

September 14, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1510-P; Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Proposed Rule

Dear Dr. Berwick:

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 – and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the calendar year (CY) 2011 proposed rule for the home health prospective payment system (PPS). Our comments address AHA's two overarching concerns with the proposed rule: 1) the significant, across-the-board cuts intended to adjust for coding and documentation; and 2) the proposed requirements pertaining to a face-to-face examination of the patient by the physician prescribing home health services.

The overall fiscal impact of this proposed rule – negative 4.71 percent – is too severe for hospital-based home health agencies. Hospital-based agencies often serve sicker patients who are medically able to transition from the hospital to home, but are difficult to place in the community due to their need for more involved, and often more costly, home care. As reported in prior years by the Medicare Payment Advisory Commission (MedPAC), hospital-based home health care agencies have lower, often negative, Medicare margins on average.

The regulation is particularly harsh in light of the \$40 billion in home health cuts authorized by the *Affordable Care Act* (ACA) for CY 2011 and beyond. While we understand CMS' concern about the rapid growth of new home health agencies, we feel



that, in the ACA, Congress set forth an overall approach to improve the home health PPS and protect against inappropriate and clinically unnecessary use. The home health provisions in the ACA include a 1.0 percent marketbasket reduction for CY 2011, a requirement to reduce the size of the home health PPS outlier pool from 5.0 to 2.5 percent, a mandate for CMS to rebase the home health PPS to improve the accuracy of the payment system, and a requirement to advance toward home health pay-for-performance, among others. It is excessive to propose further cuts that go beyond the already scheduled coding cuts and the sizeable ACA cuts. In addition, we are concerned that, even with the reinstatement of rural home health payment add-on, rural agencies still face a negative 4.38 percent cut under the proposed rule.

PROPOSED 3.79 PERCENT CODING AND DOCUMENTATION REDUCTION

Background. In the final rule for CY 2008, CMS initiated four separate payment offsets to account for coding and documentation behavior from 2000 through 2005, including cuts of negative 2.75 percent in 2008, 2009 and 2010, and a 2.71 percent reduction scheduled for CY 2011. In the final rule for CY 2010, CMS noted its expectation to increase the scheduled CY 2011 cut based on additional analysis showing further case-mix growth due to coding and documentation changes in CYs 2006 and 2007.

CY 2011 Proposal. In this proposed rule, CMS discusses its latest analysis on home health case-mix change, which found a 19.4 percent increase in the overall case mix from 2000, the year in which the home health PPS was introduced, through 2008, the year CMS implemented refinements to the structure of the home health PPS. CMS estimates that there was a 1.95 percent increase due to greater severity of illness for beneficiaries treated by home health agencies, and that the remainder, 17.45 percent, was due to changes in coding and documentation practices. The latest analysis on case-mix change from 2007 to 2008 shows a more than 4 percent increase in case mix due to coding and documentation. Therefore, as expected, CMS is proposing a coding offset for CY 2011 of negative 3.79 percent. The proposed rule also notes CMS' plans to recommend a coding cut of 3.79 percent in CY 2012. These cuts are intended to adjust for the residual impact of coding and documentation changes on case-mix change from 2000 through 2008, which is not already accounted for by the cuts authorized in the CY 2008 final rule.

AHA Recommendations. The AHA remains concerned that CMS' assessment of case-mix change results in an under-accounting of the impact of "real case-mix change." It is unlikely that only one-tenth of the home health PPS case-mix change that occurred from 2000 through 2008 was the result of home care providers treating sicker patients. Broader policy and population trends contributed to the home health patient population experiencing growth in average severity of illness from 2000 to 2008. A number of Medicare policies and program integrity activities have resulted in stricter admissions criteria for other post-acute settings, such as inpatient rehabilitation and long-term acute-care hospitals. As a result, certain patients have been shifted from these hospital-based post-acute care settings to lower-intensity settings such as home health care. In addition,

at the macro level, Medicare beneficiaries are getting sicker on average, as shown by the greater occurrence of obesity in the United States. These population trends are explained in a July 2010 report titled “Trends in Case-Mix in the Medicare Population” by Partha Deb, Ph.D., a professor of economics at Hunter College and the Graduate Center, City University of New York. Dr. Deb analyzed changes in Medicare case mix over time. Specifically he found that case mix based on overall disease prevalence in the Medicare population steadily increased from 2000 through 2007. This analysis was based on data from the Medical Expenditure Panel Survey, which is a nationally representative sample and measures medical care from all health care providers. Case mix was estimated from measures of disease indicators based on the Clinical Classification Software (CCS) system. The report is attached.

Additionally, the proposed across-the-board coding cut also fails to target the dominant influence on case-mix change reported in the proposed rule. CMS’ analysis indicates that 38 percent of case-mix change from 2007 to 2008 was due to a shift in the use of therapy visits per episode, in response to the 2008 refinements to the home health PPS therapy thresholds. An across-the-board payment reduction does nothing to address the practice of those providers who shift per-patient therapy utilization to fit the new therapy thresholds in order to optimize Medicare payments. In addition, CMS’ case-mix methodology relies on hospital data, when more than half of home health patients originate from a source other than an inpatient hospital.

We urge CMS to withdraw its proposal to increase the CY 2011 cut for coding and documentation beyond the level already implemented in the CY 2008 final rule. Instead the agency should refine its case-mix methodology so that it targets the drivers of case-mix change and more effectively captures the influence of real case-mix change.

Rather than increase the planned 2008 coding cuts, CMS should first conduct the ACA-mandated study and demonstration designed to assess the needs of patients requiring services that are not fully compensated by the home health PPS. This study was mandated to address concerns that across-the-board cuts may exacerbate the access challenges faced by medically complex patients.

The AHA also urges CMS to focus on the particular organizations that misuse Medicare’s home health benefit, rather than relying on imprecise across-the-board cuts that penalize all providers. CMS already has several such proposals on the table, which we support. In particular, we believe the following will meaningfully reduce the incidence of improper home health service use:

- the future rebasing of the HH PPS, per the ACA;
- the proposed rule’s provisions to clarify requirements for documenting therapy visits;
- the provisions on the new home health consumer satisfaction survey; and

- the more stringent provider enrollment requirements on capitalization.

These will complement the changes approved by Congress to increase the operational integrity of the home health field, especially the pending rebasing of the home health PPS.

FACE-TO-FACE PHYSICIAN ENCOUNTER

The AHA is supportive of CMS' efforts to ensure that home health services are provided to beneficiaries only when reasonable and necessary. However, we are concerned about the time requirements proposed for the ACA mandate for a face-to-face patient encounter by the physician certifying the home health plan of care.

Under the proposed rule, patients would be required to have a face-to-face encounter with a physician (or nurse practitioner, physician assistant or clinical nurse specialist in combination with a physician). The encounter must occur within 30 days prior to the implementation of the home health plan of care, or 15 days following the initiation of care if the clinical need for home care differs from the clinical condition addressed during the prior physician visit. This time requirement will be difficult to execute and will likely cause avoidable and unwarranted burden for patients, including delays in the initiation of medically necessary home care.

CMS' interest in requiring greater physician involvement in the process of referring beneficiaries to home health is appropriate. However, there are a number of scenarios where the proposed approach will generate problems for home health patients who, per Medicare guidelines, must be homebound to qualify for the benefit. Under the scenarios described below, patients will likely face delays in the initiation of medically necessary home health care, which may be detrimental to their health status.

- The most obvious problem occurs for the group of beneficiaries who, due to their homebound status, are ill-suited to meet the requirement for a face-to-face encounter if it requires a trip to a physician's office. Many of these homebound individuals will not have seen their primary care physician within the 30 days prior to needing to initiate home health care. For them, a trip outside of the home can be accomplished only with great difficulty, and perhaps medical risk in some cases.
- Some areas, such as rural communities, face a well-documented shortage of primary care physician services. In such cases, there is no option for a patient's physician to do a "house call" in order to approve the patient's home health plan of care. And given the shortage, for those who are to be transported to see the doctor, an appointment may not be available within the 15-day window.
- Some hospital patients are treated by a "hospitalist" or emergency department (ED) physicians. Typically, these physicians only provide care during a

hospitalization or ED visit and do not provide follow-up care after hospital discharge. Both hospitalists and ED doctors are generally willing to communicate with a hospital patient's private physician and provide an initial order for post-acute care. However, they most often are not comfortable signing off on a post-acute plan of care, such as a home health plan of care, for which they will not be involved as the overseeing physician. Patients treated by a hospitalist or ED physician must turn to a physician outside of the hospital to approve their home health plan-of-care in order to be transferred from the hospital to home care. This is a time-consuming process that can frequently take more than 15 days.

- Hospital-based home health agencies often treat patients who lack a primary care physician. In this case, a community-based physician must be identified who can sign the home health plan of care. Not surprisingly, this process can take more than 15 days.

These common scenarios will result in home health agencies being unwilling to initiate care for patients who lack a plan of care signed by the physician providing a face-to-face encounter. They will be unwilling to bear the risk of a Medicare denial of payment for such care if the beneficiary is unable to achieve the face-to-face encounter and plan-of-care sign-off within 15 days. This problem of delayed hospital discharge and/or home health care due to the inability of the beneficiary to meet the proposed requirement is largely avoidable if CMS provides more flexibility for the plan-of-care and encounter timeframes.

While this requirement was mandated by the ACA, we encourage CMS to implement the provision in a flexible manner in the final rule. We recommend that CMS significantly lengthen the 15-day requirement following the initiation of the plan of care. Doing so will help homebound beneficiaries fulfill the requirement while not being held to an often impossible-to-achieve standard, as described above, which may unnecessarily delay hospital discharge and/or the commencement of medically appropriate home care. For those patients remaining at home while they wait for the plan of care to be signed, health status may be avoidably compromised.

Thank you for your consideration of our comments. 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

Attachment

Trends in Case-Mix in the Medicare Population

Presented to:
American Hospital Association
Federation of American Hospitals
Association of American Medical Colleges

July 15, 2010

Partha Deb
Professor of Economics
Hunter College and the Graduate Center
City University of New York

Executive Summary

Is the Medicare population getting sicker over time? Common perception is that the population *is* getting sicker, in part because of its aging. But this perception is not reflected in the proposed CMS rule regarding Medicare payments in which it is suggested that US hospitals have seen a decline in real case-mix in the recent past.

In this study, we analyzed changes in Medicare case-mix over time to determine whether other data and tools to measure patient severity show an increase or decrease in case-mix. We used two different sources of data, with complementary strengths, both developed by the Agency for Healthcare Research and Quality (AHRQ). We used the most recent data available at the time of the study, and used alternative diagnosis-based indicators to measure case-mix.

Our main findings are:

1. Case-mix based on overall disease prevalence in the Medicare population has been steadily increasing from 2000-2007. This analysis was based on data from the Medical Expenditure Panel Survey which is a nationally representative sample and measures medical care from all healthcare providers. Case-mix was estimated from measures of disease indicators based on the Clinical Classification Software (CCS) system (Figure 1).
2. In-hospital case-mix in the Medicare population has been steadily increasing from 2000-2007. This analysis was based on data from the Healthcare Cost and Utilization Project database which is a nationally representative sample of hospital discharges. Case-mix was estimated from measures of disease indicators based on the CCS system (Figure 2).
3. An alternative measure of in-hospital case-mix in the Medicare population has been steadily increasing from 2002-2007. This measure, estimated using indicators from the Disease Staging (DS) system developed by Thomson-Reuters, was analyzed using data from the Healthcare Cost and Utilization Project database (Figure 3).

CMS' assertion that case-mix has declined in the recent past is inconsistent with our findings. Multiple data sets and different measurement tools indicate that the Medicare population is indeed getting sicker.

Figure 1

CMI Based on CCS in the MEPS data: Patients Are Getting Sicker Every Year

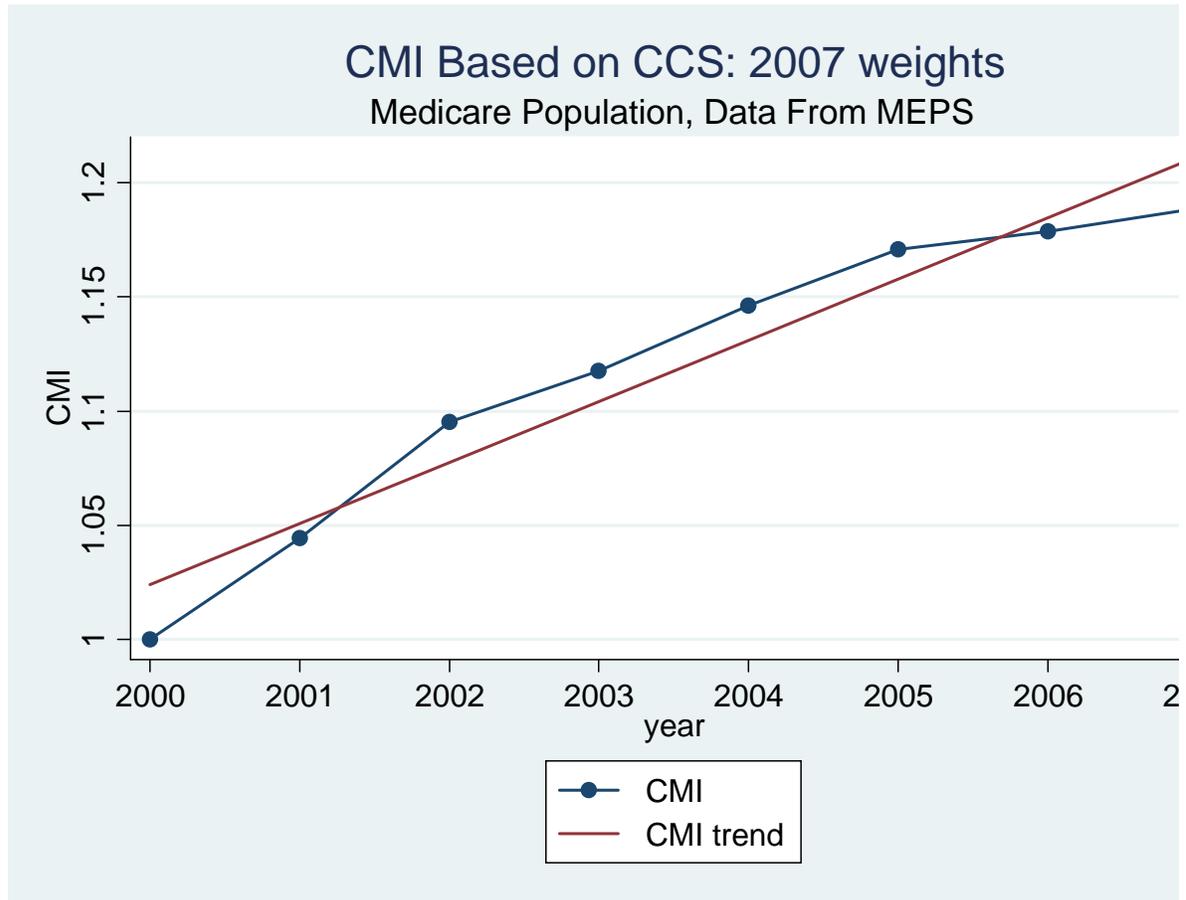


Figure 2

CMI Based on CCS in the HCUP data: Patients Are Getting Sicker Every Year

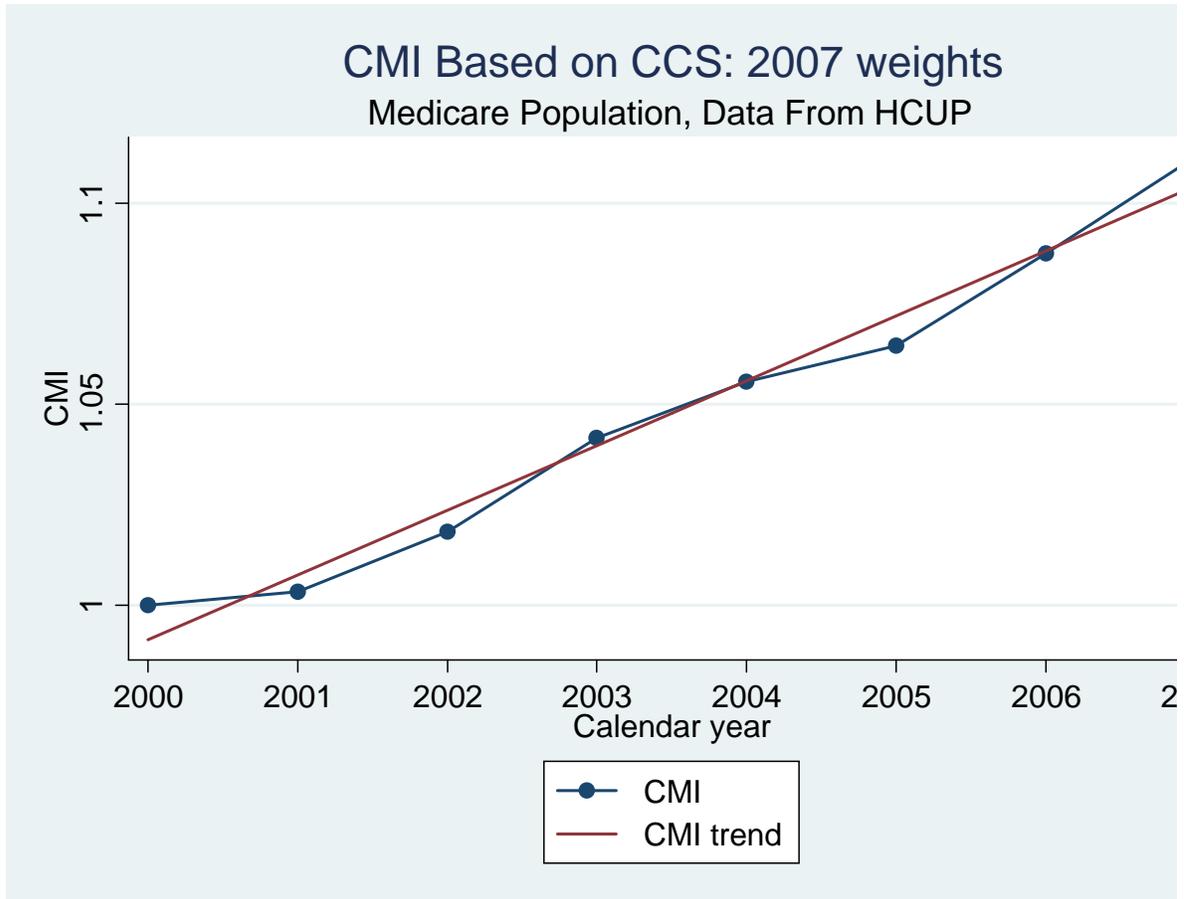
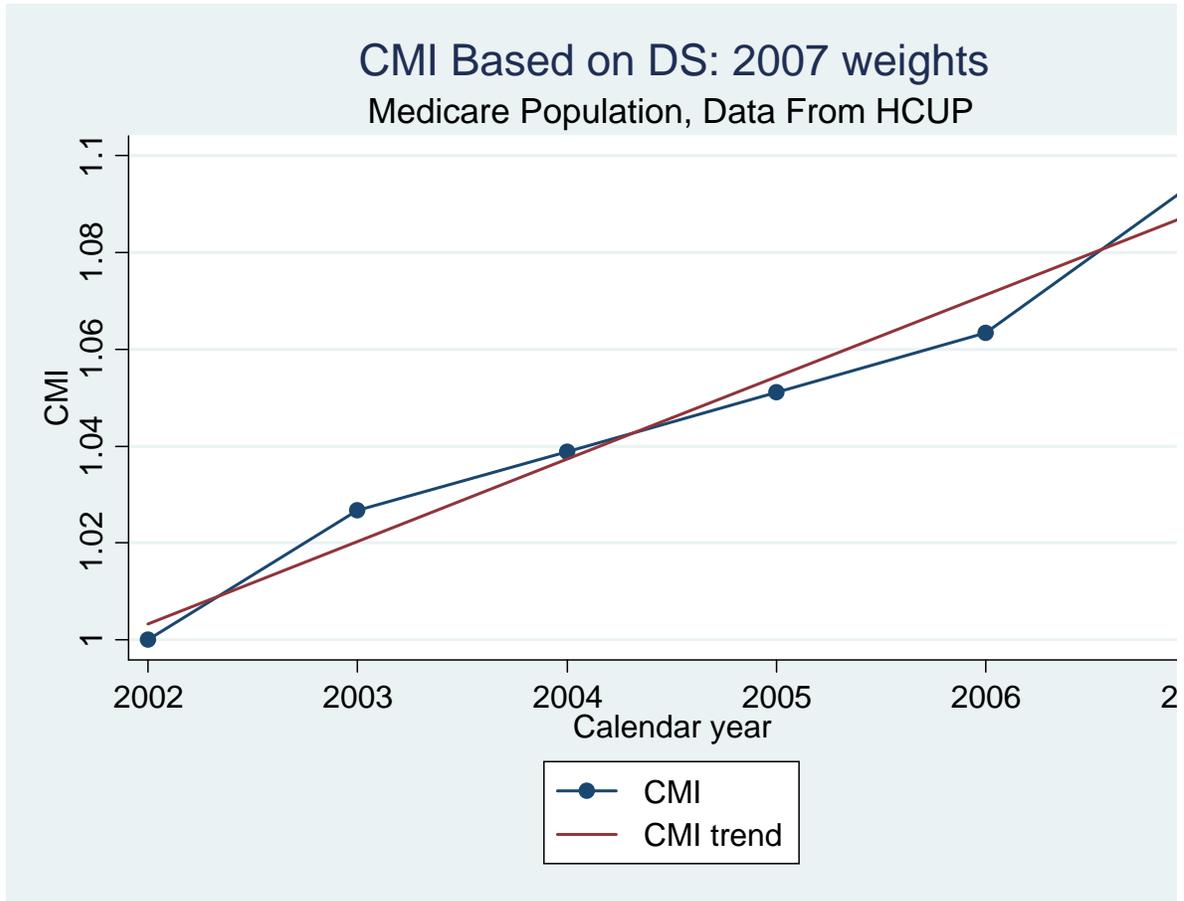


Figure 3
CMI Based on DS in the HCUP data: Patients Are Getting Sicker Every Year



Study in Detail

We analyzed changes in Medicare case-mix over time to determine whether other data and tools to measure patient severity show an increase or decrease in case-mix. We used two different sources of data, the Medical Expenditure Panel Survey and the Health Care Utilization Project databases developed by the Agency for Healthcare Research and Quality (AHRQ) for our analysis. The datasets have complementary strengths, and we used alternative diagnosis-based indicators to measure case-mix to strengthen our findings.

Data and Methods

One of the two datasets used for the analysis was constructed from the event-level health care utilization files from the household component of the Medical Expenditure Panel Survey (MEPS) from 2000-2007. In addition to inpatient hospital events, MEPS has separate files for 1. office-based medical provider visits, 2. outpatient visits, 3. emergency room visits, 4. prescribed medicines and 5. home health care visits. The data contain up to four ICD-9-CM diagnosis codes for each medical care event and also up to four AHRQ Clinical Classification Software (CCS) codes.

The Clinical Classifications Software (CCS) for ICD-9-CM is a diagnosis and procedure categorization scheme that takes ICD-9-CM's multitude of codes—over 14,000 diagnosis codes and 3,900 procedure codes—and collapses them into a much smaller number of clinically meaningful categories. CCS can be used to identify populations for disease- or procedure-specific studies or to develop statistical reports providing information about relatively specific conditions. We used it to develop a measure of disease case-mix for the Medicare population.

The other dataset used for the analysis was constructed from the National Inpatient Sample (NIS) event-level files of the Health Care Utilization Project (HCUP) from 2000-2007. The NIS is nationally representative of hospital discharges and covers all payers, not just Medicare. The NIS contains clinical and resource use information included in a typical discharge abstract. In addition to up to nine ICD-9-CM codes available uniformly across all states, the datasets include up to nine AHRQ CCS codes for each year which we use to construct measures of case-mix. In addition, from 2002 onwards, the HCUP data also include the Disease Staging (DS) classification system groups developed by MedStat (Thomson Reuters). Disease Staging is similar to DRGs in that it uses diagnostic findings to produce clusters of patients who require similar treatment and have similar expected outcomes. It can serve as the basis for clustering of clinically homogeneous patients to assess quality of care, analyze clinical outcomes, review utilization of resources, assess efficacy of alternative treatments, and analyze resource utilization. We calculated case-mix based on DS to provide additional evidence of changes in case-mix over time in US hospitals.

The formula used to estimate the case-mix index is a standard index number formula and is used in a wide variety of areas including in the calculation of price indices. Calculation of the index requires the derivation of importance weights. We calculated importance weights using total expenditures in the case of MEPS and charges in the case of HCUP. For each dataset and for each base year, we estimated the “price” or importance weight for a diagnosis related indicator as the coefficient from a regression of expenditures or charges on the set of indicators.

Results and Discussion

Figure 1 shows the values of the case mix indices (CMIs) for the Medicare population from 2000 – 2007 calculated using data from MEPS, denoted by the dots joined by line segments, along with the best-fit linear trend. The weights for the calculation of the CMI are based on data from 2007. For ease of comparison, the values of CMI have been rescaled so that $CMI(2000) = 1$. The figure shows that the CMI calculated using diagnosis related indicators and expenditure weights derived using the CCS system increases continuously from CYs 2000 through 2007.

Figure 2 displays measures of CMI for the Medicare population based on inpatient records from HCUP databases and with CMI calculated from diagnosis related indicators based on the CCS. As with the figures based on data from the MEPS, the values of CMI have been rescaled so that $CMI(2000) = 1$ in each of the panels. The figure shows that the CMI calculated using diagnosis related indicators and charge weights derived using the CCS system increases continuously from 2000 through 2007.

In Figure 3, we display values of CMI for the Medicare population from 2002 – 2007 using measures of CMI calculated from diagnosis related indicators based on the DS system. Thus the results that we observed in Figure 2 are robust to the choice of systems by which diagnosis related indicators are constructed and used to estimate the CMI. Once again, the CMI increases continuously from 2002 through 2007.

Conclusion

In conclusion, a steadily increasing disease and severity burden among Medicare enrollees is evident across datasets and measures. CMS’ assertion that case mix has declined in the recent past is inconsistent with our findings.