August 30, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1689-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations (CMS-1689-P)

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments on the Centers for Medicare and Medicaid Services’ (CMS) Calendar Year (CY) 2019 Home Health (HH) Prospective Payment System (PPS) Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise avoidable health care services. Physical therapists’ roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

APTA recognizes that the world of payment reform is dynamic, and to successfully create an alternative payment methodology for home health agencies (HHAs), all facets of payment...
reform must be considered. This includes quality measurement, value-based purchasing, and quality reporting, the development of new payment models, such as bundled payment arrangements and accountable care organizations, and the eventual adoption of a unified post-acute care payment system. As APTA has stated in previous comment letters, the frequency and duration of physical therapy services should be based solely on the needs of the patient. We appreciate CMS’s efforts to address case-mix methodology refinements that represent a more patient-driven approach to payment. However, we continue to have serious concerns that Medicare beneficiaries—particularly those with substantial physical therapy, occupational therapy, and/or speech-language pathology needs—may not receive the level, duration, amount, or frequency of therapy services medically necessary, given the potential economic incentives inherent in this revised case-mix methodology to provide less care for these beneficiaries.

The Patient-Driven Groupings Model (PDGM), much like the Home Health Groupings Model (HHGM), incentivizes providers to avoid certain types of patients for financial or other considerations, which likely will steer patients toward higher-acuity settings. It is imperative that CMS ensure that its approach to modify payments enhances the delivery of high-quality, timely, cost-effective care to home health patients, including higher-complexity Medicare beneficiaries who require substantial therapy resources. Given that the PDGM may perpetuate certain HH PPS complications while also creating new access barriers, we recommend that as CMS moves forward in the process of implementing the PDGM, the agency forms a stakeholder work group—including APTA—to solicit input and engage with CMS in a transparent and meaningful manner. This approach will aid CMS in its efforts to effectuate the PDGM. We respectfully request that you consider our more detailed comments and recommendations provided below.

**APTA Recommendations**

- APTA supports CMS’s proposal to rebase the home health market basket and update the payment rates under the HH PPS by the home health payment update percentage of 2.1%.
- APTA supports implementation of the rural add-on. However, we urge CMS to continue its work developing policies to support improved access to home health care in rural geographic regions.
- APTA recommends that CMS convene a stakeholder work group to assist the agency in its preparations for transition to the PDGM and for post-implementation. The work group should meet on a quarterly basis following implementation of PDGM to solicit input on how PDGM policies are impacting care delivery and patient access.
- APTA supports implementation of the PDGM in a budget-neutral manner.
- APTA continues to have concerns that utilizing Medicare cost-report data to measure resource use will result in inaccurate predictions, and underestimate or overestimate, of the case-mix weights of individual groupings. We recommend that CMS work with the home health industry to ensure that cost reports are standardized and accurate, and that they are used only to predict resource use for each-case mix group until they have been deemed sufficiently accurate for this purpose.
- We support CMS’s intentions to take into consideration behavior changes that could occur as a result of the new case-mix system and the transition from a 60-day
to a 30-day unit. We strongly urge the agency to closely monitor utilization patterns, billing trends, and other associated behaviors following implementation of the PDGM, to ensure beneficiary access is not negatively impacted as a result of the new case-mix system.

- APTA appreciates CMS’s efforts to ensure that HHAs maintain adequate cash flow under the new case-mix system. We support CMS’s proposal that HHAs that are certified for participation in Medicare prior to January 1, 2019 would continue to receive Requests for Anticipated Payment (RAPs) upon implementation of the 30-day unit of payment and the proposed PDGM case-mix adjustment methodology in CY 2020. We also support CMS’s proposal to phase out the split-percentage payment approach, and we recommend that the agency phase it out over a 3-to 5-year period. Until the RAP is eliminated, APTA recommends that CMS require HHAs to submit a Notice of Admission within 5 calendar days of the start of care to ensure other providers receive timely notification of a patient’s assignment to a HHA.

- To better avoid negative impacts on beneficiary access to home health services, APTA recommends that CMS consider the first two 30-day periods “early.” APTA recommends that CMS institute specific protections to ensure that patient access to maintenance therapy is not negatively impacted upon implementation of the new home health case-mix system, such as revising the Home Health Star Ratings to incorporate measures that capture maintenance of condition in addition to improvements in function.

- APTA has concerns that varying payment based on admission source could create access problems for beneficiaries admitted from the community. We recommend that CMS monitor admissions from the community versus from institutions and address any abuses of this proposed policy through future regulation.

- Relying solely on the principal diagnosis to assign a clinical grouping effectively ensures that less therapy will be delivered to a patient assigned to a nonrehabilitation group regardless of functional status, as the resources allocated to such groupings will not align with the patient’s functional needs. APTA strongly recommends that CMS closely monitor therapy utilization under the PDGM to ensure that beneficiaries receive the appropriate amount and type(s) of care, regardless of clinical grouping.

- While APTA supports the tiering of functional levels, we recommend that CMS also include quantitative and qualitative metrics—including meaningful performance-based and patient-reported outcome measures—within the Home Health Quality Reporting Program (QRP) and/or Value-Based Purchasing (VBP) Model that are more closely correlated to the delivery of physical therapy, occupational therapy, and speech-language pathology services. It is imperative that CMS evaluate the impact of PDGM implementation on therapy service delivery patterns in the context of the impact on quality and outcome measures commonly associated with effective rehabilitation services.

- APTA supports CMS’s proposal to provide a low or high comorbidity adjustment for certain 30-day periods of care. However, we encourage the agency to continue to assess whether the comorbidity adjustment amount adequately aligns with patient
characteristics and needs, and whether additional secondary diagnoses not currently captured in the proposed model should be included in the future.

- APTA supports CMS’s proposal to define remote patient monitoring under the Medicare home health benefit. We encourage the agency to clarify whether physical therapists and other qualified health professionals, acting within their scope of practice, will be permitted to use remote patient monitoring to “augment the plan of care during a home health episode.”
- APTA supports CMS’s proposals to modify the Home Health QRP and VBP Program.
- 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 as well as the reporting of stratified outcomes measures to providers to enable them to better understand the effects social risk factors have on their performance.
- On a case-by-case basis, APTA supports the addition of the proposed measure removal factor (Factor 8) for previously adopted QRP measures.
- APTA’s comments in response to the Request for Information (RFI) reflect the issues we have identified as a profession with respect to health IT adoption and interoperability.

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

**CY 2019 HHPPS Rate Update**
APTA supports CMS’s proposal to rebase the home health market basket and update the payment rates under the HH PPS by 2.1%, resulting in an estimated $400 million increase in payments to HHAs in CY 2019.

**Rural Add-on Payments for CYs 2019 through 2022**
APTA supports implementation of the rural add-on through 2022, as it will ensure that HHAs are adequately equipped to serve Medicare beneficiaries in rural areas. HHAs in these regions already face geographical and financial obstacles to providing sufficient care to this Medicare population. However, we have concerns that discontinuing the add-on payment beyond 2022 will likely prevent these agencies from furnishing care to patients with the most critical clinical conditions. Therefore, APTA urges CMS to continue its work to develop policies that support improved access to home care in rural areas. For example, CMS could explore a pilot project that provides Medicare coverage to therapy providers who furnish telehealth services to their patients. Proper application of telehealth rehabilitation therapy services, particularly in underserved areas, can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care. Particularly with the vulnerable home health population, telehealth services may prevent unnecessary hospitalizations or further health complications that may result from restricted access to care.

**Implementation of the PDGM**
APTA appreciates CMS’s efforts to ensure that the case-mix system aligns payment with patient care needs and better ensures that clinically complex and ill beneficiaries have adequate access to
home health care. As CMS moves forward with the process of implementing the PDGM, including updating interpretive guidance, revising relevant manuals, and changing claims processing systems, we encourage the agency to form a stakeholder work group to provide input and engage with CMS in a transparent and meaningful manner. Such a work group, which should include APTA, will support CMS in its efforts to effectuate the PDGM.

APTA also recommends that CMS use this stakeholder group to provide input on how implementation of PDGM is impacting patient access to services. This will allow CMS to maintain an ongoing understanding of how PDGM policies are affecting care delivery and engage in a dialogue on what revisions to PDGM may be necessary to curb any unintended consequences. We also encourage CMS to develop an email mailbox specifically for patients and providers to use to offer feedback on PDGM. Following PDGM implementation, we also recommend that CMS closely monitor the processing of home health claims, to ensure that they are handled appropriately and that providers do not experience processing delays or unwarranted denials.

**Budget-Neutral Implementation**

The overall economic impact of the proposed case-mix adjustment methodology changes, including a change in the unit of service from 60 days to 30 days for CY 2020 results in no estimated dollar impact to HHAs, as Section 51001(a) of the Bipartisan Budget Act of 2018 (BBA) requires such change to be implemented in a budget-neutral manner. APTA strongly urges CMS to implement the PDGM in a fully budget-neutral manner to ensure that beneficiary access to home health services is not inappropriately limited.

**Use of Cost-Per-Minute (CPM) plus (+) Non-Routine Supplies (NRS) to Calculate Cost of Care**

Within the proposed rule, CMS proposes shifting from the Wage Weighted Minutes of Care (WWMC) to a CPM+NRS approach to calculate costs during an episode/period of care based on the concept of resource use. CMS believes using HHA Medicare cost report data, through the CPM+NRS approach, to calculate the costs of providing care better reflects changes in utilization, provider payments, and supply among Medicare-certified HHAs.

As stated in previous comments, APTA continues to have concerns that utilizing Medicare cost report data to measure resource use will result in inaccurate predictions and under-or overestimate, the case-mix weights of individual groups. Research has found long-standing 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, and operating versus non-operating income; and the inclusion of many non-allowable Medicare costs. 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 utilize 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 “Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.” The report says 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, HHS recommends that analysts “apply an estimate of national post-tax wages.”

Therefore, as previously recommended, prior to relying on HHA cost report data to calculate the cost of home health care to align case-mix weights with the relative cost for treating patients, we recommend that CMS work with the home health industry to ensure that cost reports are standardized and accurate and that they are used only to predict resource use for each-case mix group until they have been deemed sufficiently accurate for this purpose.

**Change from 60-Day to 30-Day Unit of Payment**

APTA acknowledges that the BBA requires a switch from a 60-day episode to a 30-day unit of payment under the new case-mix system, effective January 1, 2020. We appreciate that CMS states within the rule that it will take into account behavior changes that could occur as a result of the case-mix adjustment factors being implemented in CY 2020. APTA encourages the agency to closely monitor utilization patterns, billing trends, and other associated behaviors following implementation of the PDGM, to ensure that beneficiary access is not negatively impacted as a result of the new case-mix system, particularly the switch from a 60-day episode to a 30-day unit of payment.

**Split Percentage Payment Approach for 30-Day Unit of Payment**

CMS seeks feedback on ways to phase-out the split percentage payment approach in the future given that CMS is required to implement a 30-day unit of payment beginning on January 1, 2020.

APTA appreciates CMS’s efforts to ensure that HHAs maintain adequate cash flow under the new case-mix system. APTA supports CMS’s proposal that HHAs certified for participation in Medicare with effective dates prior to January 1, 2019 would continue to receive the RAP upon implementation of the 30-day unit of payment and the proposed PDGM case-mix adjustment methodology in CY 2020. We also support CMS’s proposal to phase out the split-percentage payment approach and recommend that the agency phase it out over a period of three to five years. However, prior to, or in conjunction with the phasing out of the split-percentage payment approach, we strongly recommend that CMS require HHAs to submit a Notice of Admission within five calendar days of the start of care or endure a penalty to ensure that the proper agency is established as the primary HHA for the beneficiary and so that the claims processing system is alerted that a beneficiary is under an HHA period to care to enforce the consolidated billing edits required by law.

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Frequently, Medicare beneficiaries who are admitted to a home health Part A stay also seek outpatient physical therapy. However, numerous HHAs delay submitting the RAP to CMS, thus resulting in a beneficiary eligibility database that is out-of-date and does not accurately reflect the beneficiary’s status. Due to this delay in submitting RAPs, outpatient physical therapy providers unknowingly furnish therapy services to Medicare beneficiaries who are under a home health plan of care. Consequently, claims for such services are denied and/or overpayments are recouped.

Many of our members have communicated to APTA their concerns with the Common Working File (CWF) and the inaccuracies in the real-time beneficiary eligibility data. We instruct our members to ask the beneficiary about his or her status, check the CWF prior to delivering services, check the CWF prior to submitting a claim, check the CWF in advance of any subsequent visits, and continue to do so on a regular basis. Despite such suggestions, physical therapy private practices continue to report claim denials and overpayment recoupments for patients who are consequently deemed under a home health plan of care on the dates of service at issue.

To better understand the burden being imposed on physical therapy private practices as a result of the out-of-date CWF, APTA’s Private Practice Section recently surveyed more than 200 member physical therapists. Of those surveyed:

- 85% indicated that they had been denied payment or had to refund payment for services furnished to Medicare beneficiaries who were under a home health plan of care.
- When asked the dollar amount for both denials and refunds in the last 2 years:
  - 35% said the dollar amount equated to $500 to $1,000;
  - 24% indicated $1,000 to $2,500;
  - 18% stated $2,500 to $5,000; and
  - 6% stated more than $5,000.
- 97% of respondents stated that they ask the patient if they are under a home health plan of care; 72% of these respondents also check the CWF.
- With regard to appeals, 47% state that they have appealed, and more than half of those say they were not successful.
- Working with the HHA and getting the correct paperwork from these agencies seems to be key in some successful appeals; however, some respondents report that this does not help and their appeals continue to be denied.
- Provider frustration is evident throughout the survey.

Action to address this issue clearly is warranted, given that the financial motivation offered by a RAP to “claim” a patient does little to encourage some HHAs to act in a timely manner; the result being increased administrative and financial burdens on outpatient therapy providers. It is unfair for a provider’s actions or inactions to negatively impact another provider’s ability to deliver care. Therefore, APTA recommends that, similar to the Notice of Election that hospice providers must submit within 5 days of the start of care, CMS require HHAs to submit a Notice of Admission within 5 days of the start of care or endure a financial penalty. While submitting a Notice of Admission or facing a penalty may be perceived as a burden, it is critically important that agencies are held accountable for admitted patients. Moreover, this “new” burden will be mitigated by a decline in phone calls and communications with outpatient therapy providers.
attempting to verify a beneficiary’s status. Similarly, the administrative and financial burdens caused by phone calls, written communications, claim denials, appeals, and engagement in the overpayment recoupment process all will be reduced for outpatient therapy providers.

**Timing Categories**
CMS proposes to classify the 30-day periods under the proposed PDGM as “early” or “late” depending on when they occur within a sequence of adjacent 30-day periods. CMS proposes that only the first 30-day period in a sequence be defined as “early,” and all subsequent 30-day periods would be considered “late.” Additionally, the definition of a home health sequence will remain unchanged relative to the current system.

As stated in previous comment letters, APTA encourages CMS to mirror the current system’s 60-day period episode timing, in that the first two 30-day episodes of a sequence are considered early. We recognize that the data does not support defining the first two 30-day periods as early, given that only the first 30-day period presents marked increase in resource use. However, by shifting from a 60-day unit to a 30-day unit and reducing the case-mix weight for “late” episodes, we anticipate gross reductions in the delivery of services for both rehabilitative therapy and maintenance therapy, the latter a covered Medicare service that many agencies continue to misunderstand and underutilize. As discussed in further detail below, we have concerns the PDGM may fail to safeguard against stinting of therapy services, particularly for patients whose principal diagnosis fails to result in a rehabilitation clinical grouping. We strongly urge the agency to monitor utilization patterns and trends of home health admissions, discharges, and the delivery of therapy services.

**Implications for Maintenance Therapy**
The *Jimmo v. Sebelius (Jimmo)* settlement confirmed the availability of Medicare coverage for skilled services to maintain an individual’s condition. However, APTA has concerns that the *Jimmo* settlement is not reflected within CMS’s proposed home payment reform proposal. We are disappointed that the proposed payment model, much like the HHGM, fails to improve upon the flaws within the current home health payment system as it relates to delivering maintenance therapy. We anticipate this will continue to lead to a decline in maintenance therapy services that are designed to stabilize beneficiaries.

Maintenance therapy provides stabilization for patients, preventing decline in their 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. APTA appreciates the Home Health Star Ratings incorporate outcome of care measures that illustrate improvement in function, thus incentivizing agencies to deliver appropriate amounts of therapy. However, as discussed above, maintenance therapy is underutilized in the current home health payment system. To better promote beneficiary access to maintenance therapy, APTA strongly urges CMS to consider any and all incentives that encourage HHAs to deliver maintenance therapy under the PDGM. For example, we recommend that CMS incorporate an outcome of care measure within the Home Health Star Ratings that positively accounts for maintaining a patient at maximum practicable level of function. Alternatively, patients who receive maintenance therapy as illustrated on the claim should be excluded from the calculation of improvement in function outcome of care measures.
**Admission Source Category**

*Payment Differential Could Lead to Access Issues*

Here, CMS proposes instituting a payment differential based on admission source – community versus institution. As previously stated, APTA has concerns that varying payment based on admission source could create access problems for beneficiaries admitted from the community. There is a serious risk that differentiating payment based on admission source may inappropriately incentivize admissions from the institution rather than the community. With a strengthened effort to avoid patient hospitalization and readmissions, in addition to a growing focus on keeping patients in the community and treating them at home, it is counterproductive to devalue admissions to home health from the community.

It is critically important that the agency institute policy changes that incentivize the delivery of care to residents “in place.” Treating in place can be an effective strategy to improve the delivery of care, beneficiary outcomes and quality of life, and downstream resource utilization. We anticipate that in the future, a greater number of patients will be admitted to home health from the community, including patients with complex conditions. Given the impending shift in costs in future years, we recommend that CMS adjust the community and institutional weights annually based on costs. We also urge CMS to closely monitor admissions from the community versus institution, and address any abuses of policy through future regulation.

*Medical Review of HHA Claims Associated With Acute or Post-Acute Care (PAC) Denials*

CMS proposes creating new occurrence codes, which would allow HHAs to manually indicate on Medicare home health claims that an institutional admission had occurred prior to the processing of an acute or post-acute Medicare claim, if any, in order to receive the higher payment associated with the institutional admission source sooner. CMS also proposes that if upon medical review, after finding no Medicare acute or PAC claims in the National Claims History and finding that an HHA is systematically including occurrence codes that indicate the patient’s admission source was “institutional,” but no documentation exists in the medical record of Medicare or non-Medicare stays, CMS would refer the HHA to the zone program integrity contractor (ZPIC) for further review. CMS also intends to consider targeted approaches for medical review after the implementation of the admission source element of the PDGM.

APTA appreciates that CMS took into consideration our recommendation that the agency adopt an equitable approach toward conducting medical review of home health claims. We support CMS’s proposal to consider targeted approaches for medical review for HHAs that have claims consistently associated with acute or PAC denials or whose utilization pattern of acute or PAC occurrence codes is aberrant when compared with their peers, or other such metrics that would facilitate any targeted reviews. Further, we appreciate CMS’s clarification in the proposed rule regarding how HHAs should verify a non-Medicare institutional stay and the timeframe under which a HHA would have to resubmit a home health claim when it learns of a non-Medicare institutional stay. However, APTA requests that for the first 1-2 years following PDGM implementation, CMS consider exempting from medical review agencies that consistently have claims associated with denials of non-Medicare institutions, given the inherent difficulties associated with accurately assessing whether the non-Medicare institutional stay satisfied the payer’s coverage requirements.
Clinical Groupings
Under the PDGM, CMS proposes grouping periods into 1 of six clinical groups based on the primary reason for the home health period of care, based upon the principal diagnosis reported on the claim. 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)

As previously expressed to the agency, APTA has serious concerns that reliance on the principal diagnosis to categorize a patient into a clinical grouping 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. We urge CMS to discuss within final rulemaking how it intends to ensure that HHAs do not upcode or inappropriately assign a clinical grouping for financial gain.

Moreover, we urge CMS to recognize that a principal diagnosis does not necessarily drive the type of care a patient receives. For example, physical therapists do not treat the diagnosis; rather, they treat the consequences that result from the causes of disease, disorders, and injury, focusing on differential evaluation and the treatment of dysfunction. These are the movement system impairments, functional limitations, and participation restrictions that flow from the principal diagnosis. Using their expertise in movement science, physical therapists identify key factors that underlie movement and movement dysfunction, which are most often separate from the medical condition.

APTA has serious concerns that adopting clinical groupings that categorize patients based on principal diagnosis, specifically adopting two “rehabilitation” groupings and four non-rehabilitation groupings, strongly implies physical therapy only is appropriate for beneficiaries with a principal diagnosis that results in a rehabilitation grouping. A single diagnosis may not provide sufficient basis for assigning a clinical grouping, nor will it help to align payment with patient characteristics that would benefit from physical therapy, occupational therapy, and/or speech-language pathology services. In fact, it may lead to inappropriate underutilization of such services. We have serious concerns the clinical groupings undervalue the financial and clinical importance of physical therapy, occupational therapy, and speech-language pathology services and do not adequately reflect the roles physical therapists, occupational therapists, and/or speech-language pathologists play in treating patients across the spectrum of conditions, including the growing number of Medicare beneficiaries with multiple chronic conditions who need therapy in the home care setting. Therefore, APTA recommends that CMS modify the clinical groupings so that additional diagnoses can be used for categorization into a clinical group to better ensure appropriate assignment.

We recognize that CMS expects the ordering physician, in conjunction with the therapist, to develop and follow a plan of care for any home health patient, regardless of clinical group.
However, patients not categorized into a rehabilitation grouping but who require physical therapy, occupational therapy, or speech-language pathology services may be at risk of receiving an inordinately low level of rehabilitation due to the allocation of resources to address those patients’ other conditions. Patient characteristics between the musculoskeletal and neuro/stroke rehabilitation groups determine whether resources are directed toward preventing the loss of function, improving or restoring function, compensating for lost function, or maintaining current function. As such, we question the likelihood that resources will be directed toward preventing a patient’s loss of function or maintenance of current function if the patient’s characteristics indicate there is a need for therapy but the principal diagnosis results in that patient’s assignment to 1 of the 4 non-rehabilitation groups. This could result in a decline in access for patients who are deemed less profitable, such as those who require medically necessary therapy services but who are not categorized within either of the “rehabilitation” clinical groupings.

Accordingly, we have serious concerns that Medicare beneficiaries’ functional outcomes may significantly decline following PDGM implementation. Research shows a significant correlation between volume of therapy and improvement in mobility.\(^3\) However, adoption of the PDGM could reverse the progress in patient outcomes that was seemingly ignited by a “financial incentive” to increase therapy visits versus skilled nursing visits.\(^4\) To that end, we question whether CMS has evidence that illustrates that under the current payment system, Medicare beneficiaries have quantitatively or qualitatively received an inordinate amount of therapy that was not appropriate for their condition(s), or that the functional outcomes of Medicare beneficiaries receiving home health services have suffered.

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, regardless of functional level, given HHAs will 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 high comorbidity adjustment is afforded a case-mix weight of 1.4785, whereas a musculoskeletal grouping, high functional level, early episode, community admission, with a high comorbidity adjustment is afforded a case-mix weight of 1.5691.

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 utilize those resources in a manner that addresses the principal diagnosis that warranted placement into the MMTA, leaving fewer resources available to deliver the appropriate volume of rehabilitation. Consequently, the PDGM creates a new financial incentive, to underutilize therapy services. Given the ever-increasing effort to promote the delivery of care in the home/community setting, it is imperative that the Medicare program continues to incentivize providers to deliver care in non-facility based settings while also ensuring that patients may

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continue to receive the highest quality of care that aligns with their preferences, desires, and needs.

APTA encourages CMS to remain mindful of the real potential of significant underutilization of therapy services. While we appreciate that CMS intends to examine trends in reporting and resource utilization to determine if future changes to the clinical groupings are needed following implementation of the PDGM, the agency should strongly consider incorporating formal safeguards into the new case-mix system to ensure that patients receive the appropriate amount and type(s) of care, regardless of clinical grouping. As discussed in further detail below, we recommend that CMS use mechanisms currently in existence to hold providers accountable for the delivery of appropriate, medically necessary care. Without the use of such tools, the PDGM effectively ensures that the provision of physical and other therapies to Medicare beneficiaries will be severely limited, due to the financial disincentives associated with delivering physical therapy, occupational therapy, and speech-language pathology services. This is illustrated in Table 61 in the proposed rule, which shows that patients whose primary reason for home health is therapy to address musculoskeletal or neurological condition are less financially advantageous under the PDGM than they are under the current home health payment system. We request that CMS provide a detailed discussion within the final rule regarding how it intends to accurately monitor and regulate, within real-time, how the delivery of therapy services aligns with each patient’s characteristics and clinical needs, and what efforts the agency will undertake to curb any abuses of the new system.

Finally, we recommend that CMS consider expanding the clinical groupings to include a cardiovascular category. The number of beneficiaries admitted to home health with cardiovascular diagnoses is substantial. We recognize that the MMTA category is designed to capture patients with oncology, infection, respiratory, and cardiovascular diagnoses. Nonetheless, given the high number and complex types of therapy interventions needed by patients with cardiovascular conditions, a cardiovascular category within the PDGM may result in a more accurate resource utilization prediction under the new case-mix system.

**Functional Levels and Corresponding to Outcome and Assessment Information Set (OASIS) Items**

APTA supports CMS’s proposal to require the use of multiple OASIS items to assess functional impairment level: low, medium, or high. We also support CMS’s statement that it will examine the effects of all OASIS items, including Section GG function items, on resource use to determine if refinements to the new case-mix system are appropriate. We recommend that the agency study and validate the predictive capability of such items prior to pursuing any refinements to the PDGM’s functional level category. It is critical that CMS is confident in the capability of Section GG functional items to sufficiently predict functional impairment level and associated resource use.

**Mechanisms to monitor delivery of therapy services**

CMS states within the rule that concerns regarding HHAs changing the way they provide services to eligible beneficiaries, specifically therapy services, should be mitigated by the functional impairment level adjustment, as the case-mix payment adjustment is reflective of the resource costs associated with these reported OASIS items and therefore ensures greater payment
accuracy based on patient characteristics. CMS states this approach will help to maintain and could potentially increase access to needed therapy services.

It is imperative that CMS evaluate the impact of PDGM implementation on therapy service delivery patterns in the context of the impact on quality and outcome measures commonly associated with effective rehabilitation services. Therefore, APTA recommends that CMS clarify within the rule how it intends to ensure that beneficiaries will continue to receive an appropriate amount of therapy, whether the beneficiary’s functional impairment is low, medium, or high. While APTA believes that most HHAs will continue to deliver home health services based on patient characteristics and care needs following implementation of the PDGM, it is unclear how CMS intends to monitor beneficiary access to home health services, including therapy, is not restricted while also confirming provider compliance with Medicare regulatory requirements and guidelines.

We strongly recommend that CMS collect data on therapy provision to assure that residents are receiving therapy that is reasonable, necessary, and specifically tailored to meet their unique needs under the new case-mix methodology. As such, we encourage CMS to closely monitor service units associated with each therapy revenue code reported on the claim and compare utilization under the current payment system versus under the PDGM. If an agency exhibits a statistically significant decline in reported therapy services among any or all of the disciplines, CMS would issue a warning that it is regularly monitoring therapy utilization and the HHA may be subject to medical review in the future if this trend continues. In addition to monitoring therapy utilization and flagging providers for additional review, the agency also must be willing to make future proposals to address any abuses of the new case-mix methodology.

Although the agency may be intending to rely on the Home Health QRP and/or Home Health VBP Program to hold providers accountable and ensure that the most qualified health care professionals are delivering services they are trained to provide, neither are sufficient, or timely, for ensuring the delivery of all medically necessary services, including physical therapy. For example, 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 VBP Program will have on provider behavior. Moreover, given that the program is being tested under the current home health payment system, any data collected prior to implementation of the PDGM likely will be ineffective at predicting how the VBP program will regulate behavior under the PDGM.

However, if CMS intends to utilize the QRP and VBP Programs to monitor and regulate provider behavior, APTA recommends the agency first incorporate more robust functional measures, which may be captured using patient-reported outcome measures or performance-based instruments that are more closely correlated to the delivery of physical therapy, occupational therapy, and/or speech-language pathology services. Specifically, we recommend that in evaluating the impact of PDGM implementation on therapy service delivery patterns, CMS do so in the context of the impact on measures that are commonly associated with effective rehabilitation services.

Assessing therapy delivery and utilization with setting-appropriate quality measures, including meaningful performance-based and patient-reported outcome measures that address the domains
of function, cognitive function, and changes in function will assist CMS in its efforts to ensure that coordinated, patient-specific, evidence-based care is being delivered safely and effectively in the home care setting. Measures should reflect 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.

**Comorbidity Adjustment**
CMS proposes to provide either a low-comorbidity or high-comorbidity adjustment to 30-day periods of care for which secondary diagnoses are reported. A single secondary diagnosis that falls within a list of 11 comorbidity subgroups could qualify the patient for a low-comorbidity adjustment; 2 or more secondary diagnoses that potentially could interact could result in a high-comorbidity adjustment. If there are no secondary diagnoses reported, then the 30-day period would receive no adjustment.

APTA appreciates CMS’s proposal to provide a low- or high-comorbidity adjustment for certain 30-day periods of care. We thank the agency for taking into consideration our recommendations to modify the comorbidity adjustment proposal. We also support CMS’s future efforts to examine the relationship of reported comorbidities on resource utilization and make the appropriate payment refinements to help ensure that payment aligns with the actual costs of providing care. However, we encourage the agency to continue to assess whether the comorbidity adjustment amount adequately aligns with patient characteristics and needs, and whether additional secondary diagnoses not currently captured in the proposed model should be included in the future.

**HH PPS Case-Mix Weights Under the PDGM**
APTA strongly urges CMS to formalize a transparent process and timeline to refine the case-mix weights soon after PDPM implementation, to assess whether various factors will influence the ability of the model to better predict resource use, including Section GG items effectuated January 1, 2019, and additional secondary diagnoses. It is imperative that the case-mix weights reflect current care protocols and resource needs, and that details of this plan are included within final rulemaking.

**Proposed Change Regarding Remote Patient Monitoring Under the Medicare Home Health Benefit**
APTA supports CMS’s proposal to define remote patient monitoring under the Medicare home health benefit as “the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the HHA) and to include the costs of such monitoring as an allowable administrative cost. Within the rule, CMS also states that remote patient monitoring is not considered a Medicare telehealth service, but rather that it “uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.”

APTA requests that CMS clarify whether the agency intends that physical therapists and other qualified health professionals, acting within their scope of practice, may use remote patient monitoring to “augment the plan of care during a home health episode.” Given that remote patient monitoring is not a telehealth service, and the HHA would only be responsible for
collecting the data to better identify changes in condition and monitor compliance we believe a variety of qualified health care professionals, including physical therapists, should be permitted to use remote patient monitoring as a mechanism to enhance upon care delivery.

**Home Health VBP Program**
CMS proposes changes to the Home Health VBP Program. Beginning with Payment Year 4, CMS proposes to remove two OASIS-based measures, Influenza Immunization Received for Current Flu Season and Pneumococcal Polysaccharide Vaccine Ever Received, from the set of applicable measures; replace three OASIS-based measures (Improvement in Ambulation-Locomotion, Improvement in Bed Transferring, and Improvement in Bathing) with two proposed composite measures on total normalized composite change in self-care and mobility; change how it calculates the Total Performance Scores by changing the weighting methodology for the OASIS-based, claims-based, and HHCAHPS measures; and change the scoring methodology by reducing the maximum amount of improvement points an HHA could earn, from 10 points to 9. CMS also is providing an update on the progress towards developing public reporting of performance under the VBP Program and seeks comment on what information should be made publicly available.

APTA supports CMS’s proposed changes to the VBP Program and encourages the agency to finalize the changes as proposed.

**Home Health QRP**
CMS proposes to update its policy for removing previously adopted Home Health QRP measures and to adopt eight measure removal factors to align with other QRPs; remove seven measures beginning with the CY 2021 Home Health QRP; and update its regulations to clarify that not all OASIS data is required for the QRP. CMS also proposes to increase the number of years of data used to calculate the Medicare Spending per Beneficiary measure for purposes of display from one year to two years.

APTA supports CMS’s goal of improving the quality of health care for Medicare beneficiaries. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, it is essential that a core set of functional measures to assess patients consistently across the continuum of care be developed in the near future.

**Accounting for Social Risk Factors**
APTA recognizes that adjusting for social risk factors in certain outcome measures is a complex issue. We appreciate 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, outcomes 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 publicly reported outcome measures can be misleading to consumers.
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. We support CMS’s discussion to consider options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. Additionally, we support CMS’s efforts to consider options to address equity and disparities in its VBP programs. APTA is pleased that CMS will continue to work with ASPE, the public, and other stakeholders to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences. 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 outcomes measures.

Proposed New Measure Removal Factor for Previously Adopted Home Health QRP Measures

CMS proposes to adopt an additional factor to consider when evaluating potential measures for removal from the Home Health QRP measure set: Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program.

APTA supports the addition of this measure removal factor for previously adopted QRP measures on a case-by-case basis. We agree with CMS’s assertion that when the costs outweigh the evidence supporting the continued use of a measure in the Home Health QRP, it may be appropriate to remove the measure from the program.

Interoperability RFI

APTA appreciates the opportunity to provide feedback in response to CMS’s RFI on interoperability. After careful consideration, we offer the following suggestions:

1. If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

The proposed standards to require the electronic exchange of patient medical records would help to prevent information blocking by providers and ensure patient access to their records and the sharing of information with other providers. However, the proposed policies fail to create the same obligations for EHR vendors to ensure that they make patient information readily accessible to patients and providers. This unbalanced treatment of health care providers and EHR vendors can make it difficult, if not impossible, for providers to satisfy the proposed requirements to increase interoperability.

APTA supports CMS’s proposals to ensure that providers make health information accessible to patients and other providers. However, we recommend that the agency, along with the Office of the National Coordinator (ONC), explore similar standards for EHR vendors as conditions of their certification. We also encourage CMS and ONC to update EHR certification criteria to require EHR vendors to attest that they will not interfere with the exchange of patient data between providers and patients and that they
will address in a timely manner complaints from providers and patients regarding the exchange of and access to patient data.

2. Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

Rather than revise the existing CoPs, we recommend that CMS require acute care hospitals to comply with the QRP requirements of the IMPACT Act, along with the applicable penalties for failure to comply. Doing so would extend the current interoperability steps seen in post-acute settings across the entire continuum of care. At the same time, a hospital would not lose the right to accept patients (not a CoP) and would still suffer penalties for not sharing this information across the continuum. It is important to note that hospitals and ambulatory doctors have received meaningful use dollars that were not provided to post-acute care settings. Even so, post-acute settings are now required to increase interoperability via the IMPACT Act, whereas hospitals and ambulatory clinics are not identified in the IMPACT Act. In essence, there are unfunded mandates placed on post-acute settings. Even so, the greatest transition of care risk is from the acute hospital setting to any other setting. Post-acute providers have EHRs that are capable of receiving data; however, it is difficult for hospitals to share the data. While we disagree with the idea of mandating interoperability via the CoPs, we agree that CMS should put forth a policy to incentivize this data transaction, with no cost to post-acute providers.

With that said, we have concerns as to whether this would benefit or harm private physical therapy practices. For instance, the physical therapy practice could be pressured by the hospital to become part of the health information exchange if the practice wants access to the data. However, the fees to join the health information exchange could be too high for the private practice; hence, the private practice could be faulted for blocking information sharing, due to circumstances outside of its control.

Moreover, we recommend harmonization of data elements across all settings with the ability to capture the functional status of the patient and the outcome based on the care provided. Hospitals and other providers should be able to share information on the patient’s goals and preferences, and on preparing patients and, as appropriate, their caregivers/support person(s) to be active partners in their post-discharge care. This would help to ensure effective patient transitions from hospital to post-acute care while planning for post-discharge care that is consistent with the patient’s goals of care and treatment preferences, as well as reduce the likelihood of hospital readmissions.

We recommend that CMS create standardized data elements for discharge and transfer that incorporate information regarding functional status across settings. The patient’s ability to function and participate in society is critical to obtaining positive outcomes. A growing percentage of the US population has disabling conditions that limit their ability to carry out the major activities of their age group. As the number of older adults
increases, their vulnerability to injury and limitations of their activities of daily living increase as well. The result is an escalation of the utilization of health care resources. A focus on ensuring that individuals remain independent and functioning members of society throughout their lives will lessen the burden of disability on health care resources.

3. **Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?**

Depending on the timeframe for implementation, the use of non-electronic forms should be permitted. We suggest that CMS offer a transitional timeline to allow providers adequate time to implement and adopt interoperability. As CMS implements new and revised CoPs, we also recommend that the agency consider the variety of care settings in which interoperability will be adopted, as this type of mandate could negatively impact providers that are rural and lack internet connectivity. For example, rural providers that use a satellite dish for their internet connectivity cannot achieve speeds fast enough to support EHR systems. Further, the cost to acquire a cable connection can be more than $50,000 due to the providers’ geographic location. Other providers, such as physical therapists, will also require a transition timeline to obtain and integrate EHR technology for their practices.

4. **What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?**

APTA recommends that CMS afford small and rural practitioners and practices an exception to the interoperability and health information exchange requirements. Providers and practices in rural areas often cannot acquire the necessary technology to support EHR systems at a reasonable cost, causing financial hardship. We do recognize, however, that CMS’s goal is to encourage as many providers as possible to improve interoperability across care settings. To encourage more providers beyond hospitals and post-acute care facilities to satisfy the interoperability and health information exchange requirements, we recommend that CMS offer financial incentives to these providers.

5. **We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records.**
While APTA supports CMS efforts to increase patient access to their health data, we also have concerns that increasing access simultaneously increases the risk of unwanted disclosure of that health data. We therefore encourage CMS to implement increased safeguards to prevent data breaches and educate patients on protecting the privacy of their health data.

6. **To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public’s ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers.**

APTA recommends that CMS describe in detail what is intended by “fully interoperable health IT and EHR systems for Medicare.” We encourage the agency to ensure that all patient health data be stored and accessed from one single database, to avoid inconsistencies that may occur with multiple databases of patient information. Further, we recommend that the IT and EHR system include secure verification processes and systems to verify providers and patients who wish to retrieve patient data. Finally, we recommend that the agency work with state Medicaid agencies to resolve any barriers that exist for the sharing of health data across state lines. We support the move to a fully interoperable health system; however, many federal and state regulatory barriers will first need to be addressed to allow for data between states, providers, patients, and their families.

7. **We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.**

Physical therapists and physical therapy practices are a critical component of the medical network across the care continuum. To date, physical therapists in private practice have not formally been included in the meaningful use/promoting interoperability program, and facility-based physical therapists are not as exposed to these regulations in the facility setting. Our comments reflect the issues we have identified as a profession with respect to IT adoption and interoperability. Hence, physical therapists may need additional time to obtain EHR systems and the technical and financial capacity to collect
and share electronic health care data. APTA encourages CMS to address the health IT adoption and interoperability needs of physical therapists and physical therapy practices as the agency moves to adopt the new and revised standards. We urge the agency to consider financial incentives to alleviate the costs that physical therapists will no doubt face in complying with new interoperability requirements. We look forward to more opportunities to work with CMS to address solutions to alleviate the burden on specialty providers who have not yet been included in previous EHR incentive programs.

**Conclusion**
We thank CMS for the opportunity to comment on the CY 2019 HH PPS Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements proposed rule. While APTA supports CMS’s efforts to enhance payment accuracy with patient care needs, we believe the PDGM may create new program integrity issues, compliance challenges for providers, and access issues for beneficiaries. APTA would greatly appreciate the opportunity to work with CMS as it implements the PDGM to ensure beneficiary access to therapy services is not inappropriately limited and the agency’s approach to modify payments improves the ability of HHAs to continue to deliver high-quality, timely, cost-effective care to Medicare beneficiaries. APTA looks forward to working with the agency in implementing the proposed PDGM to ensure that Medicare beneficiaries have access to medically necessary physical therapy services within the home health setting. If you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547.

Thank you for your consideration.

Sincerely,

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

SLD: krg