September 6, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1353-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically

RE: File code: CMS-1353-P Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2012

Dear Dr. Berwick:

On behalf of our 79,000 member physical therapists, physical therapist assistants and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments in response to the Medicare Home Health Prospective Payment System (HH PPS) proposed rule for calendar year (CY) 2012 published in the *Federal Register* on July 12, 2011. 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. 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.

The physical therapist also instructs patients and caregivers in areas that will help to address specific impairments, activity limitations, participation restrictions, and environmental factors. This may include instruction in the use and performance of therapeutic exercises, functional activities and assistive or adaptive devices, including prosthetics and orthotics. Additionally, the physical therapist determines the priority needs, initiates the physical therapy program and communicates with other personnel and caregivers to ensure that there is adherence to the home program.

Since the implementation of the HH PPS and OASIS, 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 stand ready to work with the Agency as it seeks to refine and finalize the policies set forth in this proposed rulemaking.

With this in mind, we strongly urge CMS to consider the following recommendations articulated below.

Our comments address four areas:

I. Case-Mix Measurement and Revision to Case-Mix Weights
II. Home Health Quality Improvement
III. Clarifications to Therapy Coverage Requirements
IV. Payment Reform and the Home Health Study and Report

I. Case-Mix Measurement and Revision to Case-Mix Weights

Rate Reductions to Account for Nominal Case-Mix Growth

In the CY 2011 HH PPS proposed rule, CMS received significant feedback from stakeholders criticizing its methodology for making large cuts in Medicare home health payments based on its analysis of real case-mix growth. One of the main criticisms was that CMS' analysis relied too heavily on hospital discharge data. Many stakeholders believed that analysis should focus more on the severity of the patients entering home health from the community as more than half of Medicare home health patients are admitted from settings other than the hospital. Stakeholders also had other criticisms related to broad unfair penalizations based on a few bad actors and the failure to factor in shorter hospital stays.

In response to these criticisms, CMS contracted with Harvard University to do an independent review of their methodology. In this review CMS concluded that the current model adequately measures real case-mix growth for home health patients, including patients admitted to home health from the community. The one area of refinement identified by the Harvard team was to incorporate variables derived from the Hierarchical Condition Categories (HCC) data, which is used by CMS to risk-adjust payments to managed care organizations in the Medicare program.

In this proposed rule, after updating the model with the HCC data, CMS has determined that there was a 19.03 percent nominal case-mix change from 2000 to 2009. To account for the remainder of the 19.03 percent residual increase in nominal case-mix beyond what has been accounted for in previous payment reductions (i.e. the phased-in payment reductions of 3.79 percent in CY 2011). CMS estimates that the percentage reduction to the national standardized 60-day episode rates for nominal case-mix change for CY 2012 will be 5.06 percent.

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 the nominal case-mix growth. We believe that CMS, in its analysis, failed to take into consideration significant factors such as the implementation of OASIS, public and private educational initiatives to teach home health providers how to more comprehensively assess the patient's home care needs, improve documentation and quality of care, the evolving home health patient population, and changes in patient characteristics.

Physical therapists have learned to collaborate with their nursing colleagues to ensure that their OASIS data collection processes best describe and reflect the condition of the patient. An increasing number of home health agencies have realized the importance of the physical therapist when assessing the patient, and as a result, have invited physical therapists in their agencies to be involved in staff education so that assessment strategies can be shared among all disciplines in home health. Also, outreach efforts by CMS such as guidance on OASIS and educational sessions offered by professional associations and private companies have attributed to the home health community's increased accuracy in coding and use of the OASIS assessment tool.

The involvement of the physical therapist has enhanced the functional component of the comprehensive assessment through gathering observational data and considering safety factors in determining patient ability to carry out Activities of Daily Living and Individual Activities of Daily Living (ADL/IADL). As a result of this more collaborative and critical assessment, the Home Health Resource Groups (HHRG) tend to be higher, thus affecting the case-mix weights. We believe that this improved accuracy and educational outreach has, in large part, led to coding behavior changes that CMS has highlighted in its analysis. **APTA strongly recommends that CMS find alternative ways to account for these nominal case-mix changes and does not impose further cuts to the home health PPS.**

In looking at alternatives, APTA urges CMS to explore its program integrity efforts to combat fraud, waste and abuse under the Medicare home health benefit. We believe that the Agency has made real progress with the implementation of the physician face to face requirement, the tightening of regulations to better define skilled care and in its collaborations with the Department of Justice (DOJ) and the Office of the Inspector General (OIG) to root out and prosecute individuals who have greatly profited from deception of the Medicare program. These efforts put the focus on eliminating the bad actors that are truly defrauding the Medicare system and do not subsequently penalize therapists and home health agencies (HHAs) who provide quality, medically necessary services to Medicare beneficiaries in their homes.

Secondly, we recommend that CMS continue to bolster its education efforts regarding proper coding of OASIS, therapy and nursing coverage requirements, care coordination between therapists, nurses, physicians, acute care hospitals, outpatient facilities, and other post-acute care settings (such as skilled nursing facilities and inpatient rehabilitation facilities), and audit risk areas. APTA, along with other stakeholders in the home health community, are making many strides to ensure that therapists and other providers in the home health setting are well-educated in these areas but, we believe that this educational effort can only be strengthened through a strong collaborative process that combines our private efforts with CMS.

This collaboration may include a series of provider compliance conference calls, written materials (i.e. MLN articles, newsletters from the professionals associations), webinars, and town hall meetings. APTA is committed to ensuring that our members provide the highest quality of therapy interventions to its patients, and we believe that a coordinated educational effort between organizations such as APTA and CMS can aid in controlling the nominal case-mix growth under the HH PPS.

Lastly, we strongly urge CMS to re-examine the data regarding the admission of patients from community-based settings to home health. In our dialogue with home health physical therapists, we find that patients who have an acute care stay before being admitted to home health have a faster trajectory than patients with chronic diseases who enter home health without an acute care stay. Lengths of stay after surgery tend to be shorter than those of patients with diabetes, chronic obstructive pulmonary

disorder (COPD), chronic heart failure (CHF) and other co-morbidities who enter home health without a hospital stay. The role of the physical therapist is to support and treat these complex co-morbidities and to prevent these patients from requiring higher levels of therapy, readmissions to the acute care hospital and more costly care in another setting. Therefore, we strongly urge CMS not to dismiss the distinctions in the varying level of care, complexities, and intervening factors that distinguish home health episodes following an acute care stay from those in which patients enter home health from community-based settings.

Utilization of Physical Therapist Assistants under the Medicare Home Health Benefit

In the proposed rule, CMS concludes that the costs assigned to payment for home health therapy services is higher than the actual costs incurred by the HHA to provide the therapy services. One factor CMS attributes to this overpayment is the growing use of therapy assistants instead of therapists. The Agency states that based on data from the Occupational Employment Statistic (OES) by the Bureau of Labor Statistics (BLS) which was used in 2005 to develop resource costs, 15 percent of physical therapy was provided by therapy assistants. In 2008, the OES data showed that 19 percent of physical therapy was provided by therapy assistants. In 2010, the OES data showed that the percentage of physical therapy provided by therapy assistants was 20 percent. Furthermore, CMS notes that preliminary analysis of resource use data collected during the Post Acute Care Demonstration (PAC Demo) shows a higher occurrence of assistants providing therapy for patients receiving Medicare home health than the OES data.

APTA is very concerned about CMS' attribution of higher costs for home health therapy services to the use of therapy assistants in the home health setting, and we are very committed to working with the Agency to ensure that physical therapist assistants are utilized in manner that is clinically appropriate and complies with all Medicare and state laws and regulations. APTA strongly believes that physical therapists have a responsibility to deliver services in ways that protect the public safety and maximize the availability of their services. Physical therapists accomplish this through direct delivery of services in conjunction with responsible utilization of physical therapist assistants who assist with selected components of intervention.

Direction and supervision are essential in the provision of quality physical therapy services. The degree of direction and supervision necessary for assuring quality physical therapy services is dependent upon many factors, including the education, experience, skills, and responsibilities of the parties involved, as well as the organizational structure in which the physical therapy services are provided.

Therefore, we strongly urge CMS to reconvene a technical expert panel of therapists and nurses to examine the appropriate use of all therapist assistants and nursing personnel utilized under the Medicare home health benefit before proceeding with any major changes to the HH PPS based on the premise that utilization of physical therapist assistants is not clinically appropriate.

To better illustrate the appropriate relationship between physical therapists and physical therapist assistants, we have provided the following description and clinical scenarios:

Clinic Description: Clinic A is a home health agency that employs 1 physical therapist who has 15 years of clinical experience and 2 physical therapist assistants with a minimum of 10 years of experience each. The agency serves a very large, rural county. A case manager who is a registered nurse triages the patients

requiring physical therapy to the physical therapy clinicians. The agency conducts most of its business, including patient assignments, electronically.

Patient Care Delivery: The physical therapist evaluates and treats every patient and determines whether the physical therapist or one of the physical therapist assistants will provide follow-up interventions based on the results of the evaluation, and the physical therapist communicates this back to the case manager. Additionally, the physical therapist provides the case manager with the plan of care including the frequency that the physical therapist will see the patient for reassessment and treatment based on the patient's needs, projected progress with interventions, and applicable federal and state regulations. The physical therapist assistants are assigned patients based on the clinical decision making of the physical therapists.

The physical therapist provides a detailed plan of care for each patient, which is submitted electronically and available to the physical therapist assistant prior to each visit. The physical therapist assistant also has access to the all documentation and communicates any changes in patient status, vital signs, or medications to the supervising physical therapist. The physical therapist is available through phone communications to both physical therapist assistants throughout the day.

Communication: Each physical therapist assistant phones the physical therapist in the morning to review their caseload for the day, ask questions, provide updates, and review potential patient/client problems or signs that would indicate a change in the patient's status with the physical therapist. The physical therapist also sees the patient with the physical therapist assistant periodically to reassess the patient and to assess the physical therapist assistant's performance and provide feedback. The physical therapist also reassesses the patient and provides treatment to determine progress or changes in the plan of care based upon his/her clinical judgment and applicable federal and state regulations, as well as, any time the physical therapist assistant requests. Additionally, the three staff members meet one day per week to review the overall caseloads and discuss problems or opportunities that have risen during the week. Once a month, the clinicians review the patient caseload, assess their skills and knowledge relative to the patients' care, and review any evidence-based interventions that would provide optimal patient outcomes. The physical therapist works with and provides mentorship to the physical therapist assistants to assess areas of knowledge and skill that may be enhanced to improve patient/client outcomes and assists the physical therapist assistants in obtaining educational opportunities.

Decision Making: The physical therapist is solely responsible for completion of the examination, evaluation, diagnosis, and prognosis as well as the development of the plan of care. In addition, the physical therapist is responsible for ensuring that all aspects of care are consistent with OASIS-C requirements including, start of care and/or physical therapy evaluation, planned physical therapy discharge, end of care visits, and requirements for documenting and treating significant changes in condition.

The physical therapist may involve the physical therapist assistant to assist with selected interventions. Once the physical therapist has established the plan of care, the physical therapist considers the following prior to assigning interventions to the physical therapist assistant:

- Are the interventions within the scope of work of the physical therapist assistant?
- Is the patient's condition sufficiently stable?
- Are the intervention outcomes sufficiently predictable?
- Is the intervention within the physical therapist assistant's personal knowledge, skills, and abilities?

- Are there risks and liabilities that should be considered prior to directing interventions to the physical therapist assistant?
- Would any payer requirements be affected by the involvement of the physical therapist assistant in providing interventions?

When the physical therapist directs the intervention to the physical therapist assistant, the physical therapist continues to (1) maintain responsibility of patient management; (2) provide direction and supervision to the physical therapist assistant in accordance with applicable laws and regulations; (3) conduct periodic reassessment/reevaluation of the patient as directed by the facility, federal and state regulations, payers, and the needs of the patient; and (4) provide support to the physical therapist assistant, and when appropriate, assist in the physical therapist assistant's development of knowledge and skills necessary to perform selected interventions and related data collection.

Patient Care Examples

Patient 1 has unstable diabetes with peripheral neuropathy affecting his ability to ambulate safely in the home. The physical therapist has seen the patient and determined that while the patient is safety oriented and at a low-to-medium risk for falls, an area of skin breakdown is noted on the plantar surface that requires sharp debridement for removal of devitalized tissue to normalize the weight bearing surface of the foot. The physical therapist will provide all interventions with this patient until the area is healing and the patient interventions can be directed to the physical therapist assistant.

Patient 2 was hospitalized recently due to a flare up of gastrointestinal disease. During that time, the patient was extremely ill and in bed, resulting in significant weight loss and weakness. The physical therapist determines that the plan of care should include therapeutic exercise to increase strength and endurance to facilitate independence in activities of daily living, gait training, balance training, and energy conservation education. The physical therapist directs the physical therapist assistant to provide interventions to the patient as outlined in the physical therapist's plan of care because the patient's condition is fairly stable, outcomes are predictable, and there are no insurance or liability issues to create a conflict.

Revisions to Case-Mix Weights

For CY 2012, CMS proposes to revise the current case-mix weights by lowering the relative weights for episodes with high therapy and increasing the weights for episodes with little or no therapy. CMS states that it believes this proposal will discourage the provision of unnecessary therapy services and will slow the growth of nominal case-mix.

While, APTA fully supports CMS' efforts to mitigate abusive behaviors under the HH PPS, we strongly urge the Agency to rescind this proposal and to explore alternate methods to discourage medically unnecessary therapy services under the Medicare home health benefit that bases payment on clinical complexity of the patient rather than the number of therapy visits provided.

In the proposed rule, CMS highlights the recent findings in the Medicare Payment Advisory Commission's (MedPAC) March 2011 report that recommends that CMS *"revise the home health case-mix system to rely on patient characteristics to set payment for therapy and non-therapy services and should no longer use the number of therapy visits as a payment factor".* CMS states that, while

they agree with MedPAC's recommendation, more time is needed to develop a new methodology to pay for services and therefore, the Agency will provide more information on its plan in future rulemaking.

APTA wholeheartedly agrees with MedPAC and CMS' rationale. We believe that therapy frequency and duration should be based solely on the needs of the patient, and any further attempts to curb overutilization that involves payment increases or decreases based upon the number of therapy visits furnished is a step in the wrong direction. Therefore, we believe that the above proposal to revise the current case-mix weights is premature and unproductive.

In addition, due to the proposal to increase case-mix weights for episodes with little or no therapy, APTA is very concerned that this policy may pose incentives to provide minimal therapy to patients therefore hindering patient access to medically necessary therapy services. **Accordingly, we recommend that CMS rescind this proposal and convene a technical expert panel (TEP) to begin the work of developing an alternative payment system for therapy services under the Medicare home health benefit.** APTA is eager to lend our resources and member subject-matter experts to aid in this important undertaking and to serve on the panel.

II. Home Health Care Quality Improvement

CMS proposes to continue to report quality measurement on the Home Health Compare website and this information will still be pre-published to HHAs to review before it is accessible to the public. With addition of a new outcome measure which addresses emergent hospitalization.

CMS is also moving forward with its plan for Home Health Consumer Assessment of Healthcare Provider's and Systems (HH CAHPS) survey data linkage to pay-for-reporting (P4R) requirements affecting the HH PPS rates update for CY 2012. For public reporting purposes, CMS will present five measures (three composite measures and two global ratings of care). Each composite measure will consist of four or more questions regarding one of the following related topics:

- Patient care
- Communications between providers and patients
- Specific care issues on medications, home safety and pain

In addition, CMS proposes a reconsiderations and appeals process for HHAs that fail to meet the HH CAHPS data collection requirements. CMS proposes that HHAs that are not compliant with OASIS-C and/or HH CAHPS for CY 2012 annual payment update will be notified. CMS will issue a Joint Signature Memo to regional home health intermediaries/ Medicare administrative Contractors with a list of HHAs not compliant with OASIS and/or HH CAHPS. The memo will include information on how the HHA can request a reconsideration within 30 days. CMS will then review the reconsideration and make a determination by December 31, 2011. HHAs who receive an unfavorable ruling will have the right to appeal to Provider Reimbursement Review Board.

APTA applauds CMS for continuing the home health care quality reporting program as outlined in the proposed rule. 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 and have done a significant amount of educational outreach to our membership regarding OASIS-C requirements, quality reporting and the implementation of the CAHPS survey in the home health setting.

APTA is pleased to see the continued requirements around OASIS data reporting in the proposed rule. We also agree that the proposed changes to the OASIS- B1 measure for "Emergent Care" measure to "Emergency Department Use without Hospitalization" would yield a metric that is more robust while decreasing the burden of data collection by utilizing claims data. In addition, we feel that it is also important to continue the requirements around the HHCAHPS data in order to capture essential information around patient experience in care.

We encourage the Agency to continue to seek initiatives that examine the home health utilization to improve outcomes. We believe that this is particularly important as the Agency continues its work in the area of accountable care organizations (ACOs) and bundling. We also believe that outcomes measurement is integral to developing a payment system that accurately bases payment on the clinical needs of the patient.

In addition, we commend the Agency on its proposal to provide a reconsideration and appeals process for HHAs who fail to meet HH CAHPS data collection requirements. We believe that it is imperative that providers are allowed a vehicle to appeal unfavorable decisions. There are several variables that may result in the collection of inaccurate HH CAHPS data that are beyond the control of the home health agency such as patient confusion on how to complete the survey or patient refusal to complete the survey. In these instances, HHAs should not be unduly penalized and should be given the opportunity to review the unfavorable decision and provide further justification for the findings.

Lastly, we recommend that CMS provide clear instructions to HHAs on when and what information is appropriate for the HHA to share with its patients regarding the HH CAHPS survey. While we aware that some of this information has been provided by HH CAHPS contractors, there is still some confusion among providers and therefore, we feel that additional guidance from the Agency is warranted.

III. Clarifications to Therapy Coverage Requirements

The proposed rule includes a slight clarification to the finalized therapy coverage requirements that were finalized in the CY 2011 HH PPS final rule. In the CY 2011 final rule, CMS finalized flexibility for the 13th and 19th visit requirements in cases when: 1) the patient resides in a rural area; 2) documented exceptional circumstances prevent the therapists from making the required visit; and 3) patients receive more than one type of therapy. For those patients who require 13 and 19 therapy visits, the qualified therapist's visit, assessment, and documentation must occur no later than the 13th and 19th visit.

To make this point clear in the regulations, CMS proposes to correct the regulation text at §409.44(c) (2) (i) (D) (2) to read:

"Where more than one discipline of therapy is being provided, the qualified therapist from each discipline must provide the therapy service and functionally reassess the patient in accordance with §409.44 (c) (2) (i) (A) during the visit which would occur close to but no later than the 19th visit per plan of care."

While APTA appreciates the clarification included in the proposed rule, we strongly urge CMS to expand its clarification to include a number of other issues that have arisen since implementation of the therapy coverage requirements on April 1, 2011.

Specifically, APTA strongly recommends additional guidance in the following areas:

1) **The proper transition for the functional reassessment requirement when multiple therapy cases become single therapy cases.**
2) **Confirmation that there is no range for functional reassessment visits and that the language that the functional reassessment occur "close to" but no later than the 13th and 19th visit applies for all therapy episodes including single and multiple therapy visits as well as exceptional circumstances in rural areas.**
3) **Clarification of functional reassessments upon readmission to home health after an acute care hospital stay and implications for OASIS requirements regarding resumption of care and significant changes in condition**
4) **Clarification that exceptional circumstances also include patient refusals to therapy, patient cancellations, hospitalizations, and severe weather issues.**
5) **Guidance on whether to count non-covered visits when determining when to perform the next functional reassessment.**

As with the introduction of OASIS-C and the regression equation model for therapy services in CY 2008, the Agency has continually assessed the implementation of major changes and provided additional guidance or refinements as needed to ensure that home health providers had a thorough understanding of the regulations. As physical therapists and home health agencies continue their efforts to ensure compliance with the Medicare coverage requirements for home health, there are still many unanswered questions regarding the therapy coverage requirements and there has not been a consistent source to reference for answers to these questions.

Therefore, physical therapists who work in the home health setting have relied on piecemeal information that has resulted in inconsistent interpretations and implementation of strict policies by home health agencies to safeguard against non-compliance. Furthermore, with Medicare's focus on program integrity and the continued analysis of therapy utilization in the home health setting, APTA believes that it would be prudent to issue clear guidance so that medical review of home health therapy can be conducted in a manner that is accurate, consistent and equitable.

In an effort to provide further assistance to CMS to clarify the issues as articulated above, we have provided the following sample frequently asked questions and answers.

Question
What does the phrase "close to" the 13th and 19th visit mean in a multiple therapy case when completing the functional reassessment? Is there a defined range of visits for "close to" the 13th and 19th visit (i.e. 11 to 13 or 17 to 19)?

Answer:
No. There is no defined range for "close to" in individual or multiple therapy cases. This allows agencies flexibility in completing the reassessment when it makes the most sense to do so.

Examples:

- Physical therapy (PT) and occupational therapy (OT) are currently treating a patient and the plan of care anticipates a total of 15 therapy visits. The PT completes the reassessment on visit #10 as it coincides with a physical therapy assistant supervisory visit. OT completes the reassessment on visit #12. Both services are compliant with "close to".

- PT, OT and speech-language pathology (SLP) are currently treating a patient. On combined visit #7 the OT decides that in order to progress the patient, a tub bench must be secured for the patient and will not see the patient until the bench is in the home as there is no other skilled intervention that can be implemented until the equipment is in place. Making that decision on visit #7 requires all the components of a reassessment and documentation must reflect the clinical reasoning for this decision. SLP and PT continue to see the patient and complete their reassessments on visit #10 and #13 respectively. All three therapies are compliant with "close to".

Question:
When does a multiple therapy case become a single therapy case and how does this affect the requirements to complete the functional reassessment?

Answer:
There are instances when the therapies discharge at different points in the episode. When all but one therapy is left, the episode in now considered to be a single therapy and the related reassessment timeframes apply. In the event that the discharge occurs during the timeframe of the functional reassessment, a well written discharge assessment meets the same intent as a reassessment.

Examples:

- OT and SLP are ordered at the beginning of an episode. After a combined total of 4 visits are completed the SLP discharges the patient. From visit #5 and onward this is now a single therapy case.
- PT and OT are both working with a patient with each planning for 8 visits. On combined visit #10 the PT completes the reassessment and will continue with the plan of care. On combined visit #12 the OT completes the reassessment and the findings support the decision to discharge at that time. Since the OT reassessment was "close to" #13 the reassessment requirement is met and there is no need to send PT back again on literal visit #13 for another reassessment.

Question:
When a reassessment is missed, it is understood that there are now non-covered therapy visits from the point the error is made through the actual completion of the reassessment. The end result is payment will be reduced as these visits do not "count" toward the total number of therapy visits provided. Are non-covered visits still counted for the purposes of determining when to complete the functional reassessment?

Answer:
Yes. It is correct that non-covered therapy visits do not "count" in relation to how payment for the episode is calculated. This will not impact the way the visits are planned and delivered over the course of care.

Examples:

- SLP is the only therapy seeing a patient and the plan of care is for 22 visits. The reassessment is missed on visit #13 and is actually completed on #16. Visit 14, 15 and 16 are not covered and will be removed from the final payment calculation. For ongoing tracking purposes, the next SLP visit delivered is #17 with the next reassessment due on visit #19.
- PT and OT are working with a patient and the plan of care is for a total of 24 visits. The OT completes a reassessment on combined visit #10 but PT does not until combined visit

#15. Visit 14 and 15 are not covered regardless of which therapy completed them and will be removed from the final payment calculation. For ongoing tracking purposes, the next therapy visit delivered to the patient is #16 with the next reassessments due "close to" visit #19.

IV. Payment Reform: Home Health Study and Report

The Affordable Care Act (ACA) requires CMS to conduct a study on home health agency costs of providing access to care to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness (specifically patients with high levels of severity of illness). The study may analyze the need for payment adjustments for services delivered under the HH PPS. CMS states that the Agency plans to use its authority to conduct a study to evaluate the current HH PPS and develop payment reform options which might minimize vulnerabilities and more accurately align payment with patient resource costs. Congress also provides for CMS to conduct a demonstration project to test recommended payment system changes that result from the study.

As CMS undertakes this study, APTA strongly urges CMS to research the underutilization of therapy services in rural and underserved areas. While there is always emphasis placed on overutilization of therapy services, we feel that there are special opportunities to improve access and the quality of homecare for beneficiaries in rural and underserved areas, and we believe that this study can serve as an important first step in identifying these opportunities.

In addition, we strongly believe 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. **Lastly, 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.**

APTA thanks CMS for the opportunity to comment on the Home Health Prospective Payment System Proposed Rule (CY 2012), and we look forward to working with the agency to craft patient-centered payment policies that reflect quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Regulatory and Payment Counsel, at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

R. Scott Ward, PT, PhD
President

RSW: rdd