NARA
The National Association of Rehabilitation Providers and Agencies

August 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicare Program; Calendar Year (CY) 2024 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotic Supplies; and Provider and Supplier Enrollment Requirements. [CMS-1780-P]

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists and speech language pathologists through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities, assisted living facilities, retirement communities, hospital inpatient and outpatient, and in the beneficiary's home. As a member-driven organization, NARA promotes best practice and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs for home health providers. We appreciate the opportunity to provide the following comments related to the above proposed rule.

Payment Adjustments: Market Basket and Patient-Driven Groupings Model (PDGM) and Behavioral Assumptions Permanent Adjustment

We appreciate the market basket update but with the decrease in the behavioral assumptions permanent adjustment and the proposed reduction to 30-day payment, this simply is not sustainable for an industry Congress has indicated they want to grow. In 2021, the Senate introduced the Choose Home Care Act of 2021, a bipartisan bill that would allow Medicare beneficiaries to return home after a hospital stay for their post-acute care through expanded home health benefit services. The COVID-19 pandemic made it clear that for clinically appropriate beneficiaries it would reduce their risk of exposure to infectious diseases while promoting increased patient and family satisfaction. However, health care providers, particularly physical, occupational and speech language pathology providers continue to struggle with staffing shortages and high expenses due to inflation. Home health agencies are struggling to recruit and retain qualified healthcare professionals and must rely on traveling nurses and therapists which come at

a premium cost - sometimes as high as 3 times normal pay rates to meet the needs of the beneficiaries. These unprecedented high costs are felt even more by providers when providing care to rural and underserved areas. In other industries, companies can raise their prices to cover escalating costs, but in healthcare we cannot – our reimbursement continues to be cut year after year.

We continue to strongly disagree with the behavioral assumptions' adjustment. This is a very aggressive cut to home health providers and will have disastrous results not only for providers but for access to care for Medicare beneficiaries. Congress continues to recognize the devastation of these deep cuts that have become an annual occurrence. In July 2022, the Senate and House both introduced Preserving Access to Home Health Acts to stop the proposed cuts for 2023. Similarly in July 2023, US Senators Debbie Stabenow and Susan Collins again recognized the negative impact of this rule and introduced the bipartisan bill S. 2137 Preserving Access to Home Health Act of 2023 to prevent the 7.85% cut to the Medicare Home Health program to safeguard access to these essential clinical home-based healthcare services. According to the Congressional Budget Office (CBO), home health spending is projected to drop from $18 billion to $16 billion this year followed by a drop to $15 billion in 2024. According to the U.S. Census Bureau, the population of those older than 65 in the United States has grown by 20 million in the last two decades to 55 million in 2020. By 2034, it is projected that people 65 and over will reach 77 million. In a U.S. News and World Report survey, it was reported that over 90% of respondents said their goal is to age in place. Since the number of people over the age of 65 is estimated to grow by nearly 20% in the next 11 years and 90% of them intend to age in their homes, it seems counterintuitive to impose blunt payment reductions year after year because it will cause home health agencies to be non-existent by 2034.

NARA continues to express our concern for comparing simulated data to actual data – this is not comparing like data and is basically comparing apples to oranges. During the COVID-19 outbreak, there were many functions within healthcare systems impacted because of providers taking measures to keep beneficiaries and staff safe. Beneficiaries who typically would be discharged from the hospital to a skilled nursing facility are requesting to be discharged to their homes or the homes of family members with home health services. These patients demonstrate a higher acuity resulting in a higher functional impairment and less tolerance for therapy services. This coupled with a shortage of therapists and the inability for home health providers to utilize telehealth as a tool to meet patient needs or to provide supervision to therapy assistants when a therapist is unable to provide the service directly has made it difficult to provide the full range of services home health providers provided pre-PHE.

NARA strongly disagrees with the CMS' decision to permanently adjust payment based on "assumed" behavior to the 30-day payment rate in CY 2024 when CMS acknowledged there would be behavioral changes. CMS also indicated at the introduction of PDGM that there would be programs utilized to determine where behavioral changes occurred to maintain program integrity. NARA recommends CMS analyze individual provider behavior compared to the functional impairment levels to determine the root cause of the changes in care delivery. Also, CMS should consider the following when reviewing the PDGM data in consideration of making such a deep and paralyzing cut to providers:

- Were the changes in amount of therapy provided based on the higher acuity of the patient?
- Were the outcomes of the services provided in line with the plans of care?
- Was the number of rehospitalizations impacted by the behavioral changes?

In our comment letter dated September 19, 2019, we expressed concern that the change in payment models would cause a drop in the amount of therapy provided. Shifts in reimbursement should be based on outcomes rather than a decrease in therapy minutes, especially when most therapy delivered by a home health agency is not determined by the therapist or the contract therapy provider. While NARA members know the benefits therapy has in preventing rehospitalizations, it may not always be forefront in all agency minds with higher acuity level patients, which has been consistently higher than before the pandemic. NARA strongly encourages CMS to reconsider this behavioral assumption adjustment until such a time when CMS has actual evidence of provider behavior change and CMS can substantiate and identify those providers who are displaying these assumed behaviors.

Home Health (HH) Quality Reporting Program (QRP)

We do not support the removal of OASIS item M2220 – Therapy Needs. CMS is choosing to remove the one measure that tracks the need for therapy. How else will CMS be tracking the assessment of therapy need for a beneficiary? Home Health agencies are accustomed to nursing opening a majority of cases and as a result, they may not always recognize the need for therapy services. Therapy practitioners can provide a wide variety of services to address a beneficiary's physical and mental health needs. NARA requests that CMS reconsider removing this measure until analysis can be done to determine the impact of not identifying therapy needs of beneficiaries on the OASIS. NARA recommends the OASIS be thoroughly reviewed to streamline it by eliminating burdensome duplicative data and adding elements that collect meaningful data on beneficiaries to improve care and outcomes. Elements of data collection continue to be layered on while drastically cutting reimbursement.

Additionally, NARA recommends CMS focus on developing quality measures that provide meaningful information to patients, caregivers, providers, and payers that adequately distinguish the services provided in the home without creating excessive administrative burden. This should include measures that reflect the contributions of physical therapy, occupational therapy, and speech language pathology practitioners particularly on patients' abilities to participate in rehabilitation therapy and achieve therapy goals. Currently, there are no speech language pathology measures on the OASIS. This does not allow for the full picture of the beneficiaries' needs. Communication and cognition are key elements for a beneficiary's recovery and should be assessed. What steps is CMS taking to address this need? While we appreciate the removal of the bias that can exist, the Self-Care and Mobility measures should not be combined; they are separate and distinct functions. These measures separately are too critical to leave out of a post-acute care (PAC) function measure, especially in certain settings. We understand the reasoning for combining them, but this does not decrease the administrative burden on providers, and we believe they should remain separate to better understand the optimal interventions and outcomes for patients in each unique PAC setting.

The American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA) released the TOPS study last year[1], where data from 1.4 million Medicare beneficiaries in SNFs, IRFs, and home health settings was analyzed. Medicare administrative claims and functional assessment data were studied to measure therapy utilization and the reported need for assistance with core activities of daily living, including self-care and mobility, at the start and end of a post-acute care stay. The study included looking at the relationship between intensity of occupational therapy and physical therapy

[1] "Occupational Therapy and Physical Therapy Provide Significant Rehabilitative Value in Post-acute Care" *APTA/AOTA Joint Statement*. Available at: https://www.aota.org/tops

services to change in patient functional status during their first PAC episode. 'Functional status' includes the patient's ability to perform dressing, bathing, toileting, feeding, walking/locomotion, and transferring. According to the findings, the intensity of therapy is associated with improved ability to perform these everyday functional activities as well as better functional outcomes and reduced risk of rehospitalization. Receiving high or typical intensity therapy was associated with more functional improvement than low intensity across all diagnoses. These findings were consistent for different types of conditions including joint replacement, stroke, and congestive heart failure suggesting a robust relationship between therapy intensity and meaningful outcomes.

Further, the TOPS study suggests that therapy is well targeted to the differing clinical needs and treatment goals of the populations served within each PAC setting as patients move through the recovery process. Although the PAC settings studied may have some overlap of patients, each setting serves a generally different patient population, in terms of their acuity and their treatment goals. We urge CMS to review the TOPS Study materials because it has important implications for home health and PAC policies, as well as implications for CMS/RTI's current development of a prototype for a PAC unified payment model.

NARA agrees with TEP members' perspective that the salience of functional items is setting-specific and patient-dependent, and we support the examples given in Section 3.2.2 on page 17 of the PAC Function TEP Summary Report.[2] Given the TEP members' perspective and the TOPS study finding that each PAC setting serves generally different patient populations with varying clinical needs and treatment goals, NARA recommends CMS separate quality measures for self-care and mobility in order to ensure each setting is able to capture the items most relevant to its patient population needs and goals and use the measures to determine *meaningful* quality improvement activities. However, if CMS must use one measure, then NARA supports a composite functional outcome measure to ensure that it captures both self-care and mobility items rather than solely mobility items. Such a measure should include appropriate risk adjustment to account for differences in risk factors to enable more accurate comparisons of performance. In addition, we encourage CMS to allow for review and future changes to a composite functional measure as needed.

RFI: Behavioral and Mental Health

Behavioral and mental health have become more dominant underlying factors for home health patients. This was further exacerbated by the COVID-19 pandemic. Conditions such as anxiety and depression can severely impact their quality of life. Beneficiaries can experience a range of common mental health problems such as anxiety and depression to more serious mental illnesses like schizophrenia and bipolar disorder. The symptoms of depression in the elderly often go untreated because they coexist with other health needs and can go undiagnosed. This can be especially true for beneficiaries living with comorbidities such as Alzheimer's disease or other forms of dementia. Not only can therapy treat the primary conditions of the patient but they can also address behavioral and mental health through non-pharmacological approach such as group therapy, use of memory games and puzzles, or improving their physical health so they can be more physically active. Chronic pain is a significant factor in recovery and can cause beneficiaries to easily feel distressed or want to give up which directly impacts their mental health and desire to return to prior levels of function or even work through the pain.

[2] Acumen, LLC. (2021). PAC QRP Functions TEP Summary Report. https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf

Beneficiaries living with chronic pain are at increased risk for mental health problems, including depression, anxiety, and substance use disorders. Chronic pain can affect sleep, increase stress levels, severe anxiety and contribute to depression. An estimated 35% to 45% of people with chronic pain experience depression.[3] Pain assessment and management is critically important in the home health setting and is a factor in quality care that our therapy practitioners often reference. NARA believes that services provided by therapy practitioners are significantly underutilized in the community setting and underserved/rural areas. Therapy practitioners can provide support for Medicare beneficiaries with diabetes, chronic pain, behavioral health, and provision of wellness services that address their mental health by treating the source of the pain. Therapists can assess areas of weakness or stiffness which may be the source of the pain and develop a plan of care with low-impact training, strengthening exercises, stretching and massage. Therapy does not provide instant relief like pharmacological approaches do, but over time beneficiaries will regain strength and flexibility to manage pain. The ability to manage pain and be able to function can positively impact the beneficiary's mental health but giving them purpose and self-worth again.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

NARA supports the value-based purchasing model; however, in an effort of transparency we request that CMS make historical data available to providers to ensure the best care is being provided. It is indicated in this proposal that CMS will be changing the weights of individual measures due to the change in the total number of measures, we request that you provide those changes in the final rule.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

NARA supports the inclusion of this new lymphedema benefit. In the past, lymphedema garments and supplies have been non-reimbursable for a large majority of patients, creating inequal access to these needed supplies as only those who could afford to pay privately for them could access them. We support the inclusion of 2 daytime garments every 6 months and 1 nighttime garment every year, but request CMS keeps the inclusion of criteria for more frequent replacement based on damage, loss, or medical need.

We appreciate that CMS has recognized therapy practitioners often perform the measuring and fitting services for custom lymphedema garments; especially since often in rural and underserved areas there is not a DMEPOS fitter available timely to measure the patient for the garment. We believe it is important to preserve the ability for the therapy practitioner to be able to measure their patients and determine the best fit device that will meet the functional and physical needs of their patient. We are concerned that CMS's proposal for reimbursement of custom garment measuring services via payment through only the HCPC code, to the DMEPOS supplier who would then "work out" payment to the therapy practitioner who conducted the measuring service is untenable and would potentially create conflicts of interest and pressure to select the device the DMEPOS supplier wants to bill for instead of the device most appropriate to the patient's needs. We also do not think requiring all therapy practitioners who want to perform measuring services to become DMEPOS suppliers is appropriate either as many are unable to do so because of their practice setting. For instance, a therapist in a hospital outpatient setting could be restricted from becoming DMEPOS certified because their hospital management does not want to incur the administrative and financial burden of doing so. Because of these concerns, we worry that the

[3] Vadivelu, Nalini, et al. (2017). Pain and Psychology-A Reciprocal Relationship. *The Ochsner Journal*, 17(2): 173-180.

proposed structure of garment measuring reimbursement will reduce access to this service, especially in rural and underserved communities.

NARA does not support either of the proposed payment scenarios for the clinical service of measuring/fitting custom garments but would support CMS allowing separate payment for the clinical work of the measuring/fitting service when performed by a qualified healthcare professional (QHP).

RFI for Utilization of Home Health Aides Decrease

NARA supports the use of home health aides as not every beneficiary's needs require skilled services and the home health aide can provide services to fill this gap in care such as practice getting the beneficiary up, repetitive exercise, etc. There are many factors that have contributed to the decreased use of Home Health Aides including an overall shortage of individuals who want to do the work, CMS payment reforms, CMS and HHA policies and practices have de-valued and dis-incentivized the provision of aide services and created competition for available aides with other care settings. Since the inception of the prospective payment system for home health in the late 1990s, home health aides have been increasingly excluded from calculations in PPS models for reimbursement. The use of aides results in an overall lower base payment. CMS conditions of participation for Home Health Agencies require these services be available for qualifying beneficiaries; however, CMS does not reimburse appropriately for these services. The services provided by the aides are considered unskilled and CMS only pays for "skilled" services. Beneficiaries with chronic and longer-term conditions typically need more services over time to keep their conditions stable but with a shortage of qualified home health aides and no incentive in reimbursement to provide this service many home health agencies are unable to provide it.

According to the Bureau of Labor Statistics (BLS) the home health aide is one of the fastest growing jobs, with the need for 750,000 new workers every year. But approximately 332,000 existing aides may retire or leave the occupation altogether and 287,000 seek similar work elsewhere. The average hourly wage, according to indeed for an aide is $10 – $16 per hour and minimum wage is around $10/hour. A private aide can make up to $20/hour. These pay rates for the job requirements including traveling from beneficiary home to beneficiary home requiring reliable transportation and heavy case load due to shortages can be overwhelming for these individuals when they can work at Target for the same pay rate. Aides engage with beneficiaries in very intimate ways in the very private setting of their home, but it is demanding and requires physical, psychological, and emotional skills. While this work can be meaningful to aides it can also be unfulfilling, offer minimal upward growth, and result in higher than average on the job injuries.

The home health aide has a vital role as a member of the home health team serving the patient and should be supported and valued for their unique and important contribution to the well-being of the beneficiary. CMS has acknowledged Congressional intent in the importance of the role the home health aide plays in both 2024 and 2022 notices of proposed rulemaking. The home health aide services have important value for keeping beneficiaries safe and healthy at home and must be properly included in plans of care. NARA encourages CMS to develop an appropriate payment mechanism to compensate appropriately for delivering all necessary aide services including affirmative incentives to provide aide services. When beneficiaries are unable to access these services, it can lead to unnecessary admissions to hospitals or nursing facilities, inability to remain safely in their home or community, further medical complications, forced institutionalizations due to lack of assistance, or strained family relationships when family members are forced to take on the caregiving activities. NARA strongly encourages CMS to address reimbursement

practices and policies to ensure home health agencies will continue to provide these critical services to beneficiaries especially those most vulnerable in rural and underserved areas and those with chronic and longer-term conditions.

Telehealth In Home Health Setting

NARA continues to be disappointed that CMS has not allowed the use of telehealth services in the home health setting. This has been an especially useful tool in meeting the needs of beneficiaries in rural and underserved areas. During the ongoing staffing shortage, it has been especially difficult to find therapists in these areas to provide care in line with the plans of care. If an HHA were able to utilize telecommunications when appropriate, like in other settings, beneficiaries' length of stay may be able to be decreased as they would progress quicker to their goals. The inability of a HHA to utilize telehealth tools in rural and underserved areas creates an issue to access to services beneficiaries have been referred to by their physicians.

NARA members have found their patients receiving telehealth services in other settings have expressed satisfaction and appreciation of the ability to participate in care remotely during the PHE and post-PHE. In addition, most patients have reported that their needs were met through telehealth in a similar way to their in-person care experience. Therapy interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions or readmissions. Education and home exercise programs, including those focused on falls prevention and chronic pain, function particularly well with telehealth because the therapist can evaluate and treat the patient within the real-life context of the home environment. NARA sees the opportunity to recognize all these benefits in the home health setting if telehealth was expanded.

Thank you for the opportunity to comment on these vital areas. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at 765-730-9757 or via email at christie.sheets@naranet.org.

Respectfully submitted,

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