



August 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445—G
Attention: CMS-1611-P
Hubert H. Humphrey Building, 200
Independence Avenue SW
Washington, DC 20201

Submitted Electronically

RE: CMS-1611-P; Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies

Dear Administrator Tavenner:

On behalf of our 90,000 physical therapist, physical therapist assistant, and students of physical therapy members, the American Physical Therapy Association (APTA) appreciates the opportunity to submit the following comments in response to the Medicare Home Health Prospective Payment System (HH PPS) proposed rule for Calendar Year (CY) 2015. Physical therapy is a qualifying service under the Medicare home health benefit and comprises a large portion of the treatment furnished to patients in the home health setting. Therefore, our members and the patients they treat would be significantly impacted by the proposed rulemaking and subsequent implementation.

In the home health setting, physical therapists provide services to patients through a plan of care to engage and optimize the patient's participation in achieving shared goals of improved functional performance, reduced risk of injurious falls, and reduced risk of acute hospitalization thereby promoting long-term health and wellness. Physical therapists provide an examination that includes the history, systems review, and tests and measures to determine the patient's therapeutic, rehabilitative, and functional status and any environmental factors that influence the patient's activity and/or participation. Through the evaluative process, the physical therapist will develop a comprehensive plan of care to achieve the goals and outcomes of improved function.

APTA and CMS have a shared commitment to the triple aim of health care and we believe that access to high quality services with appropriate payment policies under the Medicare home health benefit is essential to achieving these goals. While, we wholeheartedly appreciate the strides that CMS has made in this proposed rule, we believe that there are additional refinements that will increase access to medically necessary physical therapy services in the home setting prior to promulgation of the HH PPS CY 2015 final rule. Therefore, we respectfully request that you consider the following comments and recommendations.

Summary of Recommendations

APTA:

- I. Urges CMS to utilize its regulatory discretion to reduce the rebasing percentage cuts and avert access to care issues in the home health setting**
- II. Endorses finalization of the 2.2 percent increase in the home health market basket**
- III. Strongly urges CMS to begin the work to overhaul therapy payment under the HH PPS to more accurately reflect patient characteristics and intensity of services**
- IV. Appreciates CMS efforts to simplify the therapy reassessment by removing the current 13th and 19th visit timeframes**
- V. Recommends that CMS take its proposal to revise therapy reassessment one-step further and extend the reassessment timeframe to every 30-calendar days**
- VI. Supports finalization of CMS' proposal to eliminate the narrative portion of the physician face-to-face requirement**
- VII. Requests that CMS allow providers to receive quality feedback reports in a timely manner prior to public display**
- VIII. Recommends that CMS revise quality assessments only (QAO) percentage thresholds in year three of the proposed quality reporting model to more realistic thresholds based on the data received in the first two years of reporting regarding QAOs**
- IX. Supports the implementation of a value-based purchasing (VBP) model and affirms our commitment to preparing physical therapists to participate in quality improvement and patient safety programs**
- X. Expresses commitment to advancing the safety and quality of healthcare through health information technology (HIT) innovation and willingness to work with the federal government on health information technology's evolving role in promoting health, health care reform and health information exchange**

Impact of Home Health Rebasing

The Patient Protection and Affordable Care Act (PPACA) mandated that CMS, starting in CY 2014, apply a payment adjustment to the 60-day national, standardized episode that reflects factors such as changes in the number of visits, the mix of services, the level of intensity of services in an episode, the average cost of providing care per episode and any other relevant factors. This process is called rebasing and must take place over a four-year period in equal

increments not to exceed 3.5 percent. In this proposed rule, CMS continues with its second year of the rebasing adjustment by reducing the national 60-day episode payment by the maximum allowable statutory amount. Home health rebasing is projected to account for a 14 percent reduction to the HH PPS over four years, or a total of \$22 billion.

The HH PPS has undergone a number of payment reductions since 2009, namely the reductions due to nominal case-mix growth, which accounted for an estimated reduction of an additional 14 percent. APTA is very concerned about rebasing cuts and the impact they will have on quality of care in the home health setting. We are very concerned about the negative impact that rebasing will have on HHAs across the country. The overwhelming positive outcomes of home and community-based care are well documented¹. We strongly believe that physical therapy provided under the home health benefit reaches the most vulnerable Medicare beneficiaries and any measure that impedes this critical care will ultimately have a detrimental effect for not only seniors across America but also the financial sustainability of the Medicare program.

Therefore, we strongly recommend that CMS not finalize this rebasing proposal. Congress has given CMS the statutory authority to implement a much smaller reduction, and we urge CMS to exercise this authority. We ask that the agency carefully weigh the positive clinical benefits that home care provides against the punitive effects that deep payment cuts will have on access to care.

Proposed CY 2015 Rate Update

The proposed multi-factor productivity (MFP) adjusted CY 2015 market basket is 2.2 percent. CMS states that it will reserve the right to update this proposed market basket in the final rule if new data becomes available. We commend CMS for proposing an increase in payment for home health services in CY 2015. A robust set of resources are needed to treat this critically complex population of patients. Therefore, we wholeheartedly support the finalization of the positive payment update.

Post-Acute Payment Reform

Although outside of the scope of this proposed rule, APTA advocates for consistency of a therapy payment model across all post-acute care (i.e. home health, inpatient rehabilitation, long-term care and SNFs) as well as outpatient settings to ensure that continuity of care in the most appropriate setting to treat the complexity and severity of the patient is optimized. APTA strongly recommends that CMS start the development of a new payment methodology for the therapy component of the HH PPS that accurately bases payment on the severity of the patient and the necessary resources to treat the condition at the requisite level of intensity.

¹ A. Dobson et al., "Clinically Appropriate and Cost-Effective Placement (CACEP) Project Working Paper Series, <http://ahhqi.org/images/pdf/cacep-wp2-baselines.pdf>, October 2012.
Mark I. Froimson et al., In-home care following total knee replacement, 80 (e-suppl1) *Cleveland Clinic J. Med.* E-S15 (Jan. 2013), http://www.ccjm.org/content/80/e-Suppl_1.toc.

Since the inception of the Medicare Prospective Payment Systems (PPS), therapy payments have been based on arbitrary thresholds that increase payment according to the volume of services provided. In fact, the home health PPS has become juxtaposed from its original intent of determining the adequate resources needed to treat the patient before care is delivered to a payment system that is retrospective in nature. The current retrospective system creates barriers to care and unnecessary administrative burdens for providers.

We strongly believe the current therapy payment models under the PPS methodologies are unsustainable and do not appropriately assign payment or the resources based on the unique clinical condition of the patient. Therefore, we wholeheartedly support moving expeditiously to develop a uniform therapy payment component across all of the Medicare post-acute care settings that recognizes the clinical reasoning and decision-making of the physical therapist's evaluative process in addition to planned interventions. This payment system should rely on a classification system based on patient characteristics, condition and complexity, promote the use of an assessment tool and quality measures that have specific applicability to physical therapy services provided in the post-acute care settings, and use electronic health records that include specific components for the documentation of therapy services. Participation in national registries to provide essential data to improve the payment model over time is also essential.

APTA believes that therapy frequency and duration should be based solely on the needs of the patient, and any further attempts to curb overutilization by promulgating coverage policies based upon the volume of services furnished is a step in the wrong direction. We believe the current system is unproductive and continues to create incentives that inappropriately influence the provision of care.

APTA requests that CMS consider the following elements as part a new payment methodology for therapy services:

1. The model should facilitate and promote the use and reporting of standardized patient assessment instruments, quality measures, electronic health records, and participation in national registries to provide essential data that will improve the model over time.
 - The methodology should incorporate the World Health Organization's International Classification of Function framework to the extent possible and applicable.
 - The model should include quality measures that foster shared accountability among providers throughout the continuum of care, specifically regarding readmissions and chronic care management.
 - The model should include a core set of functional items to be reported across PAC settings that can be imbedded into existing assessment tools such as the Minimum Data Set 3.0 (MDS 3.0), Outcomes Assessment Information Set (OASIS C), and IRF Patient Assessment Instrument (IRF-PAI) to promote uniformity.
2. The model should recognize the clinical reasoning and decision-making by the physical therapist's evaluative process in addition to planned interventions, allow for seamless

transition amongst post-acute care settings, and be amenable to account for any setting specific considerations that must be considered to ensure quality care and efficient administrative processes.

- The model should promote interdisciplinary communication to enhance quality and foster care management.
 - The model should adequately account for proper treatment, discharge and transition planning.
3. The model should promote and encourage accurate reporting and appropriate payment of services and include specific payment considerations based on unique setting needs and resources.
- The model should be directly related to the severity of the patient's condition and the intensity of therapy services needed for treatment.
 - The payment model should be weighted based on the severity of the patient and the complex resources need to treat the patient and usher in the elimination of the current arbitrary payment thresholds and stipulations dictated by the number of therapy visits and minutes of therapy provided.
4. There should be education and outreach to providers and Medicare contractors to ensure seamless implementation.
5. The model should take an incremental approach to implementation that may take place over several years that allows for adequate testing and adjustment for risk factors prior to full implementation.

Changes to the Therapy Reassessment Timeframes

CMS proposes to simplify the therapy reassessment policy by requiring a qualified therapist (not an assistant) from the respective therapy discipline (physical therapy, occupational therapy and speech-language pathology) provide the needed therapy and functionally reassess the patient every 14-calendar days. This requirement would apply to all episodes regardless of the number of therapy visits provided. APTA appreciates CMS efforts to simplify the therapy reassessment and we wholeheartedly support these efforts. While APTA believes the concept of the functional reassessment is ideal, tying this policy to arbitrary visits associated with the payment thresholds is problematic. The current policy is not clinically based and does not add value, improve quality or enhance patient care. In fact, in our analysis of the data provided by CMS since the implementation of this policy, there has been no realized positive impact on controlling costs and curbing overutilization of therapy services. Unfortunately, the therapy coverage requirements have only contributed to increased administrative burden and confusion on how to comply with complicated regulatory provisions.

As articulated above, we strongly believe that CMS should ultimately develop and implement a new therapy payment system for the HH PPS. In the interim, we recommend that the agency take

its proposal one step further and require that “a qualified therapist perform the needed therapy services, assess the patient, measure progress, and document progress towards goals at least once every 30-calendar days during a therapy patients course of treatment.” We believe that this recommendation will relieve the current administrative burdens posed by this policy while ensuring that the patient receives clinically appropriate therapy services by a qualified therapist.

Physical therapy is typically provided 2 to 3 times a week in the home health setting. The 30-day timeframe would ensure that the physical therapist is assessing the patient and providing direct treatment at least every 8 to 12 visits. This is in line with professional standards of practice as well as current state practice acts. Therefore, we urge CMS to extend the current proposal of the therapy reassessment from every 14-calendar days to every 30-calendar days.

Changes to Documentation for the Face-to-Face Requirement

CMS cites the numerous concerns that it has received from the home health industry regarding the implementation of the physician face-to-face requirement. The agency notes that the majority of improper payments have been due to insufficient documentation errors. Therefore, CMS seeks to reduce the burden to comply with the physician face-to-face requirement by proposing to eliminate the narrative requirement. Additionally, CMS proposes to review the medical record for the patient from the certifying physician or post-acute care physician used to determine home health eligibility during the face-to-face encounter. If the physician’s medical record is not sufficient to make a determination regarding home health eligibility, payment will be denied.

APTA supports the elimination of the narrative requirement. We are keenly aware of the administrative burden and undue penalizations that have been placed on HHAs because of this requirement. While we agree with the basic intent of this requirement, which is to ensure that home health beneficiaries are receiving optimal care through appropriate supervision and coordination of care with the physician and home health provider, we believe that this can still be achieved through a less prescriptive manner. Therefore, we assert that this proposal is a positive improvement, and we urge CMS to work with the home health community to set forth guidance on proper documentation of physician oversight.

Home Health Quality Reporting Program Requirements for CY 2015

CMS proposes to change the requirements for the submission of OASIS data in an attempt to capture “Quality Assessments Only” (QAO). QAOs are defined by the number of quality assessments divided by the combined number of quality and non-quality assessments multiplied by 100. CMS proposes to implement this requirement in CY2015 at 70% with a goal to move to 90% in subsequent years. For episodes beginning between July 1, 2017 and before June 30, 2018, HHAs must score at least 90 percent on the QAO metric of pay-for-reporting performance or be subject to a 2-percentage point reduction to their market basket update for CY 2019, and each subsequent year thereafter.

APTA supports the proposal to collect data on quality assessments from home health agencies with a few modifications. First, APTA believes it would be helpful for agencies to have information on their current performance of the percentage of cases that would meet the QAO definition. Knowledge of current performance would allow agencies to prepare for the proposed changes in data submission. Secondly, APTA believes that based on the current QAO data and the ability to achieve the QAO thresholds of 70% and 80% as set in years one and two of this proposal, the goal of 90% in year three may be a threshold that is not realistically achievable by many home health agencies. Although agencies strive to collect OASIS data that is complete and meets the QAO definition, many patient situations may cause episodes to fall outside of the QAO definition. APTA recommends that CMS consider setting the QAO threshold based on current data and the ability of agencies to meet the QAO thresholds in years one and two. Lastly, APTA believes that CMS should clarify if the proposed QAO percentages are based on submission versus acceptance of the OASIS data. As agencies may submit data not accepted by the state, clarification of data submission versus acceptance of the data is an important distinction in the definition as outlined in the proposed rule.

Home Health Value-Based Purchasing Model

Section 3006(b)(1) of the Affordable Care Act directed the Secretary to develop a plan to implement a VBP program for home health agencies (HHAs) and to issue an associated Report to Congress. The Secretary issued a report, which discussed the need to develop a value-based purchasing model for HHAs to align with other Medicare programs and coordinate incentives to improve quality.

CMS is considering the implementation of a HHA Value-Based Purchasing (VBP) model in CY2016. The HHA VBP model would:

- Reduce or increase Medicare payments, in a 5-8 percent range, depending on the degree of quality performance in various measures to be selected.
- Apply to all HHAs in each of the projected five to eight states selected to participate in the model. Participation of the HHAs in the selected states would be mandatory.
- Distribute payments based on quality performance, as measured by both achievement and improvement across multiple quality measures.
- Award based on the level of quality furnished above the minimal threshold with the highest performance awards going to HHAs with the highest overall level of or improvement in quality.

APTA supports the implementation of a VBP model for home health agencies. APTA strongly supports initiatives to improve the safety and quality of patient care. We are committed to being meaningful participants in quality improvement and patient safety programs implemented through the PPACA. We have supported the growth of these quality programs and believe that measures of patient function are integral to the VBP model.

To this end, APTA's Post-Acute Payment Reform Workgroup, comprised of physical therapists who have demonstrated expertise in PAC settings, conducted an analysis of the current

Continuity Assessment Record and Evaluation (CARE) item set as laid out in the Post-Acute Care Payment Reform Demonstration (PAC-PRD) along with a cross comparison to those similar items collected through OASIS C, Minimum Data Set (MDS) 3.0, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). This analysis rendered the following list of APTA's recommended core item set.

1) Self-Care

- a. Eating – The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table or tray. Includes modified food consistency.
- b. Tube feeding- The ability to manage all equipment and supplies for tube feeding. We recommend that this measure be collected as a yes or no response.
- c. Oral Hygiene – The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing.
- d. Toilet Hygiene - Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal.
- e. Upper Body Dressing - The ability to dress and undress above the waist, including fasteners. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
- f. Lower Body Dressing - Lower body dressing: The ability to dress and undress below the waist, including fasteners. Does not include footwear. Does not include hospital gown.

2) Mobility

- a. Lying to Sitting - The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.
- b. Sit to Stand - The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
- c. Chair/Bed to Chair Transfer - The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.
- d. Longest Distance Patient Can Walk - Once standing, can walk at least 150ft, walk at least 100ft, walk at least 50ft, or walk at least 10 feet (3 meters) in corridor or similar space. (*temporal component – age specific norm time spent to walk X distance and cap time at this amount)
- e. Longest Distance Patient Can Wheel - Once seated, can wheel at least 150ft, wheel at least 100ft, wheel at least 50ft, or wheel at least 10 feet (3 meters) in corridor or similar space. (*temporal component – age specific norm time spent to wheel X distance and cap time at this amount)

3) Additional Core Items

- a. Picking up objects
- b. Walking up curb or one step
- c. Walking 50 feet with two turns
- d. Walking up stairs (4 or 12)

e. Rolling left or right

APTA recommends that CMS continue their work to develop measures of patient function in this and other payment models. APTA believes that input from key stakeholders is an essential part of moving towards the implementation of this type of payment model and we look forward to working with CMS on these efforts.

Encouraging the Use of Health Information Exchanges

CMS notes the importance of the adoption and spread of health information exchanges in the home health environment and across the care continuum and highlights, the important work that the federal government has undertaken in recent years. APTA is committed to advancing the safety and quality of healthcare through health information technology (HIT) innovation and we are eager to work with the CMS, the Office of the National Coordinator for Health Information Technology (ONC) and other governmental agencies on health information technology's evolving role in promoting health, health care reform and health information exchange.

APTA is committed to the adoption of electronic health records (EHR), implementation and enforcement of privacy and security protections, and utilization of electronic health information to support new payment models such as accountable care organizations, as well as fostering health information exchange where it is not currently taking place. We support coordinated patient-centered quality care through utilization of electronic health information, and we are an active participant in the evolution of an interconnected electronic health system. APTA has many member physical therapists who have implemented electronic health record systems in their practices, despite not being defined as "eligible providers" (EPs) to receive meaningful use incentives under the Medicare and Medicaid programs.

Physical therapists play a critical role in a patient's continuity of care as the patient transitions from one health care setting to another. Physical therapy services are provided in a variety of settings, including home care, hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; Intermediate Care Facilities for People with Mental Retardation (ICF/MR); patients' education or research centers, hospices and schools. Physical therapy efficiently aids a beneficiary in gaining the best possible function within the context of their medical condition. These services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

With this expertise, physical therapists are essential participants in health care integration. Their assessment and plan of care for the patient is critical to reducing complications, particularly in the LTPAC community. Therefore, it is important that information from each care team member at the varying settings is captured and exchanged based on the specialist's area of expertise to optimize patient outcomes and reduce miscommunication among the varying providers the patient will see throughout the course of care.

APTA Comments
HH PPS CY 2015 Proposed Rule

APTA thanks CMS for the opportunity to comment on the Home Health Prospective Payment System Rate Update Proposed Rule (CY 2015), and we look forward to working with the agency to construct patient-centered reimbursement policies that reflect quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director, Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul Rockar, Jr. PT, DPT, MS
President

PR: rdd