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June 26, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn. CMS-1541-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore Maryland

Re: Proposed PPS Changes

To Whom It May Concern:

Following are comments from the Home Care Association of Colorado in a state where home care agencies provide more than three million home care visits to 60,000 plus Coloradans per year and employ more than 10,000 nurses, therapists, home health agencies and personal care providers. Thank you very much for your consideration of our comments:

**Addition of Variables** (pg 25361):

*We also propose to assign scores to certain secondary diagnoses, used to account for cost-increasing effects of co-morbidities. An example is secondary cancer diagnoses, whose cost-increasing effects are not as large as those for primary cancer diagnoses. However, with most diagnosis groups, we did not make a distinction in the final model between primary placement and secondary placement of a condition in the reported list of diagnoses.*

This sounds reasonable. We have always believed that there were numerous situations that these co-morbidities greatly increased the complexity (cost) of treating the beneficiary but were not readily identified by OASIS. We feel that this will be an improvement to both the OASIS and the resource allocation

thorough PPS. The industry has been awaiting regulatory assistance with the financial recognition for a wider range of diagnoses that has proven to affect resource allocation of home health services. An analysis of the proposed PPS changes shows a devastating change in reimbursement for the home health industry. According to a wide scope analysis conducted by Strategic Health Partners, LLC (SHP) an industrial leader in benchmarking and data mining, the home health industry will see a decline in reimbursement for the majority of the caseloads for home health. After “repricing” a full year (2006) of Medicare PPS episode data using the proposed 2008 regulations the industry will see a decline for specific populations:

CHF	-1.7%	
COPD	-2.5%	
Ulcers	-8.1%	
Diabetes		-9.6%
Orthopedic	-17.7%	
Neurological	-18.5%	

This analysis of the effects of the proposed rule certainly do not allocate the desired increase in reimbursement for the medical patients that the industry was hoping for with this PPS “improvement”. The complexities of home health service delivery are not accounted for in the official ICD-9-CM coding guidelines that allows for a margin of error in coding practices. The Health Insurance Portability and Accountability Act (HIPAA) passage has required the home health industry to adopt new coding principles. In response to the required changes the home health industry has undergone a great deal of confusion, which would be reflected in the coding analysis of the earlier HH PPS years. We suggest that CMS implement the scoring of secondary diagnosis to account for the cost-increasing effects of co-morbidities and use current diagnosis data so as not to skew the results based on out of date coding practices prior to 2005.

### **Non-routine Medical Supplies**

A more reliable case-mix model needs to be created and then payment should be included for non-routine medical supplies, including LUPA episodes that are not final episodes of care.

Medical supplies are delivered to patients in far greater numbers than reported because many home health agencies fail to list non- routine supplies on final claims. This is caused by a lack of knowledge as to how to enter supplies as well as a lack of awareness of billing for medical supplies in the PPS system since payment is not impacted. Non-routine supplies are very costly to agencies and some of the highest costs are from patients’ wounds and with ostomies including nephrostomy, urethrostomy and ureterostomy as well as supplies for closed chest drainage. Failure to identify patient characteristics that would allow payment for these supplies will result in an

underpayment for home health agencies.

LUPA episodes that are not final episodes often have high supply costs especially for those patients with foley catheters that require monthly catheter changes. Failure to pay for these supplies will result in a disincentive for home health agencies to serve these patients.

Home health patients with wound diagnoses, and their caregivers often use wound care supplies. A LUPA episode would barely cover the visit costs let alone the supplies, so agencies might be inclined to forego teaching of patients and caregivers the wound care and keep the patients on service longer in order to be eligible for full episode payments and coverage of supplies.

### **LUPA payments**

HCAC, although generally supportive of the change in LUPA payments to allow an additional per-episode payment to better reflect the costs of low utilization episodes not currently captured, would like to raise certain issues.

The reasoning for the additional LUPA payment addresses some of the costs. The proposed level still understates the actual agency cost because CMS has only included an estimate of additional time of direct service cost for assessment. This excludes the administrative cost of the agency which is fixed for either a LUPA or a full payment episode: preparing and submitting bills, OASIS transmission, non-billable visits to complete the OASIS within the allotted window of time and all the other general and administrative costs incurred to run the agency. As such, we believe the LUPA add-on payment should be included on all LUPA episodes, not just the initial one. When patients have a series of LUPA only episodes, this cost is maintained.

CMS should also reconsider the amount to account for the full administrative costs for such episodes and apply the add-on to all LUPA episodes. Also, CMS should not exclude LUPA episodes from the medical supply payment

### **Administrative Burden**

HCAC members are extremely concerned with the administrative burden of the rapid implementation schedule of such complex changes to the Prospective Pay System. Software vendors serving the home health community will not have the final rule for PPS refinement until 10/31/07 and must then have final coding of the software completed, tested, and distributed to end users before 1/1/08 for installation. The end users of the software will need to have installation of the software upgrade completed and staff trained by 1/1/08 to ensure a smooth transition in billing. Changes to the OASIS data collection needs to be implemented by providers in November, as changes to significant data elements will affect episodes that lap over into 2008. Changes of this magnitude in the past have not only affected the home health care providers' ability to adapt timely but have also had a significant impact on Medicare's fiscal intermediary contractors' ability

to be ready for the changes. This very tight implementation schedule raises great concern about the potential for claims processing delays and errors. The CMS needs to consider a viable contingency plan for cash flow to home health care providers in the event of claims payment delays or errors due to rapid system changes.

Thank you for reading and for your consideration of our comments.

Sincerely,

Susan Brown, RN  
President'

Ellen Caruso  
Executive Director