most highly preferred method for receiving care when patients are asked, or it could lead to a new round of retrenchment, and lowered availability of services for the nation's most vulnerable population, those over age 65.

We urge CMS to give careful consideration to each and every suggestion, and the detailed items discussed. If the proposal is adopted largely unchanged, care will return to a style from earlier times. The industry has transitioned from being largely one using paper record-keeping to one fully embracing information systems solutions and point of service technology. That transition was not without considerable costs to the industry, none of which has ever been reflected in increase reimbursement.

CMS can continue the success of home health, or it can see this sector decline in capability and innovation. This industry cannot absorb a massive reduction in funding as is expected from this proposal.

If you would like to discuss any of our comments directly, please call: 610-254-1402.

Very truly yours,

Theodore A. Bean

Theodore A. Bean
Financial Administration

The Home Care Network
Jefferson Health System

Extended Home Care

Home Health

Home Infusion Service

Hospice and
Palliative Care

Rehab Equipment Services

Respiratory and Home
Medical Equipment

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

RE: File Code CMS-1541-P

The Home Care Network, ***Jefferson Health System***, is pleased to provide you with our comments regarding this important initiative. We would like to express our support for the revisions to reflect more current patient characteristics. These changes coupled with the linking of co-morbidities will more closely track resource need. We also support the change to the tripartite/gradations approach for measuring higher therapy need. Lastly, we support the establishment of a Non-Routine Supplies (NRS) feature which should provide reimbursement value to those cases most likely to use supplies, although we urge CMS to consider higher rates, which we discuss more fully below.

Our detailed comments follow. We have two major concerns, and some other observations which we hope provide some further unique perspective on our assessment of these refinements.

Major Concerns:

As noted, two areas of the proposed rule cause concern:

1 - - that CMS has decided to add to the HHRG complexity by creating a "later" episode class of cases, and

2 - - the conclusion that the (theoretical) change in case-mix from the base 1997 data is indicative of anything other then a change in mix to higher needs patients.

#1 - - Higher "Later" Episode Reimbursement:

In our opinion, this aspect of the Proposed Rule should not be implemented. At a minimum, it is adding unnecessary complexity to the reimbursement

process, and at its worse, the data utilized regarding this issue does not appear correct (or is not consistent with our own patient population).

Based on our experiences under prospective payment, the majority of home health patients experience one episode of care prior to being discharged from services, and the costs associated with assessing the patient and developing, implementing and adapting an appropriate plan of care are usually incurred earlier in the episode rather than later. In addition, even those patients who experience two or more continuous episodes of care require more resources earlier in their care rather than later, as clinical staff members become more familiar and grow more accustomed to the patient and his/her healing progress, home environment, treatment plan compliance, etc.

We realize that there is a small percentage of patients (for example, wound care patients) who may experience more than two episodes of care, and whose disease state may require more expensive treatments during the course of working towards a finite resolution of their condition. Nonetheless, we have contacted a number of other home health providers in our local market, and even confirmed with our State Association that the real expense burden of care for the significant majority of home heath patients is front end loaded, and consequently we believe that any changes to the prospective payment system should be adapted to reimburse providers as such.

#2 - -Case-Mix "Creep" Reduction:

The Notice includes a proposal to reduce, annually, for each of calendar years 2008, 2009 and 2010, the HH-PPS base by even increments of 2.75%. CMS provides information in the Proposal citing the 1997 study, which designed the HH-PPS, predicated on a 1.0 rating while the 2003 average case-mix weight rose to 1.233.

CMS further details that the growth from 1.0 was partially related to changes in coverage and practice, while the HH-PPS was under development, and that only 8.7% of the growth is due to rating up-coding. CMS has not stated anywhere that the expected LUPA percentage from the 1.0 study was to drop to six-to-eight percent, while it has remained steady at about 12%, but certainly not yet at that level in 2003. A LUPA episode 'retains' its original case-mix weight, so if LUPA episodes had the same 0.233 growth they contribute to the appearance of up-coding, when no additional payments have been made.

Our general impression from reviewing the proposal is that CMS has not factored in the market-basket yearly reductions, plus the one-year market basket freeze, which presumably resulted from a "sense" this purported "creep" scenario was real. Higher margins, as asserted by MedPAC, needed to be reined in, and, naturally, higher margins would have resulted from any inherent rating up-coding raising the HHRG values.

Even if any portion of the 8.7% were real, most of any gain has already been mitigated by the market-basket adjustments and the freeze. In effect, those reimbursement reductions were the first bite of the apple to penalize all agencies for, perhaps, the sins of a few.

In addition, as CMS is aware, the high therapy-need cases, as are paid under the current PPS, added to the relative case-mix weight increase. In fact, moving from an "S0" to an "S2" was a 0.96 case-mix increase and from an "S1" to an "S3" was a 1.13 case-mix increase. So, by fully restructuring the entire Service domain with the tripartite/gradations, the Notice already compensates for this aspect of the alleged case-mix "creep". In effect, the second bite at the apple.

We are not at all convinced, from the information provided in the proposal, that CMS has justified a third bite at the apple. In fact, the information presented indicates that there has been a rise in case-mix values due to more serious aggregate conditions, which are generally at rates of increase well in excess of an 8.7% rate. We have attached a detailed review of the limited information from the proposal, and our assessment of what such information discloses.

In the context of that attachment, we offer several key observations

1. The Case-Mix values cited as the aggregate is not identified as to whether it is a Start-of-Care value, nor does it represent values actually reimbursed to agencies, in the aggregate, for 2003. In fact, some sources have stated that aggregate, per-patient, reimbursement declined in 2003 from the levels paid in the initial year of PPS.

If the 1.233 actually represented payments made to agencies in 2003, the average payment, per sixty-day episode, would have been $2,856 in 2003. This would have included both full term complete episodes and truncated payment episodes, such as: low utilization payment adjusted episodes, partial-episode-payment adjusted episodes, significant change in condition adjusted payment episodes and therapy down-code payment adjusted episodes.

Even today, after several additional market basket annual reimbursement increases, The Home Care Network is doubtful that the average Medicare PPS payment for a sixty-day period of care, after all down-codes have been made, is at $2,856 across the country, for all agencies. We ask CMS to disclose their average 2003 payment amounts, for all paid episodes, inclusive of full term and those experiencing down code adjustments.

As noted earlier, we support the new multi-level therapy threshold proposal. Since this single Service domain question could have such a large impact on agency reimbursement, there clearly has been a tendency to have a greater proportion of O.A.S.I.S. documents where Question MO825 is answered 'YES', regardless of the practice needs changing from a focus on dependency to a focus on developing patient independence. In fact, we are highly skeptical that the purported 1999-2000 base had a 27% MO825 'YES' success rate.

Clearly, answering Question MO825 'YES' more frequently will raise aggregate Case-Mix weights. However, if the Service need therapy threshold is not met, the Claims submitted by home health agencies are automatically down-coded by the intermediaries. In other words, a factor raising case mix, when using a Start-of-Care measure, is adjusted in the final payment, effectively lowering the case-mix. If an agency's billing system does not or did not in 2003 automatically adjust HIPPS codes, the observed and reported rate would be higher then it really is.

2. Patients now being seen in 2007 are older, on average, compared to those patients seen in both 1997 and 2003, the base periods from which CMS has developed its observations of an apparent case-mix creep. Older patients are typically more frail and have greater resource needs.

3. Another fact supporting greater resource need for the mix of patients now seen is that hospital average length of stay numbers have also declined, since 1997, 2003, and thru 2006. Typically, from a home health perspective, this translates into patients coming on to service who are sicker, and have more clinical, service and functional needs.

4. The Home Care Network was a participant in the original study in 1997, it has the same clinical management team in place now, and here are snapshot numbers:

Comparison	1999 Rate	2003 Rate	2006 Rate
Open wounds	28.60%	48.70%	48.18%
Abnormal gait	0.93	1.26	1.37
Urinary incontinence	8.30%	13.80%	15.10%
Decreased transfer	0.62	1.01	1.08
Cognitive function	13.00%	16.90%	19.28%
Dyspnea	0.89	1.11	1.09
Patient age over 85	26%	26%	29%
Disabled patients < age 65	9%	11%	12%

Every one of these important patient characteristic differences show growth percentages significantly greater then the 8.7%. The Home Care Network is seeing patients with greater needs.

Based on our comments above, we believe this provision of the proposal needs to be dropped. It is not supported by the facts presented – see attachment for more detail. It is duplicative of an issue addressed with the new MO826 tripartite/gradations rule for measuring increased Service domain reimbursement. It has also been largely accounted for by the one-year market-basket freeze and the annual 0.8% market-basket rate adjustments. It is also important that CMS factor in the continuing increase in patient needs through 2006, as reflected in our data.

Other Concerns:

Outlier Carve-Out:

The proposed rulemaking again adopts the so-called 5% set-aside for Outlier payments. Yet, it has been widely reported that such payments have been only in the range of 2-3%, for the five completed Claims years of the PPS Program. Accordingly, we believe it is inappropriate, methodologically, to continue to "reserve" a 5% share of total payments for Outliers when the percentage has clearly been less then three percent. We suggest that the new national average base calculation be adjusted to use a percentage no greater the 3%.

PEP Adjustment:

The Home Care Network has always viewed this feature of the rules as being harshly punitive. Home health agencies are required to discharge when no further skilled services are needed. For patients with chronic conditions, such as CHF, COPD or Diabetes, the best training in the world can not prevent a patient from going off a well developed and fully trained regimen of self-care, and having a return to service. Every agency should be able to take the patient back on care by simply re-opening the episode, just as presently is the practice for a resumption of care for a patient returning from a hospitalization. Any agency refusing to take back a patient would continue to be paid only for the period of time services were provided.

Non-Routine Supplies:

We do not find the levels proposed sufficient, at least for an agency such as ours with an active Wound Ostomy and Continence Nurse Team. Wound care since 1997 has changed significantly. There is greater use of more expensive products, for example 'silver' dressings and those with special properties to actively stimulate cell growth. Greater recognition of the need to stimulate cell growth has also brought about greater risk in avoiding or eliminating bio-burden, as use of killing agents, such as peroxide, a low-cost supply, continues to decline.

In addition, a whole new class of patient now can be treated with home care --- patients requiring chest thoracentesis or chest suction, where an innovative drainage system (Pleurex) has been in use for several years. This supply is the single most costly supply home health agencies use, we would guess, and it did not exist in either of the base periods cited.

Since supply costs taken from the filed cost reports are known to be an inadequate representation of the 'real' costs of supplies, we believe some mix escalation cost factor should be applied to the table values in the proposal. Our best estimate of this escalation value is that the table amounts should be increased by about 30%. CMS is not proposing

rates for 2003, but rates for 2008, yet treatment protocol changes since 2003 have shown a high level of change to new, more costly, technologies as knowledge has evolved.

Further Simplification for Higher Therapy Need Patients:

As noted, we wholeheartedly support the proposed tripartite/gradations changes for reimbursing higher therapy need cases. In fact, we suggest that MO826 ask only if the patient is expected to be a higher need case. To provide adequate cash flow for all agencies, since the final HHRG values would not be calculated until payment, we propose raising the Request for Advance Payment to become a fixed amount, measured as 75% of the base rate, or in the case of the notice under comment, the $2,300.

Conclusion:

The Home Care Network sees much in the proposal to provide a better matching of reimbursement to resources expended. We caution, however, that the implementation of a more complex "later episode" tier of services needs more study. Lastly, we find no justification for any case-mix "creep" proposal, recognizing that much of any such "creep" has already been taken away from the HHRG values with the market-basket adjustments and the restacking of the high-therapy threshold criteria, plus the data presented in the Notice show ratings generally greater then the 8.7% in need severity growth purportedly arising from the evaluation up-coding assertion.

We appreciate the time taken to review the above, and trust you will give our comments reasoned consideration.

The Home Care Network,
Jefferson Health System

The Home Care Network, *Jefferson Health System*

Home Health Services Division

Chart Reviewing the Notice of Proposed Rulemaking for the Medicare Program

Home Health Prospective Payment System Refinement

Case-Mix "Creep" Assessment

MO-question #	Cited Area of Measure	Responses from IPS Period	Responses from 2003	Relative Change	% Change (over 8.7% in bold)	The Home Care Network Assessment
MO175	Used inpatient rehab past 14 days	11%	13%	2%	**18%**	Resources Needed > 8.7% higher
MO200	Medical or treatment regimen change past 14 days	79%	85%	6%	8%	Greater Resources Needed
MO220	Prior Cond(1) Urinary Incontinence	15%	20%	5%	**33%**	Resources Needed > 8.7% higher
MO220	Prior Cond(3) Intractable pain	7%	9%	2%	**29%**	Resources Needed > 8.7% higher
MO220	Prior Cond(4) Impaired decision making	11%	12%	1%	**9%**	Resources Needed > 8.7% higher
MO230	Orthopedic Diagnosis Group	15%	22%	7%	**47%**	Resources Needed > 8.7% higher
MO230	Burns/Trauma Diagnosis Group	4%	2%	-2%	-50%	Lower Resources Needed
MO230	3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring	25%	31%	6%	**24%**	Resources Needed > 8.7% higher
MO240	2 - Symptoms controlled with difficulty, affecting daily functioning	57%	62%	5%	**9%**	Resources Needed > 8.7% higher
MO240	3 - Symptoms poorly controlled, patient needs frequent adjustment	16%	23%	7%	**44%**	Resources Needed > 8.7% higher
MO280	Life expectancy is 6 months or fewer	2%	7%	5%	**250%**	Resources Needed > 8.7% higher
MO290	High Risk Factors: Obesity	12%	14%	2%	**17%**	Resources Needed > 8.7% higher
MO380	Type of primary caregiver assistance: Environmental	85%	91%	6%	7%	Higher resources Needed but not addressed in proposal, or old rule.
MO410	Speech: Minimal difficulty in expressing ideas and needs	21%	23%	2%	**10%**	Resources Needed > 8.7% higher
MO420	Freq of pain: All of the time	10%	13%	3%	**30%**	Resources Needed > 8.7% higher

The Home Care Network, *Jefferson Health System*

Home Health Services Division

Chart Reviewing the Notice of Proposed Rulemaking for the Medicare Program

Home Health Prospective Payment System Refinement

Case-Mix "Creep" Assessment

MO-question #	Cited Area of Measure	Responses from IPS Period	Responses from 2003	Relative Change	% Change (over 8.7% in bold)	The Home Care Network Assessment
MO440	Skin lesion/open wound	36%	51%	15%	**42%**	Resources Needed > 8.7% higher
MO445	Pressure ulcer	5%	7%	2%	**40%**	Resources Needed > 8.7% higher
MO450	Number of pressure ulcers Declining at every stage	- - -	- - -	- - -	- - -	Lower Resources Needed
MO490	When Dyspneic: With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)	21%	23%	2%	**10%**	Resources Needed > 8.7% higher
MO500	Respiratory treatments at home: Oxygen	11%	12%	1%	**9%**	Resources Needed > 8.7% higher
MO520	Urinary incontinence: Patient is incontinent	23%	31%	8%	**35%**	Resources Needed > 8.7% higher
MO530	Urinary incontinence occurs: During the day and night	64%	67%	3%	5%	Greater Resources Needed
MO540	Bowel incontinence: One to three times weekly	3%	4%	1%	**33%**	Resources Needed > 8.7% higher
MO540	Bowel incontinence: Four to six times weekly	1%	2%	1%	**100%**	Resources Needed > 8.7% higher
MO560	Cognitive Functioning: Requires prompting	19%	23%	4%	**21%**	Resources Needed > 8.7% higher
MO570	When confused: In new or complex situations only	25%	30%	5%	**20%**	Resources Needed > 8.7% higher
MO580	When anxious: All of the time	1%	2%	1%	**100%**	Resources Needed > 8.7% higher
MO590	Depressive feelings reported/observed: Mood	19%	21%	2%	**11%**	Resources Needed > 8.7% higher
MO610	Behaviors demonstrated at least once/week: Impaired decision-making	10%	13%	3%	**30%**	Resources Needed > 8.7% higher
MO620	Frequency of Behavior problems: At least daily	3%	4%	1%	**33%**	Resources Needed > 8.7% higher

The Home Care Network, *Jefferson Health System*

Home Health Services Division

Chart Reviewing the Notice of Proposed Rulemaking for the Medicare Program

Home Health Prospective Payment System Refinement

Case-Mix "Creep" Assessment

MO-question #	Cited Area of Measure	Responses from IPS Period	Responses from 2003	Relative Change	% Change (over 8.7% in bold)	The Home Care Network Assessment
MO650	Current dress upper body: No assistance if clothing is laid out or handed to patient	24%	26%	2%	8%	Greater Resources Needed
MO670	Current bathing: Participates in bathing self but requires presence of another	21%	24%	3%	**14%**	Resources Needed > 8.7% higher
MO680	Current toileting: When reminded or assisted	20%	24%	4%	**20%**	Resources Needed > 8.7% higher
MO690	Current transferring: With minimal assistance or use of a device	47%	59%	12%	**26%**	Resources Needed > 8.7% higher
MO700	Current ambulation: Requires use of a device	58%	61%	3%	5%	Greater Resources Needed
MO700	Current ambulation: Able to walk only with supervision/assistance of another	58%	61%	3%	5%	Greater Resources Needed
MO710	Current feeding: Able to feed self independently but requires assistance	23%	30%	7%	**30%**	Resources Needed > 8.7% higher
MO720	Current meal prep: Unable to prepare any meals or reheat delivered meals	35%	38%	3%	**9%**	Resources Needed > 8.7% higher
MO730	Current transport: Able to independently drive a regular or adapted car; or uses a regular or handicap-accessible public bus	2%	1%	-1%	-50%	Lower Resources Needed
MO740	Current laundry: Unable to do any laundry	72%	76%	4%	6%	Greater Resources Needed
MO750	Current housekeeping: Unable to effectively participate in any housekeeping	52%	57%	5%	**10%**	Resources Needed > 8.7% higher

The Home Care Network, *Jefferson Health System*

Home Health Services Division

Facts from the Notice of Proposed Rulemaking for the Medicare Program

Home Health Prospective Payment System Refinement

Case-Mix "Creep" Assessment

With passage of the Balanced Budget Act of 1997, the Medicare Program was tasked with developing a prospective payment system for home health agencies. In another area, under the direction of the University of Colorado's Outcome Reporting and Enhancement Partnership (CORE), a project started in 1996 focusing on development of a new assessment reporting and outcome measurement tool was developing a form or document labeled the Outcome and Assessment Information Set (O.A.S.I.S.). The Medicare Program seized upon this tool as a substitute for measuring patient needs, and it became the backbone of the present Home Health Resource Group (HHRG) for measuring patient case mix.

After passage of the BBA of 1997, approximately fifty agencies who had been involved in the CORE effort were selected to provide data to Abt Associates, for use, as noted, in developing HHRG values. The Home Care Network was one of those agencies. To say that our agency practices the delivery of home care differently today then it did in 1997 is a certainty. As the Proposal indicates, in 1997, on average a regimen of care in 1997 saw the patient receiving over 36 visits while in 2003 that number had declined to just under 21 visits.

Why the seemingly dramatic change. Perhaps an old parable might suffice: You can feed a thousand people with a certain level of effort, but, if you teach farmers how to improve crop yields, a thousand people can be easily fed. Why the reference. Firstly, the focus of the CORE project was to find out what works, so patients have better outcomes. As a result, a change in focus, toward teaching the patients skills to become independent, and maintain that condition, has evolved. As the proposal indicates, activities of daily living and independent activities of daily living have resulted in the application of, for example, greater strength training being provided by physical therapists. Another example: Training in less exerting techniques, by occupational therapists, to enable patients to regain and maintain their ability to independently prepare meals versus a daily aide vist for this need.

We believe these real changes to the practice of delivery of home care have been clearly reflected in the slow rise in case mix weights, as doing for someone has been replaced by training them to do for themselves. At almost the instant the HH PPS started, agencies quickly realized that provision of large amounts of aide services, where the HHRG values provided no incremental reimbursement, could not be sustained. At that same time, however, agencies were also seeing, for the first time, that the O.A.S.I.S. tool provided a measurement basis for assessing if patients were making progress so that they could be safely discharged to the community.

The Home Care Network believes this has been extremely beneficial to the elderly population served by the Medicare Program. In addition, the core value of Americans being independent has been re-established for the treatment of homebound patients. We should not return to the dependency model.

Even though the population serviced by home health agencies is older then at the time the HH PPS began, and even though most observers would support a scenario that, on average, patients coming into home health care are sicker or more needy then they were those few short six years ago when the HH PPS commenced, this Proposal says otherwise. The proposal purports to find data that, seemingly out of the blue, thousands of clinicians seeing millions of patients are viewing those patients as sicker, only so their agencies can gain higher levels of revenue.

The Proposal gives no credit to the need for more instruction. The proposal gives no credit for a steady improvement in Outcomes. The Proposal gives no credit to home health agencies for changing their practices to accommodate the needs of their patients in the year 2007. We believe those patients have different expectations today then they did in 1997. At the other end of the spectrum, home health services payment growth has been among the slowest in all of the sectors covered by Medicare reimbursement. In fact, reimbursement payments for 2007 will still, most likely, remain below levels paid in 1998 for home health services, even before any adjustment for inflation, before costs for electronic systems and telehealth equipment are added to the mix.

Estimates have appeared in the trade press that this feature of the proposal will lower reimbursement to home health agencies by $7 billion, over five years. That is a significant reduction, based on so slim an argument of support. To base such a change on chaotic times when large numbers of providers left the industry would be folly.

The Home Care Network, *Jefferson Health System*

Comparative Review of Early/Later HHRG Values
Philadelphia Area CBSA

		Early (1st or 2nd) Episode Reimbursement	Later Episode Reimbursement	Later Lpisode Increase in Reimbursement	Percentage Increase in Reimbursement	7% Resource Cost Difference vs. Later episode Reimbursement
Under 13 Therapy Visits	C1F1S1	1,374.61	1,603.76	229.14	16.67%	9.67%
	C1F1S2	1,917.87	2,305.55	387.69	20.21%	13.21%
	C1F1S3	2,390.52	2,780.93	390.41	16.33%	9.33%
	C1F1S4	2,869.12	3,241.95	372.82	12.99%	5.99%
	C1F1S5	3,282.57	3,658.37	375.80	11.45%	4.45%
	C1F2S1	1,613.17	2,054.61	441.44	27.36%	20.36%
	C1F2S2	2,156.42	2,756.41	599.98	27.82%	20.82%
	C1F2S3	2,629.08	3,231.54	602.46	22.92%	15.92%
	C1F2S4	3,107.43	3,692.55	585.12	18.83%	11.83%
	C1F2S5	3,520.88	4,108.97	588.09	16.70%	9.70%
	C1F3S1	1,786.58	2,492.83	706.26	39.53%	32.53%
	C1F3S2	2,329.83	3,194.63	864.80	37.12%	30.12%
	C1F3S3	2,802.49	3,670.01	867.52	30.96%	23.96%
	C1F3S4	3,280.84	4,131.02	850.18	25.91%	18.91%
	C1F3S5	3,694.53	4,547.44	852.91	23.09%	16.09%
	C2F1S1	1,788.31	1,755.11	(33.19)	-1.86%	-8.86%
	C2F1S2	2,331.56	2,456.91	125.35	5.38%	-1.62%
	C2F1S3	2,804.22	2,932.29	128.07	4.57%	-2.43%
	C2F1S4	3,282.57	3,393.30	110.73	3.37%	-3.63%
	C2F1S5	3,696.27	3,809.48	113.21	3.06%	-3.94%
	C2F2S1	2,026.62	2,205.72	179.10	8.84%	1.84%
	C2F2S2	2,569.87	2,907.52	337.65	13.14%	6.14%
	C2F2S3	3,042.53	3,382.90	340.37	11.19%	4.19%
	C2F2S4	3,521.13	3,843.91	322.78	9.17%	2.17%
	C2F2S5	3,934.58	4,260.33	325.76	8.28%	1.28%
	C2F3S1	2,200.02	2,644.19	444.17	20.19%	13.19%
	C2F3S2	2,743.28	3,345.99	602.71	21.97%	14.97%
	C2F3S3	3,216.18	3,821.37	605.19	18.82%	11.82%
	C2F3S4	3,694.53	4,356.70	662.16	17.92%	10.92%

The Home Care Network, *Jefferson Health System*

Comparative Review of Early/Later HHRG Values
Philadelphia Area CBSA

		Early (1st or 2nd) Episode Reimbursement	Later Episode Reimbursement	Later Lpisode Increase in Reimbursement	Percentage Increase in Reimbursement	7% Resource Cost Difference vs. Later episode Reimbursement
	C2F3S5	4,107.98	4,698.55	590.57	14.38%	7.38%
	C3F1S1	2,311.00	2,270.62	(40.38)	-1.75%	-8.75%
	C3F1S2	2,854.26	2,972.42	118.16	4.14%	-2.86%
	C3F1S3	3,326.91	3,447.80	120.89	3.63%	-3.37%
	C3F1S4	3,805.51	3,908.81	103.30	2.71%	-4.29%
	C3F1S5	4,218.96	4,325.24	106.27	2.52%	-4.48%
	C3F2S1	2,549.31	2,721.48	172.17	6.75%	-0.25%
	C3F2S2	3,092.57	3,423.28	330.71	10.69%	3.69%
	C3F2S3	3,565.47	3,898.41	332.94	9.34%	2.34%
	C3F2S4	4,043.82	4,359.42	315.60	7.80%	0.80%
	C3F2S5	4,457.27	4,775.84	318.57	7.15%	0.15%
	C3F3S1	2,722.97	3,159.70	436.73	16.04%	9.04%
	C3F3S2	3,265.97	3,861.50	595.53	18.23%	11.23%
	C3F3S3	3,738.88	4,336.88	598.00	15.99%	8.99%
	C3F3S4	4,217.23	4,797.89	580.66	13.77%	6.77%
	C3F3S5	4,630.68	5,214.31	583.63	12.60%	5.60%
Over 14 Therapy Visits	C1F1S1	3,734.17	3,742.10	7.93	0.21%	-6.79%
	C1F1S2	4,196.42	4,059.43	(136.99)	-3.26%	-10.26%
	C1F1S3	4,493.69	4,516.48	22.79	0.51%	-6.49%
	C1F2S1	4,025.74	4,166.69	140.95	3.50%	-3.50%
	C1F2S2	4,487.99	4,484.03	(3.96)	-0.09%	-7.09%
	C1F2S3	4,785.26	4,941.07	155.82	3.26%	-3.74%
	C1F3S1	4,196.67	4,488.73	292.06	6.96%	-0.04%
	C1F3S2	4,658.92	4,806.07	147.15	3.16%	-3.84%
	C1F3S3	4,956.19	5,263.11	306.93	6.19%	-0.81%
	C2F1S1	4,315.08	4,473.13	158.05	3.66%	-3.34%
	C2F1S2	4,777.33	4,790.46	13.13	0.27%	-6.73%
	C2F1S3	5,074.60	5,247.26	172.66	3.40%	-3.60%
	C2F2S1	4,606.65	4,897.47	290.83	6.31%	-0.69%

The Home Care Network, *Jefferson Health System*

Comparative Review of Early/Later HHRG Values
Philadelphia Area CBSA

		Early (1st or 2nd) Episode Reimbursement	Later Episode Reimbursement	Later Lpisode Increase in Reimbursement	Percentage Increase in Reimbursement	7% Resource Cost Difference vs. Later episode Reimbursement
Over 14 Therapy Visits (contd.)	C2F2S2	5,069.15	5,214.81	145.66	2.87%	-4.13%
	C2F2S3	5,366.17	5,671.86	305.69	5.70%	-1.30%
	C2F3S1	4,777.58	5,219.51	441.94	9.25%	2.25%
	C2F3S2	5,240.08	5,536.85	296.77	5.66%	-1.34%
	C2F3S3	5,537.09	5,993.89	456.80	8.25%	1.25%
	C3F1S1	5,088.47	5,255.19	166.72	3.28%	-3.72%
	C3F1S2	5,550.72	5,572.52	21.80	0.39%	-6.61%
	C3F1S3	5,847.99	6,029.57	181.58	3.11%	-3.89%
	C3F2S1	5,380.04	5,679.78	299.74	5.57%	-1.43%
	C3F2S2	5,842.29	5,997.12	154.83	2.65%	-4.35%
	C3F2S3	6,139.56	6,454.16	314.61	5.12%	-1.88%
	C3F3S1	5,550.97	6,001.82	450.86	8.12%	1.12%
	C3F3S2	6,013.22	6,319.15	305.94	5.09%	-1.91%
	C3F3S3	6,310.48	6,776.20	465.72	7.38%	0.38%

CONCORD REGIONAL
VISITING NURSE
ASSOCIATION

June 25, 2007

Herb Kuhn, Director
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1541-P
PO Box 8012
Baltimore, MD 21244-8012
www.cms.hhs.gov/eRulemaking

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

42 CFR Part 484, Section II—Provisions of the Proposed Regulation; Subsection B—Rebasing and Revising the Home Health Market Basket

Dear Mr. Kuhn:

In this time of a rapidly aging population, the clients of Concord Regional Visiting Nurse Association are increasingly frail, often have one or more chronic diseases, and their illnesses have a higher acuity level. Adding to this situation are the challenges of increased fixed expenses and a shortage of home health workers. 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 organization to provide access to high-quality care to the Medicare population due to the 8.25% payment cut.

Case Mix

As a VNA, we 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 us, compromise our ability to maintain and increase access to cost-effective alternatives to institutional care and, in our view, is totally unjustified.

We are most disappointed and concerned about CMS' intention to cut 2.75% off of PPS payments for the next three 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.

In the proposed changes, CMS reports that at the end of 2003 the average case mix weight was 1.233. Concord Regional VNA's average case mix weight for fiscal year 2003 was 1.11947, for 2004 was 1.0978, and for 2005 was 1.09938. These are significantly below the average reported in the proposed rules.

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 being under-coded by many staff members from home care agencies. Concord Regional VNA has spent a significant amount of time providing educational programs for our professional staff focusing on accuracy in completion of OASIS documentation. 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.

CMS acknowledges and documents the fact that 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. This will force reductions in staffing, service 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.

Market Basket

The market basket index should be maintained, particularly until the other revisions of PPS are implemented and the impact of those changes is known. Those revisions will change many of the incentives that have produced margins in Medicare home health.

If payments are reduced and the market basket index is changed, Concord Regional VNA will have to re-evaluate its programs, with a potential reduction in services and staff. One of the programs at risk is our Senior Health Clinics, which provided 2,263 clinic visits for more than 550 seniors at monthly clinics at many locations in 2006. Downtown health clinics serve as a safety net for the uninsured.

Family Home Care CORP.

Date

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

Dear Sir or Madam:

Please accept these comments in response to the recently published proposed rules at 42 CFR Part 484 Medicare Program: Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008.

Please feel free to contact me if you have questions or need further clarification.

Sincerely,

Donna R. Goodwin, MN, RN-C
Vice President of Operations
9922 E Montgomery
Spokane, WA 99206
Family Home Care
509-473-4900

1. Refinements in the Case Mix Model: Due to the overall general complexity of the proposed revisions and the fact that the specifications for the changes have not yet been released, we believe there is not sufficient time to allow software vendors to prepare and test home health software in order to be ready by the January 1, 2008 date. Agencies that use point of care documentation systems do so because its more efficient to capture and analyze clinical information. We recommend the CMS allow for more time for vendor's to prepare and test their software.

   Removal of MO 610 as a case mix item – we believe that the CMS should retain this item regarding mental status as a case mix adjuster. Although there are additions of ICD-9 codes for certain mental health problem that will impact the reimbursement we do not believe this is an adequate trade off and agencies will be penalized unfairly. Patients seen in home health are very complex and this is frequently impacted by deficits in their mental status requiring more resource to care for them safely. In addition patients may demonstrate behaviors noted in MO610 which leads to increased care needs and not have an established ICD-9 psychiatric related diagnosis so again this will result in an inaccurate picture of care needs.

   Removal of MO175 – Patients referred to home health care directly from a hospital stay are frequently more acute and require more care especially when the hospital stay was short due to DRG related issues. We recommend that MO 175 be retained as a case mix variable but the points should be applied to patients who have been admitted directly from a hospital. This is not the case now. Further, the fact that a patient was hospitalized puts the patient higher on the risk assessment tools many agencies use to identify patients at risk for acute care hospitalization. This is something the CMS has insisted that agencies work to decrease. Given this, we should be able to capture additional reimbursement to allow for sufficient visits to keep patients from being readmitted to the hospital. We disagree that the burden outweighs the potential benefits.

   Exclusion of variable of dual eligible patients - we recommend the CMS develop points related to this variable for patients with both Medicare and Medicaid. This population is generally more complex to care for and creates additional costs to the agency that we should be reimbursed for. The incidence of non-compliance tends to be higher in this population. Given there is no other variable to capture this we recommend that this variable be factored into the case mix model. We disagree with the CMS assertion that there would be an additional administrative burden that would out weigh the benefit of this item contributing to the case mix model.

   Exclusion of variable of caregiver support – Patients without an established and reliable caregiver are more costly to care for and more difficult to achieve outcome improvement. We recommend this item be added as a variable to be factored into the case mix model.

sufficient evidence to substantiate this or to justify the 2.75% decrease. Providers must be well educated and fully understand the nuances of the OASIS data set and the impact on reimbursement in order to be adequately compensated to care for an increasingly frail population with acute needs. CMS should reconsider their stance on this and eliminate the 2.75% reduction. Overall the CMS proposes a reduction in the national average base rate for 2008 to $2300.60. The more that is cut from our reimbursements the fewer resources we have to care for patients and to meet CMS mandates such as decreasing unnecessary acute care hospitalization (ACH). In order to have an impact on the ACH rates, agencies must use several methods all of which cost the agency money. For example front loading the visits, adding more visits in some cases, adding telehealth, etc. We need the resources if we are going to meet this mandate.

6. The four equation model: The use of three different therapy thresholds, the addition of more HHRGs up to 153, the addition of more points for some diagnoses results in a very complex model to predict reimbursement. As stated previously we are concerned that there is not adequate time for vendors to revise and revamp their software systems and to test before the effective date. We recommend a phase in period where vendors must begin testing by January 1, 2008 and fully implement by July 1, 2008.

Lastly unrelated to this proposed regulation but very important to beneficiaries is to revise the regulation requiring that orders and plans of care for home health patients be signed by a physician. We recommend that this regulation be revised to allow nurse practitioners to be able to sign plans of care and orders similar to the hospice benefit.

Thank you for the opportunity to respond to this proposed regulation.

Sincerely,

Donna R. Goodwin, MN, RN-C
Vice President of Operations
Family Home Care
Spokane WA

VIRGINIA ASSOCIATION FOR
HOME CARE AND HOSPICE
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16.

Home Health
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Medicaid Personal Care
Medicaid Skilled Home Health
Infusion Therapy
Companion Services
Durable Medical Equipment
Pharmacy
Case Management
Consultants

June 14, 2007

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

RE: 42 CFR Part 484 Home Health PPS Refinements

Dear Sir:

The Virginia Association for Home Care and Hospice (VAHC) is submitting comments regarding the proposed refinements to the home health prospective payment system.

Provisions of the proposed regulations

VAHC is in agreement that refinements to the case-mix model that match resource utilization with reimbursement are the appropriate payment mechanism for home health. We are however concerned with the results of the CMS analysis of claims data that indicates a significant increase in the observed case-mix since 2000, which is proposed due to changes in coding practices and documentation, rather than to treatment of more resource-intensive patients. We question the statistical approach to this claim, which we believe does not adequately reflect the complexity of patients or resource utilization. Moreover, given how morbidity and mortality have been compressed and the changing nature of health care delivery modalities, the assumptions are significantly flawed given the approach utilized.

8001 Franklin Farms Drive, Suite 110, Richmond, VA 23229
(804) 285-8636 | FAX (804) 288-3303 « email vahc@vahc.org | www.vahc.org

VAHC does not support the reduction of the national standardized 60-day episode payment rate by 2.75 percent per year for three years beginning in CY 2008. In addition, given the past 24-months of high gasoline prices and increased cost of other inputs to services any reductions in episode payment rates at this time would be inappropriate.

The proposed case-mix model includes a proposal to replace the current therapy threshold at 10 visits per episode with three new therapy thresholds at six, 14, and 20 therapy visits. VAHC supports the need to more accurately reimburse providers for therapy services. We do however remain concerned with the emphasis that the overall reimbursement system places on therapy and would support a system that provides for the utilization of restorative nursing as a substitution for therapist visits. The expansion of this type of service utilization will ultimately provide better patient outcomes and address the growing demand for restorative services.

VAHC supports the proposed modifications to the low utilization payment adjustment (LUPA) and the elimination of the significant change in condition (SCIC) payment adjustment.

VAHC also supports the proposed revision in the way non-routine medical supplies (NRS) are accounted for in the standardized 60-day episode payment rate.

VAHC strongly supports CMS efforts to restructure the system and to replace a poorly functioning case-mix adjustment model.

Thank you for the opportunity to submit comments regarding the proposed refinements to the home health reimbursement system.

Sincerely,

Marcia Tetterton

Marcia A. Tetterton, MS
Executive Director

HOME CARE and HOSPICE

June 19, 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

Kno-Wal-Lin (KWL) Homecare and Hospice (provider #20-7013) is a Medicare certified Home Health provider located in Rockland, Maine. 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 appreciate the consideration that the Centers for Medicare & Medicaid Services (CMS) has given to questions and comments you have received over the years in the proposed revisions to PPS structure and case-mix. We believe that the adoption of many of the recommendations made by our agency and others, such as elimination of the Significant Change in Condition (SCIC) policy, will improve the payment system by allowing us to devote more of our time and attention toward the improvement of patient care.

We recognize the importance of refining the home health PPS to reflect current patient characteristics and agency practices. But, we believe that caution is critical when undertaking multiple changes simultaneously. In the background 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

Rockland: 170 Pleasant Street, Rockland, Maine 04841 • (207) 594-9561 • Fax: (207) 594-1498
Waldo: 147 Waldo Avenue, Suite #106, Belfast, Maine 04915 • Tel 207-338-2002 • Fax 207-338-2206
Lincoln: 605 Route One, Suite #2, Newcastle, Maine 04553 • Tel 207-563-5119 • Fax 207-563-8561

nearly doubles the complexity of the system. After in-depth analysis of the proposed refinement regulation and review of opinions from researches, financial and policy experts, and home health providers, we offer the following recommendations:

Elimination of MO175

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 this same reason.

Early and Late Episodes

We were especially pleased that CMS plans to have the claims processing system automatically adjust final claims to reflect correct responses to early/late episodes, both upward and downward based on information in the common working file (CWF). This action will alleviate the burden on providers that would otherwise exist if we had to conduct ongoing monitoring of the CWF for adjacent episodes and withdraw and resubmit a revised claim should an error be discovered.

Additional Therapy Thresholds

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

Low-Utilization Payment Adjustments (LUPA)

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

Non-routine Medical Supplies

We support the proposal to provide additional payments for non-routine medical supplies based on the severity level. We would like to note that there are a number of costly non-routine medical supplies that are not reflected in the medical supply case-mix model. The most common of these supplies are for patients with ostomies, other than for bowel elimination, such as: tracheostomy, gastrostomy, and artificial openings of the urinary tract (nephrostomy, urethrostomy, ureterostomy). Other extremely costly bundled non-routine medical supplies that made their appearance on the home care scene after the start of PPS are those supplies needed for closed chest drainage. Failure to identify patient characteristics that would allow for payment for these, and

other supplies not yet identified, will result in an underpayment of home health agencies.

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

Case Mix 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. We feel that 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. 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. We feel that CMS should withdraw its proposal to reduce base payment rates by 2.75% in 2008, 2009, and 2010. CMS should design and implement an evaluation method to analyze changes in case mix weights that utilizes proper standards related to the home health case mix adjustment model concept of "patient characteristics." Further, CMS should include relevant factors in this analysis such as changes in per patient annual expenditures, patient clinical, functional, and service utilization data, and dynamic factors in the Medicare system that impact on the nature of patients served with home health care. During 2000 to 2003, providers dramatically altered care practices to achieve improved patient outcomes. The onset of HHPPS brought a shift from dependency-oriented care to care designed to achieve self-sufficiency and independence. Indicative of this change is the significant increase in the use of occupational and physical therapy concurrent with the reduction in the use of home health aide services. The average number of home health aide visits in a 60-day episode dropped significantly between 1997 and 2003. Correspondingly, the use of Occupational Therapy and Physical Therapy use increased during that period. The purposes are obvious and the results are undeniable. Patient lengths of stay were reduced and clinical/functional outcomes improved.

SCICs

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

Home Health Care Quality Improvement

The regulation proposes that two additional quality measures be added to the ten already required. In order to reduce the regulatory burden, we recommend that if CMS adds two new measures, you delete two of the existing measures to keep the total number of quality measures at ten. In testing patient level quality measures and continuing to refine the current OASIS tool, we recommend that CMS make every effort to reduce the total number of OASIS items and, thereby, the regulatory burden of the OASIS on providers.

Wage Index

CMS proposes to maintain the current policy of using the pre-rural floor, pre-reclassified hospital wage index to adjust home health services payment rates. We would like CMS to replace its home health wage index policy with a method that achieves parity with hospitals in the same geographic market. Further, the wage index should be stabilized through the use of limits on year-to-year changes. This can be accomplished through the use of the rural floor standards and a proxy for hospital reclassifications. Alternatively, the method should be replaced with a BLS/Census Bureau data method as recommended by MedPAC. We compete with the hospital within our healthcare system for the same staff in a given geographic area. As such, the applicable wage indices should be comparable. Further, the use of a mechanism that limits year-to-year fluctuations in the wage index will offer predictability and stability to annual budgeting.

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

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

Donna DeBlois

Donna DeBlois, Executive Director
Kno-Wal-Lin Homecare and Hospice
170 Pleasant Street
Rockland, Maine 04841

LarsonAllen

101 North Tryon Street, Suite 1000
Charlotte, NC 28246-0108
704-998-5200, Fax 704-998-5250

June 22, 2007

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1541-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8012

RE: CMS-1541-P Medicare Program; HH PPS Refinement and Rate Update for Calendar Year 2008

Directory Board:

We are writing to you on behalf of our home health clients. I am a Principal with LarsonAllen LLP and have worked in health care accounting for nearly 30 years. Our firm serves hundreds of home care and hospice providers across the country through our accounting and advisory/consulting services. We are members of various State and National associations representing the home care and hospice industry. We serve on multiple committees for these organizations and have served on two national task forces; one worked with the home care industry to implement Medicare's home health prospective payment system (PPS) and the other was involved with the training of providers in the preparation of the Medicare hospice cost report. Our team of professionals is well versed on the issues that confront the home care/hospice industry and would like to give some thoughts on the following issues:

Provisions – 2.9% Market Basket Index (MBI)
I strongly encourage Congress to maintain at least a 2.9% MBI.

Provisions – 2.75% Case Mix Creep
I would suggest that this be eliminated or reduce the 2.75% base rate reduction. Changes in patient population, conflicting CMS instructions, and staff learning curves all play into the increase in the case mix. The original rates were based on a relatively small sample and the refinement analysis is now too old for appropriate consideration.

Provisions – LUPA
I fully support CMS' proposed change to increase the LUPA rate by $92.60 for the first or sole LUPA episode. Further, I encourage CMS to apply the same consideration to all LUPA episodes. Although LUPAs represent a relatively small number of patients, the administrative costs extend beyond the first LUPA episode. Our inability to cover costs may negatively impact access to medically necessary care for those long-term care patients, i.e., catheter care or B12, who would otherwise be placed in a more costly alternative.

Provisions – SCIC
I fully support CMS' plan to eliminate the SCI.

Provisions – Non-Routine Supplies (NRS)
I agree with CMS' concept of the NRS add-on; however, it 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. I fully support the proposed NRS add-on and encourage CMS to continue to study the supply issues with future data.

Provisions – Non-Routine Supplies (NRS)
I encourage CMS to allow a NRS add-on using diagnostic categories. Do not eliminate the NRS for LUPA episodes. The previous allocation in the LUPA rate of $1.96 assigned to NRS did not adequately cover the costs of a medically necessary NRS. This refinement excluded any update to NRS and may limit or negatively impact caring for patients.

Provisions – Outlier Issue
I would like to recommend that CMS maintain the current outlier standard and allow any unused allocation to be folded back into HH PPS. The 140 million CMS state they are putting into the Medicare Home Health Program is not a realistic figure. The real number is more like 10 million plus 3.9 million outlier hold back equals almost 14 million, 1/10 of your stated amount. I would recommend that CMS allocate 3% (3.9 million) of the 130 million for outlier payments, which should more than cover the national outlier rate, the remaining 97% of the proposed outlier allocation should be shifted to the base rate.

Provisions – OASIS Changes
I would like to encourage CMS to make the planned OASIS changes that exclude M0175 and M0610 and add M0470, M0520 and M0800. I fully support this change.

Provisions – Therapy Auto-Adjust
I fully support the provision for auto-adjusting therapy claims.

Provisions – Case Mix Refinement – Early / Late Episodes of Care & CWF
I would like to recommend that CMS 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, I would 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, it is slow in posting claims processed making it difficult to clearly determine status and access to care. Adding the Early/Late EP distinction would magnify the complications and may delay appropriate access to care.

Provisions – ICD-9 Coding
I fully support the use of more variations in case mix variables.

Provisions – ICD-9 Coding – Updated Guidelines
I would like to encourage CMS to update the ICD-9 list with the most recent guidelines.

Thank you very much for accepting my suggestions. If you would need further clarification on any of the issues discussed above, I can be reached at 704/998-5216 or by email at gmassey@larsonallen.com.

Sincerest regards,

LarsonAllen LLP

Gary R. Massey, CPA
Partner

Cc: AHHC
Congressman Price

GENTIVA®

June 25, 2007

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

RE: CMS-1541-P

Dear Acting Administrator Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) May 4 proposed regulation reflecting changes to the Medicare home health prospective payment system (PPS) and outcomes assessment and information set (OASIS).

Gentiva Health Services is the nation's largest provider of comprehensive home health and related services, with over 300 service delivery locations in 35 states. Last year, Gentiva provided needed healthcare to over a half million patients comprising all age groups and payer sources. We extend our reach to all 50 states through our CareCentrix managed care unit and its more than 4,000 credentialed, third-party provider locations.

Our company is known for its dedication to clinical excellence, as evidenced by our desire to work closely with CMS and other organizations to elevate clinical standards and achieve greater efficiency, including our participation in the CMS-HHQI national quality campaign designed to reduce avoidable hospitalizations of home care patients and help save Medicare more than $2.7 billion annually. We are also known for the creation and implementation of unique, specialized services that have thus far addressed the key health needs of over 140,000 older Americans. Our published national outcomes have demonstrated the ability of these programs to deliver improved care to Medicare patients with increased efficiency.

Since the implementation of the Medicare PPS reimbursement system in 2000, this is the first opportunity for a more complete, and comprehensive review of the PPS and OASIS systems. We are pleased to participate in this process and believe that the proposed regulation offers a mixture of both positive and potentially negative changes affecting the care delivered to aging Americans in their preferred home settings.

Gentiva would like to preface its comments on the specific proposals by requesting that any final rule include a realistic implementation schedule to reflect the complexity and resulting financial and structural burdens on home health and government systems. CMS should, thus, establish a grace period during which CMS and the industry would be given appropriate time after the issuance but prior to the effective date of a final rule to educate administrative staff members and clinicians, revise operational processes and procedures and complete required system changes.

Following is a brief summary of our comments on the proposed regulation, with additional detail on each to be provided at a later point in this letter:

- **Case Mix Creep:** Gentiva requests that CMS reconsider the proposed reimbursement reductions relating to the so-called "case mix creep." If this is not possible, we would urge reconsideration of the calculation methodology as it relates to the assumed outlier percentage applied to the 2007 base rate.
- **Case Mix Refinement:** Gentiva recommends that the final rule eliminate the early/late distinction and redistribute the weighting to all the episodes by creating a two-equation model that excludes reference to the enhanced reimbursement for the third and fourth episodes, a move that would reflect the way the majority of patients are currently receiving care. It would also avoid the potential for the reimbursement model to reduce the incentive for efficient care, drive up costs and possibly reduce patient independence.
- **CYO8 2.9% Annual Update:** In determining the annual update in the final rule, Gentiva requests that CMS use data from sources that more accurately reflect the realities of the current environment experienced by home health agencies, particularly with regard to rising recruitment, retention, transportation/fuel and other costs.
- **New MO110 OASIS Item:** Gentiva would recommend the two-model approach to alleviate concerns related to the MO110 and the lack of appropriate and real-time information. We further suggest that CMS develop a process to ensure that the Common Working File (CWF) provides real-time or more accurate data based on claims processed.
- **Doubling HHRGs:** Gentiva supports the change to a two-equation model, but believes that any final rule must consider the financial and operational impact of this major overhaul of the current PPS/OASIS structure on both home health agencies and the government. As a result, as mentioned above, we are asking that the final rule include a grace period for the industry to implement and adjust to any changes that emerge.
- **Therapy Thresholds Adjustments:** While Gentiva advocates the two-equation model, we support:
  1) the implementation of additional therapy thresholds,
  2) the smoothing effect of the graduated payment methodology,
  3) CMS plans to automatically adjust claims for therapy visits as outlined by the number of therapy visits, and
  4) the fact that adjustments will be made both up and down for therapy visits.
- **Non-Routine Medical Supplies (NRS) Case Mix:** Gentiva appreciates the CMS effort to appropriately reimburse for patients whose diagnoses reflect greater usage of NRS, and to ensure that these patients receive the appropriate NRS reimbursement. However, the current proposed case mix methodology is overly complex and we believe it requires simplification and additional study.

- **Outlier Provision:** Gentiva recommends that CMS allocate $3.9 million of the $130 million in the proposed outlier amount to the provision. Since there is strong historical data to suggest that no more than 3% of the outlier allocation will be utilized, it would be reasonable to have the additional dollars folded back into the PPS.
- **PEP Provision:** Gentiva appreciates the request by CMS for further consideration of possible modifications to the PEP and asks that PEP be considered from the beginning of the episode rather than the first visit due to care coordination activities. We further believe that agencies should be made whole by receiving at least the LUPA rate if the episodic payment would be lower than the LUPA.
- **Home Health Quality Measures**: Gentiva strongly supports the "evolution" of the OASIS tool to reflect healthcare improvements and clinical sophistication within home health. The evolution process should drive widespread adoption of best practices to achieve optimal clinical outcomes.
- **ICD-9 Coding Provisions:** Gentiva believes the use of more specific clinical indicators for ICD-9 coding is a positive change within the proposed regulation and requests that any final rule incorporate the most recent ICD-9 changes.
- **SCIC Provision:** Gentiva supports the elimination of the SCIC policy and appreciates CMS' acknowledgement of requests from home health providers to eliminate it.
- **OASIS Clinical Changes:** Gentiva strongly supports the continued review of the OASIS tool and the inclusion of specific disease state clinical information relating to the patients.

BACKGROUND INFORMATION

Gentiva believes that CMS and other stakeholders – as they deal with the health needs of an aging population expected to nearly double between 2005 and 2020 -- must consider the key healthcare principles of the Institute of Medicine (IOM) in developing comprehensive policies that align regulatory and reimbursement decisions for more effective and efficient care.

The IOM's key principles focus on care that is *safe, effective, efficient, patient-centered, timely and equitable*. A number of policymakers already advocate these principles as a roadmap for fulfilling the needs of Medicare beneficiaries and developing reimbursement and other policies that achieve the long-term goals of both government and healthcare providers.

Gentiva believes that the home health industry offers critical and timely solutions to the financial challenges of the Medicare program and – with appropriate government support -- has the potential to provide an even greater range and scope of rehabilitative, acute and long-term care services for our nation's seniors. In fact, the home health industry is already applying the IOM principles in delivering care to Medicare and other patients, as follows:

- Home health providers offer the opportunity for Medicare patients to receive ***safe*** treatment while they remain in their own homes.
- Home health services have been proven to be ***effective*** for rehabilitation and acute and chronic conditions, based on government, independent and industry research.
- Home care services are ***efficient,*** offering the Medicare program significant savings over more costly facility-based care.
- Home health is ***patient-centered***, as evidenced by the increasing breadth and sophistication of health services offered outside of institutions, as well as numerous surveys documenting

the overwhelming preference of patients to remain in their homes and age in place. The provision of services in the patient's residence drives patient comfort and creates a positive environment for them to learn self-care and manage their illnesses.

- Home health services are ***timely***, providing care within 24 hours of either discharge from the facility or following a referral from a physician or other source. And the continued interactions between home health agencies and the patient help to ensure a more complete understanding of their health conditions and compliance with next steps in their treatment.
- And finally, home health services are ***equitable***, providing care and treatment to all patients in a wide range of settings and environments.

Home healthcare's achievements in quality and efficiency are already well-documented by published data and research, including the following points:

- **Medicare home health services are an effective and less costly alternative to institutional care.** A February 2004 Joint Economic Committee brief produced these cost comparisons by episode of care:

Long-Term Care Hospital	***$35,700***
Inpatient Rehabilitation Facility (IRF)	***$12,500***
Skilled Nursing Facility (SNF)	***$ 8,300***
Home Healthcare Services	***$ 4,000***

- **Medicare home health providers deliver acute, post-acute, rehabilitative and chronic care, including disease management services, with positive clinical outcomes and significant potential cost savings.** The Medicare Payment Advisory Commission (MedPAC) came to a similar conclusion in its June 2005 Report to Congress that compared home health services to other post-acute care providers. MedPAC said that, compared with patients who went home after surgery, "patients who used IRFs and SNFs are more likely to be dead or institutionalized by 0.18 and 0.46 percentage points, respectively." MedPAC also found that "patients who use IRFs cost about $8,000 more in Part A spending than those who go home after surgery, and patients who use SNFs cost about $3,600 more in Part A spending than those who go home after surgery."

- **A growing body of independent research is confirming the significant capability of home care to address important national health issues. Here are several examples:**

  - **A three percentage point reduction in the national rate of avoidable and unexpected hospitalizations among Medicare home health patients could help more than 110,000 Americans remain home each year and reduce Medicare expenditures by more than $2.7 billion annually.**
    – Briggs Corporation 2006 study

  - **Elderly heart-failure patients receiving specialized care *in the hospital and at home* had a better quality of life and fewer hospital readmissions, resulting in a nearly 38% savings in Medicare costs.**
    – NIH-funded 2004 study

  - **Heart disease patients who received home visits by health care personnel after hospital discharge reported better quality of life than those who received no visits.**
    – Duke University 2003 study

- **Patients undergoing hip and knee replacements were less likely to end up in more costly institutions when they were discharged directly from the hospital to homecare after surgery. Home-based rehabilitation could save $3,500 to $8,000 per episode over similar treatment provided by skilled nursing or inpatient rehab facilities.**
  – Rand Corporation 2005 study

- **Providing hospital-level care in an elderly patient's home appears to be feasible and safe, and may reduce costs. Fewer patients in the home group than the hospital group experienced critical complications and fewer died. Costs averaged $5,081 and $7,480, respectively, indicating about a one-third reduction in costs for the home group.**
  – Research study reported in the Annals of Internal Medicine, *Dec. 6, 2005*

- **An intensive care coordination program of cancer patients that included 22% more homecare days and 62% more hospice days resulted in 30% fewer emergency room visits and 38% fewer hospital admissions than cancer patients who didn't receive the intensive care coordination. The program saved more than $18,000 per patient, on average, with virtually no change in survival rates.**
  – Blue Shield of California study release Feb. 2007

- **Multiple national and regional opinion surveys over the years have shown the vast majority of Americans overwhelmingly prefer and expect to receive their healthcare at home. For example, an early 2006 study by AARP revealed that more than three-quarters of their members said they would prefer to receive long-term care in their own homes or in home-like settings.**

With all of these elements in mind, Gentiva would like to present a more detailed view of its recommendations and comments regarding the proposed regulation.

Case Mix Creep/Upcoding Reductions

Gentiva Recommendation: Gentiva supports a two-part recommendation to the "case mix creep" provision and asks CMS to reconsider the proposed reductions due to "case mix creep." It should consider other factors as outlined below – especially the change in characteristics of the "typical" Medicare patient -- which counter the premise that home health agency "upcoding" should result in a significant reduction.

Secondly, calculations below will show that the 2.75% proposed reduction for 2008 will actually amount to 2.97%. Thus, we also recommend that the calculation be applied to the 2007 base rate with an adjustment based on the percent of outlier that is actually used (between 2% to 2.5%) rather than the assumed outlier percentage of 5% to achieve the correct reduction.

Additional Comments: The proposed regulation suggests that home health agencies have inappropriately changed their coding processes, indicating a shift by home health agencies to "upcode" or seek increased funding. As a result, CMS has proposed a cumulative 8.7% reduction over the next three years, and beginning in January 2008. Gentiva opposes the rationale behind the reduction for the Medicare home health benefit because the characteristics of the "typical" Medicare home health patient have changed since the implementation of PPS in 2000, due primarily to:

- a change in the home health reimbursement system to support care for patients with rehabilitative needs, acute illnesses and skilled services;
- the discharge of patients from the hospital to the home "quicker and sicker" due to changes in the hospital environment;

- a changing patient demographic; and
- changes affecting other Medicare providers, such as the implementation of the 75% regulation for inpatient rehabilitation facilities.

Medicare home health beneficiaries include healthy "young-old" to "frail-old" individuals. And in the middle is a diverse population of aging individuals with varying levels of disability, including patients suffering from complex co-morbid conditions requiring skilled services to help them better manage at home. Medicare home health services have evolved to support and sustain this new kind of Medicare beneficiary.

Because of this evolution of Medicare home health services, the industry now applies a higher level of clinical intervention earlier in the patient's treatment. The goal is to educate patients on their illnesses or disease states, provide training on treatment options and teach self-care, and help patients and their families develop confidence to ensure ongoing compliance with their treatment regimens.

While earlier Medicare home health services involved a significant number of home health aides, this paradigm shift has resulted in the deployment of more highly-skilled, better- compensated nurses, therapists and social workers. As you know, these skilled professionals have additional training and licensure requirements to ensure even higher levels of clinical care. While these changes have reduced the average length of stay from 150 days in the 1990s to less than 90 days today, the services are more resource-intensive and are delivered by a more costly, more experienced caregiver.

CMS has concluded that, through its own administrative action, it will reduce the annual update by 2.75% over each of three years. After closer examination, Gentiva has concluded that implementation of the CMS proposal would actually result in an overall reduction of 2.97% based on the proposed calculation below:

Step 1	**2007 Base Rate**
Step 2	x 2.9% proposed CY2008 market basket update
Step 3	x 5% increase for outliers
Step 4	*and then the reduction of 2.75% is applied.*

This actually results in a reduction of 2.97% since the calculation is derived from a higher base due to steps 2 and 3.

Example:

2.9% Annual Update Increase =		$67.83 increase per episode
2.75% Reduction	=	$69.50 reduction per episode
		$-1.67 net reduction

Thus, while the proposed regulation suggests an annual update in CY08 of 2.9%, the home health industry would actually be subject to a net decrease in its rate beginning in January 2008.

Case Mix Refinement/Shift from Early (1&2) Episodes to Late (3 or more) Episodes

Gentiva Recommendation: Gentiva recommends that CMS eliminate the early/late distinction and redistribute the weighting to all the episodes by moving from the four-equation model to a two-equation model with the new therapy thresholds. This would eliminate the third and fourth episode currently in the four-equation model, an important step given the fact that three-quarters of all Medicare patients receive care within the first and second episodes.

Our recommendation is also consistent with changes in the Medicare home health patient population and the fact that home health providers can deliver high value through their rehabilitative, disease management, chronic care and acute care services, as well as their long-term care capabilities. Patients should receive the services they need to foster independence and discourage dependence. Patients should gain confidence in self-care capability. We feel that not only is the distinction between early and late episodes unnecessary, but it may reward over-utilization, thereby increasing costs and lessening the likelihood that patients will naturally recover from or manage their conditions.

Additional Comments: As discussed above, we believe it is important for CMS to align regulatory and reimbursement decisions so that they reflect the needs of patients as outlined by the IOM. The proposed regulation signals a change in which the home health industry would be asked to move from its current focus on acute and rehabilitative services to the provision of more long-term care services of the type offered prior to PPS implementation. CMS needs to clarify whether it prefers Medicare home health services to emphasize the more sophisticated treatments described above or whether it expects our services to be used solely for long-term care and/or custodial services, which have traditionally been the purview of Medicaid.

In a budget-neutral environment, it seems counterintuitive to us to shift the funding from predominantly acute and rehabilitative home care – with its well-documented quality and growing efficiency -- to long-term care services. Because of the industry's current focus – and with the majority of Medicare home health patients receiving care within the first two episodes -- the services delivered by home health providers are more intensive and clinically sophisticated, so they require more resources in these early episodes.

Gentiva also questions the types of patients served in the third and later episodes. CMS data seem to suggest that few patients fall into the two or four new equations constructed as part of the proposed rule. One group seems to include patients with severely infected wounds, Parkinson's Disease, ALS, stroke and similar conditions. These patients would qualify for a full episodic payment. Yet another group appears to include patients who are receiving B-12 injections and catheter care, or are Medicaid patients.

It is important to note that CMS determined its four-equation model based on information collected from the OASIS data set. The data collection is required for both Medicare and Medicaid patients. The period of time analyzed by CMS was during a period when instructions dictated collection of all information from payer sources. The data is inclusive of the Medicaid

patients who, under Medicare regulations, would not be eligible for the third or additional episodes of care.

Proposed 2.9% CY08 Annual Update

Gentiva Recommendation: In determining the CY08 update in the final rule, Gentiva would recommend that CMS use data from sources that more accurately reflects the real-time environment experienced by home health agencies. We specifically request a more adequate reflection of the significant changes in fuel and transportation costs that are higher in 2007 than in 2003. We would, likewise, agree with the MedPAC discussions to use data from BLS for clinician costs.

Additional Comments: The proposed regulation would provide a CY08 update of 2.9 percent. As noted earlier, the "case mix creep" would actually result in home health agencies receiving a decrease of .07% (2.97% decrease vs. 2.9% increase) as of next January. This decrease is exclusive of any additional burden on the home health industry that would occur as a result of implementing structural and systems changes associated with the final rule.

During development of the final regulation, Gentiva believes that CMS should consider the increasing costs associated with delivering high quality, efficient services to Medicare patients, including clinician recruitment and retention, and areas such as fuel and transportation. With the recent change to review 2003 cost report data, it is important to note the significant increases in fuel costs since 2003. Our home health services are more reliant upon transportation and fuel costs than other healthcare sectors, yet these are not typically reflected in the annual update.

During 2006, for example, when the home health industry received no update beyond the rural add-on, the average national retail cost of a gallon of gasoline of all grades rose 4.4%. In 2007, with the industry receiving a 3.3% update, gasoline prices have risen 31.1% through June 11. Therefore, we would urge CMS to consider the actual cost increases that are being incurred by the industry as our clinicians focus on delivering vital services.

New MO110 OASIS Item

Gentiva Recommendation: We recommend the two-model approach to alleviate concerns related to the MO110 and the lack of appropriate and real-time information. Gentiva further suggests that CMS develop a process to ensure that the Common Working File (CWF) provides real-time data based on claims processed. Currently, the system does not offer real-time patient eligibility information and is slow in posting claims. Home health agencies have a difficult time in clearly determining state and access to care, concerns which directly affect care coordination. The addition of the four-equation model would further complicate the process and could result in limited or delayed access to care.

Additional Comments: It is our understanding that a new OASIS item, MO110, will be implemented to determine episodic timing and to reflect the new adjacent episodes. While we believe that, conceptually, this is an important data element, there will be additional administrative burdens and accuracy issues, as was experienced with the MO175.

As noted in the CMS proposed regulation, the MO175 was an "excessive administrative burden" and further research found that "operational experience with MO175 revealed that some agencies have encountered difficulties in ascertaining precise information about the patient's pre-admission location during the initial assessment. These difficulties, suggestive of unforeseen administrative complexities, contributed to our proposal to eliminate the MO175 from the case-mix model." Since the MO110 will have a broader oversight and will not focus just on hospitalizations, Gentiva believes that this new OASIS item will be even more burdensome than the MO175.

As you know, the Common Working File (CWF) does not adequately reveal the real-time status of the patient and is not a reliable source. It is currently the only source for home health agencies to determine if another agency or provider is or was caring for the patient. Without a definitive source for accurate information, the MO110 will not be effective and the four-equation model will be difficult to appropriately determine.

Here is an example of the problematic nature of this proposal:

Assume that a patient is admitted to home health services after a hip replacement. He/she also has COPD (496) and dyspnea upon exertion less than 20 feet. His/her surgical incision exhibits early/partial granulation. Twelve PT visits are ordered upon admission and 12 are performed. (Functional domain per below.). Upon admission, we were unaware of previous home health episodes dealing with exacerbations of COPD and this is actually the patient's third consecutive episode.

Initially this patient would have been scored as a C1F2S5 with an average reimbursement of $3,269.94 and case mix weight of 1.4213.

Upon discharge, the correct HHRG is: C2F2S5 with an average reimbursement of $3,956.47 and case mix weight of 1.7198.

Following are examples of scoring items from the Case-Mix Adjustment Variables and Scores table:

Table 2a, row	Clinical dimension	Equation 1 score	Equation 3 score
25	Primary or other diagnosis = pulmonary disorders	0	0
42	M0488 Surgical wound status = 2	0	3
44	M0490 Dyspnea = 2, 3, 4	2	0
	Clinical Dimension	**2**	**3**
	Functional dimension		
49	M0650 or M0660 (Dressing upper or lower body)= 1, 2, or 3	2	3
50	M0670 (Bathing) = 2 or more	3	6
54	M0700 (Ambulation) = 1 or 2		3
	Functional dimension	**5**	**12**
	Therapy visits	**12**	**12**

The MO110 will be difficult for all involved to assure appropriate payments, including home health agencies, fiscal intermediaries and, ultimately, CMS. The data will not reflect real-time information and there will be no way to appropriately track the patient. This may also result in no remedy for correct reimbursement to the providers.

Complexity of Doubling HHRGs from 80 to 153 Groupings

Gentiva Recommendation: As mentioned earlier, Gentiva supports the move to a two-equation model rather than a four-equation model because of the data that reflects a two-equation model and the resulting simplification of the current system.

However, the proposed regulation does not simply involve "refinements" but will mandate a major overhaul of the current PPS/OASIS structure. These changes have financial and operational considerations to home health agencies and to the government. Gentiva would recommend the CMS consider the impact on both in its final rule, along with a consideration of the time it would take all government sectors, fiscal intermediaries, home health agencies, their vendors and consultants to implement these changes. If a smooth transition is not possible, we would request a delay in implementation of the final rule.

Additional Comments: As currently proposed by CMS, the Medicare home health structural changes are complex, increasing the possible reimbursement groupings from 80 groups to 153 groups, while retaining budget neutrality. This complexity has involved the use of positive aspects, such as the inclusion of primary and secondary conditions, while adding other aspects, such as later episodes, that do not currently reflect significant numbers of patients. As we suggested earlier, we recommend further review of the four-equation model related to the later episodes.

We believe these changes will require immense work on the part of CMS, fiscal intermediaries, home health agencies and their vendors and consultants to fully implement the changes as of January 1, 2008. The first three groups will need to reformat their billing and clinical systems. The proposed regulation will implement OASIS modifications requiring education of clinicians, along with paperwork and software changes to adapt to the modifications.

Therapy Thresholds Adjustments

Gentiva Recommendation: We support:

1) the implementation of additional therapy thresholds,
2) the smoothing effect of the graduated payment methodology,
3) CMS plans to automatically adjust claims for therapy visits as outlined by the number of therapy visits, and
4) the fact that adjustments will be made both up and down for therapy visits.

The two-equation model would solve the problem of appropriately adjusting the therapy thresholds when the equations are changed.

Additional Comments: After a full analysis, Gentiva is concerned as to how CMS plans to adjust the therapy thresholds if the adjustment changes the equation for the therapy visits. Without the OASIS documentation, it would seem difficult to know -- from a CMS perspective -- how to appropriately make the adjustment to another equation.

Non-Routine Medical Supplies Case Mix (NRS)

Gentiva Recommendation: Gentiva appreciates the effort to appropriately reimburse for patients whose diagnosis reflects greater usage of NRS. We applaud efforts to ensure that these patients receive the appropriate NRS reimbursement. We do, however, believe that the current proposed case mix methodology is overly complex. We request that further study be done to seek ways to simplify the process moving forward.

Additional Comments: Since the implementation of PPS, there has been recognition that non-routine medical supplies are associated with specific disease states. Yet, the PPS provided a flat NRS reimbursement rate for all HHRGs. The move by CMS to more accurately reflect the use and need of the reimbursement based on diagnosis is a positive modification.

Gentiva raises several points related to the new case mix methodology for NRS:

- The new case mix structure appears overly complex for the NRS, with many in the industry now referring to the NRS case mix change as a "mini-grouper". We question the need to have a complex case mix methodology simply for NRS.
- There is a lack of clear data surrounding the NRS use. Nearly 40% of the cost reports were disallowed due to lack of data and only 10% of the claims contained NRS charges. We, therefore, believe that the resource use by home health agencies is likely underreported and should be a consideration for the final rule.
- The proposed case mix structure does not seem to recognize the use of injectible medications supplies and related need for NRS.

Outlier Provision

Gentiva Recommendation: With data over the past seven years showing that between 2% to 2.5% of the outlier payments are utilized, Gentiva recommends that CMS allocate $3.9 million of the estimated $130 million relating to the proposed outlier amount to the provision of the base rate. Since there is strong historical data to suggest that no more than 3% of the outlier will be utilized, it would be reasonable to have the additional dollars folded back into the PPS.

If the above recommendation requires legislation and is not possible through regulatory action, Gentiva would then suggest that the FDL be lowered to appropriately reflect usage of the 5% outlier based on historical experiences.

Additional Comments: In the CMS proposed regulation, the Agency projects a net increase to the Medicare home health benefit of $140 million in CY08. Of that, $130 million is reserved for the outlier provision, while the other $10 million is dedicated to the net increase to the program. The outlier provision has always represented 5% of the overall home health budget, yet since

PPS began, CMS has only issued a maximum of 2% to 2.5% in outlier payments. This has left approximately 2.5% to 3% of the allocation unused.

PEP Provision

Gentiva Recommendation: Gentiva appreciates the request by CMS for further consideration of modifications to the PEP. We would request that PEPs be considered from the beginning of the episode rather than the first visit due to care coordination activities. We further believe that agencies should be made whole by receiving at least the LUPA rate if the episodic payment would be lower than the LUPA.

Additional Comments: Since the inception of the PPS, the PEP has been implemented in such a way that an initial home health agency does not receive appropriate recognition from the beginning of the episode. This is especially important, since home health agencies are actively engaged in care coordination that is not reflective in the overall reimbursement. Currently, the PEP always begins at the first visit rather than the beginning of the episode. Similarly, home health agencies are not to receive reimbursement any lower than a LUPA rate. But in some instances, the PEP rate is lower than a LUPA. With the recent recognition for start-of-care planning and care coordination, it would seem reasonable that a home health agency should be guaranteed the LUPA rate if the episodic rate is lower.

Home Health Quality Measures/OASIS Evolution

Gentiva Recommendation: Gentiva strongly supports the "evolution" of the OASIS tool to reflect healthcare improvements and clinical sophistication within home health. The evolution process should drive widespread adoption of best practices to achieve optimal clinical outcomes. We also strongly support the development and inclusion of process measures that correlate with the OASIS tool and that seek to improve clinical care by promoting effective, efficient care delivery in the home.

We encourage the development of the various quality measure modifications in unison so that they complement the objectives of excellent clinical outcomes, patient confidence in self-care understanding and compliance, and care coordination. We further believe that these changes should always consider the burden placed on patients, clinicians and home health agencies. It would be beneficial to adopt a patient perception tool that complements and validates strong clinical outcomes and which has the objective of increasing patient confidence in managing their disease-states, especially chronic illnesses.

As the OASIS tool is modified, some data elements should be eliminated if they are no longer needed.

Additional Comments: All adjustments intended to strengthen clinical outcomes should be supported by technology, including point of care devices, electronic medical records, digital photography, telemonitoring (with appropriate clinical protocols) and other technological advances that promote efficiency and effectiveness of care. Gentiva believes that technology is a

critical cornerstone of better efficiency, effectiveness and care coordination for all healthcare providers.

As Gentiva has mentioned previously, we support the concept of pay-for-performance and, similarly, we support the current provision of "pay-for-reporting" the OASIS data. While this provision was originally implemented last year, we believe it remains important.

ICD-9 Coding Provisions

Gentiva Recommendation: The use of more specific clinical indicators is a positive change within the proposed regulation. As more emphasis may be placed on ICD-9 coding, Gentiva would request that the final rule incorporate the most recent ICD-9 changes.

Gentiva continues to review and analysis the proposed regulation and its implications to the overall healthcare policy for the Medicare program. We are very appreciative of the focus on improving the clinical aspects through OASIS modifications and inclusion of diagnoses. We further believe that health information technology is a critical component of clinical care.

Additional Comments: The proposed regulation will include primary and secondary diagnoses in determining the patient's appropriate HHRG. The diagnoses will also seek to establish a better appreciation of the co-morbidities experienced by a patient. Inclusion of more specific data related to the patient's health status is beneficial.

As home health services play a more active role in areas such as disease management and support of chronic illnesses, the reimbursement system should include more disease-specific information. Similar to the development and inclusion of process measures and patient perception information on understanding the patient's disease state, all of this combined development will further support better overall clinical assessments and outcomes, resulting in the development of improved clinical outcomes.

As we adopt the changes outlined to include primary and secondary diagnoses, or co-morbidities, of the patient, it is critical to assure the correct use of the ICD-9 coding. Further, we will need to carefully monitor the inclusion of the various illnesses, such as infected surgical wounds, abscesses, chronic ulcers, gangrene, gastrointestinal, pulmonary, cardiac, cancer, blood disorders, and affective and other psychoses to ensure that the resources allocated are appropriate.

The new focus on ICD-9 coding will require that CMS use the latest and most updated version as well. For instance, we believe that the use of ICD-9 436 may be outdated. In 2005, that particular code was clarified to a more specific code. However, the HH PPS has not yet updated.

SCIC Provision

Gentiva Recommendation: Gentiva supports the elimination of the SCIC policy and appreciates CMS' reaction to home health providers' requests for elimination.

Additional Comments: When originally implemented under PPS, it seemed reasonable that a provision should apply for a patient who potentially had a significant change in condition. As the regulation was implemented, however, few agencies (a minimal 2.1%) actually applied the SCIC. Ultimately, the SCIC policy seemed to be more an administrative burden than a help to home heath agencies.

OASIS Clinical Changes

Gentiva Recommendation: Gentiva strongly supports the continued review of the OASIS tool and the inclusion of specific disease state clinical information of the patients.

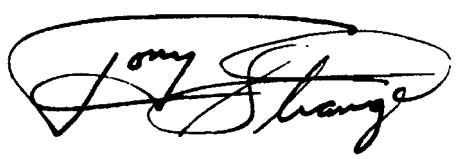
Additional Comments: The proposed rule includes changes to the current OASIS tool that are positive, particularly the exclusion of MO175 and MO610. At the same time, MO470, MO520 and MO800 will be added to the equation for payment purposes and recertification. Gentiva strongly supports the ongoing evolution of the OASIS tool to reflect the current care trends within the industry and to more accurately reflect the patient's disease state that will support better development of true clinical outcomes. We applaud the significant efforts undertaken by CMS to date to seek the next evolution of the OASIS tool.

CONCLUSION

In conclusion, we hope that our recommendations and comments will help to achieve reforms that will ultimately deliver safe, efficient, effective, patient-centered, timely, and equitable care to all Medicare beneficiaries. We are committed to positive clinical outcomes and a focus on rehabilitative, acute care and chronic care services to help reduce the Medicare spend. We believe this kind of discourse helps to break down the so-called "silos" between healthcare providers to determine the most appropriate type and location of care, and can be useful in understanding which kinds of services can be delivered most effectively in the home – where patients would overwhelmingly prefer to be.

We look forward to working with you on the development of the final rule and on other initiatives designed to deliver the highest quality patient care and control rising national health costs.

Sincerely,



Tony Strange
Executive Vice President,
Gentiva Health Services, Inc., and
President, Gentiva Home Health

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VNA

Home Health Care

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JUN 26 2007

June 18, 2007

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

Dear Sirs:

Please accept these comments 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 your summary of Home Health Payment Research you suggest "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 to any refinement is maintaining an appropriate degree of operational simplicity."

The proposed refinements increase the number of HHRG's 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.

With the release of these proposed rules the end of April and the comments being due June 26th, our experience is that the proposed rule changes are quite complex and of significant change, hardly what one would consider to be "operational simplicity". Our current software does not allow us to run a comparison, nor does the time allowed since the release of the proposed rules, allow for our agency to complete a thorough financial analysis that is necessary to adequately respond to these rules.

PROVISIONS OF THE PROPOSED REGULATIONS:

MO175
We support the proposed elimination of MO175 from the case mix model. It is often difficult for providers to code this item accurately.

50 Foden Road, South Portland, Maine 04106 • 207-780-8624 • 800-757-3326 • Fax: 207-756-8676
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CASE MIX CREEP

We disagree with the assumptions made relative to the issue of case mix creep. Coupled with this assumption is the proposal to reduce rates by 8.7 percent because of a "nominal" change in case mix. Our agency has seen our case mix change from a .97 in 2000 to a 1.01 in 2007, hardly a case of inappropriate case mix adjustments. We believe that our case mix upward shift is related to more accurate diagnosis coding and OASIS assessment accuracy. It seems arbitrary and unfair to penalize agencies that have not demonstrated measurable "case mix creep". One might make the argument that CMS has benefited from our low case mix reporting. We do think it is fair to penalize providers by eliminating almost all of the market basket updates by offsetting it with the case mix creep adjustments when the nominal change in case mix is so speculative.

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

Further, it is our belief that the provision of home health has changed markedly over the past several years. The shift in focus for patient care has moved from a dependent model to a model of optimizing patient independent function within the home setting. To accomplish this, the utilization of therapy has obviously been on the increase. We would offer this as the rationale for the gain in case mix. This change in care delivery has been revolutionary and as desired from CMS.

LUPA ADJUSTMENTS

We support the proposal to create an additional payment of $92.30 for certain LUPA's. Currently, LUPA payments per visit are significantly less than providers actual cost per visit. The additional payment will recognize the cost burden of data collection and data transmittal. We also urge CMS consider applying the Non-routine Medical supply adjustment to LUPA's. The supply cost is particularly burdensome for the monthly catheter changes, wound care assessments for staple removal, and ostomy patients for example.

SCIC

We support the proposal to eliminate SCICs. The SCIC process added unnecessary complexity that did not appear to be needed.

NON-ROUTINE MEDICAL SUPPLIES

We support the proposal to provide tiered additional supply payments for non-routine medical supplies based on the HHRG and severity level. As stated above, we believe the additional payments should apply to LUPA's.

HOME HEALTH CARE QUALITY IMPROVEMENT

This regulation proposes that two additional quality measures be added to the ten already required and publicly reported. In order to reduce the regulatory burden, we would recommend that as CMS adds two new measures, you consider deletion of two of the existing measure to keep the total number of quality measures at ten. It is our belief that focusing on ten measures is more than adequate.

Additionally, we would recommend that CMS make every effort to reduce the total number of OASIS items as the testing of patient level quality measures continues. CMS should continue to further refine and enhance the OASIS tool, thereby, reducing the regulatory burden on providers.

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

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

Sincerely,

Colleen Hilton, CEO
VNA Home Health Care
50 Foden Road
South Portland, ME 04106