CMS-1541-FC-1 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : Ms. Jan Hockensmith **09/10/2007**

Organization : Baptist Hospital East Home Health Agency

Category : Nurse

Issue Areas/Comments

Summary of the Provisions of the CY 2008 Proposed Rule

Summary of the Provisions of the CY 2008 Proposed Rule

III/ Analysis of and Response to Public Comments on CY 2008 Proposes Rule. B- Case-Mix Model Refinements. 3. Addition of Variables.

In this section, the CMS response states : we have added appropriate "status" V44 V codes and "attention" V55 V codes to the model.
I do not find any V 44 codes in any of the tables, only V 55 group.
Where are the V 44 codes?

CMS-1541-FC-2 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : Mr. Robert Bois **09/11/2007**

Organization : Walpole Area Visiting Nurse Association

Category : **Home Health Facility**

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Incorrect Final CY 2007 Per Visit Rate for Speech Therapy in Table 12.

Background

Background

Problem is in Final Rule

Collection of Information Requirements

Collection of Information Requirements

Problem is in Final Rule

GENERAL

GENERAL

Needs correction before 1/1/08 and in pricer model.

Provisions of the Final Rule with Comment Period

Provisions of the Final Rule with Comment Period

Table 12 (page 49868 in FR) lists the Final CY 2007 LUPA per visit rates that are the base of the update to the final CY 2008 LUPA rates. The Speech-Language Pathology CY 2007 LUPA rate is listed as $121.22. However the final CY 2007 Speech-Language Patholoty rate in the CY 2007 final regulations was $121.32 (Table 2 of the FR dated November 9, 2006). The correct CY 2007 rate is 10 cents higher than the amount listed in 2008.

Summary of the Provisions of the CY 2008 Proposed Rule

Summary of the Provisions of the CY 2008 Proposed Rule

The final 2008 Speech-Language Pathology LUPA rate in table 12 should be $124.65 instead of the listed rate of $124.54.

($121.32 x 1.03 x 1.05 x .95) = $124.65

Without correction, home health providers will be underpaid in thes circumstances.

CMS-1541-FC-3 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Dr. Joyce Heuman** **Date & Time: 09/14/2007**

Organization : **Absolutely Angels, Inc**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

See attachment for details
1. C3F1S1, C3F2S1, & C3F3S1 on Table 5 of casemix weights appear to be incorrect.
2. How does the therapy threshold fallback work - does C3F3S2 fallback to C3F3S1 - casemix weight?

Provisions of the Final Rule with Comment Period

A patient (no therapy needed) who scored C3F2S0 under old PPS critria nows scores C3F2S1 under the new PPS criteria. Under the old PPS system, the patient would have an episode payment of approximately $3283, under the new system the epsiode would pay approximately $1000 less. This is due to the fact that the casemix weight from the old PPS was 1.3957 and under the new PPS regulations is 0.9896. I understand that the case-mix weight change was to be accounted for by a reduction in the 60 day episode rate; however, in a comparison of the case-mix weight under the old system versus the new system (episode 1, excluding therapy)there appears to be a significant loss in case-mix weight in a one to one comparison. I believe this is due to a flaw in the model used to calculate case mix weights and needs to be addressed.

Case-Mix weight

Table 5

			m0110=01 0-13	Old PPS Weights		Case Mix Loss
C1	F1	S1	0.5827	C1F1S0	0.7169	(0.13)
C1	F1	S2	0.8507	C1F1S1	0.7978	0.05
C1	F1	S3	1.0599	C1F1S2	1.6752	(0.62)
C1	F1	S4	1.2744	C1F1S3	1.9269	(0.65)
C1	F1	S5	1.4506			
C1	F2	S1	0.6713	C1F2S0	0.8205	(0.15)
C1	F2	S2	0.9393	C1F2S1	0.9014	0.04
C1	F2	S3	1.1485	C1F2S2	1.7787	(0.63)
C1	F2	S4	1.3630	C1F2S3	2.0304	(0.67)
C1	F2	S5	1.5392			
C1	F3	S1	0.7550	C1F3S0	0.8585	(0.10)
C1	F3	S2	1.0230	C1F3S1	0.9394	0.08
C1	F3	S3	1.2322	C1F3S2	1.8168	(0.58)
C1	F3	S4	1.4467	C1F3S3	2.0684	(0.62)
C1	F3	S5	1.6229			
C2	F1	S1	0.7335	C2F1S0	0.8914	(0.16)
C2	F1	S2	1.0015	C2F1S1	0.9723	0.03
C2	F1	S3	1.2107	C2F1S2	1.8496	(0.64)
C2	F1	S4	1.4252	C2F1S3	2.1013	(0.68)
C2	F1	S5	1.6014			
C2	F2	S1	0.8221	C2F2S0	0.9949	(0.17)
C2	F2	S2	1.0901	C2F2S1	1.0758	0.01
C2	F2	S3	1.2993	C2F2S2	1.9532	(0.65)
C2	F2	S4	1.5138	C2F2S3	2.2048	(0.69)
C2	F2	S5	1.6900			
C2	F3	S1	0.9058	C2F3S0	1.0329	(0.13)
C2	F3	S2	1.1738	C2F3S1	1.1139	0.06
C2	F3	S3	1.3830	C2F3S2	1.9912	(0.61)
C2	F3	S4	1.5975	C2F3S3	2.2429	(0.65)
C2	F3	S5	1.7737			
C3	F1	S1	0.9010	C3F1S0	1.2922	(0.39)
C3	F1	S2	1.1691	C3F1S1	1.3731	(0.20)
C3	F1	S3	1.3783	C3F1S2	2.2504	(0.87)
C3	F1	S4	1.5927	C3F1S3	2.5021	(0.91)
C3	F1	S5	1.7690			
C3	F2	S1	0.9896	C3F2S0	1.3957	(0.41)
C3	F2	S2	1.2577	C3F2S1	1.4766	(0.22)
C3	F2	S3	1.4669	C3F2S2	2.3540	(0.89)
C3	F2	S4	1.6813	C3F2S3	2.6056	(0.92)
C3	F2	S5	1.8576			
C3	F3	S1	1.0733	C3F3S0	1.4337	(0.36)
C3	F3	S2	1.3414	C3F3S1	1.5147	(0.17)

C3	F3	S3	1.5506	C3F3S2	2.3920	(0.84)
C3	F3	S4	1.7650	C3F3S3	2.6437	(0.88)
C3	F3	S5	1.9413			

CMS-1541-FC-4 **Home Health Prospective Payment System Refinements and Rate Update for CY 2008**

Submitter : **Nazneen khatoon** **Date & Time: 09/24/2007**

Organization : **Best Care Home Health**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

See attached

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

Submitter : Jane Furtner **Date:** 10/01/2007

Organization : Jane Furtner

Category : Social Worker

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Current levels of funding are already inadequate, the alternative will eventually cost more

Background

Background

Proposed cuts will lead to more emergency room visits and/or increase hospital admissions

GENERAL

GENERAL

Home funding through medicaid should be increased.

Submitter : **Mrs. Monica Blaske** **Date: 10/17/2007**

Organization : **Sauk Centre Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

I.E See attachment

#6

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : Miss. M,ARJORIE E. Green R Green **Date:** 10/17/2007

Organization : Qstaff Home Health care

Category : Nurse

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

A Home Health Administartor: It is hard to keep some individuals from running to ER. They will not call and tell you what the issue is. All of our wounds heal without complication and we should get points for that. We take referrals as we get them. We do not turn people away because there is "No Profit" where other agencies tell do.! Some of this OBQI is unfair. I find it hard to get Urgent admissions and Emergency Room visits down, because Licensed Nurses get scared regarding telling someone "not to go the ER" because of potential for lawsuits. Also, like I said, even with teaching the family, sometimes a other relative, will take patient to ER when it could be resolved at MD office. I feel we are being asked to make medical desicisions at night when a Physician will not call you back. SOB is another one for chronic SOB for the COPD or asthmatic client. These are chronic diseases that only get worse. A nebulizer or inhaler can get short time relief, but there is no permanent improvement, unless client is resolving from Pneaumona, Flu, etc.which is not the case most of the time. We live in the Houston area and the air quality is bad a lot of days. This is not fair when an agency gets extra money for improvements. I have had nurses come to work for me who have said, "former agencies " just told them to automatically "upscore thier Discharges.! The reason we may not be as good as some agencies, because we are very honest here. I have had Nurses tell me what great relief they feel here, to know that they do not have to worry about thier license here. My scores may not be as good as others but I know they are honest assessments!

Background

Background

I think it is great you are paying for supplies because some of these woundcare products are very high, especially ones that work. Our Physical Therapists have all gone up to $70.00 plus for visits and Evals. Guess they did not know we did not get a raise for therapy! The service we provide, and want to provide, is very hard in dealing with clients, MD's, wages people want, preventing fraud and running this agency in a clean and effective way. I do my very best I can here and my patient's satisfaction shows. This service that you provide the Elderly thru Medicare, I am going to make sure that the client receives the best I can give them as the Administrator of this agency. Please do not give me goals that cannot be effectively achieved.

Collection of Information Requirements

Collection of Information Requirements

A big change, Money for classes and travel for key people. If I see that it is a plus and helps us care for clients in a safe and effective way., then I am for it! We get clients out of the hospital with bedsores, etc. and I have to effectively care for this client the safest and most effective way when : I did not let him lay in bed and get bedsores, the Hospital did. Is this fair-No. I sent this client to Hospital with No bedsores, but he comes out with 5 to 6 bedsores with pressure pont sores!

GENERAL

GENERAL

It is hard to believe that agencies that dumped wounds now will now be out trying to scam them all!! We have one client we received last yaer, a Ms. Satterfield that AMED in Texas City, Texas. Amed intially got referral and went out there and assessed the client. The lady was covered with extenal cancerous blisters all over her back, left shoulder and down covering her whole breast. This wound required massive dressing change material. The Nurse at Amed called client and said they could come by and get her dressing supplies for wound, but no nursing ? They said that dog in yard was mean !. This dog would lick you to the death. They made this up so they would not have to supply The care, or supplies. (High cost) The Chemo MD gave us the client after families total dissatisfaction with AMED. We sent RN out and the situation was pathetic. The client was in horrible pain and did not have enough money for woundcare products.
The husband which was the provider was unable to do his job to earn money due to no one to stay with her during day, as daughter worked out of home and helped when she could.The dressing changes were twice a day. We picked up client, provided a Nurse one time a day while husband and daughter did second visit. The visits were a good two hours due to expansive amount of open raw tissue. The pain was excrutiating for client during care. By doing the am visit, the husband was able to go back to work 3 hours a day to help pay for medicine and groceries.We provided Medical Social services also as a resource for family. This patient died and the husband called and said our company had totally restored his faith in Nurses, Home Health and the government-MCDR benefit. I work to achieve satisfaction, safe patient care,stay within guidelines of State and Federal laws, and try to also make some money for agency. This client's spouse comments meant a lot to me. He was saying everything I try to achieve here. So when your budgeting, think of these situations-please!

Provisions of the Final Rule with Comment Period

Provisions of the Final Rule with Comment Period

I am afraid of the early period as we may lose money because of impact of coding. I cannot afford a full time coder here so we do the best we can. I want with all of my heart to take good care of these clients, but sometimes it is a real struggle.

Regulatory Impact Analysis

Regulatory Impact Analysis

We are in the process of "upgrading our knowledge level regarding the changes!!

Summary of the Provisions of the CY 2008 Proposed Rule

Summary of the Provisions of the CY 2008 Proposed Rule

It will be good if it gets rid of cheaters, especially agencies that are upscoring thier OBQI, stealing patients from your agency and Peping you and you are unable to finish therapy and get part of money returned.

Submitter : **Mrs. Gloria Ross** **Date: 10/18/2007**

Organization : **Ortonville Area Health Services Home Health**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

This letter is written on behalf of the Ortonville Area Health Services Home Health. We are a hospital based home care agency located in rural Minnesota. We are writing to you in reference to CMS-1541-FC.

While we strongly support CMS's efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

Home Health has had continual rate cuts over the past ten years. Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospial care, inpatient rehab facilities services and skilled nursing facility care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an inpatient rehab facility, and the care results in better patient outcomes.

We have serious concerns aout the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the HIPPA and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system. Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changed to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes the clinicians throughout the nation are deliberately falsifying client assessment to garner higher payment for their agency. More realistically, the increase in case mix reflect the changing demographics of the home care population, the intensity of service required for today's home care client by the quicker discharge from skilled nursing facilities, decrease in hospital stays and changes in the inpatient rehab facility reimbursement that have appropriately steered more but sicker patients into home health services.

For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Gloria Ross, RN Coordinator
Ortonville Area Health Services
450 Eastvold Avenue
Ortonville, Minnesota 56278

Submitter : Mrs. Deidra Tipton **Date:** 10/19/2007

Organization : Toe River Health DIstrict

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Final Rule with Comment Period

Provisions of the Final Rule with Comment Period

The 2.75% & 2.71% cuts in the final rule will continue to drain funding from home health agencies. With minimal market basket updates the past few years, and now this, many home health agencies will see a negative profit margin. I understand this is the goal of CMS, however, they need to keep in mind that the overall cost of home care is a fraction of the cost of institutional care (skilled nursing facility, rehab facility, or hospital). Home care remains the most economical way to provide care to appropriate patients. It seems an oxymoron to cut funding of your cheapest source of medical care. Home Care should be promoted. It seems this would be the best way to save $$. CMS should also remember that not all home care agencies are privately based or hospital based. There are still a few of us that are public health based, and we work closely with some much needed programs through our local health departments/clinics that could not be offered without home care services. Once again cutting the cheapest ways of providing care. Without these clinics, the lower income level families would be forced into the hospital systems for the same care, again, costing the agencies, the state, and others involved more money, instead of saving dollars. If the real goal of CMS is to save money, then they need to look at promoting home care, not cutting our funding, and allow us to continue to provide the most cost effective care to the communities served. It seems providing more of the most cost efficient care would save money. The country just needs to know what home health and other home care agencies can do for them, at which point most would choose to recooperate in their own home and end up saving CMS millions.

Submitter : **Ms. Ginger Parrish** **Date: 10/19/2007**

Organization : **Albemarle Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

As the Director of a not for profit, health department-based home health agency in rural northeastern North Carolina, I am very concerned about the proposed reimbursement cuts of 2.75%/year. Our expenses continue to increase each year. The cost of recruiting and retaining staff increases each year. Our travel costs increase each year, and the paperwork burden increases each year. We are constantly struggling to hire, recruit, and train staff and need every penny we make to continue to be competitive with the local hospitals and the for-profit agency in the area. Please reconsider this devastating plan to cut home health reimbursement.

Submitter : Pam Tidwell **Date:** 10/19/2007

Organization : CarePartners - Home Health

Category : Home Health Facility

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

CarePartners is a non-profit certified home health agency serving Western North Carolina. We have served our community over 30 years.

Background

Background

CMI creep

Collection of Information Requirements

Collection of Information Requirements

Our agency experienced changed in our service population over past 5 years. Our percentage of orthopedic patients has increased. We can tie this increase to the changes in regulations for rehab hospitals. These patients do not fit in the primary diagnotic groups for rehab hospitals and had to be served by long term care or home health. We now serve most of these patients.

GENERAL

GENERAL

reduction in payment penalizes the providers and patients that CMS is targeting to receive services.--- patient with functional impairments and chronic care patients.

Regulatory Impact Analysis

Regulatory Impact Analysis

In 2000 - 32% of our patients received therapy service. Today over 50% of our patients receive therapy. This can be attributed to change in rehab hospital regualtions and the shift with OASIS to "functional improvement".

Submitter : Ms. Lynn Hardy **Date:** 10/19/2007

Organization : Carolina East Home Care & Hospice, Inc.

Category : Home Health Facility

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Data review by CMS of 20% of claims (OASIS for 2004-2005) does not reflect the patient characteristics of 2007, and certainly not those that will receiving services in 2010 and 2011.

GENERAL

GENERAL

As a rural home health provider that faces many challenges to provide care including, lack of credentialed personnel - nursing, therapy and in-home aides, further reduction as indicated in this proposal threatens the availability of care to our community due to the ability to attract employees. Medicare Advantage and private insurance rates are inadequate to meet the reimbursement of services provided. We are an agency that provides telehealth services and with other costs of compliance with regulatory issues - bioterrorism preparedness, systems change, and as mentioned above labor cost that includes mileage reimbursement, the ability to survive fiscally in the home health world is difficult. As a non-profit community based organization that accepts patients because they have a need rather than evaluating them for their reimbursement ability decreasing reimbursement is putting the citizens of our community in jeopardy or receiving care. The acutity of patients continues to increase - more infusions, more sysmptom management, more wounds makes the delivery of care more expensive.
Training of staff to stay updated on patient care and in the regulatory and data collection requirements of Medicare/Medicaid - CMS to ensure the correct reimbursement for services is an ongoing need that requires time and money .
We feel that this cut in PPS for home health not based upon accurate and current information and should not be implemented.
Thank you for the opportunity to comment.

Submitter : Mrs. Lynn Nelson **Date:** 10/19/2007

Organization : St. Luke's Home Health Services

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1541-FC-13-Attach-1.DOC

CMS-1541-FC-13-Attach-2.DOC

#13

St. Luke's

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of St. Luke's Home Health Services in Duluth, Minnesota. Our average daily home health census is approximately 120 patients. While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

FY1998	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
FY2000	Home health care's inflation update was cut by 1.1 percent
FY2002	Home health care's inflation update was cut by 1.1 percent
FY2003	Home health care total expenditures were cut by 5 percent off previous year's rates
CY2004	Home health care's inflation update was cut by 0.8 percent (3/4 of year)
CY2005	Home health care's inflation update was cut by 0.8 percent.
CY2006	Home health care's inflation update of 3.6 percent was eliminated.
CY2008	2.75 percent reduction of the national standardized 60-day episode payment
CY2009	2.75 percent reduction of the national standardized 60-day episode payment
CY2010	2.75 percent reduction of the national standardized 60-day episode payment

Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, and the care results in better patient outcomes.

We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers'

compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

1. Changing demographic of home care's patient population.
   a. Today, home care patients are older and more frail - 23% of home care patients are over the age of 85
2. The intensity of service required by today's home care patient has increased significantly due to:
   a. Hospital DRG policy changes leading to decreased length of stay
   b. Quicker discharge from skilled nursing facilities
   c. Changes in Inpatient Rehab Facility reimbursement that have appropriately steered more but sicker patients into home health services
3. Comparing what was happening during the IPS years to 2005 is unrealistic for the following reasons:
   a. Under IPS most agencies were having extreme cash flow issues resulting in fewer staff for education and quality assurance activities
   b. Physical therapists were in short supply and just beginning to have a presence in home health service delivery, especially for smaller providers.
   c. OASIS was new and has a long learning curve to accuracy in OASIS answers. Some agencies admit that it's only been in the last few years that they feel their clinicians have a full understanding of OASIS.

****The average case mix at our agency is just a little over 1.0, well under what CMS is stating, and we have not experienced the "case-mix creep" that is so widely publicized by CMS. In addition, since PPS, our agency has not increased our therapy visits to obtain additional reimbursement. We have also not reduced our home visits per patient to make more money per episode. We have provided the same excellent care to our home care patients that we have always done, regardless of the reimbursement system. We are hospital-based and our employees are unionized. We have to deal with at least a 3-6% salary increase on a yearly basis. How can we continue to provide services to our patients if our home health reimbursement continues to be decreased?? What will happen to our nation's elderly as home care agencies are forced to close due to declining reimbursement?**

For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Lynn Nelson, MS
Director, St. Luke's Home Health Services

Submitter : **Ms. Catherine Shoemaker** **Date: 10/19/2007**

Organization : **Roper-St.Francis Home Health Care**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

As a hard working home health PT, I must strongly voice my resentment to the proposed reimbursement cuts to agencies such as ours. My company is comprised of dedicated professionals, including billing/insurance staff, performance improvement personnel, medical records and coders, supervisory and field staff. Our Mission statement of providing the very best community health care available is always front and center. We all attend countless inservices and testing to make sure we answer all Oasis questions appropriately and not to inflate our reimbursement rates. And to think our hard work is just looked upon as 'bottom line' numbers makes me ill. It seems that no matter how hard we work, the ruling government agencies do nothing but continue to take money out of our pockets. Many times, if a patient's needs warranted it, we have stayed on-case with multiple disciplines, well over-running our optimal reimbursement rates! Never, has any supervisor questionned my plan of care based on the bottom line. I sincerely hope you will reevaluate your proposals to reduce the small amount we already receive for our hard work.

Submitter : **Ms. Christine Broeker** **Date: 10/19/2007**

Organization : **St. Joseph's Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#15

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : **Mrs. Jana Smith** **Date: 10/19/2007**

Organization : **Bethesda Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-FC-16-Attach-1.DOC

#16

BETHESDA

1604 South First Street
Willmar, Minnesota 56201
(320) 235-8364

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of Bethesda Home Health. Bethesda Home Health is a Medicare Certified home health agency serving clients in rural Minnesota.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, our agency has grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

FY1998	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
FY2000	Home health care's inflation update was cut by 1.1 percent
FY2002	Home health care's inflation update was cut by 1.1 percent
FY2003	Home health care total expenditures were cut by 5 percent off previous year's rates
CY2004	Home health care's inflation update was cut by 0.8 percent (3/4 of year)
CY2005	Home health care's inflation update was cut by 0.8 percent.
CY2006	Home health care's inflation update of 3.6 percent was eliminated.
CY2008	2.75 percent reduction of the national standardized 60-day episode payment
CY2009	2.75 percent reduction of the national standardized 60-day episode payment
CY2010	2.75 percent reduction of the national standardized 60-day episode payment

Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, and the care results in better patient outcomes.

We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the

rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

1. Changing demographic of home care's patient population.
   a. Today, home care patients are older and more frail - 23% of home care patients are over the age of 85
2. The intensity of service required by today's home care patient has increased significantly due to:
   a. Hospital DRG policy changes leading to decreased length of stay
   b. Quicker discharge from skilled nursing facilities
   c. Changes in Inpatient Rehab Facility reimbursement that have appropriately steered more but sicker patients into home health services
3. Comparing what was happening during the IPS years to 2005 is unrealistic for the following reasons:
   a. Under IPS most agencies were having extreme cash flow issues resulting in fewer staff for education and quality assurance activities
   b. Physical therapists were in short supply and just beginning to have a presence in home health service delivery, especially for smaller providers.
   c. OASIS was new and has a long learning curve to accuracy in OASIS answers. Some agencies admit that it's only been in the last few years that they feel their clinicians have a full understanding of OASIS.

For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,
Jana Smith, RN, PHN
Director
Bethesda Home Health

Submitter : **Ms. Pamela Clifford** **Date: 10/19/2007**

Organization : **Allina Home Care, Hospice & Palliative Care**

Category : **Home Health Facility**

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

See Attachment

Background

Background

See Attachment

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Final Rule with Comment Period

Provisions of the Final Rule with Comment Period

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

Summary of the Provisions of the CY 2008 Proposed Rule

Summary of the Provisions of the CY 2008 Proposed Rule

See Attachment

CMS-1541-FC-17-Attach-1.DOC

Allina Home Care, Hospice & Palliative Care
1055 Westgate Drive, Suite 100
St. Paul, MN 55114

#17

ALLINA
HOME CARE, HOSPICE
& PALLIATIVE CARE
Allina Hospitals & Clinics

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of Allina Home Care. Allina Home Care, a not-for-profit agency, is a part of Allina Health System in Minnesota. We provide skilled nursing, physical, occupational, and speech therapies, home health aides and medical social work services. We have an average daily census of around 300 patients, over 60% of who are Medicare beneficiaries. While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, our agency and the Minnesota Home Care Association members have grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

FY1998	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
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Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, and the care results in better patient outcomes.

We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

1. Changing demographic of home care's patient population.
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2. The intensity of service required by today's home care patient has increased significantly due to:
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For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Pamela Clifford, RN, MPH
Director

Submitter : **Danielle Kleine** **Date: 10/22/2007**

Organization : **St.James Health Services Home Health/Hospice**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-FC-18-Attach-1.RTF

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of the St. James Health Services Home Health/Hospice. St. James Health Services Home Health/Hospice is a hospital based home health care and hospice agency.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

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For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Danielle Kleine RN
Home Health/Hospice Manager
St. James Health Services Home Health/Hospice

Submitter : **Mrs. Dana Helton** **Date: 10/23/2007**

Organization : **Houston County Public Health**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

I have enclosed a letter addressing the impact rate cuts would have on our rural elderly population.

CMS-1541-FC-19-Attach-1.DOC

#19

HOUSTON COUNTY PUBLIC HEALTH
304 South Marshall Street
Caledonia, Minnesota 55921
Phone: (507) 725-5810 Fax: (507) 725-2150
www.houstoncounty.govoffice2.com/

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

Re: file code CMS-1541-FC

This letter is written on behalf of Houston County Public Health. Our agency provides skilled services to our rural elderly population. The home care services we provide allow our frail and vulnerable population the opportunity to live at home.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

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Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients

discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, and the care results in better patient outcomes.
We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

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For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Dana Helton, RN, PHN
Home Care Coordinator
Houston County Public Health

Submitter : **Ms. Deborah Herbst** **Date: 10/24/2007**

Organization : **Perham Memorial Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

i.c. see attachment

CMS-1541-FC-20-Attach-1.DOC

CMS-1541-FC-20-Attach-2.DOC

#20

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of the Perham Memorial Home Care is a Medicare Certified Home Care Agency providing skilled and non skilled services to a 30 mile radius of our community.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

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We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

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c. OASIS was new and has a long learning curve to accuracy in OASIS answers. Some agencies admit that it's only been in the last few years that they feel their clinicians have a full understanding of OASIS.

Please note the Home Care Access Protection Act (S.2181.H.R.3865) on the NAHC Legislative Action Network.

For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Deborah Herbst RN BSN PHN
Perham Memorial Home Care
665 3rd St. S.W.
Perham, MN 56573
Phone: 218-346-1192
Fax: 218-346-1237
dherbst@pmhh.com

Submitter : R. Scott Ward, PT, PhD **Date:** 10/24/2007

Organization : American Physical Therapy Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1541-FC-21-Attach-1.PDF

#22

ST. MARY'S
REGIONAL HEALTH CENTER
Benedictine Health System

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

October 23, 2007

Re: file code CMS-1541-FC

This letter is written on behalf of the St. Mary's Home Health. . *St. Mary's Home Health is a small agency that is part of a religiously sponsored hospital system. We struggle to provide both Medicare and Medicaid covered services as well as insurance. The introduction of Medicare D has dramatically increased the Medicare HMO participants, which in turn has changed our business. The HMO authorization and coverage has required us to hire additional billing staff. Our overhead processes above the direct patient care time has increased 25% due to the changing in billing and payment in the past two years.*

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

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We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

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For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,
Linda Hespe, RN, BSN, MBA
St. Mary's Home Health Manager
114 Frazee Street East
Detroit Lakes, MN 56501

[redacted]

Submitter : Mr. Richard Porter **Date:** 10/24/2007

Organization : Metro Home Health Care

Category : Health Care Provider/Association

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

PPS came in in 2000 after about 2000 HHA's closed. Cms and Congress did not have the forethought to limit the number of new HHA's coming back into the program so now in our county we have 255 agencies. This has lessened our number of patients and increased our cost per visit since we still need to cover our overhead especially with increased gov't regulations. We now have new inexperienced agencies that don't always play by the rules. Thanks. This also is a problem for CMS to monitor "sneaky" agencies as is seen in S. Florida. Finally we have more Medicaid patients that pay us about half our costs. We are losing money now.

Background

Background

The new rule wants to cut our rates each year through 2011. No health care provider has ever had this done for 4 years in a row and doctors and hospitals would not stand for it. CMS has no idea what will happen in 4 years and I feel that good agencies will have to suffer while CMS tries to get rid of bad ones through lower reinbursements and regulations. Many of these new agencies limit or do not take Medicaid so lowering the rates to those agencies that do will eventually cut services to Medicaid patients. In our area that is happening now so what will occur next year will be worse. By the way those Medicaid patients soon become Medicare patients only they could have more problems than those in the past which will impact Medicare costs. No matter what you think about the past the current and future problems have CMS as a major cause and there is no justification to go out 4 years in cutting rates. If we did not have so many agencies we could handle rate cuts better for a few years but nobody knows where we will be in 4 years. Just since 2003 our cost per visit has jumped almost 50%. We can't sustain those cost increases going forward at a time of lesser payments.

Submitter : Mr. Jerry Hurst **Date:** 10/25/2007

Organization : Roper St Francis Homecare

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

Our agency spends a great deal of time training staff members on correct OASIS data measurement. We go as far as having multiple disciplines answer OASIS questions individually, and then come together to discuss why one rater would rate a particular level and the other another. Occupational therapist are most adept at grading patient's occupational performance level as per OASIS data points, are not considered a qualifying service, and therefore you have a variety of skilled nursing and physical therapy clinicians performing OASIS admissions. It is important to note, that since this is the case, our agency continually trains the staff on the importance of accurate OASIS documentation. We do not adjust data to suit our needs, because that does not enable us to set goals to become a better agency. Our goal is compassionate, competent care for all, and if reimbursement cuts are made, the patient will feel its affects. Home health agencies will have a difficult time retaining highly qualified clinicians to treat what has become an ever increasingly more complex patient. Home health continually saves the government thousands of dollars per patient in Medicare costs by reducing more expensive inpatient hospital stays. The patient would rather stay at home, and generally, compliance is high when the patient is in a comfortable environment. I ask that you take into consideration these comments when discussing whether or not to cut reimbursement for home health services in 2008. Thank you.

Submitter : **Date: 10/25/2007**

Organization :

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#25

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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

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

Submitter : **Date: 10/25/2007**

Organization : **INTER COUNTY NURSING SERVICE**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-FC-26-Attach-1.PDF

#26

INTER-COUNTY
NURSING
SERVICE

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of the Inter County Nursing Service. Inter County Nursing Service is a home care agency in Northwestern Minnesota serving two counties. The agency has been in existence since 1969.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, MHCA members have grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

FY1998	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
FY2000	Home health care's inflation update was cut by 1.1 percent
FY2002	Home health care's inflation update was cut by 1.1 percent
FY2003	Home health care total expenditures were cut by 5 percent off previous year's rates
CY2004	Home health care's inflation update was cut by 0.8 percent (3/4 of year)
CY2005	Home health care's inflation update was cut by 0.8 percent.
CY2006	Home health care's inflation update of 3.6 percent was eliminated.
CY2008	2.75 percent reduction of the national standardized 60-day episode payment
CY2009	2.75 percent reduction of the national standardized 60-day episode payment
CY2010	2.75 percent reduction of the national standardized 60-day episode payment

Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients

318 North Knight Avenue • Thief River Falls, MN 56701 • FAX (218) 683-7099
Pennington County Nurse (218) 681-0876 • Red Lake County Nurse (218) 253-4378

discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, and the care results in better patient outcomes.

We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

1. Changing demographic of home care's patient population.
   a. Today, home care patients are older and more frail - 23% of home care patients are over the age of 85
2. The intensity of service required by today's home care patient has increased significantly due to:
   a. Hospital DRG policy changes leading to decreased length of stay
   b. Quicker discharge from skilled nursing facilities
   c. Changes in Inpatient Rehab Facility reimbursement that have appropriately steered more but sicker patients into home health services
3. Comparing what was happening during the IPS years to 2005 is unrealistic for the following reasons:
   a. Under IPS most agencies were having extreme cash flow issues resulting in fewer staff for education and quality assurance activities
   b. Physical therapists were in short supply and just beginning to have a presence in home health service delivery, especially for smaller providers.
   c. OASIS was new and has a long learning curve to accuracy in OASIS answers. Some agencies admit that it's only been in the last few years that they feel their clinicians have a full understanding of OASIS.

For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Anita B. Cardinal PHN

Anita B. Cardinal PHN
Director

Submitter : Lois Schuller **Date:** 10/25/2007

Organization : Lois Schuller

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1541-FC-27-Attach-1.DOC

#27

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

Re:file code CMS-1541-FC

I strongly support CMS's efforts to restructure PPS and to replace a poorly functioning case mix Adjustment model. I do however have concerns about the planned 2.71% rate reduction for 2011. Home health has had continual rate cuts over the past 10 years and can not with more cuts.

Home care is one of the most cost-effective service delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation services, and skilled nursing facility care. MedPAC showed that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an inpatient rehabilitation facility and the care results in better patient outcomes.

I have serious concerns about the viability of our home care service if we are forced to sustain a continued drop in reimbursement. Currently reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing labor costs, mileage, worker's compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrism preparedness, electronic medical records and system changes to adapt to the prospective payment system. Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to more expensive as the costs will rise in other Medicare services.

Medicare's recent changes to prospective payment system incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessments to garner higher payments.

For the viability on home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Lois Schuller RN, MS

Submitter : Mrs. Gail Olson **Date:** 10/25/2007

Organization : St. Cloud Hospital Home Care and Hospice

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1541-FC-28-Attach-1.DOC

#28

St. Cloud Hospital

CENTRACARE Health System

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC
P. O. Box 8012
Baltimore, MD 21244-8012
http://www.cms.hhs.gov/eRulemaking

Re: file code CMS-1541-FC

This letter is written on behalf of the St. Cloud Hospital Home Care and Hospice, a hospital-based agency that serves over 2,000 Medicare beneficiaries annually.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, we have grave concerns about the planned 2.71% rate reduction for 2011.

Home health has had continual rate cuts over the past 10 years as shown in the table below:

Table 1: Medicare Home Health Cuts Over the Past 10 Years

FY1998	Home health interim payment system (IPS) was implemented. During two years under IPS Medicare spending for home health care dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
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Home care is one of the most cost-effective service-delivery models in the Medicare program. Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, and the care results in better patient outcomes.

We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS). Given home care's growing population of elderly and disabled, cuts to the home health benefit will only prove to be "penny wise and pound foolish."

Additionally, Medicare's recent changes to PPS incorporate a presumption of case mix creep that we believe is completely unfounded. To assume that any change is attributable to "gaming" assumes that clinicians throughout the nation are deliberately falsifying patient assessment to garner higher payment for their agency. More realistically, the increase in case mix reflects the following:

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   a. Today, home care patients are older and more frail - 23% of home care patients are over the age of 85
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   c. Changes in Inpatient Rehab Facility reimbursement that have appropriately steered more but sicker patients into home health services
3. Comparing what was happening during the IPS years to 2005 is unrealistic for the following reasons:
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   b. Physical therapists were in short supply and just beginning to have a presence in home health service delivery, especially for smaller providers.
   c. OASIS was new and has a long learning curve to accuracy in OASIS answers. Some agencies admit that it's only been in the last few years that they feel their clinicians have a full understanding of OASIS.

For the viability of home care and to ensure continued access to care for the nation's most frail and vulnerable population, it is imperative that CMS rescind the plan to further reduce payment rates in 2011.

Sincerely,

Gail Olson
Care Center Director, Home Care Services

Submitter : **Mrs. Karen Lucas** **Date: 10/25/2007**

Organization : **Roper Saint Francis Home Health**

Category : **Nurse**

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

I am a home health nurse. I have been a supervisor, a field clinician and am currently doing staff development/education. I have been a nurse for 16 years. I have a graduate degree in Community/Home Health Nursing.

GENERAL

GENERAL

I am responsible for the orientation of new staff and the continuing education of all new and current staff. I have been involved in various projects as well. I have also been a supervisor here at my agency.

We send each of our staff members through a thorough 2-day training on OASIS. This is done well into their orientation but before they learn to do evaluations. After their training, they go out with their supervisor and complete their first OASIS admission time point. Our staff is very cognizant of the importance of answering OASIS questions correctly and efficiently.

Because they do so well with this, we do not have a separate position for someone that "reviews" all OASIS timepoints for accuracy as some other agencies do. I have always felt that doing a review of another clinician's OASIS and pretending that you know better when you were not present for the eval is pathetic. Routinely, we do not ask our clinicians to change their original OASIS answers. It is unethical and a waste of time.

It is no secret that our home care patients are coming home sicker and quicker than ever. We are getting total knees after 3 days, CHF patients that have been hospitalized for multiple days, are still extremely weak, do not qualify for rehab, and are still having multiple medications changes due to their fluid status.

For CMS to state that agencies are fixing their OASIS scores to make their patients look more acute than they truly are is an insult. They apparently need to come to our agency and do some evaluations with our clinicians.

I personally resent the fact that payment is changing based on what they "think" is happening and not based in reality. If you are having such a problem with agencies "fixing" OASIS scores, then please, focus on those agencies and stop making the rest of us, who are honest in our work, suffer.

Submitter : Mr. Andy Carter **Date:** 10/25/2007

Organization : Visitng Nurse Associations of America

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1541-FC-30-Attach-1.DOC

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

Dear Mr. Weems:

I am writing on behalf of the Visiting Nurse Associations of America (VNAA) to comment on the Home Health PPS Final Rule with Comment (CMS-1541-FC). The VNAA represents over 400 non-profit, community-based Visiting Nurse Associations (VNAs) across the United States that participate in Medicare as home health agencies. We understand that CMS has opened the final rule on home health PPS payment for comment only with regard to the proposed 4th year cut in rates based on nominal case mix growth. We will comment on that provision as well as changes in the outlier provision which arose for the first time in the final rule and were thus not previously made available to the public.

VNAA appreciates the last-minute effort CMS made in response to VNAA's comments to recompute nominal case mix change by using a new regression analysis to try to identify that portion of case mix increase that could be attributed to real case mix change. However, since CMS has not made any of the data, reports or details of this analysis public, our ability to make any meaningful comments is severely constrained. We would point out that based on the clinical experience of our members, the finding that only 8 percent of the case mix change from 2000 to 2005 was real defies reason almost as dramatically as CMS's original assertion that no case mix change was real. We believe that this unreasonably low finding of real case mix change is inaccurate and should be reexamined for the reasons outlined below.

We understand that CMS' ability to differentiate between real case mix change and nominal case mix change is limited by the power of any predictive model. But starting with the assumption that all case mix change is nominal, and then reducing that estimate only to the degree that such a limited regression model can then predict real case mix change, is inherently biased against providers. A more equitable model would assume that all case mix change was real, and only consider the amount that could be estimated as nominal to be unjustified. Were that the case, we would suggest that CMS would be less likely to proceed with a predictive model that was intrinsically inadequate.

As MedPAC has pointed out in many of its reports, there continues to be large, unexplained variation in the volume of services provided to patients under the home health benefit and no research to support what level is optimal. Over the 10 years of research developing and refining the Medicare PPS system, CMS has tested hundreds of variables to predict resource use in home health and still has achieved only modest success. Since the PPS system has incorporated virtually every strong predictor of resource use, it is not surprising that CMS was only able to predict an 8% real case mix change by using predictive variables other than those used under PPS in its regression analysis. Thus there is an inherent unfairness in the CMS approach by considering all case mix change not predicted by regression analysis to be nominal.

This bias is even stronger where the therapy variable is involved. Over 10 years of CMS research has been unable to predict therapy need under PPS. As a result, CMS has been forced to continue to use visit volume itself to predict therapy need to maintain the minimum level of predictive power needed under the PPS system. Yet CMS assumes in the rule that all case mix change attributable to therapy use is nominal unless it can be predicted by variables that 10 years of CMS research has conclusively established are not predictive. While VNAA urged CMS to reform the therapy variable to reduce the incentives to cherry pick high therapy patients to maximize payment, the growth in the number high therapy patients cannot simply be assumed to be exclusively nominal case mix change. Until CMS can establish the proportion of therapy-driven case mix increase that is nominal rather than real based on case-specific analysis of clinical information, we believe it is unjustified to include therapy-driven case mix increases in the case mix creep adjustment. And while therapy utilization is only the most transparent deficiency in the case mix creep analysis, a similar argument can be made with regard to the inferences rather than facts upon which the CMS has based its entire case mix creep adjustment.

I would like to share with you the results of a recent impact simulation conducted by the Moran Company under contract to the VNAA. This study used the most recent cost reports available from CMS to model the impact of the proposed cuts on the voluntary, non-profit home health agencies represented by the VNAA. Based on trends from 2004-2006 cost reports, Moran projects that our members' Medicare margins will dip to -6.9% in 2011 if these cuts are put in place. Assuming that CMS impact analysis is correct regarding the 3.47 positive impact of the PPS refinements and cuts on free-standing non-profits is accurate (a premise that none of our members has been able to confirm) our Medicare margins are estimated to drop to 2.9% in 2009 and turn negative (-1.9) in 2010.

Even were Congress not to impose the freeze under consideration, our members' total operating margins are projected to drop to -4.5 in 2008, -6.1in 2009, -7.5 % in 2010 and -8.8% in 2011. Were we to apply our average 3% donations from United Way and charitable contributions from other donors to subsidize Medicare rather than serve Medicaid patients and provide charity care, our members would still be in serious financial jeopardy.

Given the extraordinarily heavy impact on beneficiary access and the viability of the non-profit provider sector that the case mix creep cuts will have if imposed as proposed, we would suggest that CMS take a more measured approach to these cuts. At a minimum, we would urge that the proposed 4th year cut of 4.71 be eliminated or at least indefinitely deferred until better data is available. One reasonable approach that would preserve CMS's options yet guard against unexpectedly negative impacts from case mix cuts would be to spread the total proposed cuts across a 6-year period rather than a 4-year period with the cuts weighted more heavily during the last 3-years and predicated upon the level of nominal case mix change being confirmed through a more refined process in the interim.

We would also suggest that, given the lag in data acquisition and analysis, CMS should adopt a 1-year hiatus after year 2 of the 6-year implementation period suggested above to allow Medicare data to catch up to the impacts of PPS refinement, case mix creep cuts and other possible payment changes such as the market basket freeze currently being considered by Congress. This would allow a mid-course correction should the collective impacts of multiple changes be greater than expected. Representing the voluntary, non-profit providers, we know this impact will be disproportionately felt among our members because of our lower historic margins and our mission to take patients without regard to their profitability. We believe it is in the best interest of Medicare and its beneficiaries that VNAs, as safety net providers, not be forced into bankruptcy by the unintended effects of an overly aggressive Medicare payment reform.

Since we believe CMS has an interest in preserving safety net providers such as VNAs in addition to the more measured approach to cuts outlined above, we would urge CMS to consider the following additional steps to avoid unintended harm and beneficiary access problems.

First, CMS should use the broad authority available to it under the statute authorizing the home health PPS system to introduce an additional payment adjustment for providers serving a disproportionate number of low-income and/or uninsured patients, similar to that which CMS created under the PPS payment system for inpatient rehabilitation hospitals.

Second, CMS should use the same authority to give VNAs and other home health agencies wage index parity with hospitals serving the same geographic area. It could do so by using the weighted average hospital wage index including that for reclassified hospitals, rather than the pre-floor, pre-reclassified wage index currently used for home health agencies. The lack of parity in wage index creates an uneven playing field in recruiting and retaining skilled staff for VNAs that provide services in the same area as hospitals with higher wage indices. Wage index parity would help off-set some of the negative effects of the case mix reductions in many areas.

Third, CMS should suspend further case mix creep reduction for any VNA or home health agency that demonstrates that it has not participated in the nominal case mix increase described in the Rule. We would suggest suspending further reduction in

payment for any agency whose Medicare margin has dropped below 5%, those whose average case mix is at or below the documented level of real case mix change measured by CMS, or whose average case mix has not increased by more than 8% between 2000 and 2005.

Moving from the issue of case mix adjustment, we would also urge CMS to reexamine the change in outlier policy in the Final Rule which was not anticipated in the Proposed Rule. We understand that CMS must stay within the statutory 5% outlier payment cap. However, since recent information from a CMS contractor indicates that most of the outlier trend has been driven by abusive conduct now being pursued by CMS in Miami/Dade County Florida, we believe that a nation-wide outlier reduction is unwarranted and not in the best interests of Medicare beneficiaries. The national increase in the FDL ratio for outliers will have no impact on the alleged fraud being perpetrated in Miami/Dade County Florida but will have a negative impact on beneficiaries nationally in terms of limiting access to care. It will also unfairly punish those agencies, such as VNAs who serve legitimate outlier patients. We believe CMS should not consider fraudulent payments now under scrutiny by CMS's Program Safeguards Contractor in Florida in its analysis of the home health outlier threshold. We would urge that the decision to raise the outlier FDL threshold be re-examined in the light of this new information and reduced to a level consistent with true national expenditure trends.

On behalf of the hundreds of Visiting Nurse Associations across the United States, their dedicated staffs and the millions of Medicare beneficiaries they serve, I urge you to seriously consider the consequences of the cuts CMS has planned on the delivery of home health services under Medicare. We believe across-the-board cuts of this magnitude will have a devastating impact far beyond what CMS could have reasonably intended. We would be glad to meet with you or your staff to explain our concerns and discuss any of the proposals to mitigate this damage which we have outlined above. You may contact me at 240-485-1858.

Sincerely,

/s/

Andy Carter
Chief Executive Officer

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Submitter : Diane Omdahl **Date:** 10/25/2007

Organization : Beacon Health

Category : Nurse

Issue Areas/Comments

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

Analysis of and Response to Public Comments on the CY 2008 Proposed Rule

There are two background points. 1) Selected pertinent diagnoses in the revised case-mix receive points. 2) M0246, case-mix diagnoses, is the new data element for reporting a case-mix diagnosis when the use of a V code replaces this diagnosis and eliminates the case-mix points.
Question: When a case-mix diagnosis, such as diabetes, appears in M0246 and also as a pertinent diagnosis in M0240 (because of coding standards), how will the system award points? It's unlikely the diagnosis will receive points twice; however, for diabetes, there are more points as principal. There are other examples of when this can happen but diabetes is probably the most common.
Second question: If a V code appears as principal, moving a case-mix diagnosis down to the first pertinent in M0240, is it necessary to complete M0246? Given that the case-mix diagnosis will receive points as first pertinent (and in all but two diagnosis groups, the same points), it would not seem necessary.

Collection of Information Requirements

Collection of Information Requirements

There are two background points. 1) Selected pertinent diagnoses in the revised case-mix receive points. 2) M0246, case-mix diagnoses, is the new data element for reporting a case-mix diagnosis when the use of a V code replaces this diagnosis and eliminates the case-mix points.
Question: When a case-mix diagnosis, such as diabetes, appears in M0246 and also as a pertinent diagnosis in M0240 (because of coding standards), how will the system award points? It's unlikely the diagnosis will receive points twice; however, for diabetes, there are more points as principal. There are other examples of when this can happen but diabetes is probably the most common.
Second question: If a V code appears as principal, moving a case-mix diagnosis down to the first pertinent in M0240, is it necessary to complete M0246? Given that the case-mix diagnosis will receive points as first pertinent (and in all but two diagnosis groups, the same points), it would not seem necessary.