September 21, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Attention: CMS-1560-P

Electronic submission: http://www.regulations.gov

Re: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2010

Dear Ms Frizzera:

I am writing on behalf of the Visiting Nurse Associations of America (VNAA) to offer public comments on "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2010" (CMS-1560-P). The VNAA represents nonprofit home healthcare agencies and hospices across the United States. At the outset, I would like to express our appreciation for the opportunity to comment on these proposed rules and for your staff's meeting with us on September 1, 2009, to discuss our reactions to these proposals. Since VNAA is the only national organization that exclusively represents the nonprofit home health community that created the home health benefit, I believe we are prepared to make a unique contribution to your proposals to change and clarify Medicare home health policy and procedures. Our detailed comments our outlined by topic below.

Change in HHPPS Outlier Policy

VNAA supports the policy of putting an outlier cap in place, as reflected in VNAA's fraud and abuse White Paper published in February 2009, entitled *Medicare Home Health: Encouraging Quality and Discouraging Abuse*. We believe the approach proposed by CMS offers an effective and fair approach because it is related proportionally to each agency's overall annual revenue. We also support implementing this provision on a flow basis rather than adopting a system that holds payments to the end of a fiscal period or creates retroactive denials. We understand from our discussion with CMS

staff that outlier claims in excess of the outlier cap will still be paid at the normal episode rate. We support this approach and suggest that it be made clearer in the final rule.

We applaud CMS' approach to reducing the abuse of the outlier policy and restoring the dollars saved to full episode payments. We also appreciate a gesture towards reducing the fixed dollar loss ratio that will allow a few more genuine outlier cases to qualify for payment even with the reduced outlier pool. We urge CMS to monitor the cap expenditures closely and if outlier payments drop below the new 2.5% outlier pool amount, act to further reduce the fixed dollar loss threshold to approximate the 2.5% pool.

Case Mix Creep Cut set at 2.75% for 2010

VNAA continues to be opposed to both the imposition of further payment cuts based on estimates of nominal case mix change and particularly the continuing decision to apply such cuts to all agencies regardless of their individual average case mix or rate of case mix change. The application of equal cuts to agencies that CMS' own data indicate did not contribute to case mix creep is unfair and damages the very agencies that CMS should be rewarding for their compliance.

It is plausible that average case mix continues to increase. The fact that the ratio of for-profit to nonprofit agencies claims increases each year would have that effect because of the higher average case mix weight of for-profit agencies. But the methodology that CMS' contractor has adopted to estimate nominal case mix change is far from precise and relies on limited sources of data. It is not based on actual clinical analysis of medical records but on statistical inferences from alternative sources of data. It is so complex and abstract that, as CMS points out in this year's rule, significant data errors went undetected by both CMS and its contractor last year. Were this estimating methodology only being used to inform an academic debate, its imprecision and opportunity for undetectable inaccuracy might be excused. But, when this methodology is used to reduce the dollars available to treat patients in need and indirectly reduces access to Medicare home health for heavy care patients, the estimating methodology is not sufficient. We do not believe that the method used to differentiate nominal case mix change from real case mix change is an accurate estimate. We appreciate CMS commitment to further refine the estimating methodology using additional sources of data but urge CMS to treat these nominal case mix change estimates as what they are: guesstimates. That would suggest that CMS not continue to make dollar for dollar reductions in payment each time these imprecise estimates change.

VNAA members also suggest that further case mix refinements would improve the accuracy of the overall case mix system. These would include credit for absence of a caregiver, Medicaid status, residence in high crime areas (necessitating special security measures) and for patients suffering from the advanced stages of debilitating chronic diseases such as MS, respiratory failure, ALS, MD, COPD and heart failure. We fear that if CMS does not more appropriately pay for such cases and continues to reduce payments on an across-the-board basis, Medicare patients with such characteristics will

lose access to home healthcare as agencies find they are unable to absorb the losses on such patients.

Beyond the issue of the accuracy of overall nominal case mix change, VNAA strongly urges CMS to reconsider its policy of applying case mix creep reductions on an across-the-board basis. We note that the CMS funded reports on nominal case mix produced by Abt Associates document that free-standing, nonprofit agencies have not contributed to nominal case mix creep at a level comparable to the for-profit sector. Yet all agencies suffer equal payment cuts. This is clearly unfair and damaging to the nonprofit sector and the patients it serves.

We realize there would be significant logistical problems for CMS were it to excuse those individual agencies from further case mix creep cuts that do not have a high average case mix or have not increased their average case mix at a rate suggesting nominal rather than real change. But we believe CMS has an obligation to apply policy in a fair manner. We are unable to consider applying a cut provoked by high case mix weights by some agencies on agencies that have not participated in significant nominal case mix change. Continuing to do so will result in the most compliant agencies being forced out of Medicare or out of business long before the least compliant agencies feel significant impacts. This is not in the interest of Medicare or its beneficiaries.

VNAA urges CMS to exempt agencies that have low case mix weights or have not participated in excessive levels of case mix change from further across-the-board case mix cuts. We also believe CMS should adopt a policy that will protect safety net agencies from the impact of case mix cuts and allow them to remain viable Medicare providers. Those agencies that continue to admit patients based on patient need rather than profitability should not be pushed out of the program by case mix creep cuts that will drive them to negative Medicare margins. CMS needs to put a safety net under its safety net home health agencies or it will see a loss of critical patient access. And if safety net home health agencies are forced into bankruptcy, they will be difficult or impossible to recreate. CMS should adopt a set of criteria that identify safety net agencies that are committed to providing high quality care to all patients regardless of profitability. Such agencies should be assured that Medicare will at least pay the actual reasonable cost of care for Medicare patients so that these safety net agencies can maintain financially viable to serve Medicare patients.

VNAA would be eager to work with CMS along with other representatives of the home health community to find a more equitable approach to nominal case mix change. We would urge CMS to suspend further case mix creep cuts until a solution is found that will assure access to Medicare home healthca

demand action. It is intolerable for home health agencies to compete for labor with reclassified hospitals in the same locality enjoying as much as a 30% advantage in Medicare labor market payment adjustments. It is unfair for home health agencies to be tied to wage index payments based on erroneous data submitted by area hospitals and have no recourse. It is inaccurate to tie home health labor market adjustments to the occupational mix in area hospitals when home health agencies have a very different occupational mix. It is inaccurate and intellectually spurious to follow CBSA area designations that create arbitrary payment differences along CBSA/non-CBSA borders. Again, we realize that wage index reform is a thorny issue in which all providers have a stake and that reform will take time. But until reform is implemented, we urge CMS to make adjustments to the wage index applied to home health agencies as an interim measure.

These adjustments should include:

- Giving wage index parity to home health services provided in the same county as any reclassified hospital.
- Applying the rural floor to the home health wage index.
- Spreading any change in wage index values greater than 2% over at least two years.

These interim steps will serve not only to bring greater equity to the home health wage index process but may serve CMS' interest of creating momentum for more meaningful wage index reform based on the principles suggested by MedPAC or other alternatives such as a home health specific wage index.

OASIS-C and CAHPS Survey

VNAA and its members have been and continue to be active supporters of quality improvement measures in home health. We are supportive of the changes being made to OASIS-C and the measurement of patient experience of care represented by HHCAHPS. However, we have serious reservations about the implementation schedule for both OASIS-C and HHCAHPS as well as several specific aspects of the approach being taken with HHCAHPS.

In the case of OASIS-C, we believe a six to twelve month delay in implementation is necessary to accommodate a reasonable phase-in of such a significant change in OASIS. The vendor community reports it is not yet ready for OASIS-C. As a result, agencies can neither test the software changes needed nor can they begin training their clinical and information systems staff on the changes. As of mid-September, CMS had not released the final interpretive guidelines for OASIS-C. There is simply not enough time to do all the planning, testing and training needed to successfully implement OASIS-C on January 1. We believe outcome measurement is far too important to be implemented without adequate training and testing. Changes in OASIS implementation of this magnitude deserve a proper implementation process. The home health community has waited for many years for some of these changes so waiting a few more months to do it right would be prudent.

In the case of HHCAHPS, a similar or longer delay is needed for implementation as well as serious re-examination of several aspects of the HHCAHPS process. The required vendors for this process were not even identified until near the close of the comment period, which has not given agencies an opportunity to comment meaningfully on the qualified vendor process. There has not been an opportunity to agencies to review competing vendors' offerings and undertake a meaningful contracting process. Most agencies have already developed a 2010 budget that does not include the cost of an HHCAHPS contract. We are also concerned that the mandate to use a vendor and the possibility of a limited number of qualified vendors will give vendors no incentive to be competitive in their pricing. While many agencies already have vendor contracts for their own internal patient satisfaction/experience of care survey work, most are not as comprehensive as the HHCAHPS requirements. Moreover, there has been no opportunity for the home health community at large to familiarize itself with this instrument in a pilot process with an approved vendor to work out the inevitable bugs in such system and to determine the need for possible changes in agency practice to improve performance under HHCAHPS.

We believe the HHCAHPS process has not sufficiently articulated an appropriate way to differentiate or adjust scoring to reflect differences in experience of care that is unrelated to agency behavior. We are concerned that the application of HHCAHPS to non-Medicare patients creates great uncertainty about the validity of the instrument given the very differing nature of Medicare and non-Medicare patients. Non-Medicare patients tend to be a younger cohort, have different care needs and recover more quickly due to age and fewer chronic conditions. They are often highly motivated to return to work quickly and become fully functional while the older, more chronically ill patients may never be able to be fully rehabbed. Many non-Medicare patients also have insurers that dictate a service plan with fewer visits and a less comprehensive approach than Medicare allows. This may create differences in experience of care related more to the patient and insurance than agency behavior. Since agencies have a varying mix of Medicare and non-Medicare patients it is not clear how HHCAHPS will be adjusted to account for variation in quality scores not related to agency behavior. This would require a matching of demographic and insurance data into a risk adjustment methodology. CMS should articulate how this adjustment will be achieved to prevent the release of spurious quality measures.

A more fundamental question is whether to include non-Medicare patients in HHCAHPS at all. The requirement that agencies contract with an outside vendor raises the question of appropriate compensation from other insurers for the additional cost of this contracted service and agency time to administer it. If other insurers are neither requiring nor reimbursing for the additional cost of this service, it seems unreasonable for the agency to undertake the expense. And, as discussed above, the inclusion of non-Medicare patients complicates accurate and fair measurement. Moreover, since many agencies are committed to experience of care measurement for all their patients the inclusion of some groups and the exclusion of others from CAHPS will create the need for these agencies to operate and incur the expense for two parallel systems: one for HHCAHPS patients and one for MCH and pediatric care patients.

The HHCAHPS process does not seem to have been well explained or well thought through in terms of its impacts on the home health community. This has resulted in opposition and alarm in the home health community rather than the buy-in that could result from a more thoughtful and gradual introduction. It appears that the implementation of HHCAHPS is driven by some artificial schedule rather than consideration of the home health community and the validity of the measures.

VNAA believes that HHCAHPS implementation is too important to be a "rush job" and that some additional time to consult with the industry, address unanswered questions and allow for a deliberate contracting process will pay off in terms of better data and better quality outcomes in the long run. We urge that the home health community be given at least six months after OASIS-C is implemented to fully implement HHCAHPS.

OASIS HIPPS Coding as a Condition of Payment

VNAA supports the proposal to make OASIS HIPPS Coding compliance a condition of Medicare Payment. It is a reasonable requirement. However, we are aware that some existing software systems do not currently include the capacity to readily identify claims that need to have the HIPPS code reconciled. We suggest that CMS allow time for software vendors to accommodate the need for this type of reconciliation in their products and time for providers to develop internal procedures to assure that the HIPPS codes are properly reconciled. We also suggest that the rule clarify in greater detail what is meant by non-compliance. Will enforcement be implemented on a claim-by-claim basis or will some overall measure of compliance be required? Will payment for individual claims be recovered or withheld if they are identified as incorrectly coded? If this will be enforced on an individual claim basis, we suggest that after the delay for systems changes suggested above, the individual claims edits be tested by generating warning messages for a trial period to give providers time to assure their reconciliation procedures and software are working as intended.

Medicare Skilled Nursing Coverage Clarifications and Physician Narrative Requirement

We appreciate CMS' intent in clarifying coverage in these situations but suggest that CMS make clear that these coverage guidelines reflect a CMS policy interpretation under the Medicare program and are not intended to reflect a narrowing of nurse practice as specified in state law and regulations. We do not think that CMS intended these policy clarifications and the imposition of additional physician certification requirements to infringe on State nurse practice acts. But clarifying Medicare coverage policy through an apparent attempt to restrict the definition of nurse practice is inappropriate and counterproductive. We believe that CMS should more appropriately issue specific Medicare coverage guidelines that clearly differentiate non-covered custodial or medically unnecessary care under Medicare home health from covered rehabilitative, acute, or curative care.

We also believe that CMS may wish to reconsider the somewhat restrictive interpretation of skilled oversight of the plan of care. VNAs often are compelled to discharge patients from Medicare based on a very limited interpretation of skilled

oversight when it is apparent that the patient is in the advanced stages of one or more chronic illness and will likely relapse once nursing oversight is discontinued. Such patients may become stable for several weeks and under the policy above would be considered non-covered and discharged from Medicare home health. Yet agencies often find they must readmit such patients within a few months after their health has again deteriorated. Often this readmission follows a hospital stay that is far more costly than a continuation of homecare would have been. It is also likely that patient outcomes would be improved were such patients offered continuing care coordination during periods of relative stability rather than experiencing repeated cycles of rehabilitation or stabilization and subsequent deterioration. We suggest that CMS modify the coverage guidelines to allow home healthcare to continue skilled nursing care for observation and monitoring of a plan of care though periods of relative stability if the patient is in the advanced stages of a chronic illness and is likely to deteriorate without skilled care management oversight.

VNAA is also opposed to the provision requiring an additional physician narrative justification for these skilled services. This added physician oversight requirement further muddies the issues of nursing practice by requiring more specific physician orders for established areas of nursing practice. But it also raises very practical concerns. While VNAA supports increased physician involvement in home health, this narrative requirement will only complicate the already arduous task of obtaining complete and timely physician plans of care. Physicians are increasingly overworked and preoccupied. They are not receptive to even modest additional paperwork requirements. This proposal will not result in any worthwhile end. It is likely to generate either rote compliance or non-compliance. As such, it will not increase program integrity, but will increase agency costs to obtain physician compliance and will result in some patients that need care being discharged or not admitted for lack of physician cooperation with the plan of care process.

Patient Safeguard Requirements

VNAA is generally supportive of these requirements but is concerned that one of these changes may be misinterpreted and impose an unnecessary burden on agencies that are not engaged in abusive conduct. A specific example is the rule that an agency cannot operate multiple home health provider and/or supplier numbers from a single geographic location. As the oldest home health agencies in the country, many VNAs have undergone consolidations and acquisitions over the years and continue to do so. This results in some agencies maintaining the provider numbers of two or more merged agencies that were originally independent. In some cases, provider numbers were retained because the agencies operate in different states and CMS certification rules require that each state survey agency deal with only agencies within their own state unless a special agreement is negotiated between states (which does not happen). Such agencies operate in different areas but may consolidate back office operations for efficiency. In other situations, the merged agencies have maintained two or more of the original provider numbers for continuity in record keeping for agencies serving different parts of the same State, but have also centralized their back-office operations at a

single site. In yet other situations, merged agencies have maintained multiple numbers simply to avoid the administrative disruption or possible financial losses for Partial Episode Payment (PEP) rules under PPS for terminating provider numbers.

We are also aware of situations in which agencies have been required by States to secure a separate Medicare certified home health number but use the number to bill Medicaid only. We believe the intent of States has been to pass along the cost of survey and certification of a Medicaid-only home health provider number to the Federal government. We suggest that CMS resolve this issue with Medicaid so that home health agencies are not penalized for complying with instructions from State Medicaid authorities that have compelled them to get an additional Medicare number for Medicaid use.

We are also concerned about the proposal that a home health agency cannot operate a supplier at the same address as the home health agency. We are aware of several VNAs that have responsibly operated DMEPOS supplier numbers from their home health location for many years. We do not understand the need to disrupt such providers or create some second location for their supplier operations. Similarly, many VNAs also operate mass immunizing supplier numbers from their home health agency location. We see no reason to disrupt this process.

VNAA appreciates the intent of CMS in stemming abuse related to maintaining multiple home health numbers at a single location, which frustrates enforcement efforts. We recommend that CMS more completely articulate the permissible and non-permissible situations under which one agency can legitimately operate multiple home health provider numbers from a single site. CMS should also look into the practice of Medicaid agencies requiring the creation of additional Medicare numbers for Medicaid-only billing.

It is possible that some providers appear to be operating multiple numbers based on a simple misunderstood the appropriate location to report on a CMS-855 and should have an opportunity to correct these based on clear guidance from CMS on what is permissible when multiple provider numbers operating in different locations utilize a centralized back-office operation. CMS should reconsider or provide some exceptions to the proposed policy for long-established home health agency based suppliers as well as mass immunization suppliers. CMS should also describe the method by which agencies can consolidate under one provider number without financial consequences for PEP episodes under PPS. It should then allow agencies that notify CMS of their intention to consolidate their existing home health provider numbers a reasonable time, up to 12 months, to complete that task.

We are supportive of the provision to deactivate unused Medicare provider numbers, but, as alluded to above, CMS should be aware that some state Medicaid agencies require the Medicare certification of agencies that have no intention of serving Medicare patients. We believe they do so to increase the perception of quality and to shift the cost of certification surveys to Medicare even if agencies only intend to serve Medicaid

patients. We suggest that CMS address this issue rather than put such Medicaid only agencies in a catch-22 situation relative to state Medicaid requirements.

VNAA continues to be concerned about the abusive conduct of some Medicare home health agencies and again urges CMS to consider the suggestions we made in December 2008 to improve home health quality and reduce abuse. We have also taken the liberty of attaching the VNAA White Paper on home health fraud and abuse that we published earlier this year that reflects those suggestions. We continue to believe that much more needs to be done to improve quality in home health and reduce the opportunities for abuse. We hope you will consider these ideas in this and other rulemaking.

Increasing Physician Involvement in the Home Health Plan of Care

VNAA appreciates CMS' ongoing concern about the involvement of physicians in home healthcare. It is an area that concerns VNAA members as well. We have come to the conclusion that simple solutions such as requiring additional physician visits or phone calls or even paying more for physician oversight of the plan of care are unlikely to produce a meaningful increase in genuine physician involvement. None of these solutions address the fundamental problem of too little physician time dedicated in most physician practices to fully support the patient at home. Additional physician contact requirements are likely to produce paper or rote compliance at best and at worst will discourage some physicians from referring appropriate patients to homecare.

VNAA believes that the best approach to involving physicians in homecare rests in new models of chronic care management that integrate primary care practices that are committed to home-based care with home health agencies into single, consolidated chronic care service. Legislation that has been introduced in Congress titled "Independence at Home" is one such model. VNAA has also begun work on pilots with several of its members that combine a dedicated primary care practice with a Visiting Nurse Association to provide coordinated chronic care for high-risk patients served by Medicare Advantage Plans. VNAA would welcome the opportunity to develop a demonstration program of integrated primary care and home healthcare for traditional Medicare if given the opportunity.

Routine and Non-Routine Medical Supplies

VNAA appreciates the need to distinguish between routing and non-routine Medical supplies that are bundled under the HHPPS system. We have no concerns about CMS' reiteration of the long-standing principles that identify routine supplies. However, VNAA continues to be concerned about the identification of certain items as non-routine supplies. As a matter of principle, we do not believe CMS should continue to add non-routine supplies to the HHPPS bundle that were not represented in the original cost basis for PPS supply payment without appropriate payment increases. For example, many VNAs have expressed concern over the bundling of a product called Pleura-evac that is used to remove fluid accumulation from the chest of extremely ill patients. The application of this technology creates costs far in excess of the non-routine supply

allowances. A similar pattern exists as more sophisticated but more expensive wound care products are introduced. The continued addition of more expensive non-routine medical supplies as bundled, non-routine supplies without an additional payment allowance has become a disincentive to the adoption of new technology. It fosters the use and the application of older or less efficacious alternative treatments and supplies. We urge CMS to re-evaluate the classification of Pleura-evac as a bundled, non-routine supply and to establish a process to adjust the HHPPS non-routine supply allowance to accommodate the accretion of new, more expensive non-routine supplies.

In conclusion, VNAA and its nonprofit home health members appreciate the opportunity to comment on these proposed rules. We hope that CMS will consider our suggestions which we believe to be in the best interests of the Medicare home health benefit, Medicare beneficiaries and those members of the home health community that are dedicated to high quality care and program integrity. We appreciated the opportunity to explain our comments with CMS staff during the comment period and look forward to working together with CMS to improve the effectiveness of the Medicare home health benefit. Please contact Ms. Kathleen Sheehan of VNAA at 202-385-1456 if you have any further questions regarding our comments.

Sincerely,

Andy Carter
President and CEO
Visiting Nurse Associations of America (VNAA)

ATTACHMENT: VNAA White Paper, *Medicare Home Health: Encouraging Quality and Discouraging Abuse*