



September 9, 2010

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1510-P
Post Office Box 1850
Baltimore, MD 21244-1850

Re: File Code CMS-1510-P, Medicare Program, Proposed Home Health Prospective Payment System Rate Update for Calendar Year 2011

To Whom It May Concern:

The Home Care Association of New York State, Inc. (HCA), on behalf of its 252 member agencies that serve approximately 177,000 Medicare beneficiaries annually, appreciates the opportunity to provide comments on the proposed rule for the Medicare Home Health Prospective Payment System (HHPPS) for Calendar Year (CY) 2011. HCA members serve the majority of Medicare beneficiaries throughout the state, and HCA actively participated in the development of home health PPS.

General Comments

HCA is very appreciative of the consideration that the Centers for Medicare and Medicaid Services (CMS) has given to our questions, concerns and comments which we have submitted throughout the development and refinement of the HHPPS these past ten years. However, in reviewing the proposed 2011 PPS proposed rule, we are extremely alarmed with and vigorously oppose CMS' decision to not only continue certain payment reductions but to increase those reductions at a time when many providers, especially HCA's members in New York, are financially struggling with negative overall Medicare and total operating margins.

HCA also has some very serious concerns with two other CMS proposals – the first which will require a physician or non-physician practitioner to conduct a face-to-face encounter with the patient prior to certifying for home health services, and the second in which CMS is establishing new functional assessment and reassessment requirements for the home health benefit based on the premise that the current therapy benefit is ill-defined, resulting in a perceived inappropriate growth of services. HCA believes both of these proposals will severely threaten appropriate access to Medicare home health services, in the majority of cases.

Upon conducting a detailed analysis of CMS' CY 2011 proposed rule, HCA offers the following comments as CMS continues to evaluate refinements and reforms to the HHPPS.

Case Mix “Creep” and Payment Rate Reductions

HCA fervently protests CMS’ continued attempt to unjustifiably mischaracterize and exploit coding in Medicare home health services claims. CMS evaluated home health coding in 2007 and 2008 to adjust its plans for imposing case-mix coding adjustments to home health service payment rates. Previously, CMS implemented rate adjustments through a four year plan where a 2.75% rate reduction would be implemented for CY 2008-2010 and a 2.71% rate reduction would be in effect for CY 2011, to account for case-mix weight changes in years 2005-07.

However, CMS’ CY 2011 proposal now claims that coding weights continued to rise in 2007 and 2008 in a manner unrelated to changes in patient characteristics. After subtracting the case-mix “creep” adjustments already made in the past regulations, CMS asserts that there is still 7.58% of case-mix “creep” to be recovered. Consequently, CMS proposes to impose a 3.79% rate reduction in both CY 2011 and 2012, as well as reserve the right to further adjust for case-mix “creep” as average case-mix weight changes.

HCA ardently protests CMS’ proposed action. CMS’ case-mix “creep” provision is based on the unfounded assertion that home health agencies have intentionally gamed the system by coding their patients at a higher clinical severity in order to receive higher Medicare home health payments under the HHPPS. The data CMS used, and its consequent assumptions related to inflated coding, are flawed for numerous reasons, including the fact that the data doesn’t recognize *real* increases in case-mix due to *real* increases in the severity of need since the inception of PPS that are caused by: earlier and sicker hospital discharges; technology improvements which enable more complex patients to be cared for at home; improvements in the accuracy of OASIS coding that more precisely measure patient severity; and increased patient therapy needs which also indicate a higher level of patient acuity.

Furthermore, those agencies which did not contribute substantially to case-mix “creep” or are already at a low level of average case-mix should be protected from further cuts based on high case-mix weight. This is simple logic and fairness. To do otherwise is to unfairly punish lower case-mix agencies and lower case-mix patients, putting the very financial viability of long-standing and reputable agencies at risk. As the Medicare Payment Advisory Commission (MedPAC) has pointed out, those agencies most involved in abuse are those most able to sustain across-the-board cuts. Thus, the good actors are most vulnerable to these cuts.

HCA Comments/Recommendation

CMS should withdraw its proposal to increase the reduction in base payment rates in 2011 and 2012, due to case-mix “creep.” CMS’ implementation of this arbitrary cut has already reduced payments to New York home health agencies (HHAs) by \$61 million in 2008-2010, and any continuation of this cut will jeopardize an already financially fragile home care infrastructure in New York State.

A recent study by the National Association for Home Care and Hospice (NAHC) revealed an analysis of the potential risks from a combination of the proposed CMS’ case-mix “creep” payment

cut of 3.79% in 2011 and 2012 and the scheduled rate cuts mandated by the Patient Protection and Affordable Care Act. Factoring in these combined reductions, the national percentage of HHAs with projected margins of 0 or less would be 41.2% in 2011 and 49.6% in 2012. In New York, the percentage of HHAs with projected margins of 0 or less would be 64% in 2011 and 74.4% in 2012, significantly worse than the national percentages.

Because of this, HCA requests that CMS instead adopt the approach outlined in the Home Health Care Access Protection Act (S.2181/H.R. 3865) sponsored by Senator Collins (R-ME), to ensure accuracy and integrity in the estimates of nominal case-mix changes. This would involve working with the home care industry to develop criteria and examining a valid sample of actual medical records rather than relying on abstract and hypothetical statistical extrapolations which we believe have not fully explained the change in real case-mix.

Continuation of Last Year's Outlier Revisions

CMS' 2011 proposed rule continues all of the structural and content changes made to the outlier payment policy in last year's final rule highlighted by the reduction in the outlier fund from 5% to 2.5% of the total home health services estimated expenditures. CMS will also continue to cap per provider outlier revenues at 10%. CMS has implemented this change by requiring Medicare regional home health intermediary (RHII) claims processing systems to keep a running tally on individual agency outlier payments to ensure that the 10% ceiling is not exceeded. CMS continues to believe that only a few HHAs would be negatively impacted with the proposal, as the vast majority of providers obtain far lower than 10% of their revenues from outlier episodes.

CMS has stated that the purpose of this change was to address continued perceived abuses of outliers by a small segment of HHAs primarily located in South Florida.

In our comments to CMS last year on the proposed CY 2010 PPS, we stated our support for CMS' decision to redistribute the outlier fund so that 2.5% of the current outlier expenditures was added to the base rates as well as capping per provider outlier revenues at 10% to address continued perceived abuses of outliers by a very small segment of HHAs primarily located in South Florida. At the time, we believed these changes to the outlier payment would not only improve the payment system for most HHAs but also curtail unscrupulous behavior by a small group of providers.

However, since the implementation of this new outlier payment policy in January 1, 2010, HCA has heard from many member agencies that have been negatively impacted by this change. These agencies range from large facility-based agencies serving the New York City Metropolitan area, free-standing Certified Home Health Agencies (CHHAs) serving suburban areas in upstate New York as well as most of the state's special need or designated CHHAs that provides services to predominantly high need beneficiaries with chronic conditions like HIV / AIDS or with mental health needs and developmental disabilities. All of these member agencies that provide services to a high need population have reported being devastated by CMS' implementation of this new 10% outlier cap.

Furthermore, HCA has obtained data from National Government Services (NGS), New York's principal RHII, which indicates that the average number of outlier claims for HHAs in New York

between July and December 2009 was 7.65%. We believe this 7.65% average exemplifies the inadequacy of the current 10% outlier cap.

HCA Comments/Recommendation

HCA requests that CMS exempt special needs CHHAs that serve high cost patients with multiple clinical issues from the 10% outlier cap threshold. HCA also believes it is critical that CMS revise the 10% outlier cap to a higher cap threshold, so all agencies serving high need and cost beneficiaries can continue to do so, without losing critical outlier funding.

OASIS-C Update – Potential Pay for Reporting

CMS' proposed rule continues to reduce home health payment rates by 2.0% for HHAs that did not report OASIS quality data for the period July 1, 2009 through July 1, 2010. While HCA is supportive of CMS continuing the pay-for-reporting requirements mandated by the Deficit Reduction Act (DRA) in the 2010 proposed rule, we continue to have significant concerns as CMS continues to consider transitioning to a pay-for-performance (P4P) environment.

New York's home care system includes an innovative 1915(c) waiver program called the Long Term Home Health Care Program (LTHHCP) which provides an intensive array of Medicaid home and community-based services to nursing-home-eligible patients. The majority of the patients in the LTHHCP are dually eligible patients (Medicare/Medicaid). The state requires LTHHCP providers to meet the Medicare Conditions of Participation, but Medicaid is the appropriate payer of services approximately 90% of the time. Patients must also meet the requirements of a mandatory state assessment every 180 days, which is separate from the federal OASIS requirement.

HCA's concern is that CMS does not differentiate between NYS' LTHHCP and our traditional Medicare CHHA providers. CMS simply recognizes both as Medicare certified providers submitting OASIS data. However, the majority of patients being served by our LTHHCP members have long term, chronic needs, the progress with which are not reflected – and, indeed, are mischaracterized – in the discharge data as the LTHHCP patients do not improve in the same manner as CHHA patients with more short-term acute needs and expectations for recovery as measured by CHHA discharges. In fact, many LTHHCP patients receive ongoing chronic care to address needs that do not change over several years, where the goal is maintenance and stability.

Furthermore, HCA, under the leadership of Board member Dr. Thomas Dennison, Ph.D. and Syracuse University, conducted a study in 2008 which documents the significant differences between CHHA and LTHHCP populations and argues for the separation of the data, if not the exclusion of the LTHHCP from quality indicators constructed for an entirely different population. HCA would be pleased to share the findings from this study with CMS to make our case for a more accurate and representative profiling system.

Finally, New York also has 14 CHHAs that are designated to serve "special needs" patients with either HIV/AIDS or with mental health or developmental disability needs. These patients also have long term chronic needs that could negatively impact those CHHAs under a P4P system.

HCA Comments / Recommendation

HCA requests and urges CMS to remove NYS' LTHHCPs and any special needs CHHAs from this pay for reporting initiative. This would ensure that, in the future, when CMS actually begins rewarding HHAs for their OASIS performance measures, these unique NYS programs will not be adversely and unfairly affected / penalized.

Maintaining Current Wage Index

HCA has consistently raised concerns with CMS' decision to maintain the current policy of using the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next. CMS' decision five years ago to switch from Metropolitan Statistical Areas (MSAs) to the Core-Based Statistical Areas (CBSAs) for the wage index calculation has had serious financial ramifications for HHAs in New York. HCA estimates that this five year wage index shift from using MSAs to CBSAs has resulted in an estimated \$52 million cut in Medicare home health reimbursement statewide and over \$37.5 million in cuts for HHAs in the New York City (NYC) metropolitan area. Just as damaging for HHAs in the NYC metropolitan area is that their home health wage index has decreased over 10.1% since 2004 (1.4414 to 1.2949).

The main reason for these alarming cuts in reimbursement and significant percent decreases in wage index is because, unlike the MSA designation, the CBSA wage index designation adds Bergen, Hudson and Passaic counties from New Jersey into New York's NYC wage area. As the provision of home health care is a local endeavor, CMS' decision to view the current CBSA area designation in the "aggregate" for a large geographic region like NYC fails to represent the actual impact of the change. CMS' shift to the CBSA wage index designation has resulted in below trend reimbursement for NYC agencies since 2007.

Furthermore, counties in New York that are outside of the NYC area continue to regularly see annual reduction in their CBSA wage index designation. For CMS' proposed CY 2011 PPS, 47 out of 54 counties will experience CBSA wage index reductions, highlighted by a -2.97% reduction in Kingston, a -2.51% reduction in Ithaca, a -2.00% reduction in Buffalo and a -1.15% reduction in Long Island (Nassau & Suffolk).

In addition, HCA has consistently voiced its concern regarding the lack of parity between different health care sectors, each of which utilizes some form of a hospital wage index yet experiences distinct index values in their specific geographic area. CMS' decision to continue to use the CBSA-based labor market definition serves to exacerbate that instability.

HCA's Comments / Recommendations

HCA requests that CMS explore wholesale revision and reform of the home health wage index. This reform should consider the following:

- The impact on care access and financial stability of HHAs must be measured at the local level;
- Significant swings in the wage index cause instability and jeopardize access to care; and,
- The use of a hospital wage index with modifications that do not include hospital wage index reclassifications or the application of the rural floor creates an uneven marketplace for home care employers seeking to hire and retain comparable staff.

Existing law permits CMS a nearly unlimited degree of flexibility to utilize a wage index that recognizes the geographic differences in labor costs in the provision of home health services across the country. Section 1895(b)(4)(C) of the Social Security Act (SSA) mandates the establishment of area wage index adjustment factors, provides the CMS Secretary discretion to determine which factors to consider, and permits the Secretary to utilize the same wage index adjustment factors that are utilized in composing the hospital wage index. However, despite CMS' ongoing recognition that HHAs compete in the labor marketplace for the same health care staff utilized within inpatient hospitals, the wage index employed is comparable in name only.

HCA recommends that CMS reform the home health wage index by instituting a proxy that allows HHAs to receive the same reclassification as hospitals if they provide services in the same service area and we believe that Bergen, Hudson and Passaic counties should be removed from the NYC wage index. HCA believes that making these policy changes will result in the important goal of parity in the labor marketplace between hospitals and home health agencies.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Home Health Survey

HCA continues to have concerns that CMS' proposed rule maintains its existing policy (as promulgated in the 2010 HHPPS Final Rule) to expand the home health quality measures to include the CAHPS home health survey. Under this provision, HHAs are required to contract with an approved CAHPS survey vendor in order to collect and submit home health CAHPS data in accordance with the protocols located on the CAHPS website. HHAs that do not meet these requirements will be subject to a 2% reduction in the home health market basket increase as part of CMS' CY 2012 annual payment update.

The period of data collection for the CY 2012 annual payment update includes the dry run data in the third quarter of 2010, the fourth quarter 2010 (October, November and December 2010), and the first quarter 2011 (January, February and March 2011).

Also after a recent inquiry by HCA, CMS recently announced that home care agencies located in states with regulations or laws that govern the release of confidential and private health information for specific patient populations should exclude these patients from their CAHPS-eligible patient population. Additionally, Medicare-HHAs administering the Home Health CAHPS survey are responsible for making sure that the agency complies with all applicable state laws restricting the release of information for certain patient populations.

In enacting this new policy, CMS has indicated to HCA that it will be revising the list of patients who are not eligible to participate in the CAHPS survey to include patients for whom release of health information is restricted by state laws or regulations. The revised list will be included in the Home

Health CAHPS Protocols and Guidelines Manual, Version 3.0, which will be released in September 2010.

Since New York does have additional protections related to the disclosure of Protected Health Information (PHI) in cases of HIV, behavioral/mental health disorders, drug and alcohol information and genetic testing, patients with those diagnoses or who have had genetic testing should be excluded from the Home Health CAHPS survey.

Considering that many of our provider members are affected by this new exclusion policy, HCA has sought clarification from the Home Health CAHPS Survey Team on a number of issues highlighted by the following:

- Will HHAs not be required to seek additional consent/specific authorizations – as required by New York State law in order to include PHI-applicable patients as part of the Home Health CAHPS survey – since these patients are now exempt?
- Will CMS extend the deadline for agencies to apply for CAHPS survey exemption past the original June 16 deadline? This would allow agencies serving patients for whom release of health information is restricted by state laws or regulations, sufficient time to apply for exempt CAHPS survey status.

Since many HCA members had already included or planned to include the newly excluded patients in their survey population, HCA has requested guidance from the Home Health CAHPS Survey Team, as well as from CMS, regarding the appropriate action for these providers to take in response to the policy change. Additionally, HCA has requested guidance on whether the specifically protected populations must be excluded, or whether they could be voluntarily included as long as all the additional requirements of state privacy protections are met.

Finally, HCA continues to be most concerned with how the CAHPS survey places another **unfunded** administrative burden on HHAs, since it will require all Medicare certified HHAs to provide their prospective survey vendor with information about their survey eligible patients every month in accordance with the aforementioned guidelines.

HCA Recommendations / Comments

While HCA understands CMS' desire to develop a tool that measures the experiences of people receiving home health care from CHHAs, we have concerns that the survey is yet another unfunded administrative mandate being placed on HHAs that may require considerable time to work with CMS' approved vendor selected by the provider. HCA asks CMS to consider including an administrative reimbursement mechanism in its final rule, which will fairly cover the costs of implementing this proposed administrative mandate.

HCA requests that CMS extend the deadline for agencies to apply for a CAHPS survey exemption, from June 16 to Nov 16. This will allow agencies serving patients for whom release of health information is restricted by state laws or regulations sufficient time to apply for exempt CAHPS

survey status. HCA also asks that CMS respond to our two bulleted points of clarification listed above.

Other Program Integrity Type Proposals

Physician Face-to Face Encounter

CMS' proposed rule implements and expands upon the new statutory requirement (Section 6407 of the PPACA) that prior to physician certification of the home health plan of care, the physician must document that he/she or a designated non-physician practitioner has a face-to-face encounter (including telehealth) with the patient. While the law allows the contact to be with a Nurse Practitioner (NP) or clinical nurse specialist working in collaboration with the physician or with a PA working under the supervision of the physician, it does not alter the requirement that the physician sign the certification.

CMS' proposed rule further interprets the requirement to mean that the face-to-face contact must happen within 30 days prior to the home health start of care. However, if the clinical condition of the patient changes since the encounter such that the primary reason the patient requires home health is unrelated to the condition at the time of the encounter, there must be another face-to-face encounter within two weeks of the start of care.

Home health episodes without this face-to-face physician encounter would not qualify for payment under the Medicare program.

While HCA understands the requirement for the physician face-to-face home health encounter is statutory, and will be in the final rule regardless, HCA believes the requirement will prove to be an ineffective and burdensome requirement on physicians, HHAs and patients with little positive impact on program integrity.

HCA has many concerns and questions about CMS' proposal for implementing this provision. Some of these include:

- The requirements may negatively impact access to care for patients who are truly homebound or even worse, bedbound;
- The requirements may negatively impact access to care for patients in remote rural areas;
- The requirements will impose additional operational and possibly financial burdens on home health agencies and physicians;
- Many HHAs serve patients coming from clinics where they are referred by resident physicians, not primary or supervising physicians. How will CMS view resident physician or hospitalists?
- Whether CMS' timeframes for encounters (30 days prior to and 2 weeks after start of care) are appropriate;

- How CMS will enforce requirements that the encounters be related to the reason for home health services;
- Whether the new date-of-certification requirements will eliminate the acceptability of stamping with date of receipt if physicians fail to date signatures;
- Whether the fact that many physicians currently fail to seek reimbursement for their role in the home health certification process will have a negative impact on this new requirement for a face-to-face encounter;
- Will agencies be considered in violation of the false claims act for claims submitted if a physician face-to-face encounter is not substantiated?;
- How CMS intends to educate physicians about the new requirements; and,
- What type of notice is to be given to the patient when face-to-face encounter requirements have not been met?

HCA Recommendations / Comments

While HCA acknowledges that the implementation of the face-to-face physician encounter is not unreasonable in a hypothetical environment, we believe the strict timing of this requirement in the real world will likely cause burdens on homebound patients, their physicians and the agencies that serve them.

Therefore, we urge that CMS implement this requirement in a way that minimizes the burden on everyone. We suggest that the time periods for the encounter be made more flexible and recognize the reality that patients who are homebound have difficulty getting to the doctor and that physician visits are often hard to obtain on a timely basis.

Specifically we joined our colleagues at the NAHC in requesting that CMS allow the face-to-face encounter to occur six months prior to initiation of home health services, up to and including the date the physician signs the face-to-face encounter certification and certifies the plan of care. We would also urge that CMS consider ways in which the burdens placed on physicians could be mitigated with a simple, standardized format that would guide them and reduce the chance of inadvertent omissions or error.

Finally, we are concerned that CMS' current proposal would include the "originating site" requirement thereby excluding the home as a place where a telehealth encounter could occur, which is contrary to the intent of Congress in including telehealth as a means to comply with the face-to-face encounter requirement. HCA asks that CMS revise the proposed rule to incorporate the definition of telehealth services in Section 1834(m) meaning professional consultations, office visits, and office psychiatry services and any additional service specified by the Secretary using acceptable telehealth equipment.

Policy Clarification Regarding Coverage of Therapy Services

CMS' proposed rule addresses a specific issue covered in the Medicare Payment Advisory Commission's (MedPAC) March 2010 report which stated that an analysis of 2008 home health data revealed a 26% increase in the number of episodes with 14 or more therapy visits. The increase in episodes with 14 or more therapy visits is especially evident in areas of the country where home health fraud is suspected, such as Miami-Dade, Florida.

To address the concerns of MedPAC, CMS is proposing to clarify numerous policies regarding coverage of therapy services within the home health CoPs highlighted by the following:

- The patient's plan of care would include a course of therapy and therapy goals which would be consistent with the patient's functional assessment, both of which are included in the patient's clinical records;
- The new therapy goal criteria would be described in the plan of care, and they would be measurable, in that progress towards those goals could be objectively measured;
- For patient's requiring 13 or 19 therapy visits, the patient would have to be functionally re-assessed by a "qualified therapist" (rather than therapy assistant), thus requiring reassessment prior to the HHPPS therapy thresholds of 14 and 20 visits and at least every 30 days; and,
- Physician collaboration would be required on decisions about therapy needs based on patient progress and restoration potential and guidance for maintenance therapy coverage criteria.

HCA believes the majority of our members in New York have historically been compliant agencies and is hopeful that the majority of them will be unlikely to experience significant denials based on these changes. However, these policy changes, will lead to additional administrative burden to assure that all required documentation is completed appropriately. Given the human element, we believe it is also going to take time, resources and money to train providers on the extent of these new therapy rules, to assure compliance going forward.

HCA Recommendations / Comments

HCA supports CMS' efforts to rein in abuse and overuse of the therapy variability in HHPPS and supports sound documentation, objective measurement and appropriate involvement of qualified therapists.

However, HCA is very concerned about the amount of qualified therapist time and effort that will be expended to adapt to these more detailed and stringent requirements in an environment in which many home health agencies are already short of therapists. Many HCA agencies currently struggle regularly with recruiting and retaining enough fully qualified therapists and this change will exacerbate existing shortages.

Consequently, we encourage CMS in the final rule to provide sufficient time and specific guidance to help agencies train therapists and modify systems to assure that they are fully compliant with these requirements.

Also, we are concerned that patients who clearly require covered therapy may be unable to receive it as more therapist time is diverted to meeting paperwork requirements. Thus, we urge that CMS work with representatives of the home care industry to consider ways in which the intent of these rules can be met with as little additional paperwork as is needed to achieve its intended effect.

Removal of Hypertension Diagnosis Coding Under HHPPS

CMS' proposed rule removes ICD-9-CM code 401.9, Unspecified Essential Hypertension, and ICD-9-CM code 401.1, Benign Hypertension, from the HHPPS case-mix model's hypertension group due to CMS' analysis of HHPPS claims from 2001 to 2008 which shows a sudden increase in the reporting of unspecified hypertension and benign hypertension on home health claims beginning in 2008.

CMS states that recent developments in clinical guidelines may have led to ambiguity in the definition of hypertension in the ICD-9-CM classification system and that the continued inclusion of the unspecified and benign hypertension codes in the HHPPS case-mix system threatens to move the HHPPS case-mix model away from a foundation of reliable and meaningful diagnosis codes that are appropriate for home care.

However, HCA believes hypertension is a common home health comorbidity that impacts the patient plan of care and should therefore be separately coded. Furthermore, as many New York providers serve patients with not only complex needs but with multiple diagnoses, agencies should be able to list the appropriate primary and secondary diagnoses that will assist Medicare in calculating an equitable home health payment rate.

HCA is concerned that CMS' proposal to remove these important codes deprives the extra reimbursement providers receive for serving patients with hypertension, and is not compelled by HHAs misuse.

HCA's Recommendations / Comments

HHAs in New York are appropriately using the hypertension diagnoses codes and CMS' proposal to remove the hypertension case mix diagnoses merely serves as an additional case-mix "creep" adjustment, resulting in significant additional reductions in reimbursement rates. CMS should remove this proposal from the final rule.

New Home Health Claims Data Collection Codes

CMS' proposed rule calls for establishing new Healthcare Common Procedure Coding System (HCPCS) "G" codes and reporting these new codes on home health claims. The codes would provide more specific information about the covered service provided and the qualifications of the clinician making the visit.

CMS proposes to request new therapy G codes to collect information that could be used to evaluate the extent of any shift in the provision of therapy visits by therapy assistants, rather than qualified therapists and similarly about the category of nursing services being provided on visits.

While HCA understands this information would help CMS determine if the current therapy case-mix weights, which were established based on an assumption that 79% of therapy services are provided by qualified therapists, accurately reflect the cost of home health therapy and nursing, HCA is concerned about CMS adding yet another administrative burden on agencies by asking them to absorb the costs of systems changes in a time where CMS is also implementing significant payment reductions.

HCA's Recommendations / Comments

While HCA understands the purpose of this proposal, the potential cost-benefit is not supported by the additional costs and disruption to the systems of agencies and patient care. HCA request that these coding changes be deferred until at 2014, when CMS begins to create a more comprehensive set of reforms.

Capitalization & Change of Ownership (36-Month Rule) Revisions

HCA supports CMS' proposal to revise the current longstanding capitalization requirements for new HHAs to require verification of adequate capitalization at the time of application, during the period while they are being reviewed for compliance with the conditions of participation, and within the three months following the issuance of a Medicare billing number rather than merely at application.

However, HCA recommends that the existing 36-month rule and any revisions be applied prospectively only. Specifically, no HHA that is currently Medicare enrolled should be subject to the rule in the event of any implicated ownership change as they entered into Medicare without a restriction on the sale of the HHA other than those restrictions existing at that time. At most, CMS should apply the rule to HHAs initially enrolled in Medicare on January 1, 2010 or later, the effective date of the original 36 month rule. Otherwise, the application of the rule to pre-existing HHAs alienates the value and financial stability of the business in ways that will affect existing creditors, investors, and owners.

HCA Comments

HCA supports CMS' capitalization proposal. HCA also believes that the change of ownership (36-month rule) proposal is well-founded in its purpose and intent however, the rule is not appropriate to the problem it seeks to address as it will negatively impact on bona fide home health agencies and the patients they serve. The rule should be redesigned wholesale or significantly revised to better balance the interests of patients, providers, and Medicare. HCA recommends that CMS work with the home care industry and in particular our colleagues at NAHC, to achieve the program integrity protection purpose behind this rule.

Solicitation of Comments on Centralized Grouping of PPS Claims

CMS' proposed rule asks for comments on its concept of requiring agencies to report all grouper relevant OASIS elements on HHPPS claims and having CMS produce the correct grouper category rather than the current system of agencies using OASIS to group the claims and reporting the grouper category as a HIPPS Code.

HCA believes this proposal could be a better way to reduce the chance of error in the grouping process and eliminates some provider burden; however, agencies will still need to group claims to manage their accounts receivable function and guard against CMS errors.

HCA's Recommendations / Comments

HCA is supportive of a centralized grouping in concept; however, HCA believes it is critical that the revised / new system be accurate and provide real-time feedback of the grouper to agencies to enable them to maintain and verify their accounts receivable.

In conclusion, we thank you for this opportunity to submit comments and respectfully requests your consideration of our serious concerns and recommendations.

I would be pleased to answer any questions or to assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or at (518) 810-0661.

Sincerely,

A handwritten signature in cursive script that reads "Patrick Conole".

Patrick Conole, MHA
Vice President, Finance & Regulatory Affairs
Home Care Association of New York State, Inc.