

September 28, 2009

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

RE: CMS – 1560 –P: Medicare Program; Home Health Prospective Payment System for Calendar Year 2010; Proposed Rule (Vol. 74, No. 155), August 13, 2009.

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations – including approximately 1,200 hospital-based home health agencies (HHAs) – and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the calendar year (CY) 2010 proposed rule for the home health (HH) prospective payment system (PPS). This regulation includes the mandatory market basket update, an offsetting coding reduction and major changes to outlier policy and patient assessments, among other changes.

Proposed Changes to Outlier Policy

The AHA understands and supports the Centers for Medicare & Medicaid Services' (CMS) proposed changes to address the problem of overuse of outlier payments by certain providers, as documented by CMS, the Medicare Payment Advisory Commission and the Government Accountability Office. CMS proposes two outlier policy changes – a 10 percent cap per provider, per year; and a reduction of the outlier pool from 5.0 percent to 2.5 percent. The execution of the cap should allow for provider status relative to the outlier cap threshold to be assessed on a rolling basis rather than through a year-end assessment accompanied by a retrospective reduction for any cases exceeding the 10 percent cap. A year-end adjustment has the potential to cause cash-flow problems for smaller agencies and those with lower Medicare margins, such as hospital-based providers. In addition, we ask CMS to clarify in the final rule the method it will use to identify outlier cases that exceed the cap and will therefore be paid at the normal episode rate.



The AHA also supports the related changes to restore the 2.5 percent in payments that would move from the outlier pool to the funds allocated for standard payments; and the reduction of the outlier loss threshold to allow a greater number of legitimate outlier cases to qualify for outlier payments, if they fall below the new cap. We also ask CMS to detail in the final rule the methods that it will use to monitor outlier payments to ensure that the full 2.5 percent outlier pool is expended in CY 2010.

Proposed 2.75 Percent Coding Reduction

For CY 2010, CMS proposes a 2.75 percent reduction for CY 2010 HH payments – the third in a series of four payment cuts that collectively offset nominal case-mix changes from 2000 through 2005. While we appreciate CMS’ prior efforts to study and account for real case-mix change by removing it from the adjustment, we are troubled about the impact of these cuts on hospital-based agencies. The substantial coding cuts already scheduled for 2010 and 2011 will pose great challenges for hospital-based home health agencies (HHA). Furthermore, hospital-based providers cannot withstand the additional coding reduction in either 2010 or 2011 that is being considered by CMS to adjust for coding practices in 2006 and 2007.

Proposed Transition to OASIS-C

CMS proposes revising the HH patient assessment instrument, known as the OASIS, beginning January 2010. At that time a new tool – OASIS-C – would be implemented. While we support these long-awaited improvements to OASIS, we ask CMS to further detail in the final rule its plans for provider education and other preparations that need to occur prior to the January 1 implementation. In addition, we ask CMS to provide a target date for the issuance of the pending, final interpretive guidelines for OASIS-C. Given the absence of these guidelines, lagging vendor preparation and the short window of opportunity to complete these steps and necessary training, we urge CMS to delay implementation of OASIS-C for at least six months to accommodate the remaining preparation activities needed for a seamless transition.

New Business Requirements

To address CMS’ concerns related to fraud among some HHAs, the proposed rule would implement new business requirements to help CMS verify that HHAs meet minimum enrollment criteria; ensure that Medicare conditions of participation are met by HHAs that change ownership; and improve quality of care. One of the regulation’s recommended changes is of particular concern for hospital-based agencies. CMS proposes to prohibit HHAs from sharing, leasing or subleasing a practice location or base of operations listed in its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier. This requirement would impose harmful and unnecessary restrictions on hospital-based agencies that are part of an organization that also has a hospital-based supply business under Medicare for durable medical equipment (DME). Such arrangements pose no risk to the Medicare program and are subject to substantial program integrity safeguards – such as new quality and accreditation standards for DME suppliers and the outlier changes proposed in this regulation. We urge CMS to modify this proposal to allow hospitals to continue conducting both

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operations, which provide tremendous value to patients seeking to transition back to their homes following a hospital stay.

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