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Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1711-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirement (CMS-1711-P)

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2020 Home Health Prospective Payment System (HH PPS) Rate Update; Home Health Value-Based Purchasing (VBP) Model; Home Health Quality Reporting (QRP) Requirements; and Home Infusion Therapy Requirement proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA recognizes that the world of payment reform is dynamic and that to successfully create an alternative payment methodology for home health agencies (HHAs), all facets of payment reform must be considered. This includes quality measurement; value-based purchasing; quality

reporting; development of new payment models, such as bundled payment arrangements and accountable care organizations; and eventual adoption of a unified postacute care (PAC) payment system. As APTA has stated in previous comment letters, the frequency and duration of physical therapy services should be based solely on the needs of the patient.

We appreciate CMS' efforts to address case-mix methodology refinements that represent a more patient-driven approach to payment. However, due to continued concerns that Medicare beneficiaries—particularly those with substantial physical therapy, occupational therapy, and/or speech-language pathology needs—may not receive the level, duration, amount, or frequency of therapy services medically necessary, given the potential economic incentives inherent in this revised case-mix methodology to provide less care for these beneficiaries, we encourage CMS to closely monitor utilization of therapy services upon patient-driven groupings model (PDGM) implementation.

We respectfully request that you consider our more detailed comments and recommendations below.

CY 2020 Home Health PPS Rate Update

APTA supports CMS' proposal to rebase the home health market basket and update payment rates under the HH PPS by 1.3%, resulting in an estimated $250 million increase in payments to HHAs in CY 2020.

Rural Add-on Payments for 2020 through 2022

The Bipartisan Budget Act of 2018 (BBA) provided rural add-on payments for episodes or visits ending during CYs 2019 through 2022. CMS states in the rule that its claims processing system will increase the proposed CY 2020 60-day and 30-day base payment rates by the appropriate rural add-on percentage prior to applying any case-mix and wage index adjustments.
APTA supports continuing the rural add-on through 2022, as it will ensure that HHAs are adequately equipped to serve Medicare beneficiaries in rural areas. HHAs in these regions already face geographical and financial obstacles to providing sufficient care to this Medicare population. However, we have concerns that discontinuing the add-on payment beyond 2022 will likely prevent these agencies from furnishing care to patients with the most critical clinical conditions. **Therefore, APTA urges CMS to continue its work to develop policies that support improved access to home care in rural areas.** For example, CMS could explore a pilot project that provides Medicare coverage to therapy providers who furnish telehealth services to their patients. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas, can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care. Particularly with the vulnerable home health population, telehealth services may prevent unnecessary hospitalizations or further health complications that may result from restricted access to care.

PDGM

Within the rule, CMS states that it seeks feedback on behavior assumptions finalized in the CY 2019 HH PPS final rule regarding any potential issues that may result from taking these assumptions into account when establishing the initial 30-day payment amount for CY 2020. CMS notes that in the previous year's rule, the agency proposed three assumptions about behavior change that could occur in CY 2020 as a result of implementation of the 30-day unit of payment and implementation of the PDGM case-mix adjustment methodology:

- Clinical Group Coding: A key component of determining payment under the PDGM is the 30-day period of care's clinical group assignment, which is based on the principal diagnosis code for the patient as reported by the HHA on the home health claim. CMS assumes that HHAs will change their documentation and coding practices and would put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period of care be placed into a higher-paying clinical group.

- Comorbidity Coding: The PDGM further adjusts payments based on patients' secondary diagnoses as reported by the HHA on the home health claim. While the Home Health Outcome and Assessment Information Set (OASIS) only allows HHAs to designate 1 primary diagnosis and 5 secondary diagnoses, the home health claim allows HHAs to designate 1 principal diagnosis and 24 secondary diagnoses. CMS assumes that by taking into account additional ICD-10-CM diagnosis codes listed on the home health claim (that exceed the 6 allowed on OASIS), more 30-day periods of care will receive a comorbidity adjustment than periods otherwise would have received if CMS only used OASIS diagnosis codes for payment.

- LUPA Threshold: Rather than being paid per-visit amounts for a 30-day period of care subject to the low-utilization payment adjustment (LUPA) under the proposed PDGM, CMS assumes that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold, HHAs will provide 1 to 2 extra visits to receive a full 30-day payment.

APTA has serious concerns with the proposed application of the behavioral assumptions as described in the proposed rule. The 8.01% decrease in payments for HHAs is significant and would impose serious financial burdens on HHAs. Beneficiaries with complex rehabilitative care needs and patients who reside in rural areas are more likely to be adversely impacted if HHAs are forced to close their doors or reduce their services due to the economic impact of the behavioral assumptions. Moreover, patients who are unable to access home health services would be diverted to more costly post-acute care settings, contrary to CMS' goal to ensure care is delivered to the patient at the right time in the right place. Given the risks associated with the proposed behavioral assumption payment cuts and the threat the assumptions pose to beneficiaries' access to home health services, we urge CMS to reconsider its proposal and ensure that any assumption is based in actual data and observed evidence.

APTA also urges CMS to recognize that with the evolution of the Medicare program and the pursuit of value-based payment models, including episodic payments, many beneficiaries are bypassing institutional-setting care and being admitted directly to home health.

The OASIS manual instructs:

> *Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed.*

Recognizing that ICD-10 coding of patient diagnoses is dependent upon the patient's presentation and the clinical documentation to support those coding decisions, the number of active diagnoses that HHAs are treating will continue to increase and the seriousness of the diagnoses will intensify. **Thus, we question how CMS intends to reconcile what likely would result in a significant decline in beneficiary access if the agency does not afford adequate payment to HHAs for the care of sicker, more complex patients?** Accordingly, APTA recommends that CMS consider instituting a behavioral assumption **only** for those agencies that **significantly** alter their coding practices upon implementation of PDGM.

Additionally, to ensure that any assumptions made do not impact or have unintended consequences to the way in which patients receive care and the way in which home health services are delivered, we encourage CMS to closely monitor whether there are any changes in patient access by establishing a complaint hotline and/or email mailbox that patients and their providers can contact to report problems with access.

Questionable Encounters

APTA recommends that CMS consider M62.81, Muscle weakness (generalized) valid and receive primary diagnosis grouping status. At the recommendation of neurologists, M62.81 was originally added to the code set to capture muscle weakness of unknown etiology. Beneficiaries with generalized muscle weakness, where underlying causation cannot, or has not, been established by the physician are commonly homebound and require assistance with activities of daily living. Per ICD-10 Official Coding and Reporting guidance, it would be appropriate to code this type of muscle weakness as the primary diagnosis when the diagnosis has not been established (confirmed) by the physician.[1] We recognize, however, that M62.81, Muscle weakness (generalized) would not be appropriate to code as the primary diagnosis when there **is** a physician-confirmed etiology. In situations where the muscle weakness is due to a known condition, and it is considered an integral component of that known condition, it would not be appropriate to code the muscle weakness, but the underlying etiology.

Generalized muscle weakness is frequently a residual of other, now resolved, conditions such as pneumonia. Per ICD-10 Official Coding and Reporting guidance, it would not be appropriate to code the home health claim with a resolved condition, leaving only the M62.81, muscle weakness (generalized) code as the primary condition being treated, assuming all other eligibility requirements have been met.[2]

It is the experience of many home health physical therapists and physical therapist assistants that muscle weakness is a frequent contributor to both the occurrence of falls as well as an elevated fall risk in the elderly homebound population. A study performed in 2017 found that muscle

[1] https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf
[2] *Id.*

weakness significantly increases health care costs among the elderly.[3] Muscle weakness is a common complaint among patients presenting to family physicians.[4] Muscle strength is a critical component of walking and its decrease in the elderly contributes to a high prevalence of falls.[5] The Centers for Disease Control and Prevention identifies falls as an epidemic in the elderly population, with more than one in every four persons over 65 years of age falling annually and sustaining traumatic injuries that require costly medical care and hospitalization.[6]

Hospitalization in the Medicare population can also result in hospital-associated deconditioning (HAD) due to prolonged periods of inactivity. For instance, older adults spend approximately 83% of a hospital stay in bed and 12% in a chair,[7] a significant contributor to generalized muscle weakness. Medicare beneficiaries that are referred to home health as the first post-acute setting and experience generalized muscle weakness related to HAD can be determined to need skilled, reasonable and medically necessary services to either maintain or restore functional abilities.

Split Percentage Payment Approach

Home health payment is currently made under a split percentage payment approach that includes an initial percentage payment and a final percentage payment. The claim that the HHA submits for the final percentage payment determines the total payment amount for the episode or period. The request for the initial percentage payment is called a Request for Anticipated Payment (RAP). **APTA has concerns with CMS' proposal to reduce the RAP split percentage payment to 20% for existing HHAs beginning in CY 2020 with elimination of split percentage payments for all HHAs in CY 2021. We recommend that CMS phase out the RAP split percentage payment approach over a period of 3-4 years.** Alternatively, or in conjunction with this transition, CMS could consider phasing out the split-percentage payment approach with bi-annual or quarterly reductions, allowing for a smooth transition until the split percentage payment approach is completely phased out. Smaller agencies and those in rural areas have a significant need for cash flow support; therefore, instituting a longer transition period will help agencies continue to remain financially viable, particularly with implementation of the 30-day unit of payment under the PDGM and the behavioral adjustment of 8.01%. With each transitional year, we urge CMS to monitor utilization patterns and trends of home health admissions, discharges, and delivery of therapy services, particularly in rural and underserved areas, and to examine whether any policy changes may be necessary to ensure continued beneficiary access.

Notice of Admission (NOA)

APTA supports CMS' proposal to require HHAs to notify CMS within 5 calendar days of the start of care to establish that the beneficiary is under a Medicare home health period of care and trigger the home health consolidated billing edits. As stated in previous comments, a change to the notification process is necessary to ensure that the proper agency is established as the

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5708194/
[4] https://www.ncbi.nlm.nih.gov/pubmed/15832536
[5] Baumgartner RN, Koehler KM, Gallagher D, Romero L, Heymsfield SB, Ross RR, et al. Epidemiology of sarcopenia among the elderly in New Mexico. *American Journal of Epidemiology*. 1998;147(8):755–63.
[6] CDC Home and Recreational Safety. https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html
[7] Falvey,JR, et.al. Rethinking Hospital-Associated Deconditioning: Proposed Paradigm Shift. *Phys Ther*.2015. 95(9): 1307-1315.

primary HHA for the beneficiary and so that the claims processing system is alerted that a beneficiary is under an HHA period to care to enforce the consolidated billing edits required by law.

However, we recognize that the NOA requirement as currently proposed may be unduly burdensome. **As such, to ensure that the claims processing system is alerted in a more timely manner that a beneficiary is under an HHA period to care to enforce the consolidated billing edits required by law, rather than require HHAs to submit a NOA, we request that CMS consider adopting a simple mechanism by which HHAs can make a notation in the Common Working File (CWF) or Electronic Data Interchange (EDI) system or require agencies to submit a no-pay RAP to indicate the beneficiary has been admitted under a home health plan of care. Further, we recommend that CMS consider making the "admission notification" a survey requirement in the future.** If CMS does move forward with the NOA process, we recommend that CMS not require the completion of the OASIS or a signed plan of care before accepting the NOA.

Additionally, a significant administrative burden we anticipate with the move to the 30-day unit of payment is the obtaining of signed orders from the physicians. HHAs are highly dependent upon physicians who establish the plan of care and must have a face-to-face encounter with the beneficiary. Therefore, to minimize the impact to Medicare beneficiaries and for HHAs, we request that CMS not require signed orders until the completion of the entire 60-day episode.

Notice of Discharge

We respectfully request that CMS consider adopting a simple mechanism for HHAs to use to timely notify the claims processing system that the beneficiary has been discharged. For example, requiring HHAs to make a notation in the CWF or EDI system to indicate the patient has been discharged or submit a no-pay RAP. Such notification could be required to be submitted within 3-5 days following beneficiary discharge to establish that the beneficiary is no longer under a Medicare home health period of care.

HHAs may not submit a claim until after all services are provided for the episode and the physician has signed the plan of care and any subsequent verbal order, which may take weeks. In many instances, however, a beneficiary may be discharged from the HHA on a Friday and is expected to begin receiving therapy in the outpatient setting on the following Monday. As such, beneficiaries who are discharged from home health and instructed to receive outpatient therapy cannot be treated until such time the CWF is updated to reflect the beneficiary is no longer in a home health episode. This inevitably delays beneficiary access to care and may lead to a decline in condition.

To promote continuity of care, thereby ensuring each patient's needs are met in a timely manner, it is critically important that a beneficiary's eligibility status is updated within a reasonable amount of time. Therefore, to reduce delays in access to care, it is advisable for CMS to adopt a **simple** mechanism for HHAs to use to timely notify the claims processing system that the beneficiary has been discharged, such as requiring HHAs to make a notation in the CWF or EDI system or submit a no-pay RAP to indicate the patient has been discharged.

Proposed Regulatory Change to Allow Therapist Assistants to Perform Maintenance Therapy

APTA supports CMS' proposal to allow therapist assistants (rather than only therapists) to perform maintenance therapy under the Medicare home health benefit. We agree that this regulatory change would give HHAs more latitude in resource utilization. Furthermore, allowing assistants to perform maintenance therapy would be consistent with the situation in other PAC settings, including skilled nursing facilities. Please see below our comments responding to CMS' specific request for feedback:

Does this proposal require therapists to provide more frequent patient reassessment or maintenance program review when the services are being performed by a therapist assistant?

Frequency of visits by the physical therapist is determined by the physical therapist in accordance with the needs of the patient.[8] Apart from the expected outcomes and goals of treatment, skilled maintenance therapy is not different from skilled restorative therapy. The physical therapist is professionally trained to oversee and direct a patient's course of care, and to assign responsibilities to the assistant as clinically appropriate.

Requiring more frequent reassessments by the physical therapist would be contrary to CMS' stated intent to afford more latitude in resource utilization. Further, as stated in the Medicare Benefit Policy Manual Chapter 7 Section 40.2.1, Medicare covers necessary periodic reevaluations by a qualified therapist of the beneficiary, and maintenance program are covered if the specialized skills, knowledge, and judgment of a qualified therapist are required. **Therefore, APTA recommends that CMS not require more frequent patient reassessments or maintenance program review. We also encourage the agency to emphasize in final rulemaking that it is the qualified therapist who shall determine whether it is clinically appropriate for the therapist assistant to perform maintenance therapy.**

Should CMS revise the description of the therapy codes to indicate maintenance services performed by a physical or occupational therapist assistant (G0151 and G0157) versus a qualified therapist, or simply remove the therapy code indicating the establishment or delivery of a safe and effective physical therapy maintenance program by a physical therapist (G0159)?

APTA recommends that CMS adopt a new therapy code to indicate maintenance services performed by a physical therapist assistant. We also recommend that CMS maintain therapy code G0159 to indicate maintenance therapy furnished by a physical therapist. Based on feedback from our members, we are aware that physical therapists do not provide maintenance therapy to many Medicare beneficiaries out of fear of claim denials, or fear that by delivering maintenance therapy providers are opening themselves up for an audit. Accordingly, tracking delivery of services by the physical therapist versus the physical therapist assistant will assist CMS in its efforts to monitor the delivery of services and identify whether there are any statistically significant declines in therapy being delivered by a physical therapist assistant. To that end, we encourage CMS to discuss in final rulemaking whether it has examined data

[8] APTA House of Delegates Policy (2018). https://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/DirectionSupervisionPTA.pdf

reflecting utilization levels of maintenance versus restorative therapy, and if it intends to use the data to compare utilization under PDGM beginning in 2020.

Is it important to track whether a visit is for maintenance or restorative therapy or would it be appropriate to only identify whether the service is furnished by a qualified therapist or an assistant?

APTA recommends that CMS require tracking of rehabilitative versus maintenance therapy, and whether skilled treatment is furnished by the qualified therapist or therapist assistant. We also request that CMS make this data publicly available. This data would be relevant to future discussions on changes in intensity/duration of therapy services delivered under PDGM and could be used to examine whether there is a need for CMS to deliver additional education to providers and the Medicare Administrative Contractors on maintenance therapy coverage.

Are there any possible effects on the quality of care that could result by allowing therapist assistants to perform maintenance therapy?

APTA appreciates CMS' efforts to promote beneficiary access to maintenance therapy by proposing to allow therapist assistants to deliver it. Allowing physical therapist assistants to furnish both restorative *and* maintenance therapy may, in part, ease previously stated concerns that there will be a decline in the delivery of maintenance therapy under PDGM. There are no possible effects on the quality of care that could result from allowing therapist assistants to perform maintenance therapy.

However, this proposal, in conjunction with implementation of PDGM, creates other unique challenges for the physical therapy profession. For instance, we are aware that some HHAs may exclusively rely on physical therapist assistants to conduct all physical therapy visits and may restrict physical therapists to conducting solely the initial evaluation and required reassessment(s) beginning in 2020. Again, while we support CMS' proposal, we encourage the agency to be aware of this likely consequence of PDGM. Thus, it is imperative that CMS closely monitor the amount of therapy being delivered and the professional who is delivering treatment interventions. **To that end, we recommend that CMS discuss in final rulemaking how it intends to monitor the quality of care being delivered to Medicare beneficiaries and whether quality metrics are sensitive enough to ascertain whether there are changes in the quality of care.**

Finally, as stated in previous comment letters,[9] we again recommend that CMS incorporate an outcome of care measure within the Home Health Star Ratings that positively accounts for maintaining a patient at maximum practicable level of function. Alternatively, patients who receive maintenance therapy as illustrated on the claim should be excluded from the calculation of improvement in function outcome of care measures.

[9] APTA Comments CY 2019 Home Health PPS proposed rule.

Proposed Changes to the Home Health Plan of Care Regulations at 42 CFR 409.43

APTA supports CMS' proposal to revise the regulations text at 42 CFR 409.43. We appreciate CMS' assertion that violations for missing required items are best addressed through the survey process, rather than claims denials for otherwise eligible periods of care.

Given our previously stated concerns that there may be inappropriate underutilization of therapy services following PDGM implementation, we encourage CMS to consider how it may use the survey process to monitor the disciplines, frequency, and duration of therapy visits to identify potential stinting on services—thereby helping to ensure that beneficiaries continue to receive the skilled therapy services that are medically necessary to treat or manage their conditions(s).

HH VBP Model

APTA supports CMS' proposal to publicly report the Total Performance Scores (TPS) and TPS Percentile Ranking from Performance Year 5 for each HHA in the 9 states that qualified for a payment adjustment in 2020. This data is appropriate for public reporting.

HH QRP

APTA supports CMS' goal of improving the quality of health care for Medicare beneficiaries. The physical therapy profession is committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice.

Proposed Transfer of Health Information to the Provider and Patient PAC Measures
APTA supports CMS' proposal to adopt the Transfer of Health Information to the Provider–PAC quality measure and Transfer of Health Information to the Patient–PAC quality measure. We agree that transfer of a medication list between providers is necessary for medication reconciliation interventions—this has been shown to be a cost-effective way to avoid adverse drug events by reducing errors, especially when medications are reviewed by a pharmacist using electronic medical records. However, we have concerns that the proposed Transfer of Health Information to the Provider-PAC quality measure denominator fails to recognize the importance of transmitting the medication list to other providers (beyond those included in the current definition of "admitting provider").

It is important to note that outpatient physical therapy is often provided following a patient's discharge from home health, and that in many instances a physical therapist in private practice serves as the first provider after discharge. Physical therapists performing medication management in accordance with their state practice act is a critical element of a physical therapist's patient evaluation. It is imperative that the physical therapist is aware of the risk of potential adverse events that may occur due to current, changed, and/or new medications. Addressing medications in a drug regimen review and medication reconciliation should be an integral part of practice to help ensure that appropriate patient care is delivered and that optimal clinical outcomes are obtained.

APTA has previously issued a statement on the role of physical therapists in medication management as related to home care. As stated by the association, "It is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue. The physical therapist is competent and qualified to serve as case manager and facilitate coordination of care with physicians and nurses."[10]

Moreover, physical therapists have the professional capability and ability to refer to others in the health care system for identified or possible needs that are beyond the scope of physical therapist practice. Therefore, although physical therapists are not acknowledged as an "admitting provider" under the measure definition, **APTA requests that CMS monitor whether there may be a need in the future to include physical therapists as an "admitting provider" under the Proposed Transfer of Health Information to the Provider-PAC quality measure denominator, given the frequency that physical therapists in private practice receive the medication list following discharge from home health.**

Proposed Update to the Discharge to Community – PAC Home Health QRP Measure
APTA supports CMS' proposal to exclude baseline nursing facility residents from the Discharge to Community– AC Home Health QRP Measure beginning with the 2021 HH QRP.

Home Health QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs) under Consideration for Future Years: Request for Information
APTA supports inclusion of the proposed SPADEs in future years of the Home Health QRP. Each of these categories represents element(s) that will provide a fuller picture of the patients that physical therapists and physical therapist assistants serve in the home health setting, and therefore could be used for a variety of purposes, including informing payment and creating and risk adjusting quality measures. In response to CMS' request for input on the SPADEs, measures, and measure concepts under consideration listed in the Table 27 for future years in the HH QRP, we offer the following comments:

We support:

- Potentially preventable hospitalizations, as this metric is in other settings and is an important measure on acute care use (overutilization).
- Functional improvement outcomes, as this aligns with other PAC settings.
- Maintenance outcomes, although this needs testing for development and to better understand what the data typically shows in this patient population. This measure should really examine a clinician's ability to "maintain" function or prevent functional decline.
- Exchange of electronic health information.

We also support the proposed SPADEs. SPADEs can be used to better illustrate patient needs, complexities, and care preferences. Collecting this data is important for ensuring that care being

[10] American Physical Therapy Association. Official Statement: The Role of Physical Therapists in Medication Management. 2010 https://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/Home_Health/Comments/Statement_MedicationManagement_102610.pdf

delivered is patient-centered. These data elements also can be used to refine risk adjustment models for quality measures and payment, plan for successful discharges from care, etc.

Proposed Standardized Patient Assessment Data Reporting Beginning with the CY 2022 HH QRP

Cognitive function and mental status data

While APTA supports inclusion of standardized items such as the Brief Interview for Mental Status (BIMS) and Confusion Assessment Method (CAM) to collect data regarding cognition and mental status, these assessments lack the sensitivity needed to identify mild-moderate cognitive impairments that may impact performance of activities of daily living (ADLs). We appreciate, however, that CMS recognizes that these assessments are imperfect and is seeking data to support the identification of better cognitive assessments.

We also encourage CMS to consider inclusion of other elements in future years to increase the sensitivity of these assessments. Further, while we would support CMS' efforts to use these data elements as risk adjusters for quality measures, we recommend that the agency continue to monitor these risk adjusters in the future, and make adjustments to the risk adjustment methodology as warranted. For instance, if there is a high use of cancer services in this patient population and it therefore seems as if that question should be explored further to stratify that population more appropriately, we would support expansion of the category.

Finally, APTA supports inclusion of the Patient Health Questionnaire 2 to 9. We appreciate CMS' proposal to include these data elements within the definition of standardized patient assessment data under the category of cognitive function and mental status.

Special services, treatments, and interventions

APTA supports collection of data on special services, treatments, and interventions. Collecting this data will help better inform CMS and HHA providers on the severity and needs of patients in this setting in the future. Patients who receive services such as dialysis, ongoing oncology care, and nutritional support are often more complex in their clinical presentation. APTA does not have any additional suggestions for data elements in this category.

Medical condition and comorbidity data

APTA supports inclusion of pain interference data elements. Pain interference is an important dimension in assessing the impact of pain. Including pain interference questions on sleep, therapy, and day-to-day activities will provide a more accurate picture of how pain impacts a patient's ability to function throughout the day. Such information also will support providers in their efforts to deliver pain treatment and management services, including pharmacologic and nonpharmacological interventions, in a more effective manner.

Impairments

APTA supports collection of information on hearing and vision in the assessment. Vision and hearing impairments can impact multiple aspects of care and the quality of life of patients across settings.

Social determinants of health

APTA supports CMS' proposal to adopt the following 7 data elements as SPADEs under the proposed Social Determinants of Health category: race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation.

Home Health QRP Measure Removal

CMS is proposing to remove the Improvement in Pain Interfering with Activity Measure (NQF #0177) from the Home Health Quality Reporting Program (HH QRP) beginning with CY 2022. Under this proposal, HHAs would no longer be required to submit OASIS Item M1242, Frequency of Pain Interfering with Patient's Activity or Movement, for the purposes of the HH QRP beginning January 1, 2021. CMS is proposing this to mitigate any potential unintended over-prescription of opioid medications inadvertently driven by these measures.

APTA opposes the removal of this measure and disagrees with the above rationale. Rather, it further indicates the need for provider education on nonpharmacological interventions that are available to patients with pain. Physical therapists treat and manage pain non-pharmacologically and are one of the solutions for patients with pain issues. The assessment of pain is an essential component of the physical therapy examination.[11] Pain is important to the patients served by physical therapists, as it impacts their quality of life and their ability to participate in activities. Pain remains a concern for many patients, and removal of this item would leave the OASIS without a pain assessment. Pain interference speaks to how pain may limit a patient's function and provides important information to providers to ensure that they assist the patient with pain management strategies that can limit the pain they have during functional activities. These interventions go beyond opioid interventions. Further, pain interference remains one of the best pain assessments due to its focus not just on pain intensity, but also on the impact of pain on function.

Input Sought to Expand the Reporting of OASIS Data Used for the HH QRP to Include Data on All Patients Regardless of Their Payer

APTA supports CMS' proposal to expand the reporting of OASIS data used for the HH QRP to include data on all patients, regardless of their payer, in future rulemaking. We agree that collecting data on all HHA patients, regardless of their payer would align CMS data collection requirements under the HH QRP with data collection requirements currently adopted for the Long-Term Care Hospital (LTCH) QRP and the Hospice QRP.

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

CMS proposes to remove Question 10 from all HHCAHPS surveys (both mail and telephone). It asks, "In the last 2 months of care, did you and a home health provider from this agency talk about pain?" This is one of 7 questions (numbers 3, 4, 5, 10, 12, 13 and 14) in the "Special Care Issues" composite measure, beginning July 1, 2020. The "Special Care Issues" composite measure also focuses on home health agency staff discussing home safety, the purpose of

[11] Guide to Physical Therapist Practice. http://guidetoptpractice.apta.org/

medications being taken, side effects of medications, and when to take medications. CMS is proposing this to avoid potential unintended consequences that may arise from their inclusion in CMS surveys and datasets.

APTA disagrees with CMS' proposal to remove Question 10 from all HHCAHPS Surveys. HHCAHPS reflects patient experience, and pain remains an issue that is important to patients served in the home health setting. Regardless of the use of opioids, it is important for a provider to have a discussion with the beneficiary regarding whether he or she has pain, to ensure that the beneficiary receives appropriate care. Moreover, as previously stated, there is a need for greater provider education on nonpharmacological interventions that are available to patients with pain. For these reasons, we recommend that HHCAHPS Surveys continue to include this question.

Additional Recommendations

As discussed in previous comment letters, APTA encourages CMS to remain mindful of the real potential of significant underutilization of therapy services. We recommend that CMS collect data on therapy provision to ensure that residents are receiving therapy that is reasonable, necessary, and specifically tailored to meet their unique needs under the new case-mix methodology—and that the agency share that data with the public annually. APTA also encourages CMS to closely monitor service units associated with each therapy revenue code reported on the claim and compare utilization under the current payment system versus under the PDGM. In addition to monitoring therapy utilization and potentially flagging providers for additional review, the agency must be willing to make future proposals to address any abuses of the new case-mix methodology. Finally, we recommend that in evaluating the impact of PDGM implementation on therapy service delivery patterns, CMS do so in the context of the impact on measures that are commonly associated with effective rehabilitation services.

Conclusion

We thank CMS for the opportunity to comment on the CY 2020 Home Health PPS proposed rule. APTA looks forward to working with the agency in implementing the PDGM to ensure that Medicare beneficiaries continue to have access to medically necessary physical therapy services within the home health setting. If you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

Sharon L. Dunn PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President

SLD: krg