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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention CMS-1390-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

**Submitted Electronically**

RE: CMS-1390-P RIN 0938-AP-15 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2009 Rates; Proposed Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral rules; Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians

The National Association for Home Care & Hospices (NAHC) is the largest trade association representing home health agencies, hospices, and durable medical equipment suppliers and the beneficiaries that they serve. NAHC appreciates the opportunity to comment on this notice and make recommendations on those proposals that will impact home care providers and their patients. The primary issue of concern to NAHC is the Proposed Changes to the Post-acute Care Transfer Policy at §412.4 in Section IV. Specifically, we wish to address the Centers for Medicare & Medicaid Services' (CMS) "Proposed Policy Change Relating to Transfers to Home with A Written Plan for the Provision of Home Health Services."

**ISSUE: Lack of Supporting Evidence for 7 Day Policy**

CMS proposes to extend the timeframe for initiation of home health services to 7 days after a hospital discharge. It is implied in the justification offered for this extension that patients are being discharged prematurely and that home health services are being inappropriately substituted for acute hospital stay days. However, there is insufficient evidence to demonstrate that early hospital discharges are premature and adversely affect patients. The conclusions that affected parties may draw from the notice could result in longer hospital stays that are not medically necessary.

Although the notice addresses payment differences to home health agencies for services to patients subject to the transfer policy, it does not address quality and the outcomes of the care. In fact, the notice implies that patients who are discharged early and transferred to home health have been subject to premature discharge without providing supporting evidence.

Expanding the transfer window from 3 to 7 days may result in further delay of referrals to home health agencies with negative consequences for patients. NAHC has received anecdotal information that physicians have been instructed by a few hospitals to delay referrals to home health agencies until passage of 3 days. The information offered in the proposed rule does not support the premise that expanding the window to 7 days will change this behavior. In fact, the proposed policy change may:

- Incentivize hospitals to keep patients longer than necessary, or
- Discharge patients early, but delay in admission to home health until passage of 7 days.

Either of these responses could have a negative impact on patient outcomes. Delay of referrals to home health could lead to unmet needs resulting in preventable emergent care visits and re-hospitalizations. Evidence shows that, the sooner a patient is admitted to home health services, the better their outcomes. Agencies with the best outcomes, including the lowest re-hospitalization rates, admit patients within 24 to 48 hours of hospital discharge and frontload visits during the days immediately following hospitalization. Consideration of these findings is especially important in light of CMS' goals and plan to create incentives to reduce avoidable readmissions to hospitals.

From the payment perspective, CMS has not provided sufficient evidence to demonstrate that extension to a 7 day window will positively impact payment. Although a comparison of cost per visit for home health services for patients subject to the transfer policy was provided, it did not include data about reduced payments to hospitals for these patients. Therefore, the true impact of the proposed policy change is unknown. Further, it is impossible to pinpoint the specific reason for increased payments for home health visits since Home Health Resource Groups (HHRG) and numbers of visits in each episode were not provided.

Detailed information about the HHRGs and number of visits in each episode is necessary to determine whether patients had higher acuity levels than average, as would be expected for patients discharged to home earlier, or if fewer visits delivered over the course of home health episode resulted in higher visit costs. Further, higher payment per visit of itself does not prove that transfer to home care at the earlier point in an individual's recovery is inappropriate. If early discharge and transfer to home health results in improved outcomes and greater patient satisfaction, CMS should adopt policies that promote this behavior regardless of whether they result in increased payment for home health that is greater than the savings in hospital payment.

## **ISSUE: Burden on Hospitals and Accuracy of Reporting**

NAHC has have received reports that are suggesting that a great deal of confusion still exists on the part of hospitals about the hospital transfer policy. Many hospitals are not aware of the multiple considerations that must be made or the complex processes needed for correctly coding claims for Transfer to Home with a Written Plan for the Provision of Home Health Services. Further, the information hospitals need to code transfers correctly is not reported to them from other sources, such as the Common Working File (CWF). Often the only way hospitals can obtain the information is by directly contacting home care providers. The information that must be collected in order to code transfers correctly includes:

- **Confirmation that the home care provider is Medicare certified:** Medicare beneficiaries receive home care services from a variety of sources. Many home care services are delivered by non-certified organizations not paid by Medicare, such as private duty nursing and homemaker aide organizations. Hospitals do not always have information about community services needed to differentiate between these home care providers and Medicare certified home health organizations for which reporting the Patient Status Discharge Code 06 is required. Furthermore, some patients referred to Medicare certified home health agencies are not eligible for Medicare covered because the patient does not meet qualifying criteria and/or services don't meet coverage criteria. Non-covered home health transfers are also not included to the transfer policy provisions.
- **Determination of Whether the Home Health Condition is Related to Inpatient Hospital Admission:** Hospital billing instructions require reporting condition code 42 for full DRG payment if home health services are unrelated to the reason for admission. However, a patient's physician and the home health agency determine the primary diagnosis and reason for home health services. These determinations are based on information collected during the comprehensive assessment at the time of admission to home care. This information, which may not be available for several days after a hospital discharge, is not reported to the hospital.
- **Admission to Home Health within a Window:** The current transfer policy requires reporting condition code 43 for full DRG payment if a patient is transferred to home health but does not begin care within a certain number of days (3 currently, 7 proposed). Home health agencies do not report dates of admission to hospitals.
- **Referrals that Occur After Discharge:** Often home health referrals are made by a patient's physician days after hospital discharge. Hospitals are not notified when discharged patients are referred for home health services subsequent to hospital discharge.

Home health information is not readily available to hospitals in a timely manner. Although hospitals can access home health date of admission from the Common Working File (CWF), the diagnosis or condition for which a patient receives home health services is not provided in CWF. Further, home health admission information is not available in CWF until after a home health agency submits a request for anticipated payment which may be weeks or months after services are initiated. The only way for hospitals can be 100% certain that they have the details needed to correctly code transfers to home health

is by contacting every patient discharged to home to inquire about receipt of home care services, followed by contact with the identified agency for the admission date and reason for services.

The complexity of the current provisions of the transfer policy is likely the basis for underpayment to hospitals. In the recent RAC demonstration project 3 of the 4 percent of underpayments identified were to hospitals. Of these underpayments, a significant number were related to improper coding of transfers. According to the RAC demonstration report "\$14 million in underpayment amounts were repaid to providers in FY 2007, and most of these were repaid to inpatient hospitals." Extension of the time line for home health transfer to 7 days will make this process even more burdensome for hospitals.

In summary, CMS implies in this notice that the current 3 day policy should be extended to 7 days because patients are being discharged inappropriately to home health, and at a higher cost to Medicare. However, NAHC believes that CMS has not proven this premise. Further, NAHC contends that expanding the days to 7 could adversely affect both Medicare payment and quality of care. Medicare beneficiaries prefer to be in their own homes. They will likely have improved outcomes with shorter hospital stays. NAHC understands the government must adopt policies that increase financial savings. However, the government also has a responsibility to prevent underpayments, ensure the highest level of quality, and avoid the imposition of burdensome procedural requirements on providers.

**RECOMMENDATIONS: CMS should**

- Retain the 3 day timeline in the current Post Acute Care Transfer Policy
- Provide financial data needed to carry out a thorough analysis of the impact of the home health provisions of the transfer policy on overall Medicare payments for home health and hospital
- Conduct an analysis of outcomes of home health patients transferred early to home health to determine if they are the same, better or worse than other patients. If it is too burdensome to evaluate all outcomes, limit the analysis to adverse events, including hospitalization and emergent care rates.
- Undertake an in-depth analysis of hospital and home health claims to determine the extent of payment errors related to the transfer policy, including both underpayments and overpayments.
- Use the information for future transfer policy decisions

In closing we are requesting that CMS consider these comments to serve as a Freedom of Information (FOIA) request for access to the data used to derive the home health cost per visit and hospital payment data considered for the "Proposed Policy Change Relating to Transfers to Home with A Written Plan for the Provision of Home Health Services" provisions in this notice.

Thank you for considering our comments. If we can provide further clarification I can be reached at (202) 547-7424.

Sincerely,

Mary St. Pierre  
Vice President for Regulatory Affairs