American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703/684-2782
www.apta.org

September 25, 2017

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1672-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements (CMS-1672-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 regarding the Centers for Medicare and Medicaid Services (CMS) Calendar Year (CY) 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements proposed rule. APTA's goal is to foster advancements in physical therapist practice, research, and education. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public. Physical therapy is an integral service provided to patients in the home health setting.

While APTA appreciates the overall intent of the CMS proposals, we are very concerned that the Home Health Groupings Model (HHGM), as currently proposed, is being implemented too soon, with significant flaws, and without adequate protections for Medicare beneficiaries. We are most concerned that high-risk beneficiaries—those with substantial physical therapy needs—may not receive the level and frequency of physical therapy services needed, given the potential economic incentives inherent in this revised case-mix methodology to provide less care for these beneficiaries. The HHGM incentivizes providers to maneuver patients into the most financially beneficial clinical grouping or inappropriately decrease the length of stay. Implementation of the

HHGM also will lead to providers avoiding certain types of patients for financial or other considerations, likely resulting in those patients being steered into higher-acuity settings. It is imperative for CMS to ensure that its approach to modify home health payments enhances the delivery of high-quality, timely, cost-effective care to home health patients, including higher-complexity home health agency (HHA) patients who require substantial resources.

Given that the HHGM may perpetuate certain complications of the home health prospective payment system (PPS) while also creating new access barriers, we recommend that CMS not advance implementation of the HHGM without first engaging in an extensive discussion with the home health industry to understand the full implications of the HHGM on patient care.

APTA's Concerns and Recommendations

1. **APTA encourages CMS not to eliminate the rural add-on payment beginning in 2018. Without the add-on payment, HHAs will be unable to adequately serve Medicare beneficiaries in rural areas.**

2. **APTA supports the CMS proposals to modify the Home Health Quality Reporting Program (QRP) and Value-Based Purchasing (VBP) program. We encourage CMS to include additional patient outcome measures in the VBP program in the future.**

3. **APTA supports the overarching strategies outlined in the Office of the Assistant Secretary for Planning and Evaluation (ASPE) report regarding social risk factors. We also support the testing of social risk factor adjustment models and the reporting of stratified outcomes measures to providers to enable them to better understand the effects of social risk factors on their performance.**

4. **APTA disagrees with implementing the HHGM in a non-budget neutral manner and does not believe CMS has the authority to make such significant adjustments to the PPS. APTA strongly urges CMS to implement the HHGM in a budget-neutral manner.**

5. **APTA disagrees with proposed implementation of the HHGM in CY 2019. The HHGM is far more complex than the current PPS without any evidence that it would improve care. APTA recommends that the agency not implement the HHGM until it has made significant alterations and improvements to the model.**

6. **APTA has major concerns that the proposed methodology undervalues the important role of rehabilitation and creates perverse financial incentives to deliver less than appropriate care.**

7. **APTA strongly recommends that CMS use several diagnoses, in addition to the principal diagnosis, to categorize an episode into a clinical grouping, as a single diagnosis does not provide sufficient basis for assigning a clinical grouping, nor will it help to align payment with patient characteristics that would benefit from therapy.**

8. **APTA strongly recommends that CMS expand the list of comorbidity subcategories to better capture diagnoses that cause higher resource utilization.**

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

CY 2018 Payment Updates

For CY 2018, CMS proposes to reduce home health payments by 0.4% or $80 million. This payment update is based on a 1% payment increase required under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a pre-floor, pre-reclassified hospital wage index, and the discontinuation of rural add-on payments to designated HHAs in rural areas. While APTA supports CMS efforts to review home health payments on an annual basis and streamline the payments across the Medicare program, we have concerns that these payment reductions could create barriers to patients' access to care, particularly in rural areas.

Sunset of Rural Add-On Payment

APTA has concerns that the expiration of the rural add-on provision of 3% from MACRA will further restrict HHAs from adequately serving Medicare beneficiaries in rural areas. HHAs in these areas already face geographical and financial obstacles to supplying sufficient care to meet the needs of their Medicare population. Discontinuing the rural add-on payment will likely prohibit these agencies from furnishing care to patients with the most critical clinical conditions. Thus, APTA urges CMS to develop a policy to support improved access to home care in rural areas *prior to* the elimination rural add-on payments to HHAs. Such policy would ensure that Medicare beneficiaries have access to integral services, including physical therapy.

APTA also recommends that CMS explore policies that provide Medicare coverage for services from therapy providers who furnish telehealth services to their patients. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas, potentially can have a dramatic impact on improving care, diminishing negative consequences, and reducing costs. 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. Prior to reinstatement of the rural add-on payment in 2010, HHAs in rural areas reported that they were unable to deliver services in remote areas, due to financial constraints. We fear that rural agencies will face similar outcomes if CMS allows add-on payments in CY 2018 to expire without providing an extension of this policy through its authority.

Further, APTA has concerns that the elimination of rural add-on payments would lead to workforce shortages in rural areas, as agencies would be forced to reduce wages or eliminate positions altogether. Such shortages in these areas will lead to further restricted access to care for Medicare beneficiaries living in remote areas. Specifically regarding physical therapy services, rural HHAs may not be able to afford to employ physical therapists, further reducing the breadth of services the agencies can furnish and, in turn, decreasing their potential reimbursement rates. We foresee smaller agencies being forced to either drastically reduce essential staff such as physical therapists or close their doors as a result of this proposed policy change.

We strongly urge CMS to take action and extend the rural add-on payment under its authority until the agency has put in place alternative safeguards to ensure Medicare beneficiaries' continued access to care regardless of their geographical location.

Home Health VBP Program

CMS is proposing 2 changes to the home health VBP program for CY 2018. First, CMS proposes to increase the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) minimum of completed surveys from 20 to 40. Second, CMS proposes to remove 1 Outcome and Assessment Information Set (OASIS)-based measure in performance year 3 of the program—Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care—because many providers have achieved full performance on this measure. APTA supports both of these changes.

CMS also suggests several possible measure areas for future years of the home health VBP including: total change in activities of daily living (ADL)/IADL performance by HHA patients, composite functional decline measure, and behavioral health measures. APTA supports the development of future measures in these areas for the home health VBP program.

Home Health QRP

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the implementation of new data-reporting requirements for certain post-acute care providers, including HHAs. The IMPACT 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 provider setting. The IMPACT Act requires that post-acute care providers use standardized assessment tools as the data source for quality measures that are risk adjusted (as determined appropriate by the Secretary) and endorsed by the National Quality Forum (NQF). These standardized assessment tools need to be incorporated into existing setting-specific assessment tools (OASIS, Inpatient Rehabilitation Facility Patient Assessment Instrument, and Minimum Data Set).

CMS proposes to remove 247 data elements from 35 OASIS items collected at specific time points during a home health episode. These data elements are not used in the calculation of quality measures already adopted in the home health QRP, nor are they being used for previously established purposes unrelated to the home health QRP, including payment, survey, the home health VBP program, or care planning. CMS also proposes the collection of standardized data elements as required under the IMPACT Act. APTA supports these changes and appreciates that CMS is removing data elements that are not currently in use while planning to add new standardized data elements; we believe this will help balance the burden of data collection for home health providers.

CMS proposes to replace the current pressure ulcer measure—Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)—with a modified version of the measure. The agency also proposes adopting 1 measure on patient falls (Application of Percent of Residents Experiencing One or More Falls with Major Injury - NQF

#0674) and 1 measure on assessment of patient functional status (Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function - NQF #2631). APTA supports the inclusion of these measures in the home health QRP program, as they align with measures in other post-acute care settings.

Accounting for Social Risk Factors

In the proposed rule, CMS seeks public comment on whether the home health QRP should account for social risk factors, and what method or combination of methods would be most appropriate for accounting for social risk factors.

APTA recognizes that adjusting for social risk factors in certain outcome measures is a complex issue. APTA appreciates that the lack of adjustment for social risk factors in outcome measures utilized in value-based payment programs and models negatively impacts providers and facilities in certain geographic areas where the incidence of specific social risk factors are highest. However, we also acknowledge that implementing social risk factor adjustments may increase health disparities by essentially masking these factors. Currently, outcome measures are not adjusted for social risk factors, which has led to reduced payments for providers and facilities caring for large numbers of disadvantaged patients. In addition to financial repercussions, these publically reported outcome measures can be confusing to beneficiaries.

APTA is an active member of NQF and has been following the social risk factor adjustment project; our organization has also reviewed the work performed by ASPE and the National Academies of Sciences, Engineering, and Medicine. APTA supports the overarching strategies outlined in the ASPE report, which include: measure and report quality for beneficiaries with social risk factors; set high, fair quality standards for all beneficiaries; and reward and support better outcomes for beneficiaries with social risk factors. APTA encourages CMS to take immediate action on these recommendations, including testing of social risk factor adjustment models and reporting stratified outcome measures to providers so they can better understand how social risk factors affect their performances. Once risk-stratified data have been shared with providers, we recommend that CMS work with stakeholders to share these data with beneficiaries in easily comprehensible and actionable terms.

APTA believes that the understanding of social risk factors and their impact on the health care system will continue to evolve over time. We encourage CMS to be responsive to future developments and strategies that provide solutions for adjustment of social risk factors in outcome measures.

HHGM

APTA appreciates that CMS has been working diligently to build a health care delivery system that is better, smarter, and healthier. The basis of the agency's Quality Strategy is to improve the quality of care, reduce the cost of quality health care, and enhance the health of Americans *by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care*. However, we believe the HHGM is contrary to this

Strategy, as it lacks person-centeredness and it fails to support proven interventions to address behavioral, social, and environmental determinants of health. While CMS has committed to putting first the best interest of the people it serves, the motivation behind the HHGM appears to focus solely on reducing Medicare spending. We recommend that CMS modify the HHGM to ensure that it appropriately captures the objectives of the agency's Quality Strategy.

Our comments and concerns regarding the HHGM are discussed in further detail below.

HHGM Must Be Implemented in a Budget-Neutral Manner

APTA strongly recommends that CMS only move forward with implementation of the HHGM in a budget-neutral manner. Imposing a new payment system on HHAs while also instituting significant reimbursement cuts could affect the financial viability of many HHAs, particularly low-volume and rural agencies, resulting in a decline in patient access to care.

Moreover, we question whether CMS has the authority under the statute to implement the HHGM in a non-budget neutral manner. The home health PPS statute generally requires that changes to case-mix and area wage adjustments are made in a budget-neutral manner.[1] Absent specific authority from Congress that permits non-budget neutral payment system alterations, any adjustments, including episode length, must be made in a budget-neutral manner across the PPS. CMS states within the proposed rule that its proposed refinements to the case-mix methodology, including a change in the unit of payment, would result in an estimated $950 million cut to reimbursement in 2019. We strongly believe that CMS's proposed action is not merely a case-mix refinement, and instead constitutes a rebasing of the PPS. However, at no point has Congress granted authority to the agency to revise and rebase the home health PPS beyond 2017.

We recognize that the Social Security Act specifies that in certain instances, PPS adjustments may be made in a non-budget neutral manner.[2] Specifically, we refer to §1895(b)(3)(A)(iii) (as added by §3131 of the Patient Protection and Affordable Care Act), which is a one-time direction to the agency to use its discretion to determine an appropriate percentage reduction under the system that would apply to the home health PPS for 2014 and subsequent years. The adjustment was required to be fully implemented for 2017. This direction appears to permit the adjustment to be made in a non-budget neutral manner; however, any future home health PPS amounts, as adjusted under this one-time authority, are to be updated under §1895(b)(3)(B) beginning with 2018.

APTA believes the CMS proposal to implement the HHGM in a non-budget neutral manner is contrary to its authority under the statute. Rebasing the PPS in a non-budget neutral manner is the role of Congress—not the agency. Unless the statute says otherwise, changes to elements of the home health PPS must be made in a budget-neutral manner across the system. Further, implementing any payment policy changes in a non-budget neutral manner is better done through the deliberative process of Congress. If the HHGM unintentionally causes access problems

[1] *See* 1895(b)(3)(A)(i)

[2] See §1895(b)(3)(A)(i)(III) and §1895(b)(3)(A)(iii) (as added by §3131 of the Patient Protection and Affordable Care Act).

through rate cuts instituted by regulation, Congress would then be tasked with finding budget offsets to cover the "cost" of fixing the mistake.

Additionally, we question how implementation of the HHGM in a non-budget neutral manner would impact patient access to high-quality home health services. HHAs are competing with the entire health care industry for high-quality, educated practitioners. Unfortunately, the demand for many home health professionals may outpace supply. For instance, we anticipate there will be an increased demand for physical therapy services due to the aging baby boomers, who are staying active later in life than were their counterparts of previous generations. Based on current trends in the physical therapist workforce, there is a projected unmet demand ranging from 13,000 to 27,000 within the next several years.[3] As such, imposing significant reimbursement cuts on agencies could significantly impact their ability to recruit and retain quality health care professionals.

The proposed model has the risk of leading to numerous adverse unintended consequences. We recognize that one of CMS's primary goals by implementing the HHGM is to address the overutilization of therapy services in the home health setting. While rebasing the home health PPS and effectuating the HHGM may result in reduced reimbursement afforded to therapy services, thus decreasing the incentive associated with delivering therapy, we anticipate the HHGM will have a harsh and dramatic effect on patient care. Moreover, by driving payment away from therapy and toward medically complex services, the HHGM may generate provider integrity concerns.

APTA strongly urges CMS to only advance implementation of the HHGM in a budget-neutral manner, taking into consideration our concerns outlined above. We believe that effectuation of the HHGM in a non-budget neutral manner has serious negative implications for patient access to high-quality home health services.

Implementation of HHGM by CY 2019 Fails to Enable CMS to Implement Necessary Modifications to the Model

APTA strongly recommends that CMS postpone the effective date of the HHGM to CY 2020, at the earliest. The HHGM is far more complex than the current PPS without any supporting evidence to show it would improve patient care or increase access to home health services. The proposed payment system represents a marked departure from the current payment methodology and is likely to cause a significant disruption to care. Given that the HHGM may create new incentives to inappropriately decrease therapy utilization, we believe CMS should not advance the HHGM until it can ensure the model would not perpetuate, or intensify, existing patient access issues. Additionally, we encourage CMS to solicit input and engage in meaningful dialogue with stakeholders, including APTA, in advance of the release of any final rule to determine what modifications to the model may be necessary to ensure that patient access to home health services is not negatively impacted in any manner.

[3] APTA Physical Therapy Workforce Data. http://www.apta.org/WorkforceData/ (Last accessed September 8, 2017).

Further, implementation of the HHGM should not occur until CMS can ensure that all stakeholders are adequately prepared to make the transition to the new model. Considerable time and interactive discussion will be needed to develop operational guidance and procedures; update information collection and transmittal tools, including new software and programming to support the HHGM; and conduct provider training. We anticipate that the HHGM will also require HHAs to devote more staff time and resources aimed at administrative processes to ensure payment, rather than delivering patient care, in addition to other notable new costs, including repurposing and training staff as well as requiring many smaller agencies to hire additional billers and staff with health care coding expertise and certification. Additionally, CMS will need to conduct webinars, town halls, and open-door forums, as well as develop sub-regulatory guidance and other resources to ensure that providers can successfully comply with the proposed changes.

HHGM Fails to Align With IMPACT Act Implementation

APTA has significant concerns that the effort to develop the HHGM was done in isolation, without consideration for the current health care payment environment. The implementation of provisions within the IMPACT Act has been under way since 2014, and the Medicare Payment Advisory Commission (MedPAC) has formulated considerations for the unified post-acute care payment system, publishing its research and recommendations in its June 2016 and June 2017 Reports to Congress. However, the HHGM appears to ignore the current work related to implementation of the IMPACT Act as well as the unified payment system. While the HHGM reflects MedPAC's recommendation to align payment with patient characteristics, CMS has not proposed to implement any of the other policies recommended by MedPAC to enhance payment accuracy.

Given that Medicare appears to be moving towards adoption of a unified payment system across post-acute settings, we request that CMS provide clarification on how the HHGM would impact, or be impacted by, additional efforts by the agency to revise the reimbursement system for post-acute care settings. We urge CMS to illustrate to stakeholders how a new home health payment model aligns with ongoing development of the unified post-acute care payment system and quality measurement. Additionally, we recommend that CMS evaluate how it may align any final home health PPS payment methodology changes across all settings.

We encourage CMS to be mindful that to create a cohesive post-acute care payment system, there must be consistency among documentation and billing requirements. As such, any post-acute care reforms must be supplemented by meaningful and carefully crafted regulations that reduce redundancies, eliminate administrative burden, and increase efficiency.

HHGM Could Impose Serious Barriers to Therapy Services

Home health physical therapists play an integral part in minimizing re-hospitalizations, helping patients maximize their functional independence. Home health physical therapists leave a lasting impact on the independence and well-being of their patients, keeping them safe in the comfort of their own homes and out of the hospital or other high-acuity setting. Physical therapy services benefit the patient by providing functional improvement, educational opportunities, social

support, and motivation. It is the responsibility of the therapist to make judgments that are in the best clinical interests of the patient. The therapist's professional judgment is used to determine the combination of modes or disciplines of therapy most appropriate to treat the patient and in accordance with Medicare coverage guidelines for skilled therapy.

While the physician is, to an extent, the gatekeeper of a home health patient, and is responsible for ensuring that the patient receives the appropriate level of care, in many instances the physician has very limited oversight of the patient. Physicians rarely visit patients in their homes. Moreover, patients often have several physicians directing their care – the treating physician at the hospital, the physician at the skilled nursing facility (SNF) the patient was discharged to from the hospital, and the primary care physician. It is the physical therapist who establishes the treatment or exercise program with the proper dosage, frequency, intensity, type, and duration. While physicians may ultimately be responsible for the delivery of patient care, physical therapists are gatekeepers of the delivery of physical therapy and are responsible for their own treatment programs. However, due to the monetary disincentives associated with delivering physical therapy under the HHGM, APTA has serious concerns that the clinical judgment of home health physical therapists likely will be overridden by HHAs' financial considerations. As such, implementation of the currently proposed HHGM could lead to patients not receiving the rehabilitative services they need, placing them at risk for serious harm.

CMS Must Adopt Quantitative and Qualitative Metrics to Safeguard Patient Access to Home Health Services under the HHGM

As stated above, APTA has considerable concerns that the proposed rule lacks any discussion as to how CMS intends to protect beneficiaries against stinting of therapy services and premature discharges. Although the agency may be intending to rely on the new Home Health Conditions of Participation (CoPs), Home Health QRP, physician plan of care, or the requirement to report each visit in line-item detail on the claim to hold providers accountable and ensure that the most qualified health care professionals are delivering services they are trained to provide, none are sufficient or timely for ensuring the delivery of all medically necessary services, including physical therapy.

We understand that CMS may also be intending to use medical review and the VBP program as a means to safeguard beneficiary access while ensuring provider compliance with Medicare regulatory requirements and guidelines. However, we fail to see how medical review is a sufficient option to remedy the consequences associated with delivering inadequate care, as medical review does nothing that would allow care delivery to be modified during the episode. APTA requests that CMS provide a detailed discussion of how it intends to use medical review to ensure the appropriate delivery of patient care. Should CMS proceed with medical review, we recommend that the agency analyze the medical review findings and publically report any observed patient care trends via Home Health Compare.

APTA also has concerns with CMS's intention to use the home health VBP program as a potential mechanism to protect patients against stinting of therapy services or premature discharges. The VBP program is not currently a viable option, as the program is still in its infancy, and it continues to be unclear what impact the program will have on the behavior of

HHAs. Moreover, given that the program is being tested under the current home health PPS, any data collected prior to implementation of the HHGM likely will be ineffective at predicting how the VBP program will regulate behavior under the model. Nonetheless, if CMS believes the VBP program is a valid means to monitor and regulate provider behavior in the future, the agency must first incorporate more robust patient outcome measures, such as total change in ADL performance by HHA patients or a composite functional decline measure (as recommended in the proposed rule).

Because of the financial disincentives associated with delivering therapy services to patients under the HHGM, APTA strongly recommends that CMS develop quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcome measures, by which it can ensure that coordinated, patient-specific, outcome-based care is being delivered safely by properly qualified professionals to patients in the home care setting. CMS must be able to monitor provider behavior to detect inappropriate responses to implementation of the HHGM, including withholding of therapy services, which could result in poor outcomes; selecting patients who are likely to be relatively more profitable; generating unnecessary episodes; or prematurely discharging patients. To assist CMS in its efforts, APTA would greatly appreciate the opportunity to serve as a resource to CMS and share data results at the clinician, practice, and national levels for the measures included in APTA's Qualified Clinical Data Registry.

The quality measures that we recommend CMS develop and adopt are measures that could monitor and track patient outcomes and provider performance, as well as any changes in utilization of services. This would help to safeguard the delivery of therapy services and ensure accountability on the part of the provider. MedPAC has previously stated that providers should be accountable for the quality of care they furnish for a period of time after discharge of the patient. As such, CMS could consider tracking measures for 60-90 days, holding providers accountable for a longer period of time after discharge from home health. Such accountability could help to protect beneficiaries from providers skimping on services while also encouraging providers to coordinate care with the patient's next provider (or caregiver) so the patient has a safe transition.[4]

As CMS develops setting-appropriate quality measures—including performance-based and patient-reported outcome measures, we encourage the agency to ensure such measures address the domains of, and changes in, function and cognitive function, particularly Medicare beneficiaries' improvements in cognitive, physical, and psychosocial function as well as outcomes for successfully maintaining function or delaying decline in beneficiaries with chronic and progressive conditions. As a starting point, CMS should refer to the measures MedPAC discussed in its June 2017 Report to Congress regarding potential measures that could monitor quality in the post-acute setting. These measures include:

- Potentially avoidable readmissions
- Potentially avoidable admissions (for community admissions)
- Changes in patient function
- Length of episode

[4] MedPAC June 2017 Report to Congress, Chapter 1. http://medpac.gov/docs/default-source/reports/jun17_ch1.pdf?sfvrsn=0 (Last accessed September 11, 2017).

- Potentially avoidable complication rates
- Potentially avoidable emergency department visits and observation stays
- Days elapsed between discharge from post-acute care and follow-up appointment with a clinician
- Beneficiary experience[6]

Alternatively, or in conjunction with the recommendations above, we encourage CMS to monitor patient responses to OASIS questions that query risk of hospitalization and whether the patient had a multi-factor falls risk assessment using a standardized, validated assessment tool. Currently, when these questions are answered in the affirmative, indicating a risk for falls, in most instances, a therapy evaluation is conducted. CMS could monitor these OASIS items, analyzing how current responses compare to responses under the HHGM, noting any significant changes in responses or a decline in the number of therapy evaluations; when inappropriate actions are identified, CMS would revise the home health PPS accordingly.

We also recommend that CMS closely examine any changes in patient discharge trends related to function level and change in function using Section GG of the OASIS, the rate of hospitalization during the first 60 days of the home health stay and rehospitalizations during the first 30 days of home health, as well as discharge to community rates. CMS also could use the OASIS outcome measures to monitor patient outcomes. Generally, patients' function levels and changes in function in fiscal years 2017 and 2018 should be comparable to patients' function levels and changes in function subsequent to implementation of the HHGM, holding all other factors constant. Following implementation of the new model, if patients demonstrate smaller changes in function or lower function levels upon discharge, the rate of hospitalization during the home health stay increases over previous years' rates, and/or HHA performance levels drop, this likely would be indicative of the flaw that we believe exists within the new payment model. That is, as currently designed, the HHGM incentivizes providers to disregard patients' rehabilitative needs and fervently steer patients away from therapy services.

Other potential accountability mechanisms that CMS could implement include:

- Monitoring utilization of therapy more frequently through claims
- Alerting state agencies to be aware of the changes to the home health payment system and instructing them to closely monitor complaints made against HHAs
- Educating physicians on not only the changes occurring to the home health payment system, but also their responsibility for the overall home health plan of care
- Following implementation of the HHGM, conducting open door forums on a quarterly basis and inviting home health industry stakeholders, in addition to patients, their families, and caregivers, to provide feedback on the effects of implementation
- Developing an email box that allows the public to submit a question or provide feedback regarding the HHGM

APTA strongly urges CMS to take into consideration our suggestions outlined above and provide a detailed discussion within the final rule the mechanisms by which it intends to accurately monitor and regulate, within real-time, the alignment of the delivery of therapy services with each patient's clinical needs. We also recommend that prior to implementation of the HHGM, CMS solicit additional input from home health industry stakeholders on this topic.

HHGM 30-Day Episode with Early and Late Timing Categories May Incentivize Improper Behavior

30-Day Unit of Payment

The goals of home health care are to help patients improve function, be more independent, remain at home, and avoid hospitalization or admission to long-term care institutions. Unfortunately, the HHGM incentivizes providers to disregard the goals, desires, and needs of the patient. Shifting from a 60-day episode to a 30-day episode and "frontloading" payments to the first 30-day episode creates a perverse financial incentive for providers to inappropriately decrease the lengths of stay and/or avoid admitting patients who will require care beyond the initial 30-day episode. CMS notes within the rule that it expects it will see an uptick in the number of single 30-day episodes; we urge the agency to view this trend with caution, as an increase in single 30-day episodes could indicate that patients are not receiving the appropriate amount of care they need due to financial constraints.

Moreover, switching from a 60-day to a 30-day unit of payment could financially penalize HHAs that treat more complex patients, who may require care over the span of multiple episodes. This, too, could lead to premature discharges, resulting in increased hospital admissions during the home health stay, poorer outcomes, reduced quality of life, and additional costs for the Medicare program. Further, by changing the unit of payment to a 30-day episode, HHAs will be compelled to expend increased financial and administrative resources to bill on a more frequent basis, a factor not accounted for by the HHGM.

Implications for Maintenance Therapy

The HHGM fails to safeguard against stinting for therapy services, particularly for patients whose functional impairment does not rise to the level of the principal diagnosis that results in a rehabilitation clinical grouping. By shifting from a 60-day episode to a 30-day episode and reducing the case-mix weight for "late" episodes, we anticipate gross reductions in the delivery of maintenance therapy, a covered Medicare service that many providers continue to misunderstand and underutilize.

The *Jimmo v Sebelius* settlement confirmed the availability of Medicare coverage for skilled services to maintain an individual's condition. However, APTA is concerned that the *Jimmo* settlement is not reflected within CMS's proposed home health payment reform proposal. We are disappointed that the proposed new payment model fails to improve on the flaws within the current home health payment system as it relates to the delivery and coverage of maintenance therapy. Rather, the HHGM undermines the mandates of the *Jimmo* settlement and decision, as the model imposes significant financial disincentives associated with providing rehabilitative care, particularly over the span of multiple episodes. Consequently, we anticipate this could lead to a significant decline in services designed to stabilize patients, particularly maintenance therapy.

In APTA's experience, despite the 2013 settlement, widespread confusion continues on the part of Medicare Administrative Contractors (MACs) on whether skilled maintenance care qualifies

for payment. This has led to numerous instances of MACs denying payment for appropriately applied skilled maintenance therapy due to a beneficiary's lack of restoration or improvement potential. We believe this is in large part due to a lack of education and awareness about the implications of *Jimmo*. While the agency continually states there is no improvement standard and recently launched a *Jimmo* settlement agreement webpage, all providers, including HHAs, continue to have a fear of denial if and when they pursue delivering maintenance therapy to patients.

Maintenance therapy provides stabilization for patients, preventing a decline in condition while optimizing function. With a rapidly growing aged population, maintenance therapy will only become more critical in helping patients uphold their health and quality of life. The financial disincentives associated with providing rehabilitative care under the HHGM, particularly over the span of multiple episodes, will lead to a significant decline in furnishing this type of care. Consequently, patients' conditions will deteriorate, necessitating additional treatment, possibly in a higher-acuity setting. APTA strongly urges CMS to protect patient access to maintenance therapy in any future revisions to the home health payment system.

Episode Timing

APTA recommends that the HHGM mirror the current home health payment system's episode timing, in that the first two 30-day episodes of a sequence of adjacent 30-day episodes are considered early. Patients who require home health services beyond the initial 30-day episode have serious functional impairments and are at risk of adverse events, requiring providers to continue to allocate significant resources to care for these patients. Given that CMS has proposed assigning different low-utilization payment adjustment thresholds to each of the 144 groups to better align payment with patient characteristics, the agency will avoid having to furnish the full episodic payment when it is unwarranted. We believe that maintaining the current episode timing process, albeit under a 30-day episode as opposed to a 60-day episode, will reduce the incentive to prematurely discharge patients, withhold therapy services, and/or avoid admitting higher-complexity patients who require care over the span of multiple episodes.

Admission Source Categories May Impose a Significant Financial and Administrative Burden on Providers

APTA has concerns regarding CMS's proposal to potentially conduct post-payment medical review of the home health claim to assess whether a home health admission was preceded by an institutional stay. The HHA should not be held responsible and possibly subject to post-payment medical review for instances in which it manually indicates on the claim an institutional admission source, and the institution's claim for an acute/post-acute stay is subsequently denied or not filed in a timely manner. Denial for the acute/post-acute stay could be for a number of reasons of which the HHA has no knowledge or involvement. The denial of an institutional claim, as well as the timely filing of a claim, is outside of the control of the HHA. It is unreasonable for CMS to subject HHAs to post-payment medical review and face potential penalization for an acute/post-acute institution's actions or inactions.

To ensure a more equitable approach toward conducting post-payment medical review of home health claims, we recommend that CMS consider conducting post-payment review only for HHAs whose claims are consistently associated with acute/post-acute claim denials or whose utilization pattern of acute/post-acute occurrence codes is aberrant compared with their peers.

Further, we request that home health claims with non-Medicare institutional admission sources be exempt from post-payment medical review, given the inherent difficulties associated with accurately assessing whether the non-Medicare institutional stay satisfied the payer's coverage requirements, was timely filed, etc. Should CMS disagree with this recommendation, we encourage the agency to discuss within final rulemaking the process by which HHAs should verify a non-Medicare institutional stay. In the same vein, it is unclear how CMS's processing system will verify a non-Medicare institutional admission source and the process and timeframe by which CMS intends to conduct such verification. Again, we urge CMS not to penalize HHAs that have little to no control over where a patient is transferred to or referred from.

APTA also recommends that CMS consider including within the definition of "institution" the hospital outpatient department setting, including emergency room departments. Patients admitted to the hospital as outpatients, through the emergency room for example, often have underlying chronic conditions that are associated with increased costs and necessitate follow-up care. The criteria for inpatient hospital admission versus outpatient are not always clear and frequently, the differences between a patient admitted as an inpatient versus as an outpatient are minimal. As such, we encourage CMS to consider expanding the definition of institutional stay to include observation stays.

Finally, APTA requests that CMS clarify within the final rule the length of time that a HHA would have to resubmit a home health claim when it learns of a non-Medicare institutional stay occurring within 14 days of the home health admission. Moreover, we urge CMS to provide a detailed discussion related to the timeframe by which Medicare will make payment modifications to a claim when the HHA categorizes a community admission source, but an acute/post-acute Medicare claim for an institutional stay occurring within 14 days of the home health admission is subsequently submitted.

Placement into a Clinical Grouping Based on Principal Diagnosis May Result in Stinting of Services

Under the HHGM, CMS proposes placing episode periods into 1 of 6 clinical groups based on the principal diagnosis. The principal diagnosis reported would provide information to describe the primary reason that patients are receiving home health services under the Medicare home health benefit. The clinical groupings are:

- Musculoskeletal Rehabilitation
- Neuro/Stroke Rehabilitation
- Wounds—Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care
- Complex Nursing Interventions
- Behavioral Health Care
- Medication Management, Teaching, and Assessment (MMTA)

APTA strongly recommends that CMS modify the HHGM clinical grouping proposal and allow multiple diagnoses to be used for categorization into a group. Relying solely on the principal diagnosis to categorize a patient into a clinical grouping may not be the most meaningful approach. A single diagnosis does not provide sufficient basis for assigning a clinical grouping, nor will it help to align payment with patient characteristics that would benefit from therapy. In fact, it may lead to underutilization of services, particularly therapy. Given the majority of Medicare beneficiaries have more than one primary condition, we strongly believe CMS should use several diagnoses, not solely the principal diagnosis, to classify episodes into clinical groupings. The Medicare Chart Book on chronic conditions indicates that in 2015, 15% of all Medicare beneficiaries had 6+ chronic conditions; 20% had 4-5 chronic conditions; and 30% had 2-3 chronic conditions.[5] Given that approximately 2/3 of Medicare beneficiaries suffer from more than 1 chronic condition, we strongly recommend that CMS categorize episodes into clinical groupings based upon more than 1 diagnosis.

Additionally, while CMS may believe the primary diagnosis is apparent from the hospital, SNF, or other institution's records, such documentation does not always allow for proper identification of the principal diagnosis. Rather, in many instances, a HHA receives only partial information about the patient upon admission; it then takes the HHA several days to compile and review all relevant medical records related to the patient. Because it is unclear whether CMS expects the principal diagnosis on the home health claim to be linked to any specific data on the acute/post-acute institutional claim, the HHGM could incentivize manipulation of the principal diagnosis in an effort to categorize a patient into a grouping that solicits the highest payment. Diagnosis coding poses a significant challenge to HHAs, and the HHGM increases the likelihood that providers may attempt to maneuver patients into the most financially beneficial clinical grouping, leading to new compliance and program integrity issues.

Further, under the HHGM, patients who are medically complex and require rehabilitation but who do not have a primary diagnosis that would categorize them into a musculoskeletal or neuro/stroke rehabilitation group would be less likely to receive the appropriate amount of therapy, placing them at risk for serious harm. CMS states within the rule that "therapy continues to be a valued home health service, as two of the six clinical groups (neuro/stroke rehabilitation and musculoskeletal rehabilitation) under the HHGM reflect instances where therapy would be the primary focus of home health care." The majority of patients who require therapy in order to live at home and ambulate independently, however, will not be grouped into either of these therapy categories, because rehabilitation often will not be the primary reason for home health services. This is confirmed by CMS's estimation that the majority of home health episodes will be categorized under the MMTA clinical group.

The musculoskeletal rehabilitation group focuses on individuals with impairments or disabilities due to disease, disorders, or trauma to the muscles or bones, while the neurological rehabilitation group is designed for individuals with disease, trauma, or disorders of the nervous system. CMS states within the proposed rule that patient characteristics between the 2 rehabilitation groups determine whether resources are directed toward preventing the loss of function, improvement or restoration, compensation for lost function, and maintenance of current function. As such, APTA

[5] Medicare Chart Book, Chronic Conditions. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html (Last accessed September 21, 2017).

questions the likelihood that resources will be directed toward preventing a patient's loss of function or maintenance of current function if a patient's principal diagnosis results in that patient's assignment to 1 of the 4 *non-rehabilitation* groups (and therapy services are warranted).

For example, a patient placed into the wounds, complex nursing interventions, MMTA, or behavioral health grouping versus the musculoskeletal or neuro/stroke rehabilitation grouping has "different care goals and expected outcomes," which affect resource use. Although the assignment of patients into functional categories of low, medium, or high is designed to communicate the beneficiary's level of need for rehabilitation, unfortunately, we anticipate that agencies will associate rehabilitation solely with the musculoskeletal and neurological rehabilitation groupings, irrespective of functional status. Thus, because the majority of patients are expected to be categorized into MMTA and the resources directed to that grouping are intended to resolve the principal diagnosis, as opposed to improving or maintaining function, we anticipate that many patients will not receive the level of rehabilitative care their condition(s) require. We urge CMS to discuss within the final rule how it intends to ensure resources will be directed toward improving or maintaining function when the patient's principal diagnosis results in categorization into 1 of the 4 non-rehabilitation groups.

Regardless of function level, due to financial considerations, providers are likely to deliver lesser amounts of rehabilitation to patients who require such services but are not categorized into either the musculoskeletal rehabilitation or neuro/stroke rehabilitation group, given the HHAs would not be afforded the same level of resources to provide therapy services to patients in the non-rehabilitation groupings as they are in the rehabilitation groupings. For instance, a MMTA grouping, high-functional level, early episode, community admission, with a comorbidity adjustment is afforded a case-mix weight of 1.3950, whereas a musculoskeletal grouping, high-functional level, early episode, community admission, with a comorbidity adjustment is afforded a case-mix weight of 1.4977. Despite the parallel function levels and holding all other factors constant apart from the clinical grouping, not only are the resources allocated to the MMTA grouping less, but the HHA would have to use those resources to address the principal diagnosis that warranted placement into the MMTA, leaving very few resources available to deliver the appropriate amount of rehabilitation. Consequently, the HHGM creates a new incentive to underutilize therapy services.

An additional example better demonstrates how we expect the HHGM to negatively impact patient access to medically necessary therapy services:

> Patient A with cerebrovascular disease is frail and lives on his own with no social support. This patient's functional level is high; his principal diagnosis results in assignment to MMTA.
>
> Patient B has cerebral infarction due to embolism of precerebral artery; he also is frail and lives on his own with no social support. This patient's functional level is high; his principal diagnosis results in assignment to the neurological rehabilitation grouping.
>
> Holding all other factors constant, although both patients score in the high-function range, the reimbursement amount aligned with Patient A's characteristics is significantly less than a

patient with the same or similar characteristics but who is assigned to the neurological rehabilitation grouping.

As such, despite the similarities between the principal diagnoses and the fact that both patients' functional levels are high and may require the same level of physical and other therapy services, Patient A is likely to receive less rehabilitation, as the resources allocated to his case-mix group are significantly lower. Irrespective of functional status, the HHA will be much less inclined (financially or otherwise) to deliver the appropriate amount of therapy (physical, occupational, and/or or speech-language pathology) to Patient A, given the financial constraint being imposed on the HHA solely due to his principal diagnosis. Moreover, this illustrates how the HHGM may incentivize the maneuvering of a patient into the more profitable clinical grouping.

As stated above, APTA is concerned that patients not categorized into a rehabilitation grouping but who require physical therapy, occupational therapy, or speech-language pathology services will be at risk of receiving an inordinately low level of rehabilitation due to the allocation of resources to address those patients' other conditions. We encourage CMS to adopt the safeguards we recommend in our comments to help to ensure that patients receive the appropriate levels of care based upon their medical condition(s). CMS also could consider monitoring claims submitted and comparing the principal and secondary diagnoses with the visit information. Hence, if a claim indicates the patient had a principal or secondary diagnosis that warrants therapy but the visit information on the claim illustrates very little to no therapy is delivered, CMS would flag that claim for further review.

Alternatively, should CMS adopt the "Notice of Admission," the agency could require the HHA to list the anticipated services to be delivered to the home health patient on the Notice of Admission. This would allow CMS to monitor whether therapy utilization is increasing or decreasing, and in instances when therapy is included in the Notice of Admission, but not reflected on the claim, CMS would flag that claim for further review. While these proposals do not address potential up-coding concerns nor does it prevent real-time negative impacts on beneficiary access to care, they could assist CMS in its efforts to ensure that patients receive the appropriate amount, and discipline, of therapy services. Again, we emphasize the importance of implementing a means by which CMS can ensure that patient access to rehabilitative services is not negatively affected by the HHGM.

APTA Seeks Clarity on Future of Functional Status Assessments

APTA appreciates that CMS proposes to require the use of multiple OASIS items to assess function, but we have questions regarding how this proposal supports the ongoing development of the IMPACT Act. As outlined in the IMPACT Act, standardized functional assessment items are included in Section GG of the Quality Indicator section of the OASIS, proposed for implementation starting January 1, 2019. HHAs will be required to report standardized assessment data on functional status, incidence of major falls, and transfer of health information through the OASIS beginning on the same effective date of the proposed HHGM. The standardized functional status items being collected will be used to calculate the adopted quality measures intended to meet the IMPACT Act requirement for measure domain: functional status, cognitive function, and changes in function and cognitive function.

Given that continued implementation of the IMPACT Act may affect the functional status assessment items proposed for the HHGM, APTA requests that CMS provide a detailed discussion within the final rule on whether it anticipates modifying the OASIS items proposed to assess functional level under the HHGM. Because the agency fails to make mention of, or refer to, the IMPACT Act's timeline and required data submission within the proposed rule, CMS's intentions are unclear.

CMS Must Expand Proposed Comorbidity Subcategories to Capture All Significant Secondary Diagnoses

APTA appreciates CMS's proposal to provide a comorbidity adjustment for periods that have at least 1 secondary diagnosis that falls into 1 of the proposed 15 subcategories. We strongly urge the agency, however, to expand the list of secondary diagnoses that would trigger the comorbidity adjustment. CMS notes within the proposed rule that research has repeatedly shown comorbidity to be associated with high health care utilization and expenditures, and patients with comorbidities are high users of home health visits. However, despite CMS's attempt to account for higher costs associated with comorbidities, only a small number of diagnoses will trigger a comorbidity adjustment, confirmed by CMS's estimation that only 14.77% of episodes are expected to qualify for the comorbidity adjustment.

CMS states within the rule that it identified common chronic comorbid conditions frequently cited as drivers of increased health resource utilization, including congestive heart failure and chronic obstructive pulmonary disease (COPD). Despite this assertion within the rule, utilization of the HHGM grouping tool demonstrated that a principal diagnosis of heart disease and a secondary diagnosis of COPD does *not* result in a comorbidity adjustment. Numerous other diagnoses, including cardiovascular disease, myocardial degeneration, cerebrovascular disease, and type 2 diabetes mellitus, alone or in combination with other diagnoses and unrelated to the listed principal diagnosis, also fail to generate a comorbidity adjustment. It is perplexing that diagnoses such as those listed above, which have been shown to be directly connected to increased health resource utilization, are omitted.

The number of comorbidities a patient has correlates highly to the degree of resources needed to care for the patient. Even 1 or 2 comorbidities could require significant, high-cost intervention. Comorbidities often are tied to poorer health outcomes, more complex medical need and management, and higher costs.[6(p35295)] A comorbidity adjustment that accounts for the presence of multiple secondary diagnoses would better align payment with anticipated resource use. As illustrated in the following example, there is a distinct difference between patients with 1 chronic condition versus 2, 3, or more: In 2008, spending for Blue Cross Blue Shield of Michigan patients with 1 chronic condition averaged $6,573 per patient per year. The amount doubled to $13,146 for patients with 2 chronic conditions, and it quadrupled to $27,763 for patients with 3 or more chronic conditions.

[6] Centers for Medicare and Medicaid Services' CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements proposed rule. https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf (Last accessed September 22, 2017).

Thus, a patient who has multiple comorbidities would, in most clinical cases, require more time and resources to treat than a patient who has 1 comorbidity. We strongly recommend that CMS take this into consideration and modify the comorbidity adjustment proposal. For example, much like the agency proposed in the SNF Advance Notice of Proposed Rulemaking, CMS could count the number of comorbidities and assign a score to the patient based upon this count. Those comorbidities with a greater impact on home health costs are assigned more points, while those with less of an impact are assigned fewer points. There would be thresholds associated with the total number of points assigned; each threshold would be associated with a corresponding comorbidity adjustment. Other possible options include:

1. Increasing the adjustment amount when the episode period presents with multiple secondary diagnoses that fall into more than 1 subcategory.

2. Increasing the number of comorbidity adjustments based upon the number of secondary diagnoses present, with the maximum number of adjustments set at 3. For example, if the patient has 4 or fewer secondary diagnoses, the period receives 1 adjustment; for 5-9 secondary diagnoses, the period receives 2 adjustments; for 10+ secondary diagnoses, the period receives 3 comorbidity adjustments.

3. Increasing the adjustment amount based upon the number of secondary diagnoses in a manner similar to Example 2.

APTA has considerable concerns with the comorbidity adjustment proposal and strongly urges the agency to expand the number of secondary diagnoses and comorbidity subcategories to ensure that the comorbidity adjustment is fairly distributed for patients with diagnoses associated with higher resource utilization. Additionally, we request that prior to, or in conjunction with, the release of the final rule, CMS release the ICD-10 codes associated with each comorbidity subcategory.

Concerns with Accuracy of Medicare Cost Report Data

Within the proposed rule, CMS provides a discussion of the methodology used to calculate the case-mix weights for each group. CMS proposes to use the cost per minute (CPM) approach as opposed to the wage-weighted minutes of care (WWMC) approach because WWMC does not as evenly weigh skilled nursing costs relative to therapy costs.

APTA does not believe CMS has provided sufficient justification to switch data sources, as the agency has furnished limited evidence that the data used from the Medicare HHAs' cost reports is sufficiently accurate to calculate costs. Additionally, APTA has concerns that using Medicare cost report data to measure resource use may result in inaccurate predictions and will underestimate or overestimate the case-mix weights of individual groupings.

We recognize that CMS is proposing to use the CPM plus non-routine supplies (NRS) approach, as CMS believes these costs are more HHA-specific than the aggregated Bureau of Labor Statistics' estimated costs. However, research has found longstanding problems in Medicare cost reports, including major differences in reported profits; variations in reporting of both revenues

and expenses; an absence of relevant details, such as charity care, bad debt, operating versus non-operating income; and the inclusion of many non-allowable Medicare costs.[7] Consequently, the use of Medicare cost report financial data may give only a limited and inaccurate portrayal of the financial position of HHAs.

Moreover, we question CMS's rationale to use Medicare cost report data to calculate case-mix weights when the U.S. Department of Health and Human Services (HHS) made no recommendation that the value of time be assessed via cost report data in its June 2017 report on "Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices."[8] The report states that currently, for "on-the-job activities undertaken by employees, HHS Guidelines recommend using estimates of pre-tax wages for the particular industry and affected occupation, to the extent possible, and adding estimate of benefits and indirect costs. The Guidelines direct analysts to assume benefits plus indirect costs equal to 100 percent of pre-tax wages." The report goes on to state that for activities undertaken during unpaid time, analysts should "apply an estimate of national post-tax wages."[9]

Therefore, prior to incorporating the use of cost reports to calculate the case-mix weights of each group, we recommend that CMS work with the home health industry to ensure that cost reports are standardized and accurate. We further recommend that the agency not use cost reports to predict resource use for each case-mix group until those cost reports are shown to provide standardized and accurate data appropriate to this task.

Request for Information on CMS Flexibilities and Efficiencies

APTA Recommends that CMS Encourage Multidisciplinary Teamwork in Home Health Setting

APTA believes that cohesive teamwork among different disciplines leads to improved patient outcomes. To enhance the quality and safety of patient care, we encourage CMS to consider revising current Medicare policies so that different disciplines—including the physical therapist, occupational therapist, speech-language pathologist (SLP), physician, registered nurse (RN), physical therapist assistant, occupational therapy assistant, and home health aide—are encouraged to work as a unified home health care team. Requiring home health professionals to work as an interdisciplinary team would not only increase communication and cooperation among providers but also improve effectiveness of the care delivered to patients.

Current Medicare home health policies fail to incentivize interdisciplinary collaboration; as such, there is very little cohesiveness between therapy, nursing, and physician care. Accordingly, APTA recommends that in an effort to improve patient outcomes and quality of care, CMS more effectively promote coordination and communication between health care professionals in such a manner that does not create an increased financial burden on HHAs and other health care

[7] The Medicare Cost Report and the limits of hospital accountability: improving financial accounting data. https://www.ncbi.nlm.nih.gov/pubmed/11253456 (Last accessed September 11, 2017).

[8] https://aspe.hhs.gov/system/files/pdf/257746/VOT.pdf (Last accessed September 18, 2017).

providers. For example, CMS could create a clinical improvement activity requirement that rewards the delivery of care that is focused on care coordination, patient engagement, and patient safety in the home health setting. Alternatively, CMS could update home health regulations and require an interdisciplinary team meeting at least once every 2-4 weeks. During the meeting, the members of the treatment team can coordinate care and communicate regarding the home health patient's plan of care and treatment goals.

Plan of Care 30-Day Initial Certification and 90-Day Recertification

APTA strongly recommends that CMS modify or eliminate the 30-day initial certification and 90-day recertification requirements for the plan of care.

Initial certification
In many instances, Medicare beneficiaries may seek therapy services without first being evaluated by a physician or obtaining a referral. However, once a therapist determines that therapy is medically necessary, Medicare requires that the patient be under the active care of a physician or non-physician practitioner. As outlined in §1861(r) of the Social Security Act, as well as 42 CFR §424.24(c) and 42 CFR §410.61(e), outpatient therapy services must be furnished under a plan of care.

Certification of the plan by the physician or non-physician practitioner satisfies all certification requirements for the duration of the plan of care or for 90 calendar days from the date of the initial treatment, whichever is less. The provider or supplier should obtain certification as soon as possible after the plan of care is established and must obtain it within 30 days of the initial therapy treatment. Payment may be denied if the physician does not certify the plan of care.

Timely certification of the initial plan is met when the certification is documented, by signature or verbal order, and dated within the 30 days following the first day of treatment. If the order to certify is verbal, it must be followed within 14 days by a signature.

Recertification
Pursuant to 42 CFR §424.24(c) and 42 CFR §410.61(e), recertifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initial treatment under that plan, unless services are delayed.

APTA encourages CMS to modify or eliminate the plan-of-care 30-day initial certification and 90-day recertification requirements. Compliance with the physician signature requirement is a logistical and administrative burden on therapy providers, taking valuable time and resources away from delivering patient care. In many instances, the plan of care is incomplete, and it may take up to several weeks for the physician to furnish a complete plan of care. Although it is not intended, unsigned plans of care result in therapy providers having to delay treatment while they obtain a physician signature, thus placing the beneficiary at risk and/or hindering the provider's ability to bill for the services rendered. Moreover, in instances of delayed certifications, the therapist must then identify and compile evidence that is necessary to justify the delay, further increasing the burden on the provider.

While the medical record may illustrate the medical necessity of therapy services, CMS will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or if the signature is of marginal or questionable legibility. The administrative burden of this regulation is untenable, and we strongly encourage CMS to modify or eliminate these requirements.

SNF 3-Day Waiver

APTA strongly recommends that CMS modify the SNF 3-day inpatient hospital stay requirement to allow days spent in observation to be considered for satisfying the requirement for Part A coverage of SNF care. Congress has also expressed support for such a policy change, as members in both the House and Senate have introduced the Improving Access to Medicare Coverage Act of 2017 (H.R. 1421/S. 568). The legislation expands the definition of "inpatient" for purposes of the 3-day inpatient stay requirement, and allows time spent in observation to count toward satisfying the requirement.

Telehealth

APTA strongly recommends that CMS exercise its discretionary authority to allow physical therapists to perform telehealth services while participating in alternative payment models, as well as establish a demonstration program to evaluate the clinical benefit of services by physical therapists, occupational therapists, and speech-language pathologists. Allowing providers such as physical therapists to provide telehealth services under Medicare will help reduce health care expenditures, increase access to care, and improve a provider's ability to manage chronic disease in rural and underserved areas. Telehealth services may also help to ensure access to specialized care in isolated rural areas facing difficulties in maintaining and staffing full-service hospitals.[9]

APTA believes CMS has discretionary authority under §1115A of the Social Security Act to allow physical therapists to perform telehealth services while participating in alternative payment models. As noted by MedPAC in its June 2016 Report to Congress, several Center for Medicare and Medicaid Innovation (CMMI) models involving bundled payment and accountable care organizations include coverage of telehealth services broader than the standard Medicare benefit. Within such models, CMS exercised its authority to waive the requirement that benefits offered in these programs be equivalent to the standard benefit. CMS should consider expanding these waivers to include a broader range of telehealth services in either current or future CMMI programs.

We also recommend that CMS establish a demonstration program to evaluate the clinical benefit of physical and occupational therapists, as well as SLPs furnishing telehealth services to Medicare beneficiaries. Many states permit physical therapists, occupational therapists, and SLPs to furnish telehealth services, and these providers do so safely and effectively. 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.

[9] Medicare Payment Advisory Commission June 2016 Report to Congress, Chapter 8. http://www.medpac.gov/docs/default-source/reports/chapter-8-telehealth-services-and-the-medicare-program-june-2016-report-.pdf?sfvrsn=0 (Last accessed July 22, 2017)

In the SNF setting, telehealth therapy services in underserved areas may make the critical difference in preventing falls, functional decline, and costly emergency room visits, and reducing hospital admissions/readmissions.

APTA strongly encourages CMS, through CMMI, to conduct a demonstration to evaluate the clinical benefit of physical therapists, occupational therapists, and SLPs furnishing telehealth services to Medicare beneficiaries in all settings, including SNFs, in states that permit such services. The results of such a demonstration on the Medicare population would help inform policymakers who are considering whether to include physical therapists, occupational therapists, and SLPs as authorized practitioners of telehealth services.

To that end, APTA will continue to work with Congress to secure the appropriate statutory language. We have been steadfast in our advocacy efforts for the passage of the Medicare Telehealth Parity Act (H.R. 2550), which would add physical therapists and several other therapy provider groups to the list of authorized telehealth providers under Medicare. We also are supportive of the CONNECT for Health Act of 2017 (S. 1016/H.R. 2556), which would expand where telehealth can take place, as well as which patients and providers can participate, including physical therapists participating in some bundled payment models, accountable care organizations, and Medicare Advantage plans.

Conclusion

While APTA supports CMS's efforts to enhance payment accuracy relative to patient care needs, APTA's concern is that, as currently proposed, the HHGM would not improve patient care or aid CMS in aligning the home health PPS with its overarching Medicare payment policy goals. We believe the HHGM would create new program integrity issues, compliance challenges for providers, and new access issues for beneficiaries. As currently designed, the HHGM would create barriers to rehabilitative services and lacks guardrails to prevent stinting on therapy, such as outcome measures. Moreover, it does nothing to enhance the agency's goals to shift toward rewarding value-based care. As previously stated, there is no clear evidence that implementation of the HHGM would improve care, nor does it appear to align with CMS's other payment policy initiatives such as adoption of a unified post-acute care payment system.

APTA stands ready to work with CMS to modify the HHGM to ensure that patient access to therapy services is not inappropriately limited and that the model's approach to modify payments improves the ability of HHAs to continue deliver high-quality, timely, cost-effective care to their patients. We thank CMS for the opportunity to comment on the CY 2018 Home Health PPS proposed rule. APTA is eager to actively engage with the agency and participate in future discussions on the HHGM.

Should you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547, Heather Smith, Director of Quality, at heathersmith@apta.org or 703/706-3140, or Sharita Jennings, Senior Regulatory Affairs Specialist, at sharitajennings@apta.org or 703/706-3391. Again, we look forward to working with CMS in making revisions to the proposed policies within this rule to ensure that

Medicare beneficiaries continue to have access to medically necessary physical therapy services within the home health setting.

Thank you for your consideration.

Sincerely,

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

SLD: krg, hls, sj