September 9, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1718-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: 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. (CMS-1711-P)

Dear Administrator Verma:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists, and speech-language pathologists through its member organizations who provide needed rehabilitation services to Medicare beneficiaries across the United States. Our members furnish services in all settings across the continuum of care including, inter alia, home health agencies, outpatient clinics, skilled nursing facilities, assisted living facilities, hospital inpatient and outpatient facilities, beneficiary homes, and retirement communities. As a member-driven organization, NARA promotes the growth and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics afford it unique insight into payment and quality programs applicable to home health agencies. For this reason, NARA appreciates the opportunity to comment on the above-referenced proposed rule.

Proposed Payment Rate Changes under the HH PPS for CY 2020

NARA is supportive of CMS' reasons for reforming the current home health prospective payment system with the Patient Driven Grouper Model (PDGM). In 2018, NARA's members were concerned that providers would significantly reduce therapy services and this in turn would adversely impact home health beneficiary outcomes as well as inhibit beneficiary access to needed care. While NARA remains concerned, we feel that providers know the benefits of

providing therapy services to beneficiaries and will not significantly reduce needed services because there is no incentive to provide them. We recommend that CMS use the data collected from claims and provide a plan to monitor utilization.

NARA is concerned about the changes in the rural add-on 0.2 percent decrease. We understand this reduction is mandated by the Bipartisan Budget Act of 2018 (BBA) but the necessity of providing services to beneficiaries in rural areas still exists and the costs of providing such services certainly have not abated. NARA encourages CMS to consider the impact on smaller agencies and beneficiary access to services and eliminate this payment reduction. Furthermore, NARA recommends continued monitoring during the post-implementation period in order to determine the impact on accessibility to care and the ability of providers to fill open staffing positions.

NARA appreciates that the Partial Episode Payment Adjustments (PEP) and the methodology for calculating outlier payments would remain the same with PDGM as they currently are with PPS.

Regulatory Burden Reduction – Patients Over Paperwork and Enhance and Modernize Program Integrity

NARA is concerned that the proposed rule will create significant additional administrative burdens and financial constrictions for providers while failing to offset those burdens elsewhere. While NARA understands the rationale for phasing out the Request for Anticipated Payment (RAP), we would encourage CMS to consider doing it over a longer period of time—i.e. phase it out over a 3-year period rather than 2-years. Furthermore, NARA is of the view that the reduction of the RAP payment to 20% in CY 2020 would take a significant toll on home health agencies, especially because it would take place at the same time they are absorbing the changes related to the Patient Driven Grouper Model. For this reason, NARA requests that CMS consider keeping the RAP payment at 50% for the first year, reduce it to 30% the second year, and 15% the 3rd year before phasing it out. NARA believes that the elimination of the RAP will significantly impact the cash flow of small and rural-based home health agencies, at the same time that administrative burdens and costs are increasing. Accordingly, NARA recommends a longer phase-in of the RAP elimination so home health agencies have time to make the necessary adjustments.

NARA is not opposed to the Notice of Admission (NOA) because it will provide notice to other providers that a beneficiary is receiving home health services and will ensure a smoother transition of care to subsequent providers. However, NARA urges CMS to make the NOA optional in CY 2021 and mandatory in CY 2022. We also do not believe a penalty should apply during the implementation period of the NOA: since this would be a new process to which providers must adjust, a penalty during the implementation phase would not be appropriate or fair.

Paraprofessional Roles – Improving Access to Care

NARA appreciates CMS adding therapy assistants as qualified professionals who can perform skilled maintenance therapy under the Medicare home health benefit in accordance with individual state practice requirements because it is consistent with other post-acute settings. NARA strongly believes this will provide greater access to care for beneficiaries who would benefit from skilled maintenance therapy. NARA does not believe the use of assistants would cause an additional burden on the physical or occupational therapists. Physical and occupational therapists are accustomed to providing oversight with a plan of care when an assistant is providing care.

In response to CMS's request for input about whether HCPCS codes are necessary to distinguish therapy provided by the therapist versus the assistant, NARA is of the view that there is no need to distinguish between who is providing the services since both are delivering a skilled service. However, CMS should revise G0151 and G0157 to indicate the establishment or delivery of a safe and effective physical therapy (G0151) or occupational therapy (G0157) skilled maintenance program. CMS also requested input about the necessity to track the type of skilled visit being delivered – e.g. whether the visit is a skilled maintenance visit or a skilled restorative therapy visit. NARA finds it difficult to respond without additional data about whether there is a significant difference in the amount of restorative versus skilled maintenance care being provided. Both types of care require skilled intervention provided by therapists and therapist assistants, but it does provide helpful information about the types of care models home health agencies are implementing to maintain health outcomes. NARA believes CMS must conduct more provider education on the value and benefit of skilled maintenance therapy, and in the absence of such direction providers are reluctant to utilize these programs, even six years after the Jimmo v. Sebelius settlement. While it may be an additional burden to track this information as a provider, NARA recommends collecting such data in order to determine the efficacy of tracking these two types of skilled therapy programs.

Admission Source and PDGM

NARA requests additional clarification from CMS on what the expectation is when a patient is discharged to the hospital or other post-acute care setting before the end of an episode of care. The National Provider Call on August 21, 2019 provided more explanation but the language used in the proposed rule is still confusing.

Standardized Patient Assessment Questions

NARA respects CMS's desire to collect information and sees a need for this information. However, NARA is concerned that the required collection of this information, in addition to all the other administrative changes with PDGM implementation, will cause significant and costly burdens on providers. For this reason, NARA recommends evaluating the information currently being collected on the OASIS and eliminating unnecessary or redundant information to reduce

the burden. One suggestion is to eliminate the functional mobility M items as they are redundant with the introduction of the GG items earlier this year. The concept of adding some of the additions from Table 27 would be welcome such as Cognitive Status for this underserved and under-identified population. However, with the large number of substantial changes to which providers must adjust, NARA believes it would be best to delay for one or two years for the items in Table 27.

Behavior Assumptions

NARA is especially troubled by the assumption-based behavioral adjustment in the proposed rule. This methodology is not utilized in any other post-acute care setting and should not be applied to home health. As with any new program, there will be an adjustment period for providers as they make changes in operations to accommodate the requirements of a completely different payment method. CMS should expect that provider behavior will change, especially in light of the number of codes included as questionable encounter codes, but it is not appropriate to penalize all providers using a behavioral assumption methodology that is untested and has no supporting factual basis. As the industry prepares for an increase in beneficiaries from the Baby Boomer population, the need for health care resources will significantly increase. This policy has the potential to negatively impact access to care, and hence timely interventions, especially in smaller, underserved communities. It could also inadvertently and adversely impact re-hospitalization rates for beneficiaries. The proposed rule indicates this adjustment is the result of the BBA and its obligation to remain budget neutral. However, there is current legislation in both the House of Representatives (H.R. 2573) and the Senate (S. 433) to remove the ability to adjust rates based on behavior that has not yet been demonstrated. NARA strongly encourages CMS to reconsider this adjustment until such time that it has actual evidence of provider behavior change and CMS can substantiate and identify those providers who are in fact displaying the assumed behaviors.

Additional Comments

- NARA is supportive of CMS' addition of the new pain measures but encourages CMS to seek measures that focus on alternatives to pharmaceuticals such as therapy intervention. In 2016, the Centers for Disease Control and Prevention (CDC) released guidelines[1] that recommended nondrug approaches such as physical therapy over long-term or high-dosage use of addictive prescription painkillers;
- NARA supports the two new measures assessing the transfer of health information as it is consistent with other settings and encourages providers to share patient information with downstream providers resulting in better outcomes for the beneficiary;
- NARA does not support the requirement for OASIS data collection for non-Medicare beneficiaries as this is an unjustified increase in administrative burden for providers;

[1] CDC Guidelines for Prescribing Opioids for Chronic Pain – United States 2016
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm

- NARA supports no recalculation of case-mix weight for episodes that span implementation through February 28th as proposed by CMS; and
- NARA supports the update in changing the regulation text for the Conditions of Participation.

Should you have any questions concerning these comments, please contact George G. Olsen, Esq. at ggolsen@wms-jen.com.

Respectfully submitted,

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President
National Association of Rehabilitation Providers and Agencies