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

"Technical Changes" Create Major Downward Adjustments for Connecticut
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 D. Ellsworth
President & CEO
CT Association for Home Care

Cc: Representative Nancy L. Johnson