Submitter : **Date & Time:** 06/23/2004 02:06:31

Organization :

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

TO: Mark B McClellan, MD, PhD. Administrator. Centers for Medicare and Medicaid Services. U.S. Dept fo Health and Human Services. Attention: CMS-1610-IFC.

I am a physical therapist who has been practicing in the state of CA for the last five years. I graduated from UCS with a Doctoral Degree in PT in 1999. I have been practicing at the same outpt PT clinic in San Diego since receiving my degree. I am writing to comment on the March 26 interim final rule on "Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II)" I wish to express multiple concerns with the current ruling which allows POPTS clinics to exist. First, history has shown that the potential for fraud and abuse exists when physicians are able to refer to clinics which they own. In a 1992 study by the Journal of the American Medical Association, POPTS generated higher charges and higher utilization than independent rehab practitioners. In 1992, the New England Journal of Medicine found higher costs of care associated with physical therapy care under CA workers compensation program in POPTS. PT care was initiated 2.3 times more often by physicians in self-referral clinics than in independently run practices. In 1991, in a study by the Florida Health Care Costs Containment Board, both licensed and non-licensed therapy workers spent less time with each patient in a POPTS, leading to a decreased level of care for the patient. These studies all show that physician-owned physical therapy clinics have over utilized, overcharged and regularly provided a lower standard of care than independently owned physical therapy practices. How will things be any different this time around? With the exploding costs of health care, can we afford to go down this same road of poor care and higher costs once again.

I attended 3 years at USC to receive my Doctoral degree at a huge financial cost to myself ($120,000). I did not obtain this level of education just so that others who do not have my skills can profit from my work, especially if patient care is compromised. My clinic has seen a significant decrese in the # of referrals from a local POPTS since it opened its doors a few months ago. Not only do I fear for my own livelyhood and that of my family, but I fear for my profession as a whole. I worry about all of the students in my profession who are striving to obtain a high level of education, only to find a weakened market for their valuable services. If physicians are allowed to profit from our hard work, then the future of our profession as a whole will be in serious jeopardy. Our profession has come a long way, and our history of providing excellent pt care and advocacy is at risk.

In closing, the past arguments which for some time outlawed POPTS clinics are still just as valid today as they were in the past. We cannot afford to make the same mistakes and jeopardize the future of the profession of physical therapy and the valuable services we provide to the public every day. History will repeat itself, and hopefully we can prevent it from happening again.

Thank you.

Amos Mansfield, MBA, ATC, LAT

Assistant Athletic Trainer

The University of Southern Mississippi

118 College Drive #5017

Hattiesburg, MS 39406

September 13, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

Submitter : **Date & Time:** 06/24/2004 11:06:14

Organization :

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I wish to comment on the March 26, 2004 Phase II interim final rule and request that my concerns be addressed in the phase III regulation.

When a physician may benefit financially from referrals, this physician has an inherent incentive to refer patients to physical therapy practices he has invested in and operates. In the absence of effective controls there is and additional financial incentive for overutilization of these services. Within CMS definition of Medicare abuse these financial incentives clearly set the stage for abusive referral patterns.

Here is one example from my experience. When I was employed as a physical therapist to provide in-office ancillary services, the MD was so confident in my skills that he was happy to refer enough patients to keep me busy providing on average 16 patient visits daily for almost 3 years. However, after I left his employment to establish and operate my own practice, using the same highly valued skills, the referrals dropped to perhaps 2 per year. Clearly the earlier referrals were based upon financial incentive rather than concerns over quality of care.

As a second example, I am also familiar with a large orthopedic group practice in our town that keeps Physical therapy referrals in house. Patients who received care there, then subsequently sought treatment from me complained that their treatment at the POPTS was inconsistent, provided by different therapists on different days and often by aides (who are not licensed to provide therapy services) The ?in-office ancillary services? exception has been defined so broadly that, rather than restricting referral for profit it actually makes such referral patterns more attractive, It does nothing to prevent the provision of services billed as ?physical therapy services? under the physician's provider number by non-physical therapists. In our state, ?Physical Therapy? as legally defined may only be practiced by licensed physical therapists and licensed physical therapist assistants. The purpose of this restriction is to protect to quality of treatment for patients.

My third example is that of a solo practice Medical Doctor who opened a practice solely for the provision of so-called ?Rehabilitation? services under his provider number, primarily to senior patients. Initially, an aide provided these services. (Later, to his credit, the MD became convinced that a licensed PT under his employ would be more appropriate than an aide) Once again, the ?in-office ancillary services? exception does nothing to prevent referral practices such as this.

Thanks for the opportunity to comment, and for your careful considerations of my comments.

Issues

BACKGROUND

Subject: Medicare Program; Physicians? Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II); Interim Final Rule with Comment

Dear Dr. McClellan:

I am a practicing physical therapist with 16 years of clinical experience. I currently (and for the last 8 years) am a Physical Therapist in Independent Private practice. Besides my early hospital experiences, I have also been employed in a joint-venture (Physician-hospital clinic) and in a captive POPTS where the orthopedic surgeon employed me directly.

Submitter : Ms. Marilyn Litka-Klein **Date & Time:** 07/09/2004 12:07:00

Organization : Michigan Health & Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see the MHA's attached comment letter regarding the FY 2005 Inpatient Proposed Rule.
CMS-1428-P

Submitter : Mrs. Derwin Manning **Date & Time:** 07/13/2004 12:07:18

Organization : PROMISED LAND FAMILY SERVICES,

Category : Home Health Facility

Issue Areas/Comments

Issues

BACKGROUND

We are having a large quanity of individual that need long term home health care receiving medicare being referred to our agency. Will there be any changes in the future funding for long term medicare patients. Please send a reply at your earliest convience.

dmanning910@yahoo.com

CMS-1265-P-5

Submitter : Mr. Patricia Kelleher **Date & Time:** 07/29/2004 03:07:14

Organization : Home & Health Care Association of Mass., Inc.

Category : Home Health Facility

Issue Areas/Comments

Issues

PROVISIONS OF THE PROPOSED REGULATIONS

Please see comments attached.

CMS-1265-P-5-Attach-1.pdf

Home & Health Care Association of Massachusetts, Inc.
31 St. James Ave. ste 780
Boston, MA 02116
617/482-8830
www.hhcam.org

July 30, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1265-P
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-1265-P; Medicare Program, Home Health Prospective Payment System Rate Update for Calendar Year 2005

Greetings:

The Home & Health Care Association of Massachusetts (HHCAM), on behalf of our 100 member home health care agencies, appreciates this opportunity to comment on the proposed rule for the Calendar Year 2005 Medicare Home Health Prospective Payment System (IPPS).

Provisions of the Proposed Regulation

Case Mix Weight

We are disappointed that CMS does not propose any modifications or adjustments to the current case mix weight system used to calculate the episode reimbursement levels for the 80 different Home Health Resource Groups in the PPS system. After three years of PPS, we believe CMS should have adequate data available to review and revise the case mix weight system.

We note in particular two areas of concern. First, anecdotal evidence from our member home health agencies indicates that Medicare/Medicaid dually eligible patients require substantially more services than Medicare-only patients, even within the same HHRG case mix classification. We recommend that CMS investigate this concern, and either assign additional points for case mix classification for patients who are dually eligible, or establish an add-on for services to dually eligible patients.

Second, the current project to recoup "overpayments" when agencies incorrectly answer MO175 on the OASIS assessment has raised a significant question about how to classify Long Term Acute Care (LTAC) Facilities for purposes of this OASIS item. The financial incentives for LTACs have shifted dramatically in recent years with the advent of in-patient PPS. This change in financial incentives emerged AFTER the home health PPS system was developed. Information supplied by our member home health agencies show that patients that come out of an LTAC are much more similar to patients coming from rehab facilities in terms of service requirements than they are to patients coming from traditional acute care hospitals. We believe that classifying

LTACs as acute care hospitals for purposes of MO175 does not properly reflect the service needs of these patients, and could create disincentives for home health agencies from accepting these patients in the future.

We strongly urge CMS to:

1. **immediately change the way LTACs are classified for purposes of MO175,**
2. **incorporate an adjustment for Medicare/Medicaid dually-eligible patients into the HHRG case mix weighting system, and**
3. **undertake a thorough review of the HHRG case mix weight system over the next year prior to establishing rates for calendar year 2006.**

Outlier Fixed Dollar Loss Ratio

We strongly support the proposed reduction in the fixed dollar loss ratio from 1.13 to 0.73 in the outlier provision. This change will increase both the percentage of episodes that quality for outlier payments, and the payment amount that an agency will receive for a given outlier episode. We concur that this change will increase overall outlier payments to be closer to the 5% overall target established in the original PPS rule in July, 2000.

However, we note that for the past three years, outlier payments have amounted to only three percent of total home health PPS payments. We raise this issue for two reasons: First, we believe that the 40% underestimation of outlier payments in the original PPS rule raises serious questions about the validity of the entire PPS system and the underlying data analysis. We urge CMS to conduct a thorough review of the PPS system over the next year to improve its validity. Second, this significant shortfall in outlier payments means that home health agencies have been UNDERPAID by two percent in the aggregate for each of the past three years.

To make up for these three years of underpayments, we recommend that CMS increase the proposed CY 2005 national 60-day episode rate and the corresponding CY 2005 per-visit payment amounts by 2%.

Hospital Wage Index

We have serious concerns about the CY 2005 pre-floor and pre-reclassified hospital wage index used to calculate the 2005 home health PPS rates. For FY 2004 home health rates, CMS used the CY 2003 hospital wage index. Your proposal would apply two years worth of wage index changes in just 15 months. According to the corrected wage index tables released by CMS on July 23, 2004, a very high percentage of MSAs will have significant swings in their wage index. Three of the five MSA and Rural areas in Massachusetts will experience dramatic reductions in their wage indices: The Barnstable MSA index will drop by 6.6%, the Springfield MSA index will drop by 6.9%, and the Rural index will plummet by 9.5%. If these changes go through as proposed, agencies in these areas will be unable to compete in an already tight health care employment market, and will be put at significant financial risk.

We also note that, in the inpatient hospital PPS regulation for 2005 published on May 18, 2004, CMS has proposed major changes to the MSA definitions, which will dramatically change the MSA map for Massachusetts. Although CMS does not plan to use these revised MSA definitions for home health PPS in 2005, we expect that they will be implemented in 2006.

We believe that any changes to the MSA definitions and wage index should conform to the following principles:

1. The Medicare wage index adjustment should accurately reflect wage level differences among labor market areas throughout the nation.
2. Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary, and that reclassifications that are allowed to hospitals competing in the same labor markets must also be available to home health agencies.
3. There should be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in a local wage index to give agencies time to adjust.
4. Relief for providers that are impacted negatively by the changes should not come at the direct expense of the providers that benefit from the changes.

Given these principles, we believe that modifications in the proposed rule must be made to accommodate realities in the labor market and to avoid sudden financial dislocations that could threaten many financially fragile Massachusetts home health agencies.

Transitional Hold-Harmless

When significant changes are made in the wage index there should be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in a provider's reimbursement to allow adequate time for adjustment. In the Inpatient Hospital PPS regulation, CMS proposes a three year hold harmless for former urban hospitals changed to "rural", citing a disproportionate impact on these hospitals as the reason for the hold harmless. We believe the CMS should also offer a hold harmless provision for home health agencies where there is a sudden reduction in the local wage index. **We recommend that, in the final rule, CMS limit to 2% the amount that a local wage index can drop from one year to the next.**

Geographic Reclassification

Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary. CMS recognizes this fact by allowing hospitals to reclassify to a neighboring MSA. Home health agencies must also be allowed to reclassify to avoid inequities among providers competing in the same labor market. Home health agencies are currently put at a serious competitive disadvantage because reclassification is not available to them. For example, the largest hospital in the Springfield, MA, MSA recently reclassified to the Hartford, CT, MSA. That hospital now gets higher Medicare reimbursements than other providers in the MSA, and can afford to pay its employees a higher rate of pay. The home health agencies in the area are unable to compete with the higher wages that the hospital can pay, because reclassification is not available to them.

We recommend that home health agencies in a given MSA automatically be reclassified to a neighboring MSA if the largest hospital in the MSA is reclassified. Additionally, we recommend that home health agencies be allowed to apply for reclassification, subject to the same process and criteria currently available to hospitals.

MA Rural Wage Index

As noted previously in our comments, the proposed CY 2005 wage index for Rural counties in Massachusetts is 9.5% lower than the wage index for FY 2004. We believe this large drop is due to the fact that last year, CMS began excluding data from the wage index calculation data for hospitals that were subject to the PPS in the year that wage data are collected, but subsequently converted to Critical Access Hospital (CAH) status. Two of the three rural hospitals in

Massachusetts were recently granted Critical Access status, so their wage data is no longer included in calculating the rural wage index. Home health agencies located in the high wage counties of Dukes and Nantucket – where the hospitals now have CAH status – will have their payments adjusted by an artificially low rural wage index, which is based on data from only *one* low wage rural hospital located in Franklin county. The proposed 2005 rural wage index in no way characterizes the labor market in Dukes and Nantucket counties.

We urge CMS to include the wage data from these Critical Access Hospitals and re-calculate the wage index for Rural counties in Massachusetts.

Thank you for this opportunity to comment. I would be happy to discuss any of these recommendations in detail with CMS staff.

Sincerely,

Patricia M. Kelleher
Executive Director

Submitter : Ms. Michelle Pascetta **Date & Time:** 07/30/2004 01:07:14

Organization : Avery Heights Home Health Agency

Category : Home Health Facility

Issue Areas/Comments

Issues

PROVISIONS OF THE PROPOSED REGULATIONS

The estimated financial impact of the latest changes in the wage index for the Avery Heights Home Health Agency is ($15,000).

This reduction will make it almost impossible for us to remain competitive in terms of wage offerings to current and future employees.

We respectfully request that CMS return the three hospitals located in Litchfield County to the Hartford MSA per previous longstanding CMS policy.

In addition, Providers must be given adequate advance notice of signficant downward adjustments and such adjustments should be capped.

Furthermore, we request that home health agencies receive the same wage index reclassification rights as hospitals.

Submitter : Mrs. Theresa Bachhuber **Date & Time:** 07/30/2004 01:07:38

Organization : Bristol Hospital Home Care Agency

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

The estimated financial impact of the latest changes in the wage index for my agency is more than substantial. Bristol Hospital Home Care Agency is ultra-efficient and runs with minimal staff. Cutting the wage index will kill my already anorexic agency. At current levels, my staff is burnt out due to the ongoing and continued paperwork burden imposed on home care agencies. In an environment which is already difficult to recruit and retain scarce nurses, therapists and home health aides, this measure to DECREASE payment to home care agencies will cripple recruitment and retention efforts, leaving the most vulnerable population without the care they deserve.
I am requesting that CMS return the three hospitals located in Litchfield County to the Hartford MSA as per the previous longstanding CMS policy; and in the future, providers be given adequate advance notice of significant downward adjustments; and that such adjustments be capped; and that home health agencies receive the same wage index reclassification rights as hospitals.

Submitter : Ms. Maureen Moore **Date & Time:** 07/30/2004 02:07:03

Organization : Regional Hospice of Western CT, Inc

Category : Health Care Professional or Association

Issue Areas/Comments

Issues

BACKGROUND

We are a small Hospice organization located in Danbury CT with 1/5 of our patients being on Medicaid and Medicare Home Care benefits. Since this is a brigde program to hospice theses patients are very ill and require many more services than our PPS payment will begin to cover. Last FY we provided $47,000 of live-in home health services for these frail elderly patients who either live alone ofr have a frail elderly care giver. The average age of our patients is 88. We actively fund raise to pay these and other expenses. Now you are asking home care providers to take a further reduction in reimbursement. Many of the small non-profit agencies that have served the frail elderly will be forced to cut services or go out of business.

PROVISIONS OF THE PROPOSED REGULATIONS

The financial impact will make it difficult for us to recruit and retain scarce nurses, therapists and home health aides. Already the this year we have lost 2 or our 5 experienced nurses to for-profit organizations that can afford to pay more for the nurses we have trained.
In addition we request that we providers be given adequate advance notice of significant downward adjustments and that such adjustments be capped, I have just prepared my budget for next year and already there will be a significant shortfall because of your late notice.
Our sister home care organization has had to lay off several employees because of low reimbursement.
?

Submitter : Diane Poole **Date & Time:** 07/30/2004 04:07:24

Organization : Holyoke Visiting Nurse Association, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

I believe that any changes to the wage index should conform to the following principles:
1. Medicare wage index adjustment should accurately reflect wage level differences among labor market areas throughout the nation
2. Wage areas must recognize the realities of labor markets, notable that area borders are somewhat arbitrary, and that reclassifications that are allowed to hospitals competing in the same labor markets must also be available to other types of Medicare providers, including home health agencies.
3. When significant changes are made in the wage index there shold be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in provider reimbursement to allow adequate time for adjustment.
4. Relief for providers that are impacted negatively by the changes should not come at the direct expense of the providers that benefit from the changes.
I feel that modifications in the proposed rule must be made to accommodate realities in the labor market and to avoid sudden financial dislocations that cold not only threaten many financailly fragile Massachusetts providers but also have an enormous impact on our Agency.
Our Agency struggled during IPS, prior to the implementation of PPS, to eliminate a projected $1.7 million loss. Since that time we have eliminated overhead, reduced visits, invested in technology to gain efficiencies while still creating positive outcomes for our patients. At this point we have a meager 3% profit margin which we are using to invest in technology for our visiting staff.

Issues

BACKGROUND

FY 2005 Inpatient Prospective Payment System

PROVISIONS OF THE PROPOSED REGULATIONS

Update wage index for MSA 8003

REGULATORY IMPACT ANALYSIS

The proposed regulation, if implemented, will create a $231,216 loss for our Agency. Changing the wage index from 1.0927 to 1.0174 will mean a 7.53% reduction in our current wage index. It is beyond my comprehension how a wage index can be decreasing when we are forced to increase Nursing wages just to compete with our local hospitals and the local nursing shortage. Over the last year we have increased wages 5%, our health insurance has increased 12%, and our dental insurance has increased 6%. With costs consistently increasing, how can our wage index decrease so dramatically?

Submitter : Brian Ellsworth **Date & Time:** 07/30/2004 05:07:43

Organization : Connecticut Association for Home Care

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The Connecticut Association for Home Care (CAHC), on behalf of 82 Medicare-certified home health agencies serving over 47,500 Medicare beneficiaries annually in Connecticut, is pleased to submit the following comments on the proposed rule for the Calendar Year (CY) 2005 Medicare Home Health Prospective Payment System (PPS).

CAHC has major concerns about the proposed technical changes to the wage index. Those changes will have a significant negative effect in two of CT's four wage index regions. Our specific concerns and recommendations are outlined in the Provisions of the Proposed Regulations section of these comments.

CAHC is very supportive of the proposal to reduce the outlier fixed dollar loss threshold as a good first step in improving access to care for higher cost patients. CAHC has repeatedly advocated for full expenditure of the already-appropriated outlier funds. We believe that encouraging access to home health care for heavy care patients actually saves the Medicare system overall by encouraging placement in less costly non-institutional settings. CAHC recommends that CMS institute a periodic analysis of outlier expenditures in order to bring about timely and appropriately targeted adjustments. CAHC also recommends that the outlier formula be modified to recognize medical supply costs and other non-visit related costs such as telemedicine.

The current project to recoup overpayments when agencies incorrectly answer MO 175 on the OASIS assessment has raised significant issues due to the inherent complexity and unworkability of this adjustment. CAHC strongly recommends that CMS identify underpayments by the same methods as CMS proposes to identify overpayments, and to offset one by the other prior to recovery.

The classification of Long Term Care Hospitals (LTCHs) for purposes of MO 175 has also raised issues of fairness in the MO 175 recovery process. The financial incentives for LTCHs have shifted dramatically in recent years with the advent of LTCH PPS. We believe that classifying LTCHs as acute care hospitals for purposes of MO175 does not properly reflect the service needs of these patients, and could create disincentives for home health agencies for accepting these patients in the future. We strongly urge CMS to change the way LTCHs are classified for purposes of MO 175 and to disregard any prior overpayments due to unintentional misclassification of LTCHs as inpatient rehabilitation facilities.

Home care benchmarking vendor Outcome Concept Systems (OCS) has provided national data to CAHC which indicates that Medicare/Medicaid dually eligible patients receive substantially more nursing and home health aide visits per Medicare episode than Medicare-only patients, despite having similar case mix classification. We believe this occurs because dually eligible patients have more comorbidities, fewer informal supports and are less compliant than Medicare-only patients. These factors are not adequately recognized in the existing home health resource groups (HHRG) case mix system. We recommend that CMS consider a disproportionate share adjustment for HHA PPS in order to appropriately reimburse agencies caring for high proportions of dually eligible patients.

Cc: Representative Nancy L. Johnson

Issues

PROVISIONS OF THE PROPOSED REGULATIONS

The Connecticut Association for Home Care (CAHC), on behalf of 82 Medicare-certified home health agencies serving over 47,500 Medicare beneficiaries annually in Connecticut, has serious concerns about recently announced changes to the wage index for home health PPS.

According to an announcement from CMS made only last week, the June 2, 2004 Federal Register notice contained technical errors in the proposed CY 2005 wage index tables. The CMS proposal would apply two years worth of wage index changes in just 15 months. Moreover, the changes

appear to reverse longstanding policy with respect to treatment of certain Connecticut (CT) hospitals.

Two of the four regions in CT will experience dramatic reductions in their wage indices: Hartford MSA will decline by 4.2 percent and the CT Rural index will decline by 6.5 percent. If these changes go through as proposed, agencies in these areas will be less able to compete in an already tight health care employment market, and could be put at significant financial risk.

CAHC believes that the reason for these dramatic changes is that CMS unilaterally changed the designation of three hospitals in Litchfield County (The Charlotte Hungerford Hospital, New Milford Hospital, and Sharon Hospital) from their longstanding placement in the Hartford MSA to the Rural region, apparently lowering both wage indices in the process. CAHC strongly urges CMS to restore these hospitals to the Hartford MSA.

We also note that, in the hospital PPS regulation for 2005 published on May 18, 2004, CMS has proposed major changes to the MSA definitions. CAHC supports CMS' stated decision not to use these revised MSA definitions for home health PPS in CY 2005. It is possible that the re-designation of the three hospitals was done as part of CMS' proposal for revised MSA definitions. If so, than that re-designation is in conflict with CMS' stated intent not to apply revised MSA definitions for home health agencies in CY 2005.

CAHC recommends that CMS adhere to the following three principles before instituting any major wage index reforms: 1) a comprehensive impact analysis must be performed to determine the effect of any proposed change on patients and providers of home health services; 2) no systemic change in the wage index should be implemented without adequate warning; and 3) a limit on the percentage change reduction in any wage index update should be instituted.

In the Hospital PPS proposed rule, CMS proposes a three-year hold harmless for former urban hospitals changed to rural, citing a disproportionate impact on these hospitals as the reason. CAHC recommends that CMS should also offer a transitional hold-harmless provision for home health agencies where there is a sudden reduction in the wage index and that CMS limit to 2 percent the amount that a wage index can drop from one year to the next.

CAHC strongly recommends that CMS reconsider its historical rejection of geographic area reclassification rights and application of the rural floor to home health agencies. Such rights are not precluded by statute even though they are not specifically allowed. Given CMS' recognition that home health agencies compete for workforce resources with hospitals and other health care providers, it is inconsistent to provide reclassification rights and the rural floor to hospitals while denying these options to home health agencies. About half of the 30 general hospitals in CT are reclassified to different MSAs. CAHC recommends that CMS institute geographic area reclassification rights comparable to those available to hospitals, apply the rural wage index floor, and allow an agency the option to be automatically reclassified in the event that an area hospital has been approved for reclassification.

CMS-1265-P-10-Attach-1.pdf

CMS-1265-P-10-Attach-1.pdf

THE CONNECTICUT ASSOCIATION for **Home Care,** *Inc*

July 30, 2004

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1265-P
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-1265-P; Medicare Program, Home Health Prospective Payment System Rate Update for Calendar Year 2005

Dear Dr McClellan:

The Connecticut Association for Home Care (CAHC), on behalf of 82 Medicare-certified home health agencies serving over 47,500 Medicare beneficiaries annually in Connecticut, is pleased to submit the following comments on the proposed rule for the Calendar Year (CY) 2005 Medicare Home Health Prospective Payment System (PPS).

PROVISIONS OF THE PROPOSED REGULATIONS

Wage Index

<u>"Technical Changes" Create Major Downward Adjustments for Connecticut</u>
According to an announcement from CMS made only last week, the June 2, 2004 Federal Register notice contained "technical errors" in the proposed CY 2005 wage index tables. CMS inadvertently published the 2004 pre-floor and pre-reclassified wage index tables instead of the intended 2005 pre-floor and pre-reclassified wage index tables. **CAHC has serious concerns about this change**. CMS' proposal would apply two years worth of wage index changes in just 15 months. Moreover, the changes appear to reverse longstanding policy with respect to treatment of certain Connecticut hospitals.

Following is a chart with the revised proposed CY 2005 Wage Indices as compared to the FY 2003 wage indices currently in use. Two of the four regions in Connecticut will experience dramatic reductions in their wage indices: the Hartford Metropolitan Statistical Area (MSA) index will decline by 4.2 percent and the Connecticut Rural index will decline by 6.5 percent. If these changes go through as proposed, agencies in these areas will be less able to compete in an already tight health care employment market, and could be put at significant financial risk.

110 Barnes Road, P.O. Box 90, Wallingford, CT 06492-0090
Telephone: 203.265.9931 ◆ Fax: 203.949.0031 ◆ Web: www.cthomecare.org

Comparison of Originally Proposed and Revised Wage Indices
Connecticut Wage Index Regions
CY 2005

Wage Index Region	FY 2003	Originally Proposed CY 2005	% Change Original '05 Over FY 2003	Revised Proposed CY 2005	% Change Revised '05 Over FY 2003
Hartford	1.1549	1.1555	0.1%	1.1068	-4.2%
New Haven	1.2408	1.2385	-0.2%	1.2254	-1.2%
New London	1.1767	1.1631	-1.2%	1.1596	-1.5%
Rural	1.2394	1.2183	-1.7%	1.1586	-6.5%

CAHC believes that the reason for these dramatic changes is that CMS unilaterally changed the designation of three hospitals in Litchfield County (The Charlotte Hungerford Hospital, New Milford Hospital, and Sharon Hospital) from their longstanding placement in the Hartford MSA to the Rural region, apparently lowering both regions' wage indices in the process. **CAHC strongly urges CMS to restore these hospitals to the Hartford MSA.**

We also note that, in the inpatient hospital PPS regulation for 2005 published on May 18, 2004, CMS has proposed major changes to the MSA definitions, which will change the MSA map for Connecticut. **CAHC supports CMS' stated decision not to use these revised MSA definitions for home health PPS in CY 2005**. It is possible that the re-designation of the three hospitals was done as part of CMS' proposal for revised MSA definitions. If so, than that re-designation is in conflict with CMS' stated intent not to apply revised MSA definitions for home health agencies in CY 2005.

Transitional Hold-Harmless

CAHC recommends that CMS adhere to the following three principles before instituting any major wage index reforms: 1) a comprehensive impact analysis must be performed to determine the effect of any proposed change on patients and providers of home health services; 2) no systemic change in the wage index should be implemented without adequate warning; and 3) a limit on the percentage change reduction in any wage index update should be instituted.

In the Inpatient Hospital PPS proposed rule, CMS proposes a three-year hold harmless for former urban hospitals changed to "rural", citing a disproportionate impact on these hospitals as the reason. **CAHC recommends that CMS should also offer a transitional hold-harmless provision for home health agencies where there is a sudden reduction in the wage index and that CMS limit to 2 percent the amount that a wage index can drop from one year to the next.**

Geographic Reclassification and Application of the Rural Floor

CAHC strongly recommends that CMS reconsider its historical rejection of geographic area reclassification rights and application of the rural floor to home health agencies. Such rights are not precluded by statute even though they are not specifically allowed. Given CMS' recognition that home health agencies compete for workforce resources with hospitals and other health care providers, it is inconsistent to provide reclassification rights and the rural floor to hospitals while

denying these options to home health agencies. About half of the 30 general hospitals in CT are reclassified to different MSAs. **CAHC recommends that CMS institute geographic area reclassification rights comparable to those available to hospitals, apply the rural wage index floor, and to allow a home health agency the option to be automatically reclassified in the event that an area hospital has been approved for reclassification.**

Occupational Mix Adjustment

CAHC recommends that CMS begin to consider refinements in the wage index to appropriately reflect the occupational mix in home health services. The hospital occupational mix data published in the May 18, 2004 proposed rule clearly indicates that hospitals have a significantly different mix of employees than home health agencies. This potentially leads to major distortions in the hospital wage index as it is applied to home health PPS.

In the absence of reliable home health specific wage data, CMS should have the capability to utilize existing home health and Bureau of Labor Statistics data in a manner that is consistent with the occupational mix adjustment methodology proposed for hospitals. For instance, data is readily available to determine the proportion of episodes that involve each of the six disciplines of Medicare home health-covered services. **CAHC endorses the National Association of Home Care's suggestion of a joint industry/CMS technical advisory group to explore the options available for a refined wage index to assess the impact of such available options**.

Outliers

CAHC is very supportive of the proposal to reduce the outlier fixed dollar loss threshold as a good first step in improving access to care for higher cost patients. CAHC has repeatedly advocated for full expenditure of the already-appropriated outlier funds. We believe that encouraging access to home health care for heavy care patients actually saves the Medicare system overall by encouraging placement in less costly non-institutional settings. **CAHC recommends that CMS institute a periodic analysis of outlier expenditures in order to bring about timely and appropriately targeted adjustments. CAHC also recommends that the outlier formula be modified to recognize medical supply costs and other non-visit related costs such as telemedicine.**

MO 175 Overpayment Recoveries

The current project to recoup "overpayments" when agencies incorrectly answer MO 175 on the OASIS assessment has raised significant issues due to the inherent complexity and unworkability of this adjustment. **CAHC strongly recommends that CMS identify underpayments by the same methods as CMS proposes to identify overpayments, and to offset one by the other prior to recovery.**

The classification of Long Term Care Hospitals (LTCHs) for purposes of MO 175 has also raised issues of fairness in the MO 175 recovery process. The financial incentives for LTCHs have shifted dramatically in recent years with the advent of LTCH PPS. We believe that classifying LTCHs as acute care hospitals for purposes of MO175 does not properly reflect the service needs of these patients, and could create disincentives for home health agencies for accepting these patients in the future. **We strongly urge CMS to change the way LTCHs are classified for purposes of MO 175 and to disregard any prior overpayments due to unintentional misclassification of LTCHs as inpatient rehabilitation facilities.**

Underpayment for the Dually Eligible

Home care benchmarking vendor Outcome Concept Systems (OCS) has provided national data to CAHC which indicates that Medicare/Medicaid dually eligible patients receive substantially more nursing and home health aide visits per Medicare episode than Medicare-only patients, despite having similar case mix classification. We believe this occurs because dually eligible patients have more comorbidities, fewer informal supports and are less compliant than Medicare-only patients. These factors are not adequately recognized in the existing home health resource groups (HHRG) case mix system. **We recommend that CMS consider a "disproportionate share adjustment" for HHA PPS in order to appropriately reimburse agencies caring for high proportions of dually eligible patients.**

Thank you for attention to these comments and recommendations. If you have any questions, please do not hesitate to contact me at (203) 265-9931.

Sincerely,

Brian Ellsworth

Brian D. Ellsworth
President & CEO
CT Association for Home Care

Cc: Representative Nancy L. Johnson

CMS-1265-P-11

Submitter : Ms. carla braveman **Date & Time:** 07/30/2004 06:07:59

Organization : VNA & Hospice of Cooley Dickinson, Inc

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on the proposed rule changes and how they affect Home Health Prospective Payment System. My comments support those provided by the National Association for Home Care and Hospice written by William A Dombi and the Home & Health Care Association of Massachusetts, Inc. written by Patricia Kelliher.

My comments and concerns relate to the Wage Index and to the MSA changes.

Wage Index: The effect of dramatic changes in the wage index, which we believe to be a 7.58% drop for Springfield, Massachusetts MSA in an era of increasing wages is not reasonable.
1. I request that CMS perform a comprehensive analysis of the impact of any proposed change on patients and providers
2. look at a hold harmless clause that would limit this and future wage index decreases to a maximum of 2%
3. Wage index changes will be announced at 1 year in advance to allow agencies to make the changes necessary with staffing and overhead
4. The Medicare wage index adjustment should accurately reflect wage level differences among labor market areas throughout the nation.
5. Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary, and that reclassifications that are allowed to hospitals competing in the same labor markets must also be available to home health agencies.
6. Allow reclassification as hospitals are allowed to reclassify. Further, if any hospital in the MSA has been reclassified, automatically reclassify all home health agencies to this MSA.

Sincerely:
Carla Braveman, BSN, RN, M.Ed, CHCE
Executive Director
VNA & Hospice of Cooley Dickinson, Inc
Northampton, MA 01060

CMS-1265-P-12

Submitter : Mr. Todd Rose **Date & Time:** 07/30/2004 06:07:25

Organization : Visiting Nurse & Health Services of Connecticut

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

The estimated reduction in Medicare reimbursement to our agency as a result of the proposed decrease to the Hartord, CT MSA wage index is $440,000 per year. This financial impact will drastically effect our ability to retain and recruit scarce nurses, therapists and home health aides as we will be unable to provide competitive wages. Every 3% increase to wages results in an annual increase to Agency and Benefit costs of $250,000.

We would like to request that CMS return the three hospitals located in Litchfield County to the Hartford MSA per previous longstanding CMS policy. Also, providers should be given adequate advanced notice of significant downward adjustments and such adjustments should be capped to a maximum of 2% to avoid devistating financial impacts in one year.

In addition, home health agencies should receive the same wage index reclassification rights as hospitals. For example, CMS proposes a three-year hold harmless for former urban hospitals citing disproportionate impact on these hospitals as the reason. CMS should also offer transitional hold-harmless provision for home health agencies where there is a sudden reduction in the wage index.

Given CMS recognition that home health agencies compete for workforce resources with hospitals and other health care providers, it is inconsistent to provide reclassification rights to hospitals while denying them to home health agencies. About one half of the 30 general hospitals in CT are reclassified to different MSA's.

Finally, in the inpatient hospital PPS regulation for 2005 published on May 18, 2004, CMS proposed major changes to the MSA's definitions, which will change the MSA map for Connecticut. CMS stated its decision not to use these revised MSA definition for home health PPS in CY 2005. If so, than the re-designation of the three Litchfield County hospitals is in conflict with CMS' stated intent not to apply revised MSA definitions for home health agencies in CY 2005.

Submitter : Mr. Michael Caselas **Date & Time:** 07/30/2004 07:07:00

Organization : Foothills Visiting Nurse & Home Care, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Regarding CMS-1265-P; Medicare Program, Home Health Prospective Payment System Rate Update for Calendar Year 2005.

Foothills Visiting Nurse & Home Care, Inc. a non-profit,state licensed, medicare certified home care agency located in Winsted, CT for over 82 years and in the Hartford CT MSA will be severely negatively impacted by the proposed -4.2% reduction in this wage index. Foothills estimates $50,000 in reduced medicare payments on an annual basis due to this change. This reduction will greatly impact our ability to recruit and retain qualified nurses, therapists and home health aides in an already tight and competitive market. We request that CMS return the 3 hospitals located in Litchfield County to the Hartford MSA or give home health agencies the same wage index reclassification rights as hospitals. In closing we feel this reclassification is greatly unfair to us as we are located in and serve more rural communities than that of a hospital 8 miles away who is able to be classified rural.

Thank you for your consideration, if you should have any questions, please contact me at 860-379-8561.

Sincerely,
Michael Caselas
Executive Director

Submitter : Mr. Michael Caselas **Date & Time:** 07/30/2004 09:07:34

Organization : Foothills Visiting Nurse & Home Care, Inc.

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Re: Previous submitted comments on CMS-1265-P Wage Indexes.
Upon further review Foothills would like to rescind it's previous comments regarding this issue. As all of Litchfield county would be considered rural and all of our patients reside in Litchfield county
we would be roughly the same as previously classified as Hartford county.

Thank You
Michael Caselas
Executive Director

Submitter : Mrs. Sharon Bradley **Date & Time:** 08/02/2004 04:08:08

Organization : Nursing & Home Care, INc.

Category : Health Care Professional or Association

Issue Areas/Comments

Issues

PROVISIONS OF THE PROPOSED REGULATIONS

I respectfully request a reconsideration of the proposed decrease to the wage indices for each county in Connecticut. As a home health provider in Fairfield County Connecticut, where the cost of living is extraordinarily high and the care needs of the Medicare population are only increasing, the proposed reductions will only further hobble our ability to retain and recruit qualified caregivers at all levels.

We currently are unable to fill 4 full time RN vacanies, primarily due to an uncompetitive wage structure. While we have increased our wages to secure individuals skilled in meeting the challenging needs of the Medicare population (over 75% of the patients we serve) the stripping away of an additional 1.2% over the originally proposed CY05 rates, will indeed not be helpful to support the increasing needs of the Medicare population.

Thank you for your consideration.

Sincerely,

Sharon Bradley, RN, MSN, CNA, CPHQ, CHCE
President/CEO
Nursing & Home Care, Inc.
180 School Rd.
Wilton, CT 06897

Submitter : Dr. Lawrence Bernstein **Date & Time:** 08/02/2004 07:08:05

Organization : Chicopee Medical Center

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

The attached letter is being submitted on behalf of Holyoke Visiting Nurse Association, Inc.

Issues

BACKGROUND

FY 2005 Inpatient Prospective Payment System

PROVISIONS OF THE PROPOSED REGULATIONS

Update wage index for MSA 8003

CMS-1265-P-16-Attach-1.doc

CMS-1265-P-16-Attach-1.doc

CMS-1265-P-16-Attach-1.doc

August 2, 2004

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
PO Box 8010
Baltimore, MD 21244-1850

Re: CMS-1428-P; Medicare Program, Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates

Dear Dr McClellan:

As a Physician, of the Chicopee Medical Center, who supports the Holyoke Visiting Nurse Association, Inc. (HVNA), I appreciate this opportunity to comment on the proposed rule for the FY 2005 Inpatient Prospective Payment System (IPPS). Although home health is not immediately impacted, we are very concerned that the wage index will have significant disruptive implications in the way our agency is reimbursed for care to Medicare beneficiaries in the future. We are therefore providing specific comments on those proposals. If implemented the Holyoke Visiting Nurse Association, Inc. is projected to loose ($231,216) is FY 2005 based on current Medicare census. Our current wage index is 1.0927 and under this proposal will decrease 7.53% to 1.0174. Further, 81% of our current patient census is Traditional Medicare. This high percentage of Medicare patients coupled with the wage index reduction creates a disproportionate disadvantage for our Agency compared to other certified agencies in the State.

We believe that any changes to the wage index should conform to the following principles:

1. The Medicare wage index adjustment should accurately reflect wage level differences among labor market areas throughout the nation.
2. Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary, and that reclassifications that are allowed to hospitals competing in the same labor markets must also be available to other types of Medicare providers, including home health agencies.
3. When significant changes are made in the wage index there should be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in provider reimbursement to allow adequate time for adjustment.
4. Relief for providers that are impacted negatively by the changes should not come at the direct expense of the providers that benefit from the changes.

Given these principles, we believe that modifications in the proposed rule must be made to accommodate realities in the labor market and to avoid sudden financial dislocations that could not only threaten many financially fragile Massachusetts providers but also have an enormous impact on our Agency.

Transitional Hold-Harmless

When significant changes are made in the wage index there should be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in a provider's reimbursement to allow adequate time for adjustment. CMS proposes a three-year hold harmless for former urban hospitals changed to "rural", citing a disproportionate impact on these hospitals as the reason for the hold harmless. We believe such a hold harmless provision should apply to all providers located in counties that are adversely affected by the discontinued use of New England County Metropolitan Areas (NECMAs), or, in fact, in any instance where there is a sudden reduction in the local wage index. **We recommend that CMS limit to 2% the amount that a local wage index can drop from one year to the next.**

We support the suggestion from the Massachusetts Hospital Association that CMS calculate *two* wage indices, one using data from those hospitals in the new CBSA and a second "blended" wage index calculated using data from all hospitals in counties formerly included in the NECMA but now in separate CBSAs. Hospitals and home health agencies in a given CBSA would get the higher of these two calculations.

Massachusetts is a state with relatively small variation in the wage distribution across the state. It is also very common for workers, especially home health agency workers, to commute from one area to another. Furthermore, it is common for a single home health agency to serve patients residing in more than one CBSAs – even for a single nurse to visit patients in two CBSAs in a single day. It makes no sense that the home health agency should be reimbursed at two different rates for those services. The blended wage index would serve to smooth out these anomalies.

Geographic Reclassification

Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary and that reclassifications must be allowed – for both hospitals and home health agencies -- to avoid inequities among providers competing in the same labor markets but that may fall in different wage areas. Yet, under current regulation, home health agencies are put at a serious competitive disadvantage because reclassification is not available to them. Given the nature of the labor market in Massachusetts, and the relative ease of commuting from one labor market area to another within the state, providers in Hampden county must also compete for scarce professionals with providers that are included in the Hartford, CT wage area and paid based on a higher wage index. The lowering of the wage index for these CBSAs would make it difficult for us to compete.

We support a recommendation from the Massachusetts Hospital Association to modernize the geographic reclassification criteria to protect providers when they are "redistricted" out of a high wage area. Criteria could be designed for a county wide reclassification for hospitals (and home health agencies) in such redistricted counties to reclassify back into the area to which they were formerly included if they meet criteria including:

- The county is contiguous to the requested area of reclassification.
- There is a two-way commuting percentage of at least 20% to the former area.
- The county's hospitals have an average hourly wage of at least 82% of the area to which they request reclassification.

- There is a stronger two-way commuting exchange to the former area than to any adjacent county to which the county has been combined into a different MSA.

We strongly urge CMS to allow the same reclassification process for home health agencies, which directly compete with hospitals for workers.

Imputed Rural Floor Provision

HVNA supports the CMS proposal to establish an Imputed Rural Floor for All-Urban States. However, we believe that the proposed methodology needs to be modified to reflect the experience of Medicare providers in rural Massachusetts.

Last year, CMS excluded from the calculation of the 2004 Area Wage Index data for hospitals that were subject to the PPS in the year that wage data are collected, but subsequently converted to Critical Access Hospital (CAH) status. The preamble of the 2004 IPPS final rule stated that the purpose of the exclusion of CAH hospitals from the AWI calculation was to *assist* hospitals by excluding CAH wage data that tends to distort downward the wage index for other short term hospitals. Yet, exclusion of the CAH wage data has had precisely the *opposite* effect in Massachusetts. There was a disproportionate *decrease* in the rural Massachusetts AWI, which fell by over 7.5% the largest drop in the nation. Medicare providers in rural Massachusetts that are located in the high wage counties of Dukes and Nantucket – where the hospitals now have CAH status -- had their payments adjusted by an artificially low rural wage index, which was based on data from only *one* low wage rural hospital located in Franklin county. The 2004 rural AWI in no way characterizes the labor market in rural Massachusetts.

Now, for 2005, CMS proposes to incorporate Franklin County (home of the only remaining rural PPS hospital in the state) into the Springfield CBSA, eliminating the rural wage index entirely for Massachusetts. An imputed rural floor for Massachusetts that does not incorporate the wage data for the hospitals in rural Massachusetts, or account for the historically higher rural wage index in the state by modifications in the proposed methodology, would not reflect the labor market realities of those Medicare providers (including critical access hospitals and home health agencies) that are located in Dukes and Nantucket Counties. **We urge CMS to include these costs in the calculation of the imputed rural floor for Massachusetts.**

We urge CMS to move cautiously as the new CBSAs are implemented, and to consider not only the immediate impact on hospitals but also the longer-term impact on home health agencies that would be adversely affected by this major change.

Sincerely,

Lawrence Bernstein, M.D.

Submitter : Mr. RICH VISCARDI **Date & Time:** 08/02/2004 07:08:31

Organization : Stratford VNA

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

A couple of comments

Our financial impact of the wage index change is approz 1% of revenues. We should have the same wage index reclass rights as hospitals. This change seems unfair.

Submitter : Ms. Carol Rodat **Date & Time:** 08/02/2004 08:08:27

Organization : Home Care Association of New York State, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

The Home Care Association of New York State, Inc. (HCA), on behalf of its 252 member agencies that serve over 170,000 Medicare beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the Medicare Home Health Prospective Payment System (PPS) for Calendar Year (CY) 2005. HCA members serve the majority of Medicare beneficiaries throughout the state and HCA actively participated in the development of and support for the PPS for home health care.

We regret that CMS did not extend the comment period after finding the ?technical errors? that were originally published in the Federal Register. We believe that the publication of the 2004 pre-floor, pre-reclassified wage index tables rather than those for 2005 and the changes therein are substantial and deserved more time for review and evaluation.

HCA believes that the multitude of component parts of the PPS reimbursement methodology demand regular review and update and that specific components deserve the review of technical advisory groups. For example, the use of technology has increased dramatically, first as a necessity for PPS billing and OASIS processing, and second, with the application of telehealth to extend the workforce, improve the quality of care, and decrease costs. At the same time that home health has needed these applications, they lack adequate capital for these acquisitions. In addition, personnel shortages that can be somewhat ameliorated through the application of technology, have continued to cause escalating costs. Home health can neither keep up nor compete with facilities that have both access to capital and the ability to gain wage index reclassifications. Home health care, particularly with the advent of telehealth applications, is providing Medicare with substantial savings in hospitalizations and emergency room use. These cost components deserve timely attention and are essential to PPS refinements and updates.

Issues

BACKGROUND

LUPA Rates

Most recent data for New York (July 2003 ? December 2003), shows that 11.07 percent of the episodes qualify for Low Utilization Payment Adjustment (LUPA) reimbursement. Although CMS predicted that the proportion of LUPA episodes would drop from 15 percent to 5 percent once PPS was implemented, HCA has not found support in either New York or national data. We therefore recommend that there be a review and increase to the LUPA per visit rates to ensure that they cover the costs of care for these patients.

Case Mix Weight

HCA wishes to call attention to specific areas with respect to case mix weight. First, we believe that the HHRG case mix classification does not recognize the added costs of the dually eligible. This population has more comorbidities and often lack the informal supports others have. Since the existing Medicare case mix system does not recognize these complexities that add to the cost of care, we recommend that an add-on for these patients be implemented until refinements to the case mix system can be made.

In addition, we believe that the case mix system does not adequately recognize the costs of wound care given the intensity of some of these patients and the newest supplies that can facilitate rapid healing.

Finally, we urge CMS to institute ongoing analysis of the case mix weights along with a mechanism to refine the case mix adjustments. CMS has three years of data that should assist in this process and should make use of that data.

PROVISIONS OF THE PROPOSED REGULATIONS

Market Basket Update

While the changes in the market basket update outlined in the Proposed Rule comport with the statutory obligations, there are still specific areas in which HCA urges CMS to take action. We strongly urge CMS to convene a technical advisory committee that includes economists that can review the costs going into the home health market basket. In addition to the aforementioned technology costs, home care is extremely sensitive to increases in gasoline and transportation, general liability, and workers compensation ? all of which have had rapid escalation. Also, the home health sector is essential to emergency preparedness and supportive of the surge capacity readiness of the hospital sector. Costs for home health preparedness have not received the same reimbursement that the hospital and public health sector has, and these need to be considered going forward.

Wage Index

HCA strongly supports the CMS decision not to implement the expanded wage index areas based on new definitions. HCA has consistently recommended that policy with respect to the home health wage index have as its foundation:

-Implementation of geographic reclassification rights for home health that are comparable to those of hospitals; and,

- Allowance for automatic reclassification for home health providers in those areas in which hospital reclassification has been approved.

Home health providers not only compete with hospitals for skilled personnel, but have the costs of at least six months of additional training for new nursing school graduates who graduate with insufficient preparation for community-based settings.

HCA has reviewed the proposed changes in the wage index and finds that the changes are both significant and abrupt. These wage index changes proposed for CY 2005 will result in an estimated loss to New York of $25.93 million. In part, the financial dislocation is caused by switching from the fiscal year 2003 wage index to calendar year 2005. HCA strongly recommends that these changes be implemented only with the addition of a transitional stop-loss mechanism that would limit the loss in the wage index update.

HCA also recommends that future changes be accompanied by a comprehensive impact analysis and at least one year?s notice in advance of the proposed change. Home health is a clinical service industry that must have adequate notice in order to sustain its capacity for ongoing care for Medicare beneficiaries. Adaptations to large swings in Medicare reimbursement cannot be accommodated on short notice and threaten the stability of the provision of services.

Going forward, not only does HCA support CMS? decision to delay the implementation of the Office of Management and Budget?s (OMB?s) expanded wage areas, but HCA opposes the provision in that proposal which modifies the New York area wage index through the inclusion of the New Jersey counties of Bergen, Hudson, and Passaic. We find no support for this inclusion. Utilizing the new wage areas would add an additional destabilizing factor to the home health sector and should not be undertaken until there is additional review of the appropriateness of the changes and the dislocation that will occur.

CMS-1265-P-18-Attach-1.doc

CMS-1265-P-18-Attach-1.doc

CMS-1265-P-18-Attach-1.doc

HOME CARE ASSOCIATION
of New York State, Inc.

August 2, 2004

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1265-P
Post Office Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-1265-P, Medicare Program, Home Health Prospective Payment System Rate Update for Calendar Year 2005

Dear Dr. McClellan:

The Home Care Association of New York State, Inc. (HCA), on behalf of its 252 member agencies that serve over 170,000 Medicare beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the Medicare Home Health Prospective Payment System (PPS) for Calendar Year (CY) 2005. HCA members serve the majority of Medicare beneficiaries throughout the state and HCA actively participated in the development of and support for the PPS for home health care.

General Comments

We regret that CMS did not extend the comment period after finding the "technical errors" that were originally published in the *Federal Register*. We believe that the publication of the 2004 pre-floor, pre-reclassified wage index tables rather than those for 2005 and the changes therein are substantial and deserved more time for review and evaluation.

HCA believes that the multitude of component parts of the PPS reimbursement methodology demand regular review and update and that specific components deserve the review of technical advisory groups. For example, the use of technology has increased dramatically, first as a necessity for PPS billing and OASIS processing, and second, with the application of telehealth to extend the workforce, improve the quality of care, and decrease costs. At the same time that home health has needed these applications, they lack adequate capital for these acquisitions. In addition, personnel shortages that can be somewhat ameliorated through the application of technology, have continued to cause escalating costs. Home health can neither keep up nor compete with facilities that have both access to capital and the ability to gain wage index reclassifications. Home health care, particularly with the advent of telehealth applications, is providing Medicare with substantial savings in hospitalizations and emergency room use. These cost components deserve timely attention and are essential to PPS refinements and updates.

194 WASHINGTON AVE., 4TH FLOOR, SUITE 400 • ALBANY, NY 12210
PHONE: 518.426.8764 • FAX: 518.426.8788 • E-mail: info@hcanys.org • www.hcanys.org

Market Basket Update

While the changes in the market basket update outlined in the Proposed Rule comport with the statutory obligations, there are still specific areas in which HCA urges CMS to take action. We strongly urge CMS to convene a technical advisory committee that includes economists that can review the costs going into the home health market basket. In addition to the aforementioned technology costs, home care is extremely sensitive to increases in gasoline and transportation, general liability, and workers compensation – all of which have had rapid escalation. Also, the home health sector is essential to emergency preparedness and supportive of the surge capacity readiness of the hospital sector. Costs for home health preparedness have not received the same reimbursement that the hospital and public health sector has, and these need to be considered going forward.

Wage Index

HCA strongly supports the CMS decision not to implement the expanded wage index areas based on new definitions. HCA has consistently recommended that policy with respect to the home health wage index have as its foundation:

- **Implementation of geographic reclassification rights for home health that are comparable to those of hospitals; and,**
- **Allowance for automatic reclassification for home health providers in those areas in which hospital reclassification has been approved.**

Home health providers not only compete with hospitals for skilled personnel, but have the costs of at least six months of additional training for new nursing school graduates who graduate with insufficient preparation for community-based settings.

HCA has reviewed the proposed changes in the wage index and finds that the changes are both significant and abrupt. These wage index changes proposed for CY 2005 will result in an estimated loss to New York of $25.93 million. In part, the financial dislocation is caused by switching from the fiscal year 2003 wage index to calendar year 2005. **HCA strongly recommends that these changes be implemented only with the addition of a transitional stop-loss mechanism that would limit the loss in the wage index update.**

HCA also recommends that future changes be accompanied by a comprehensive impact analysis and at least one year's notice in advance of the proposed change. Home health is a clinical service industry that must have adequate notice in order to sustain its capacity for ongoing care for Medicare beneficiaries. Adaptations to large swings in Medicare reimbursement cannot be accommodated on short notice and threaten the stability of the provision of services.

Going forward, not only does HCA support CMS' decision to delay the implementation of the Office of Management and Budget's (OMB's) expanded wage areas, but HCA opposes the provision in that proposal which modifies the New York area wage index through the inclusion of the New Jersey counties of Bergen, Hudson, and Passaic. We find no support for this inclusion. Utilizing the new wage areas would add an additional destabilizing factor to the home health sector and should not be undertaken until there is additional review of the appropriateness of the changes and the dislocation that will occur.

LUPA Rates

Most recent data for New York (July 2003 – December 2003), shows that 11.07 percent of the episodes qualify for Low Utilization Payment Adjustment (LUPA) reimbursement. Although CMS predicted that the proportion of LUPA episodes would drop from 15 percent to 5 percent once PPS was implemented, HCA has

not found support in either New York or national data. We therefore recommend that there be a review and increase to the LUPA per visit rates to ensure that they cover the costs of care for these patients.

Case Mix Weight

HCA wishes to call attention to specific areas with respect to case mix weight. First, we believe that the HHRG case mix classification does not recognize the added costs of the dually eligible. This population has more comorbidities and often lack the informal supports others have. Since the existing Medicare case mix system does not recognize these complexities that add to the cost of care, we recommend that an add-on for these patients be implemented until refinements to the case mix system can be made.

In addition, we believe that the case mix system does not adequately recognize the costs of wound care given the intensity of some of these patients and the newest supplies that can facilitate rapid healing.

Finally, we urge CMS to institute ongoing analysis of the case mix weights along with a mechanism to refine the case mix adjustments. CMS has three years of data that should assist in this process and should make use of that data.

In conclusion, HCA thanks CMS for this opportunity to comment. We would be happy to assist CMS staff in any way going forward.

Sincerely,

Carol A. Rodat
President
Home Care Association of New York State, Inc.

CMS-1265-P-19

Submitter : Ms. Robin Frank **Date & Time:** 08/02/2004 08:08:28

Organization : Healthcare Association of New York State (HANYS)

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1265-P-19-Attach-1.txt

August 2, 2004
Dear Secretary Thompson:

The Healthcare Association of New York State (HANYS) represents more than 550 hospitals and health systems whose home care agencies provide their communities with vital services. HANYS welcomes the opportunity to comment on the Medicare Home Health Prospective Payment System (PPS) rate update for calendar year 2005.

HANYS and our members were dismayed by CMS' rejection of the National Association of Home Care's request for an extension of the comment period. CMS stated that the publication of outdated wage index tables in the June 2, 2004 Federal Register was a "technical" error. However, HANYS' calculations using the corrected data reveal that for agencies across New York State, the change is indeed a substantial one.

Although the regulations implement several statutory provisions from the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (e.g., the marketbasket update reduction), there are other provisions over which CMS has authority that deserve comment:

- wage index changes;
- case mix weight; and
- the outlier fixed dollar loss ratio.

Wage Index Changes
The MMA changed the update of the Home Health PPS from a federal fiscal year to a calendar year basis. Therefore, the proposed rate changes for home care would go into effect on January 1, 2005. The Home Health PPS 2005 update proposes to use a wage index based on the pre-floor, pre-reclassified hospital wage index that is effective for the Inpatient PPS during federal fiscal year 2005.

HANYS' Comments
The proposed Inpatient PPS regulation for 2005 contained major changes to Metropolitan Statistical Area (MSA) definitions that will have a substantial impact on many urban and rural areas. HANYS submitted comments on the Inpatient PPS proposed rule addressing the proposed wage index changes. HANYS' comments include our opposition to the addition of three New Jersey counties to the New York City MSA for determining wage indexes. HANYS also urged CMS to provide protection for facilities located in counties that would change status due to the redefinition of rural and urban areas.

In the home care update, CMS indicates that it does not plan to use these revised MSA definitions for home health in 2005—but they could be implemented in the future.

HANYS urges CMS not to redefine the wage index areas for the Home Care PPS in 2005. CMS should postpone any change in the definition of wage index areas until the proposed Inpatient PPS wage index changes can be evaluated.

The home care update calls for using the 2005 pre-floor, pre-reclassified hospital wage index. It has been CMS' policy to use the most recent pre-floor and pre-reclassified hospital wage index available for the Home Care PPS. The change from a fiscal year to a calendar year update cycle will result in an immediate update from a wage index based on 1999 data to a wage index based on 2001 data. For many areas, this causes an abrupt and substantial decrease.

HANYS urges CMS to use a Home Health PPS wage index based on the 2004 pre-floor, pre-reclassified hospital wage index. This would provide a more equitable wage index transition that would avoid a sudden change due to skipping a year.

Case Mix Weight
Chronically ill, long-term patients in home care require more resources and staff to manage. These patients are also functionally more dependent because of debilitating comorbid conditions, requiring more physical supports to remain in the community. These factors increase the costs of providing care to this population that are not addressed by rate updates. These patients are frequently known as the "dually eligible" as they are often eligible for both Medicare and Medicaid.

HANYS' Comments

HANYS recommends an adjustment for the dually eligible be factored into the case mix weight system in recognition of the higher costs of service for these beneficiaries.

HANYS also will recommend review and refinements to the Home Health Resource Group case mix weight system over the next year.

Outlier Fixed Dollar Loss Ratio
HANYS supports the CMS proposal to reduce the fixed dollar loss ratio from 1.13 to 0.73. CMS states that outliers have been underpaid in prior years and this will increase the percentage of episodes qualifying for outlier payments.

HANYS and our members see a tremendous value for patients receiving necessary and vital health care services in their homes. Home care is the most cost-effective method of delivering chronic, long-term care outside of a nursing home. We appreciate the opportunity to offer comments on the Home Care PPS update and encourage CMS to adopt HANYS' recommendations moving forward.

Sincerely,
Robin Frank
Vice President of Governmental Affairs and Continuing Care

Submitter : Mr. Marvin Goldenberg **Date & Time:** 08/03/2004 12:08:42

Organization : NA

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The new Medicare Prescription program needs much better coverage than is currently in place. A savings of more than 75% per prescription is needed through the Medicare Coverage Program.

CMS-1265-P-21

Submitter : Ms. Phyllis Wang **Date & Time:** 08/02/2004 12:08:00

Organization : NYS Association of Health Care Providers, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please accept these comments from the New York State Association of Health Care Providers, Inc. on CMS-1265-P

August 2, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1265-P
P.O. Box 8016
Baltimore, MD 21244-8
www.cms.hhs.gov/regulations/ecomments

Re: File Code CMS-1265-P
Comments on Proposed Rule:
42 CFR Part 484
Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2005; Proposed Rule

On behalf of the members of the New York State Association of Health Care Providers, Inc. (HCP), I am writing to provide comments on the proposed changes to the Home Health Prospective Payment System Rate Update for Calendar Year 2005. HCP is a statewide trade association representing home care and community-based providers through advocacy, information and education. Founded in 1974, HCP represents approximately 500 offices of Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Hospices and related health organizations throughout New York State. Through a strong network of regional chapters and an active State office in Albany, HCP is a primary authority of the health care industry.

General Comments

HCP recognizes that much of what CMS has included in the proposed regulation was dictated by the Medicare Prescription Drug, Improvement, and Modernizations Act of 2003, including the shift to a calendar year and reductions in the market basket. It is, however, important that the issues these changes pose for the home care industry are raised with CMS as they were with Congress, and thus, HCP's comments will include concerns relative to these changes. Also, HCP is pleased that CMS has reviewed the outlier fixed loss ratio and that CMS will consider changes to the geographic designations after a comprehensive assessment has been made.

Following are more specific comments regarding the HHPPS Proposed Rule.

Home Health Market Basket

HCP is pleased that CMS has proposed "to rebase and revise the home health market basket to ensure it continues to adequately reflect the price changes of efficiently providing home health services." This is an important step in

ensuring that home care providers are adequately reimbursed. HCP strongly urges CMS to develop a rebasing process that occurs on a timely basis so rising costs of delivering care and unique changes in the environment are captured. For instance, the current reimbursement structure has not captured the rising gasoline prices, which have resulted in new costs to home care agencies, and there is not a mechanism to address new costs such as this.

Although required by law, HCP opposes the implementation of the 0.8% reduction to the market basket. The financial viability of agencies continues to be compromised by ongoing reductions in reimbursement. If the market basket calculation reflects the cost to providers of "efficiently providing home health services," the market basket should not be reduced. Home health agencies are still recovering from the financial effects of the Interim Payment System (IPS), M0175, Partial Episode Payment (PEP) and Significant Change in Condition (SCIC) recoupments, and other financial pressures that are inherent in the health care environment, and thus, additional reductions in the market basket and PPS rates are inappropriate.

Outlier Fixed Dollar Loss Ratio

The change made to the Outlier Fixed Dollar Loss Ratio, which allows more outlier episodes to qualify for extra payments, is a positive step. Many agencies have been punished for taking high cost patients. They have been forced to absorb a portion of the costs associated with caring for this type of patient, but have not been able to access outlier payment assistance. Now, the ability to qualify for outlier payments may help alleviate these payment shortfalls.

Rural Add-On

HCP encourages CMS to join HCP in advocating for a continuation of the rural add-on for home health services furnished to beneficiaries living in rural areas. Agencies serving rural beneficiaries face many issues including workforce shortages and high travel time. The add-on becomes especially critical in light of the recent decreases in the wage index for rural areas.

Wage Index

HCP is extremely concerned about the wage index used for home health agencies. While HCP supports CMS' effort to use the most recent pre-floor, pre-classified wage index available, steps must still be taken to begin identifying home health specific data that can be used to ensure the accuracy of the wage index data currently being used. In order to diminish the fluctuations that occur in the wage index for home health, a limit on the wage index fluctuation should be established and employed annually. Home health agencies are also at a disadvantage by CMS' refusal to consider requests from home health agencies to change their wage index designation. Hospitals are allowed to request such a change to secure a better rate, and thus, at a minimum CMS should permit a home health agency in the same region to secure the same change. Home health agencies compete with hospitals for the same workforce and remain at a competitive disadvantage because of the wage index limits. CMS has the discretion to make some of these modifications and should do so.

Types of Payments

HCP continues to be concerned about payments made to providers for specific types of claims. Low Utilization Payment Adjustments (LUPA) to providers do not take into account the high costs associated with these visits. CMS should undertake an evaluation of the costs to an agency when beneficiaries receive fewer than five visits to help determine the true per-visit costs to agencies. Analysis done to-date has shown that the costs associated with LUPA episodes are significantly greater than the LUPA rate provides. While CMS anticipated that the number of LUPA episodes would decrease, that in fact has not happened and the proportion of episodes qualifying for LUPA payments remains fairly constant at 15%. HCP strongly recommends that CMS address the inadequate LUPA rates as soon as possible so agency payments are consistent with the cost of care.

PEP and SCIC episode payments should also be reconsidered. At the outset of PPS, it was not the intent to punish providers when the care given to a beneficiary changed as a result of a change in their condition or the site of care. Even now, CMS pays providers a full episodic rate for beneficiaries that expire during an episode and providers that service beneficiaries who become sicker do not need to file a SCIC if they will be paid a lower amount for the episode. Agencies are reporting higher costs at the beginning of episodes and CMS should study and evaluate what the actual costs associated with the number and intensity of visits that occur at the beginning of an episode and reconsider the PEP and SCIC payment methodology to reflect the cost of care. CMS should also evaluate the appropriateness of using the dates within the episode as opposed to the dates of first and last billable visits.

Home health agencies are still dealing with myriad payment issues, including PEP, SCIC and M0175 reconciliations, and others are still addressing IPS financial problems that left many agencies struggling to survive. Although current payment is intended to cover the cost of visits, supplies, outpatient therapies and patient assessments, the fact is no matter how well-qualified and well-organized an agency, there are volume, personnel, and other factors that contribute to and increase the cost of delivering care. It is imperative that CMS thoroughly study the cost to agencies of covering these different types of episodes and adequately compensate agencies.

Case Mix Adjustment

HCP has concerns about the current case mix adjustments and urges CMS to continue its evaluation and identification of refinements. It is imperative that as CMS evaluates the case mix, a determination of costs associated with high intensity nursing visits, wound cases, and the cost of supplies associated with those visits, be established.

CMS should also re-evaluate payments based on the recent issues with M0175. The changes to certifications including hospital, rehabilitation hospital and long-term care hospital classifications have caused even greater confusion in what was an already difficult situation.

HCP appreciates the work CMS has done in updating the HHPPS methodology and evaluating specific issues associated with the payment system. If HCP can be of any assistance in evaluating specific components of the HHPPS, please do not hesitate to contact HCP staff or me.

Thank you in advance for consideration of HCP's comments.

Sincerely,

Phyllis A. Wang
President

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Submitter : Mr. Rick Pollack **Date & Time:** 08/02/2004 12:08:00

Organization : American Hospital Assocation

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached.

American Hospital Association

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

August 2, 2004

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Room 314-G
Washington, DC 20201

Re: CMS-1265-P; Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2005.

Dear Dr. McClellan:

On behalf of the American Hospital Association (AHA), its 4,700 member hospitals and health care systems, and 31,000 individual members, we appreciate the opportunity to comment on the June 2, 2004 proposed rule concerning the home health prospective payment system (HH PPS).

The AHA strongly supports the proposed rule's provision to reduce the high cost outlier threshold. This provision will greatly assist our member hospitals, which operate nearly 1,800 home health agencies. Hospital-based home health agencies – 30 percent of the field – treat many homebound patients with advanced needs, and these providers have been struggling with negative Medicare margins. This has resulted in a steady pattern of closures. The additional support provided by outlier payments made available for more patients will protect access to care for patients requiring extensive and costly services during a home health episode of care. In addition to supporting this provision, **we also encourage the Centers for Medicare & Medicaid Services to annually review HH PPS outlier expenditures to ensure that all funding removed from base HH PPS rates and set aside for outliner payments are spent.**

Please contact me or Rochelle Archuleta, senior associate director, at 202-626-2320, to discuss any questions you may have about our comments on this proposed rule.

Sincerely,

Rick Pollack
Executive Vice President