LAKEVIEW
HOMECARE &
HOSPICE
A member of Lakeview Health

5610 Norwich Parkway
Stillwater, Minnesota 55082
Phone: (651) 430-3320
Fax: (651) 275-5775

September 20, 2007

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

Lakeview Homecare and Hospice is a Medicare-certified agency providing services to approximately 1,500 patients per year.

While we strongly support CMS' efforts to restructure PPS and to replace a poorly functioning case mix adjustment model, Lakeview 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.

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,

Geri Wagner
Director of Homecare and Hospice

>Public Comments on Medicare Program; Home Health Prospective Payment
>System Refinement and Rate Update for Calendar Year 2008:========
>
>Title: Medicare Program; Home Health Prospective Payment System
>Refinement and Rate Update for Calendar Year 2008 FR Document Number:
>07-04184 Legacy Document ID:
>RIN: 0938-AO32
>Publish Date: 08/29/2007 00:00:00
>Submitter Info:
>
>
>First Name: Greta
>Last Name: Kostac
>Category: Nurse Practitioner - HC015
>Mailing Address:
>City:
>Country: United States
>State or Province:
>Postal Code:
>Organization Name:
>
>Comment Info: ==========
>
>General Comment:Serious consideration should be given before the
>legislative and regulatory provisions proposed to reduce the Medicare
>home health services rates by
>$8.63
>billion over the next five years (fiscal years 2008-2012) are decided
>upon. It is evident that CMS has attempted to resolve issues of "case
>mix creep'

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>with With
>continued Medicare and Medicaid costs already in effect, the result
>will be devastating for many home care agencies who service a majority
>of Medicare patients. It seems on the surface that the consideration
>given to the multiple variables involved, we cannot take the chance
>that disservice occurs to those who qualify for these services. Through
>16 years of home care experience, I can testify to the fact that solid
>home care, in addition to decreasing hospitalizations and complications
>of chronic disease, improves the quality of life for the patients it
>touches.
>

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

Re: file code CMS-1541-FC

This letter is written on behalf of ELEAH Home Care, a rural, hospital based home care agency providing care to persons in the West Central Minnesota area.

While we would strongly support CMS' efforts to restructure PPS and replace a poorly functioning case mix adjustment, MHCA (Minnesota Home Care Association) members have serious concerns about the planned 2.71% rate reduction for 2011.

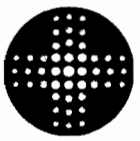
We have serious concerns about the viability of home care providers if they are forced to sustain a continued drop in reimbursement. Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs of labor, transportation, worker's compensation,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

The demographics of the home care's patient population are older and more frail with 23% of home care patients being over the age of 85. The intensity of service required by today's home care patient has increased significantly due to the hospital DRG policy changes leading to decreased length of stay, quicker discharge from SNFs, changes in inpatient rehab facility reimbursement that have appropriately steered more but sicker patients into home health services.

Comparing what was happening during the IPS year to 2005 is unrealistic for the following reasons: under IPS most agencies were having extreme cash flow issues resulting in few staff for education and quality assurance activities and OASIS was new and has had a long learning curve to accuracy in OASIS answers. Some agencies admit that it's only been 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,
Mary Scherr RN
Mary Scherr RN, ELEAH Home Care Manager



October 26, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-FC, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Acting Administrator Weems:

We very much appreciate the opportunity for Gentiva Health Services, Inc. to comment on the Centers for Medicare & Medicaid Services' (CMS) August 24 final rule with comment period regarding the Medicare home health prospective payment system (PPS) and outcomes assessment and information set (OASIS).

Gentiva is the nation's largest provider of comprehensive home health and related services. 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. For example, we were among the first companies to commit all of our home health offices (in our case, over 300 in 36 states) to 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. In addition, we share your commitment and desire for a high-quality and affordable health system in America that is available to the populace, especially the elderly and the disabled. However,

> **our internal team has been reviewing and analyzing the final rule and has come to the conclusion that there is not sufficient information available for Gentiva and the rest of our industry to provide you with intelligent and constructive comments.**

As a result, we offer the following recommendations:

- **We ask CMS to release the technical report** that we understand has been completed by Abt Associates under your agency's direction, so that our industry can determine whether it offers sufficient data and information for us to offer meaningful comments.

- **We urge CMS to extend the public comment period** to permit adequate time for the release and analysis of the Abt report. This extended period would help to ensure that the process is transparent and that home health stakeholders have the opportunity to thoroughly review the significant reductions proposed by CMS.

- **We ask CMS to adopt a more transparent process when determining any future case mix creep upcoding reductions.** The due process outlined in legislation introduced by Senators Susan Collins and Robert Casey (S. 2181) and Representatives Jim McGovern and Walter Jones (H.R. 3865) would be appropriate and useful in further reviews of the case mix creep.

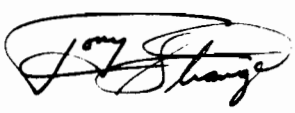
As a national provider, Gentiva was surprised and disappointed that the CMS home health final rule with additional comment period not only maintained the three-year case mix reduction at 2.75%, but further outlined an additional one-year reduction at 2.71%. Our position is that reductions for *potential* "upcoding" are arbitrary and excessive. We believe it would be better for CMS to look more closely at specific agencies it suspects may be upcoding and then seek financial restitution from those that are ultimately deemed to be following this practice. Across-the-board cuts of this magnitude are unwarranted at a time when the home health industry should be receiving additional support to serve an expanding older population.

Home health advances in clinical sophistication through the combined use of therapists and nurses have resulted in far superior outcomes for patients suffering with acute, chronic and rehabilitative needs. In this regard, Gentiva has created unique, specialized therapies and services that have thus far addressed the key health needs of over 170,000 older Americans. Our published national outcomes have demonstrated the ability of these programs to improve the lives of Medicare patients, allowing them to live more independently at home and avoid unnecessary visits to costly institutions. These and other home health advancements have occurred as our healthcare system has been affected by federal requirements (such as the so-called "75% rule" involving in-patient rehabilitation), changes in the marketplace and the discharge of patients from institutional settings "quicker and sicker." As a result, there are too many nuances in the Medicare home health program for your agency to respond with across-the-board cuts.

We ask you to consider our recommendations above and to create a more transparent process for improving the quality and efficiency of the Medicare home health program. You will find Gentiva and other home health providers eager to join you in the quest for enhanced care and greater independence for a growing population of older Americans.

Thank you for this opportunity to comment.

Sincerely,



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

The Home Care Network
Jefferson Health System

October 26, 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-FC
P. O. Box 8012
Baltimore, MD 21244-8012

RE: Final Rule with comment Period (CMS-1541-FC)

Attn: Herb B. Kuhn

With the addition of a fourth year of reimbursement reduction, due to the CMS-calculated "creep", the increase in Case-Mix weight through 2005 measured against the adjusted Case-Mix value from the final four quarters of home health agency reimbursement under the Interim Payment System (IPS), we are concerned that CMS has not correctly assessed factors measuring this apparent "creep".

It was useful to have CMS clarify that they had excluded LUPAs from the two measurement bases utilized. That fact did, however, raise an issue that CMS did not address in the proposed rule. Namely, when the original home health prospective payment system (HH-PPS) was proposed (October 1999) and finalized (July 2000), CMS asserted that the expected LUPA incidence, as estimated by its actuaries, would be five percent---this in the face of actual numbers of sixteen percent. Using just a five percent rate of occurrence resulted in every original home health resource group (HHRG) assigned a lower value than if CMS has used, say, a fifteen percent rate of incidence.

It was also useful to have confirmed by CMS that the rate of episodes where a high therapy need occurred rose from seventeen percent during the IPS period to twenty-six and four-tenths percent in 2005. These two measuring points confirm the home health agencies' contentions, in responding to the proposed rule, that all of the "creep" was due to higher needs for the Service component of home health care. This of course resulted because home health agencies moved from a model wherein patients were provided services as long as needed to a model where patient's outcomes were focused on their return to the community as soon as practicable. In other words, the new HH-PPS motivated agencies to return seniors to the community more expeditiously using higher-skilled services.

Our review of this rise in higher service-need episodes supports the assessment that the 8.7% "creep" noted in the proposed rule was totally the result of the increase in the Service Domain of the HH-PPS. We have estimated that moving from a seventeen percent rate of high therapy need to a twenty-six and four-tenths rate of need resulted in the average Case-Mix increasing by 9.25 basis points (see illustration, attached).

In addition, as noted above, we have confirmed that the initial HH-PPS rule ignored the actual facts of a LUPA incidence rate of sixteen percent, instead opting for an actuarially estimated rate of just five percent. Nonetheless, once the HH-PPS became the regimen for reimbursement, the LUPA incidence rate not only consistently reached the observed sixteen percent level from the IPS era, but may have been higher in many of the years since the HH-PPS has been implemented. Accordingly, agencies were under compensated by approximately 11% for LUPA savings. A fifteen percent incidence rate (see illustration, attached) shows that home health agencies have been under-reimbursed for every year under the HH-PPS by 5.55 basis points.

Using the sum of both of these observations, compared to CMS's assertion of an observed 11.75 basis point average gain, after factoring in growth in real patient need, we believe this confirms the conclusion the home health industry has been underpaid by the HH-PPS regimen. We observe these numbers show that agencies should be getting a boost of 3.05 basis points. It is likely that agencies have been underpaid, due to CMS using an incorrect actuarial assumption for LUPA incidence, for each year of the HH-PPS reimbursement regimen. Agencies may even expect about a 3.00% upward revision for each of the next four years, once CMS fully assesses the impact of using an incorrect actuarial assumption.

In our opinion CMS will need to study this scenario for how it will implement any appropriate upward adjustment, in view of the adoption of the new four-equation approach to determining HHRGs, and that any upward adjustment will likely not be able to be implemented with the start of 2008. It is also our opinion, however, that the downward adjustment of 2.75% to the 2008 base should be eliminated. We urge CMS to make this change with a timely announcement so that 2008 claims can be correctly submitted, thereby avoiding the need for mass resubmissions.

Very truly yours,

Theodore A. Bean

Theodore A. Bean
Finance

Assessment of the Impact of Growth in High therapy Need Episodes in Comparison to the Base (Theoretical) 1997 Period

Impact on Average Case Mix Growth

Estimated Number of Episodes in 2005, excluding LUPAs	4,380,995		
2005 HHRG Average Case Mix	1.2361		1.2361
Aggregate equivalent Case-Mix, for estimated population		5415347.9195	
CMS estimate of unadjsuted case-mix "creep"			0.1278
Impact of growth in successful MO825's			
Percentage of 2005 sample successful	26.40%		
Percenatage under IPS	17.00%		
Increase in success ratio	9.40%		
Growth in total number of successes	411,814		
Distribution to S2 and S3 levels			
S2 =	85%		
S3 =	15%		
Absolute Case Mix value			
S2 =	0.9583		
S3 =	1.1290		
Impact to aggregate case mix value			
S2 =		335444.7699	
S3 =		69740.6213	
Adjusted total case mix, back to IPS success rate level		5010162.5283	
Adjusted average Case Mix			1.1436
Growth, after compensating for MO825's			**0.0925**
Net potential "creep" after adjusting for MO825's			0.0353
Adjustment for CMS-calculated real patient severity growth			0.0103
Possible Case-Mix "creep"			0.0250

Assessment of the Impact of Incidence of LUPA Episodes on "Savings" Redistributed to All Other Episodes

Impact on Average Case Mix - - Savings Not "Awarded"

Assumed Sample Size		5,400,000		
IPS Average Case Mix		1.0000		1.0000
Aggregate HHRG, for sample			5400000.0000	

Impact of LUPA's at an Incidence Rate Greater then 5%:

If 5% of episodes are LUPA's:				
LUPA's, at estimated 5% incidence		270,000		
Reimbursement, @ $300 average	$	81,000,000		
Budget neutral target - estimated	$	11,400,000,000		
Average reimbursement, if no LUPA's		$2,111.11		
LUPA savings, built into final rate	$	489,000,000		
Average initial episode payment		$2,115.00		
If 10% of episodes are LUPA's:				
LUPA's, at estimated 10% incidence		540,000		
Reimbursement, @ $300 average	$	162,000,000		
Additional LUPA savings, at 10% incidence	$	978,000,000		
'Savings' adjusted episode payment		$2,215.62	$ 100.62	(0.0483)
Adjusted HHRG value, because LUPA 'savings' never distributed				0.9517
If 15% of episodes are LUPA's:				
LUPA's, at estimated 15% incidence		810,000		
Reimbursement, @ $300 average	$	243,000,000		
Additional LUPA savings, at 15% incidence	$	1,467,000,000		
'Savings' adjusted episode payment		$2,328.07	$ 213.07	**(0.0555)**
Adjusted HHRG value, because LUPA 'savings' never distributed				0.9445
If 20% of episodes are LUPA's:				
LUPA's, at estimated 20% incidence		1,080,000		
Reimbursement, @ $300 average	$	324,000,000		
Additional LUPA savings, at 20% incidence	$	1,956,000,000		
'Savings' adjusted episode payment		$2,434.61	$ 319.61	(0.0703)
Adjusted HHRG value, because LUPA 'savings' never distributed				0.9297

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NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

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

228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD
President

October 26, 2007

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

Re: CMS-1541-FC
Medicare Program; Home Health Prospective Payment System
Refinement and Rate Update for CY2008

To whom it may concern:

The National Association for Home Care and Hospice (NAHC) is the largest trade association in the United States representing providers of home health care and the patients they serve. We appreciate the opportunity to provide comments on the "Final Rule with Comment Period" that refines the Home Health Prospective Payment System (HH PPS) and the rate update for 2008 as published in Vol. 17 Fed.Reg. 49762 (April 29, 2007).

NAHC appreciates the consideration that the Centers for Medicare and Medicaid Services (CMS) gave to comments that we had submitted in response to the May 4, 2007 proposed rule. Specifically, we believe that the final rule revisions to HH PPS with respect to any revised case-mix adjustment model and PPS structure should lead to improvements in the accuracy and reliability of payments made in Medicare home health services. However, we continue to object to the HH PPS changes that reduce those payment rates to reflect the alleged increase in average case-mix weight scores that is unrelated to changes in patient characteristics.

The manner in which CMS undertook an evaluation of changes in case-mix weights and provided public information regarding such represents a significant departure from the

valuable openness and transparency that CMS had developed with the provider and beneficiary communities over the years. That departure can only lead to a serious deterioration in the quality of home health rulemaking within the Medicare program. NAHC respectfully recommends that CMS return to its previous approach to the rulemaking process that operated in an open and inclusive manner taking advantage of the opportunity to gain the input, insights, and expertise outside of CMS in order to avoid the risks the present rule will trigger relative to continued access to high-quality home health services. Otherwise, CMS has begun a journey down a path that endangers Medicare beneficiaries across the country as well as the integrity of the Medicare Trust Fund.

2011 Proposed Base-Rate Adjustment

The August 29, 2000 rule provides an opportunity for public comment on the proposal to extend to 2011 a reduction in the episodic and per-visit base rates to account for changes in case-mix weight scores that are unrelated to changes in patient characteristics. Specifically, that proposal reflects an extension on the adjustment analysis through 2005 claims data experience and plans a base-rate reduction of 2.71 percent in 2011 to follow the three consecutive years of 2.75 percent base rate reductions.

NAHC would like to take the opportunity to offer specific, detailed, and well-focused comments on the 2011 proposal. However, the failure of CMS to make available the details of the methodology and data utilized to evaluate changes in case-mix weight scores nearly two months after the issuance of the Interim Final Rule makes the comment opportunity virtually useless. Despite repeated requests from the home care community, as well as Congressional offices, to secure a release of the technical report regarding case-mix weight score evaluations, the world outside of CMS remains in the dark as to how the proposed base rate reduction is justified. The limited display of the analytical direction taken by CMS in the Interim Final Rule does not provide for a sufficient understanding that would allow NAHC and others to offer appropriate and constructive comment.

NAHC recommends that CMS withdraw its proposal for base rate reductions for 2011 until such time as the technical report and other comprehensive documents that support the analysis are made publicly available. Further, since the 2008 to 2010 reductions in base rates of 2.75 percent appear to be based on the same analysis that affects the proposed 2011 cut, NAHC recommends that CMS withdraw those scheduled cuts also until such time as all reports and documentation are released and a reasonable opportunity is made available to the public to submit comment.

With the limited information available through the Interim Final Rule, only one thing relative to the rate adjustment is clear and understandable: CMS utilized an entirely different

methodology for evaluating case-mix weight scores and changes in patient characteristics than had been used in the May 4 Notice of Proposed Rulemaking (NPRM). NAHC and many others offered extensive comment and evaluation of the NPRM displayed process for calculating changes in case-mix weight scores. In addition to its own internal analysis, NAHC offered the independent review of that methodology by the Lewin Group, which found significant weaknesses and holes in the evaluation methodology expressed by CMS in the NPRM. With the dramatic change in the CMS analytical method and process, the public has been denied the opportunity to offer effective comments on this significant change in HH PPS.

With the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress expressed its dissatisfaction with rulemaking actions such as those employed by CMS here. Congress did so by establishing a limitation on the inclusion of new matter in a final regulation that is different from anything issued in proposed form. Specifically, Congress amended Section 1871(a) of the Social Security Act [42 U.S.C. §1395hh(a)], to mandate that:

> "If the Secretary publishes a final regulation that includes provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is further opportunity for public comment and a publication of the provision again as a final regulation."

The instant Interim Final Rule does not pass the "logical outgrowth" test set out in Section 1871(a)(4). CMS cannot consider this Interim Final Rule simply the evolution of the proposed rule when the central basis of the proposal to reduce base payment rates has changed. The heart of the CMS proposal on that matter was its evaluation process and data utilization. While the details of the new process and data aspects are not fully known, it is apparent that it is a wholly different methodology that relies on completely different data.

The concept of "logical outgrowth" in a rulemaking proceeding is satisfied only if a reasonable person could connect the dots from the proposed rule to the final rule. While the end results of the rules, *i.e.*, a rate cut, may be of the same type, the road to that action has completely changed. As a result, the public faces a moving target in the rulemaking process, submitting comments directed to the basis of the rate cut in the proposed rule only to find a final rule with a comparable cut but a foreign basis. Accordingly, NAHC strongly recommends that CMS re-enter the rulemaking process with openness, transparency, and complete disclosure in order to provide the public with a meaningful opportunity to offer comment as is their right under the Administrative Procedures Act, 5 U.S.C. §552, and Medicare law, 42 U.S.C. §1395hh.

A Process for Evaluating Changes in Case-Mix Rates

The likely impact of the changes in base rates, including those that CMS considers final as well as the proposed extension through 2011, cannot be understated. NAHC has analyzed the financial condition of home health agencies participating in the Medicare program. Based upon a review of cost reports, primarily from 2006, NAHC estimates that the planned rate cuts will lead to serious access problems throughout the United States. Specifically, NAHC estimates that nearly 52 percent of all home health agencies will have Medicare margins at zero or below by 2011 as a result of the HH PPS cuts. In some states, the number of home health agencies with negative margins will exceed 80 percent. It should be further noted that this analysis utilizes the same method of calculated Medicare margins as is used by the Medicare Payment Advisory Commission and thereby excludes many business and health care costs that are part of the normal operation of a home health agency, such as telehealth services and marketing. Therefore, it can be reasonably assumed that the threats to access are even greater than the 52 percent figure indicates.

NAHC believes that the CMS process for evaluating growth and case-mix weight scores is seriously flawed. Of the little that is known regarding that process, CMS relies upon indicators of patient characteristics that have been disregarded, discounted, or determined unreliable in the creation of the case-mix adjustment model. To now rely upon those factors to evaluate the propriety of case-mix weight scores is astounding. Further, the most glaring weakness in the CMS analysis is the manner in which score changes related to therapy utilization are considered. The existence of the service utilization domain in the case-mix adjustment model is a direct result of the inability of CMS to find objective sources of data that demonstrate the patient characteristics that lead to the need for therapy services. However, CMS appears to now rely upon some type of data inputs to effectively determine that hundreds of thousands of Medicare beneficiaries receiving therapy services had no need for that therapy.

NAHC recommends that CMS withdraw the base rate cuts and establish an appropriate process for evaluating changes in case-mix weight scores to distinguish those changes relating to patient characteristics from those changes relating to other factors. That process should include the following:

1. An outside technical advisory group consisting of stake holders should be created to advise Medicare concerning appropriate standards to distinguish between real changes in case-mix and changes in coding or classification of different units of service that do not reflect real changes in case mix.

2. CMS should establish the standards and criteria to be utilized in the evaluation through rulemaking or an alternative public process.

3. All data, reports, and supporting materials, including any activities of the technical advisory group, should be made available concurrent with any proposal to adjust payment rates.

4. Changes in the Medicare program overall should be considered in terms of the impact on the characteristics of individuals receiving home health services.

5. Changes in the provision of health care services by providers of services other than home health care agencies should be evaluated for the impact on home health care.

6. Distinctions in the characteristics of individuals initiating home health services from the community and institutional care settings should be considered.

7. Changes in coding or case-mix rates that do not lead to a change in overall home health care expenditures should be disregarded.

8. With respect to changes in case-mix weights that relate to changes in the volume or nature of services provided to home health service patients, CMS shall evaluate that increase through actual review of claims and services and shall not use any proxy or surrogate for determining whether the change in volume or nature of services is reasonable and necessary.

Utilizing the process standards set forth above would bring both transparency and integrity to this important area of rulemaking. Further, utilizing such standards would significantly reduce the risk of compromising access to care for Medicare beneficiaries.

Outlier Payments Standards

In the NPRM, CMS proposed to continue the existing standards for determining the application of outlier payments. Specifically, the proposal was to maintain the 0.67 Fixed-Dollar Loss (FDL) ratio. At the same time, the NPRM noted that, with the data available at the time, the FDL may need to be lowered to 0.42 to achieve a payment level sufficient to distribute the full outlier budget that representing 5 percent of annual Medicare home health expenditures. Accordingly, the Interim Final Rule change that sets the FDL at 0.89 is nothing short of a complete surprise.

After endless years where the incidence of outlier payments has fallen far short of the budgeted level, it would be an understatement to say that it was a shock that the Interim Final Rule revealed an estimate of spending in excess of the 5 percent budget in the event that the FDL was maintained at 0.67.

It has now come to light that the outlier spending has accelerated due to anomalous claims practices in the Miami-Dade area. While the exact depth of the issue is yet to be fully uncovered, it appears that outlier expenditures in Miami-Dade exceeded $300 million in 2005-6. This figure is in stark contrast to outlier claims in the rest of the nation, which total less than $500 million. NAHC also understands that a range of oversight efforts are underway to address this unusual circumstance.

It would be very reasonable to conclude that the Miami-Dade experience in outlier claims will not continue in 2008. As such, NAHC recommends that CMS recalculate the FDL ratio for 2008 disregarding the Miami-Dade anomaly. Alternatively, CMS should consider monitoring the Miami-Dade outlier claims as they are received to determine whether the estimates made in the Interim Final Rule remain valid. With that monitoring, if CMS finds a continuation of in the spending trend, Medicare can revise the FDL at an early point in 2008.

A viable outlier payment system is essential to address weaknesses inherent in any case-mix adjustment model. Home health shares outlier experiences with other health care provider sectors. One difference is that the home health patient is more predictably an outlier at admission. If a reasonable outlier payment policy is not in effect, there is great risk that the predictable outlier patient will experience serious access problems. CMS should take all steps to avoid victimizing these patients because of an anomalous action in a limited part of the country.

NAHC respectfully recommends that CMS reinstate the FDL at 0.67 and adjust it during CY2008, if needed, to respond to changes in outlier spending. Using this approach rather than one that presumes anomalous behavior would continue in the face of stepped-up oversight provides safeguards for those Medicare beneficiaries receiving home health services at extensive levels. The alternatives to providing support for the care of such individuals only serve to harm those beneficiaries and the Medicare Trust Fund in the event that such beneficiaries are shifted to alternative care sitings.

Contingency Plan

In its comments to the proposed rule, NAHC recommended that CMS develop a contingency plan to be used in the event that "best laid plans" go awry in the transition to the

revised HH PPS. NAHC renews that recommendation as indications are surfacing that Medicare contractors, home health agencies, and IT vendors may not be fully prepared to bring about a smooth transition to the new system.

NAHC is prepared to work with CMS to develop the specifics of that contingency plan. However, minimum standards for that plan should include:

1. The expedited implementation of a payment proxy method to account for the inability to submit or process RAPs and final claims on a timely basis.

2. A comprehensive systemic approach to payment proxies when the problems lie with Medicare contractors as distinct from the providers and their vendors.

3. A reconciliation process to be used when systems are fully operative to ensure financial stability to the home health agencies. That reconciliation process should include expedited claims processing to eliminate any payment shortfalls that come through the payment proxy process.

NAHC recommends that this contingency plan be established well before January 1, 2008.

Conclusion

Thank you for the opportunity to submit these comments. NAHC stands ready to work with CMS on the issues discussed herein as well as any others related to the new HH PPS.

Very truly yours,

William A. Dombi
Vice President for Law

VNAA Visiting Nurse Associations of America®

the voice of home healthcare

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.

Administrative Office
99 Summer Street, Suite 1700
Boston, MA 02110
617-737-3200
1-888-866-8773
617-737-1144 (fax)
www.vnaa.org

Washington Government Affairs Office
8403 Colesville Road, Suite 1550
Silver Spring, MD 20910
240-485-1857
240-485-1818 (fax)
www.vnaa.org

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,

Andy Carter
Chief Executive Officer