American Hospital Association

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

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Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1541-P, Medicare Program; Home Health Prospective Payment System for Calendar Year 2008 Proposed Rule (Vol. 72, No. 86), May 4, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 35,000 individual members, including 1,385 hospital-based home health agencies, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year 2008 proposed rule for the home health prospective payment system (PPS). We applaud the proposed refinements to increase the number of payment categories to improve accuracy in payment and make other appropriate improvements.

While we support refinements to better align Medicare payment with the actual cost of delivering home health care, the proposed methodology overlooks additional steps that would further improve payment accuracy. In particular, CMS should reconsider a payment adjustment for higher-cost patients such as dually eligible Medicare/Medicaid beneficiaries. CMS' finding that dually eligible status is not associated with higher costs runs counter to the widely accepted correlation between Medicaid status and higher resource utilization. We urge CMS to revisit this issue and include an adjustment to help ensure that this vulnerable population receives the high-quality care it needs.

CMS proposes to apply a 2.75 percent reduction in payment in each of the next three years to offset historic coding changes. Instead of making these dramatic cuts, we urge CMS to further analyze the increase in case mix due to the implementation of the home health PPS. Case mix has increased due to several factors, including earlier discharges from general acute hospitals, PPS changes that provided incentives to treat higher-acuity patients, and other post-acute

regulations such as the inpatient rehabilitation "75% Rule," which divert more medically complex patients to the home health setting. While coding changes do account for part of the increase, we urge CMS to more adequately account for these concurrent factors.

The proposed coding cut would be particularly severe for hospital-based home health providers that often treat medically complex, post-acute patients not admitted by community-based home health agencies. Hospital-based home health agencies face additional vulnerability because they already lose money serving Medicare patients, as reflected in their negative Medicare margins. In addition, many hospital-based agencies are rural providers. We encourage CMS to implement measures to improve access and payments to rural home health agencies.

We thank CMS for the opportunity to comment on this proposed rule. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President