American Physical Therapy Association

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August 26, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1450-P
P.O. Box 8106
Baltimore, MD 21244-8016

Submitted Electronically

RE: CMS-1450-P; Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses; Proposed Rule

Dear Administrator Tavenner:

On behalf of the American Physical Therapy Association (APTA) and its 82,000 member physical therapists, physical therapist assistants, and students of physical therapy, I am submitting comments regarding the Medicare Home Health Prospective Payment System (HH PPS) proposed rule for Calendar Year (CY) 2014. Physical therapy is one of the qualifying services under the home health benefit and comprises a large portion of the therapy furnished to patients in the home health setting. Therefore, we are very interested in the proposed policies contained within this rulemaking and the impact they will have on our membership and the patients they serve.

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

APTA has worked diligently to ensure that CMS has a comprehensive picture of the services that physical therapists provide under the Medicare home health benefit. APTA

has also undertaken significant educational outreach efforts to ensure that physical therapists and physical therapists assistants understand how to comply with Medicare home health laws and regulations. In recent years, we have worked extensively with CMS on the implementation of OASIS C, the regression equation model for home health therapy threshold levels, and therapy coverage requirements.

Therefore, we respectfully request that the Agency give the following comments careful consideration.

Rebasing the National, Standardized 60-Day Episode Payment Rate, Low-Utilization Payment Adjustment (LUPA) Per Visit Amount, and Non-routine Medical Supply (NRS) Conversion Factor

The Affordable Care Act mandated that CMS, starting CY 2014, apply an adjustment to the 60-day national, standardized episode that reflects factors such as changes in the number of visits, the mix of services, the level of intensity of services in an episode, the average cost of providing care per episode and any other relevant factors. This process is called rebasing and must take place over a four-year period in equal increments not to exceed 3.5 percent.

CMS concludes that a -13.63 percent reduction in the episode payment rate is warranted. Therefore, CMS proposes to reduce payments in each year from CY 2014 to CY 2017 by 3.5 percent. CMS determined that the per-visit, per-discipline cost for LUPA episodes is higher than the 2013 per-visit payment rates. The rates exceeded the per-visit rates by as much as 33.1 percent. CMS proposes to increase the per-visit payment rates for LUPA episodes by 3.5 percent every year for 2014 to 2017.

APTA is very concerned about these additional cuts to the home health 60-day payment episode and how these reductions will translate to quality of care. As we have previously articulated in earlier comments, we strongly urge CMS to further examine the underlying causes of factors such as the growth in the number of visits, mix of services and necessary resources. APTA believes that the proportional increase in physical therapy services is due to both a decrease in other services such as nursing and aide services and a change in patient characteristics and rehabilitation needs as patients are being admitted to home health with more complex conditions. Therefore, we strongly recommend that CMS not finalize this rebasing proposal but in the alternative, start the development of a new payment methodology for the therapy component of the HH PPS that accurately bases payment on the severity of the patient and the necessary resources to treat the condition at the requisite level of intensity.

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

retrospective system creates barriers to care and unnecessary administrative burdens for providers.

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

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

CMS has begun this work for the therapy component of payment under the Skilled Nursing Facility PPS, and we strongly urge that this critical undertaking extend to the HH PPS reform.

Secondly, APTA is concerned about the proposal to increase payments for LUPA episodes and the resulting impact on utilization of therapy services. Once again, we believe that real reform to develop a new therapy payment methodology must take place first before substantial changes to the HH PPS payment structure are implemented. Furthermore, we caution CMS to consider the incentives this policy may pose to provide minimal therapy to patients; therefore hindering patient access to medically necessary therapy services.

In the HH PPS CY 2012 final rule, CMS revised the case-mix weights by lowering the relative weights for episodes with high therapy and increasing the weights for episodes with little or no therapy. We believe that this policy coupled with the proposed increase to LUPA payments will encourage HHAs to stint therapy services to Medicare beneficiaries receiving care under the home health Part A benefit and further exacerbate the issue of "cherry-picking" in the post-acute care settings.

Proposed CY 2014 Rate Update

CMS proposes to add two claims-based measures to the home health quality reporting program; rehospitalization during the first 30 days of home health and emergency department use without hospital readmission during the first 30 days of home health. The

first measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases in which the patients who had an acute inpatient hospitalization during the 30 days following the start of the HH stay. The second measure focuses on cases in which the patients who had acute inpatient hospitalization in the 5 days before the start of a HH stay used an emergency department but were not readmitted to an acute care hospital during the 30 days following the start of a HH stay.

APTA strongly supports initiatives to improve the safety and quality of patient care. We are committed to encouraging physical therapists to participate in quality improvement and patient safety programs, including those that focus on reducing hospital readmissions. As approximately, 20% of all Medicare patients are readmitted within 30 days of an acute care discharge and readmissions account for an estimated $17 billion in health care spending, this is an issue that demands immediate attention.

APTA supports the proposed home health measures of acute care utilization: acute care hospitalization, and emergency department use with hospitalization. As there are factors well beyond the control of the home health agency that could affect a return to the acute care setting, we also support a risk adjustment methodology that attempts to capture some of these factors. Therefore, we are pleased to see that the risk adjustment methodology takes into account factors that may influence a patient's decision to access acute care such as health status and disability status.

Payment Reform: Home Health Study

The Patient Protection and Affordable Care Act of 2010 mandates that CMS conduct a study on HHA costs required to provide ongoing access to care to low-income Medicare beneficiaries for beneficiaries in underserved areas with varying levels of severity of illness. A report is due to Congress no later than March 1, 2014. CMS has done extensive work with its contractors L&M Policy Research and subcontractors Avalere, Mathematica and Social Scientific Systems to develop an analytic plan, perform detailed analysis and possible recommendations. CMS plans to provide updates on this work in future rulemaking and other appropriate venues.

APTA strongly believes that physical therapists and other home health clinicians should be active participants in the collection and analysis of data gathering in the study. APTA is more than willing to provide CMS with physical therapists who can serve in this capacity as the Agency begins its work. Therefore, we recommend that CMS provide updates to the stakeholder community on the plan and design of the study, as they are available in a similar manner to the Special Open Door Forum that was held earlier this year regarding the mandate to conduct the study.

<u>Conclusion</u>

APTA thanks CMS for the opportunity to comment on the Home Health Prospective Payment System Rate Update Proposed Rule (CY 2013), and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality

health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director, Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

Paul Rockar, Jr. PT, DPT, MS
President

PR: rdd