



September 9, 2019

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: (CMS-1711-P) Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS's) proposed rule entitled, *Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements* (the Proposed Rule).¹ CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function.

Overview

The Proposed Rule updates the home health prospective payment system (HH PPS) payment rates and implements the transition in the unit of payment from a 60-day episode of care to a 30-day episode of care, as required by the Bipartisan Budget Act of 2018. The Proposed Rule also implements the Patient-Driven Groupings Model (PDGM), proposed payment rate changes for home infusion therapy temporary transitional payments, and adjustments to the home infusion therapy benefit. It also proposes to phase out the Request for Anticipated Payment (RAP) and

¹ Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements, 84 Fed. Reg. 34,598 (July 18, 2019).

would change the Home Health Value-Based Purchasing Model (HH VBP) and the Home Health Quality Reporting Program (HH QRP), among other things.

Although some components of CMS's new home health payment reform were finalized last year, we continue to have concerns regarding the implementation of and rationale behind the new payment methodology. Our comments will focus largely on the proposed implementation of the PDGM, the proposed authorization of therapist assistants to provide maintenance therapy, and the impact of these proposals on patients receiving rehabilitative care in the home health setting.

Concerns with the Patient-Driven Groupings Model

CPR continues to be concerned with the potential impact of the proposed PDGM on patients with rehabilitative needs. Under the PDGM, CMS proposes to make assumptions about changes in provider behavior that could occur as a result of the implementation of the 30-day unit of payment and the PDGM case-mix adjustment factors. CMS is proposing three behavioral assumptions: clinical group coding, comorbidity coding, and a low-utilization payment adjustment (LUPA) threshold. Together, these assumptions are used to significantly decrease reimbursement levels under the HH PPS, raising concerns about the sufficiency of resources home health agencies will have to provide quality patient care and afford appropriate access to patients.

Under the clinical group coding assumption, CMS proposes to assume that home health agencies will change their documentation and coding practices in order to assign the highest-paying diagnosis code as the principal code for the 30-day period of care. According to CMS, this assumption "is based on decades of past experience under the case-mix system for the HH PPS and other case-mix systems."² CMS specifically cites data concerning the "substantial increase in payments when transitioning from the diagnosis-related groups (DRGs) to the Medicare Severity (MS)-DRGs that were not related to actual changes in patient severity."³ In support of its behavioral assumption, CMS points to inpatient hospital claims data and case-mix increases in the first year of the inpatient rehabilitation facility (IRF) PPS, and case-mix growth in the HH PPS.

Under the comorbidity coding assumption, CMS proposes to assume that more periods of care will receive comorbidity adjustments when taking into account all additional diagnosis codes listed on the home health claim. CMS provides that "using the home health claim for the comorbidity adjustment as opposed to the OASIS provides more opportunity to report all comorbid conditions that may affect the plan of care."⁴

Under the LUPA threshold assumption, CMS proposes to assume that home health agencies will provide extra unnecessary visits to receive a full 30-day payment when cases are near the LUPA threshold. In support of this behavioral assumption, CMS references data suggesting that home health agencies "changed their practice patterns such that, upon implementation of the HH PPS,

² *Id.* at 34,615.

³ *Id.*

⁴ *Id.*

more than half of 60-day episodes that would have been LUPAs received the full 60-day episode payment amount.”⁵ It also relies on the fact that certain groups have only a two-visit threshold.

In the CY 2019 HH PPS final rule, CMS indicated that applying behavioral assumptions would result in a 6.42 percent reduction in Medicare payments to home health providers in CY 2020.⁶ In the Proposed Rule, however, CMS forecasts that applying these behavioral assumptions would reduce payment amounts by 8.01 percent, as compared to those that would be paid in the absence of behavioral adjustments:

Clinical Group Coding Assumption	-5.91 percent
Comorbidity Coding Assumption	-0.37 percent
<u>LUPA Threshold Assumption</u>	<u>-1.86 percent</u>
All Behavioral Assumptions	-8.01 percent ⁷

CPR strongly opposes the proposed application of these behavioral assumptions without better, evidence-based data of actual home care provider behavior. We are concerned that these behavioral assumptions will threaten patient access to home health services. The 8.01 percent decrease in payments is excessively high and would result in the elimination of approximately \$1.3 billion dollars from the Medicare home health payment system in 2020. These payment cuts would impose a significant financial burden on home health agencies, which may force home health agencies to reduce their home health operations or leave certain markets altogether.

We believe that patients with more complex rehabilitative care needs and patients who reside in rural areas are more likely to be adversely affected if home health agencies are forced to close or reduce their services due to the economic impact of the proposed behavioral assumptions. These patient populations are associated with higher operational costs, as they require more frequent visits or lengthier travel to provide care. If patients are unable to access home health services, they will likely be diverted to more costly post-acute care settings.

Given the risks associated with the proposed behavioral assumption payment cuts, we urge CMS to reconsider its proposal and ensure that any assumption is based in actual data and observed evidence. We have concerns that the proposed behavioral assumptions are overly broad and largely unsubstantiated. The PDGM was not subject to pilot testing, and CMS has not provided adequate justification to support the accuracy and legitimacy of the proposed behavioral assumptions.

Although CMS cites some past home health experience underlying the behavioral assumptions, much of the cited evidence is conjectural or extrapolated from payment systems other than the

⁵ *Id.*

⁶ 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, 83 Fed. Reg. 56,406, 56,455 (Nov. 13, 2018).

⁷ In the Proposed Rule, CMS notes: “Adding all the percent decreases for each behavior assumption results in a total percent decrease of -8.14 percent. However, there is overlap and interactions between the behavior assumptions and when combined, the budget-neutral payment amount results in a -8.01 percent decrease from the payment amount without these assumptions applied.” 84 Fed. Reg. at 34,616.

HH PPS. As such, we question whether such evidence is an appropriate basis to predict provider behavior in the home health space. Basing substantial payment cuts on insufficient or non-existent evidence deviates from behavioral impacts applied to other prospective payment systems and sets a problematic precedent. In fact, CMS declined to make any prediction about providers' reaction to the proposed skilled nursing facility payment model, noting that it "lacked an appropriate basis to forecast behavioral responses."⁸ CMS should have similarly refrained from proposing unsubstantiated assumptions to predict provider behavior in the HH PPS.

Lastly, we believe that this proposal deviates from last year's proposal without explaining why these same factors create a more significant behavioral adjustment. In the CY 2019 HH PPS final rule, CMS announced that the same behavioral assumptions would constitute a 6.42 percent reduction in Medicare payment for 2020; however, in the Proposed Rule, the proposed behavioral assumptions are tied to a 8.01 percent payment cut for 2020.

Therefore, CPR urges CMS to revisit the behavioral assumptions to ensure that they do not threaten patients' access to home health services.

Maintenance Therapy by Therapist Assistants

The Proposed Rule would permit therapist assistants (in addition to therapists) to perform maintenance therapy under a maintenance program created by a qualified therapist under the Medicare home health benefit, if acting within the therapy scope of practice defined by state licensure laws. Qualified therapists would be responsible for "the initial assessment; plan of care; maintenance program development and modifications; and reassessment every 30 days, in addition to supervising the services provided by the therapist assistant."⁹

CPR supports CMS's proposal to permit maintenance therapy to be furnished by therapist assistants. We appreciate CMS's efforts to ensure that patients have access to essential maintenance therapy services. Expanding the types of providers that are authorized to perform this therapy under the Medicare home health benefit would increase home health agencies' ability to provide medically necessary maintenance therapy to patients who are in need of such services. We support CMS' proposal and hope to see this provision implemented in the final rule.

Change from 60-Day Billing to 30-Day Billing

The Bipartisan Budget Act of 2018 mandates the transition in the unit of payment from a 60-day episode of care to a 30-day episode of care. The Proposed Rule implements the required change in the length of the episode of care. We have detailed our concerns regarding the negative impact of the transition to a 30-day period of care in our [comments](#) on the 2018 HH PPS proposed rule. CPR believes that the truncated payment periods, along with the PDGM case-mix adjustments,

⁸ Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program; Proposed Rule, 83 Fed. Reg. 21,017, 21,073 (May 8, 2018).

⁹ 84 Fed. Reg. at 34,641.

will create financial incentives that will likely lead to increased access issues for Medicare beneficiaries who need ongoing or longer-term home health services to meet their needs.

A large majority of home health episodes are greater than 30 days in length. Patients with significant longer-term needs, including those with multiple sclerosis, Parkinson’s disease, brain injuries, and paralysis, who meet the legal criteria for Medicare home health coverage, are already disfavored by home care providers. These patients will be left behind by the proposed system that further encourages providers to care for short-term, acute care patients.

This transition in the unit of payment would create incentives for home health agencies to provide more intensive therapy in the first 30-day episode, and less following that time period. In addition, the proposed system will reward agencies for serving healthier patients with fewer, long term rehabilitation needs.

Moreover, CPR is concerned that a shorter payment period is particularly inappropriate given the *Jimmo v. Sebelius* Settlement and CMS Corrective Action Plan that confirm the availability of Medicare coverage for skilled home health care to maintain an individual’s function, not only to improve it. Pursuant to *Jimmo*, medically necessary skilled nursing and skilled therapy services provided by or under the supervision of skilled personnel are covered services by Medicare if the services are needed to improve a beneficiary’s condition, maintain the individual’s condition, or prevent or slow their decline.

By reducing the payment period, access to essential, ongoing skilled home care for longer-term patients will be compromised. Under *Jimmo*, patients need not demonstrate improvement in order for skilled services to be covered as reasonable and necessary. A 30-day payment period, however, will create a payment system in which providers will have further financial incentives to “cherry pick” patients who are more likely to improve and who have rehabilitation or skilled care needs that are more intensive and shorter in duration. This may significantly interfere with the *Jimmo* Settlement for Medicare beneficiaries in need of greater-than-average or prolonged home health services.

Although we recognize that a payment proposal is mandated by statute, we think this proposal will establish incentives that are likely to harm Medicare patients, especially those needing rehabilitation and long-term services and supports in the home.

Conclusion

CPR supports CMS’s proposal to allow therapist assistants to perform maintenance therapy. However, we urge CMS to reconsider the implementation of the PDGM. We believe that the Proposed Rule will have the unintended consequence of harming Medicare patients, especially those needing complex rehabilitative home health services and longer term home health care, and those in rural areas of the country. CMS should work with stakeholders, including patients and their advocates, to develop a payment system that promotes equal access to Medicare and necessary home care for all beneficiaries who qualify under the law.

We greatly appreciate your attention to our concerns and your interest in our comments. If you have any further questions regarding this information, please contact Peter Thomas, CPR coordinator, at 202-466-6550 or by email at Peter.Thomas@PowersLaw.com.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
The Arc of the United States
Association of Academic Physiatrists
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Falling Forward Foundation
Lakeshore Foundation
National Association of Social Workers
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
United Spinal Association