

September 3, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1622-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically

RE: CMS-1625-P; Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

Dear Acting Administrator Slavitt:

On behalf of the 90,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I would like to submit the following comments in response to the Home Health (HHA) Prospective Payment System (PPS) Fiscal Year (FY) 2016 proposed rule. Physical therapy is an integral service provided to Medicare beneficiaries in the home health setting. Physical therapists furnish medically necessary services to patients in their home to improve their overall health, function and to optimize their quality of life.

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 support the overall proposed polices included in this rulemaking, we respectfully request that you consider the comments and recommendations provided below.

Home Health Value-Based Purchasing Program (SNF VBP Program)

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

- Geographically group the United States into 9 regions with one state randomly selected from each group to participate. The states proposed for selection are: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee.
- CMS proposes the first payment adjustment would begin January 1, 2018 and would be based on 2016 performance data. Payment adjustments would begin at a maximum of 5 percent (upward or downward) in 2018 and 2019, a maximum payment adjustment of 6 percent in 2020, and a maximum payment adjustment of 8 percent in 2021 and 2022.
- CMS proposes quality measures for the HHVBP model that include measures, the majority of which, are currently collected and utilized as part of the HHQRP.
- CMS proposes that participating HHAs would receive a total performance score which would determine their payment adjustment in a given year. The total performance score would be determined using the higher of an HHA's achievement or improvement score for each measure.

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.

APTA also supports a value-based scoring methodology that rewards performance and improvement as both are critical components to ensuring high quality patient care. APTA recommends that the methodology be easy to understand and that CMS provide education to HHAs in the early years to assist them in understanding the various aspects of the VBP methodology. APTA supports public reporting of this, and all other quality measures, and encourages CMS to provide regular feedback with home health agencies prior to data publication.

APTA does have concerns regarding the impact of this model and other value-based payment models on patients who receive physical therapy services where the goal of care is to maintain function or prevent functional decline versus those patients receiving physical therapy services for the purpose of restoring or improving function. The *Jimmo v. Sebelius* settlement in 2013 clarified that Medicare determinations for SNF, Home Health, and Outpatient Therapy turn on

the need for skilled care – not on the ability of an individual to improve. As all of the proposed functional measures in the HHVBP model look at functional gains, these measures could create unintended consequence for providers who are treating patients with the goal of maintaining function. APTA would recommend that CMS consider removing these patients from the functional improvement measures. As the patients receiving maintenance therapy are identified in the home health setting through the use of non-payable codes (G0159, G0160, G0161), we believe this can be accomplished easily through revisions to the exclusion criteria for the relevant measures.

APTA believes that further work should be done to examine more appropriate quality measures for those patients that are receiving maintenance therapy services. APTA suggests that CMS could look at the types of patient populations that most often receive these services, as many of these patients have chronic degenerative conditions. Types of quality measures that may be appropriate for these patients include: measures that examine return to community, measures that look at unintended consequence or patient harm (i.e. readmissions, falls), and overall Medicare resource use on an annual basis.

Home Health (HH) Quality Reporting Program (QRP)

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted on October 6, 2014, requires the implementation of new data reporting requirements for certain PAC providers, including HHAs. The Act requires that the Secretary specify quality measures and resource use and other measures with respect to certain domains not later than the specified application date that applies to each measure domain and PAC provider setting. The IMPACT Act requires that post-acute care providers use standardized assessment tools as the data source for quality measures that shall be risk adjusted (as determined appropriate by the Secretary) and endorsed by NQF. These standardized assessment tools need to be incorporated into existing setting specific assessment tools (OASIS, IRF-PAI and MDS).

Skin integrity and changes in skin integrity (outcomes measure): Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)

CMS proposes 1 new quality measure addressing pressure ulcers for the CY 2018 HH QRP and subsequent years, addressing 1 of the quality domains identified in the IMPACT Act. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. APTA supports this measure and is pleased to see this measure proposed for HH agencies in accordance with the IMPACT provisions. APTA believes that monitoring skin integrity and changes in skin integrity is important in the post-acute care setting. This measure has been endorsed by NQF in the SNF short-stay setting, but has also been proposed and finalized for inclusion in the LTCH and IRF settings. Although this measure is currently risk adjusted, this methodology is specific to each setting and based on data obtained from the data collection tools specific to each PAC setting. As CMS moves toward a standard data set under IMPACT, APTA would advocate for continued ongoing evaluation of the risk adjustment methodology.

HH QRP Quality Measures under Consideration for Future Years

APTA recognizes that the overall goal of IMPACT is for PAC providers (HH, IRF, SNF and LTCH) to collect and report standardized and interoperable patient assessment data, quality and resource use measures. We acknowledge that during the initial IMPACT implementation years that there will be a transition period from existing data collection tools to incorporate standardized assessment tools. APTA encourages CMS to consider a short transition period to standardize the patient assessment data in order to decrease the issues around duplicity and provider burden in data collection. This includes considering the removal of items from the existing data sets that are duplicative where possible. Additionally, we believe that achieving a standardized and interoperable patient assessment data set as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.

APTA would like to encourage CMS to continue in ongoing stakeholder engagement in this process as we move toward PAC data standardization; this includes changes that are made through the regulatory process as well as the measure endorsement process through NQF. Although new measures of patient function were not proposed for inclusion in the home health setting in this proposed rule, several new measures of function were proposed and finalized in the other post-acute care settings (LTCH, SNF, and IRF) in this year's FY2016 rule making period: Functional status, cognitive function, and changes in function and cognitive function: application of percent of patients or residents with an admission and discharge functional assessment and a care plan that addresses function NQF#2631; IRF Functional Outcome Measure: Change in self-care score for medical rehabilitation patients NQF #2633; IRF Functional Outcome Measure: Change in mobility score for medical rehabilitation patients NQF #2634; IRF Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients NQF #2635; IRF Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients NQF #2636. We anticipate that the post-acute care functional measures will evolve over time to include CARE self-care and mobility items such as those that are going to be introduced into the other post-acute care settings (LTCH, SNF, and IRF). Given the wide ranging functional limitations and abilities of patients in the post-acute care settings, the inclusion of new items should help to ensure true representation of patient function at the low, as well as the high ends of the spectrum. APTA and its members appreciate the opportunity to work with CMS during the implementation phase of IMPACT.

Consistency in Regulations across PAC Settings

We urge CMS to be mindful that in order to create a cohesive post-acute care payment system there must be consistency among documentation and billing requirements. Therefore, post-acute care reform must be supplemented by meaningful and carefully crafted regulations that reduce redundancies, eliminate administrative burden, and increase efficiency. In tandem with quality measure development, CMS should conduct a comprehensive analysis of existing rules and regulations. As a result of this analysis, CMS must eliminate or significantly revise current regulations, included but not limited to the home health functional reassessment, SNF Change of Therapy OMRA, SNF 3-day hospital stay admission requirement, definitions of group and

concurrent therapy, IRF short stay policy and IRF 60 percent rule. The elimination or revision of onerous regulations should take place prior to full implementation of the site-neutral payment.

Conclusion

In conclusion, APTA thanks CMS for the opportunity to comment on the Home Health Prospective Payment System proposed rule (CY 2016), and we look forward to working with the agency to craft patient-centered payment policies that reflect quality health care for all Medicare beneficiaries. If you have questions regarding our comments, please contact Heather Smith, Director of Quality at (703) 706-3140 or heathersmith@apta.org.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD, OCS President

SLD: hls