August 29, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1767-P, P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically at http://www.regulations.gov

Re: Calendar Year 2024 Home Health Prospective Payment System Rate Update (CMS-1780-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to submit comments in response to CMS' Calendar Year 2024 Home Health proposed rule (CMS-1780-P). APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA provides comments below on the proposed changes and requests for information regarding updates and modifications to home health payment and policies considered in the rule, and the issues described therein. APTA is submitting a separate comment letter to respond to the agency's proposals implementing the new Medicare benefit for lymphedema compression garments.

Initial Assessment for Non-Therapy and Some-Therapy Cases

APTA urges CMS to permit physical therapists to initiate episodes of care for not just "only therapy" episodes, but also episodes with "some therapy," to ensure care can be provided in a clinically necessary and timely fashion. Under current regulations, physical therapists may perform only the initial and comprehensive assessment when "only therapy" services are ordered. However, during the COVID-19 PHE, CMS waived this requirement, allowing PTs to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care. It is our understanding that nursing shortages in home health agencies have continued well beyond the end of the pandemic, and in cases where both nursing and therapy services are ordered, practitioners in HHAs have frequently reported challenges in initiating care, leading to unnecessary referral rejections.

Specifically, under current regulations when both therapy and nursing are required under an order, HHAs without adequate nursing staff are not able to start the care episode in a timely fashion. Further, despite the availability of PTs on staff, the necessary PT services cannot be provided until a nurse becomes available to begin care since PTs cannot provide so-called "start-up" care. It would be appropriate and

even necessary for CMS to modify existing regulations to permanently allow PTs to provide start-up care for not just “only therapy” episodes but also for “some therapy” episodes.

Anecdotally, many HHA therapists have even described a concerning level of desperation to ensure patients can get the services they need; notably, a significant number of providers have described the need to consult the referring physician to identify cases that do not truly require nursing so that they can refer the patient as therapy only, and the PT can begin the care episode in a clinically appropriate timeframe. This is a desperate practice borne entirely by the needlessly strict provisions in the existing regulations.

Data supports these assertions, too; more referrals are being turned away than ever, with a 76% referral rejection rate across home health as recently as January 2023. Further, APTA held discussions with several university research institutions that are currently conducting studies on the impact of delayed home care on functional recovery for Medicare beneficiaries. These studies have revealed significant disparities in functional recovery due to delays. According to the research institutions, these findings are undergoing peer review and should be available before the end of 2023.

Again, CMS allowed PTs to operate under an even broader flexibility during the pandemic than what APTA is requesting, and there is no reason to believe that the staffing problems described above will be resolved expediently. With every passing month, the referral rejection rate continues to grow, and considering additional cuts being levied against HHAs and nurses migrating to other care settings it is unlikely to get better. Ultimately, PTs have no influence on staffing in HHAs, but CMS can provide them with the flexibility to initiate the care patients need whether the episode requires “only” or “some” therapy, potentially chipping into these astronomical referral rejection rates.

The requirements around PTs initiating care should permit flexibility, and we ask CMS to move toward a more discipline-agnostic approach to care initiation, which should be based on clinician availability. In the post-PHE world, we are starting to understand what is likely or unlikely to return to pre-pandemic levels, and such flexibility will ensure patients can get care they need and reduce the number of rejected referrals in the home health setting. Further, it will enable more appropriate use of physical therapists, who are doctoral-level providers, and who had previous experience during the PHE to show that it is possible to provide quality and safe care when they initiate episodes that have more than just therapy services. This is an urgent matter, and one that CMS should try to establish during this rulemaking cycle to create a more timely environment of care in home health.

Therapy Utilization and the Permanent and Temporary Behavioral Adjustments

In its proposed rule, CMS discusses its proposed 5.653% cut stemming from the permanent behavioral adjustment. APTA reiterates its concerns with the behavioral adjustment methodology below, and urges CMS to consider additional data collection and program integrity efforts to both understand post-PDGM trends and ensure that medically necessary therapy services are not underutilized as a result of PDGM.

Overview of Adjustments

APTA understands that CMS is statutorily obligated to ensure that PDGM is implemented in a budget-neutral manner. The Social Security Act mandates that CMS annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. The statute also makes clear that these adjustments are intended to ensure that the estimated aggregate amount of expenditures under PDGM is equal to the estimated aggregate amount of expenditures that

otherwise would have been made under the system during such period PDGM had not been implemented.

The agency administers its charge through the permanent and temporary behavioral adjustments, outlined below:

- **Permanent Adjustment.** Calculate the percent change between the actual 30-day base payment rate and the recalculated 30-day base payment rate. The percent change is converted into the adjustment factor, and then applied to the base rate.

- **Temporary Adjustment.** Calculate the dollar amount difference between the estimated aggregate expenditures from all 30-day periods using the recalculated 30-day base payment rate, and the aggregate expenditures for all 30-day periods using the actual 30-day base payment rate for the same year.

Concerns Stemming From PDGM's Methodological and Theoretical Flaws: A Downward Spiral

APTA believes that the behavioral adjustment and its theoretical flaws have created a downward spiral that incentivizes underutilization of necessary services in the face of unavoidable cuts. During 2023 rulemaking, APTA explained its concerns that the methodology, as well as CMS' understanding of therapy utilization, underlying the permanent behavioral adjustment was flawed in its approach. The central flaws are not in the methodology's effectiveness in achieving budget neutrality, but in its inherent circularity and reliance on inadequate claims data. As administered, the methodology has the propensity to exacerbate — and rely upon — its own shortcomings and misattributions of therapy needs in the system.

Specifically, the previous payment model rewarded utilization, while PDGM does not; as APTA has stated in the past, **comparing the two datasets is essentially an exercise intended to punish any drop in utilization regardless of its cause. More concerningly, CMS has not attempted to explore this issue in any meaningful way.** As a result, steep payment cuts have forced HHAs to reduce services and cut staff, exacerbating these behavioral cuts year-after-year, which are tied only to service utilization and not to quality, efficiency, or safety of care. This has resulted in a perverse standoff between CMS and HHAs, leaving many HHA clinicians and beneficiaries frustrated and helpless in ensuring they operate at the top of their training to provide, safe, quality, and necessary care to their patients.

CMS Underestimates the Impact of COVID-19

While CMS is charged only with correcting behavioral changes driven by PDGM, its methodology results in an adjustment that accounts for any fluctuation in behavior or patient characteristics and assumes these are solely the result of PDGM. We continue to believe that CMS is therefore overstepping its authority by implementing a payment adjustment that assumes any and all changes to HHA behavior occurring over the past two years was solely the result of PDGM and the pandemic, and that other factors had no influence on providers.

Additionally, CMS' methodology ensures that the goal of PDGM will not be met until it concludes its annual budget neutrality assessment in 2026. While the previous model paid HHAs for the utilization of an individual HHA treating an individual patient, CMS' methodology now retroactively pays HHAs for the utilization trends of their industry. HHAs effectively have no control over the payment they receive and will be punished for their peers' performance. Accordingly, an HHA is now incentivized to reduce services as

much as possible to maximize profit, knowing that regardless of their individual actions, a pay cut is likely in the following year. Without a more targeted approach to weed out bad actors, CMS has essentially created a race to the bottom.

Further, CMS has operated under the assumption that behavioral changes, and the precipitous drop in therapy since PDGM's implementation in 2020, are entirely attributable to the implementation of PDGM and the removal of existing therapy thresholds. In response to APTA's and others' concerns regarding the impact of COVID-19 on this methodology, CMS claimed two things: first, that after the early months of CY 2020, the health care system largely normalized; and, second, that the methodology controls for COVID-19 data, based on MedPAC's comments on the 2023 proposed rule:

> "Applying the case-mix system in effect prior to 2020 reflects how Medicare would have paid in the absence of the BBA 2018 changes. In applying the prior case-mix system to the claims for 2020 and 2021, the method also incorporates the utilization and coding changes that occurred in these years. **As the effect of the PHE is included in the estimated budget-neutral amount and actual home health expenditures, the method ensures that any difference between the two calculated spending amounts is not attributable to the PHE."**

We disagree with the oversimplified approach CMS has taken. To support its first claim, CMS cited studies on the return of elective surgeries and medical treatments, satisfied that this represented the entire health care system, rather than analyzing trends in home health utilization/claims data. While this sentiment tracks across some metrics, such as total episodes, the analysis should be more nuanced. According to Part A/B claims data sourced by the CMS Office of Enterprise Data and Analytics, home health utilization changes under traditional Medicare continued to decline into 2021 across several major metrics — service visits per person, service visits per episode, and total persons utilizing services. The drop in total persons utilizing care in the context of increased episodes paints a more complex picture that calls into question the efficiency of these services being provided, and whether the system correctly incentivizes HHAs to provide the appropriate mix of medically necessary care that reduces hospitalizations and results in successful discharges to the community.

Further, the return to pre-pandemic utilization does not paint a full picture of the issues — while utilization increased to pre-pandemic levels and beyond 2020-21, according to the Bureau of Labor Statistics, home health workforce issues persisted into late 2022. However, since care and workforce needs are not static, to judge workforce adequacy more accurately, KFF compared workforce deficits based on **projected** growth (pre-pandemic), which suggests that as of June 2023, home health maintains a -6.7% employment difference compared with where it was projected to be. One could argue that since total utilization appears to exceed pre-pandemic levels, the workforce projections underestimate the differential. Collectively, these datapoints make it challenging to understand how the PHE would not (or does not) impact utilization and HHA behavior during this period at all.

CMS Should Explore the Precipitous Drop in Therapy Utilization and Implement Targeted Program Integrity Efforts to Prevent Bad Actors

As we noted last year, in the CY 2020 HH PPS final rule, CMS stated "the elimination of the therapy thresholds will remove the financial incentive to provide therapy solely for increased payment." It would follow that at least some marginal amount of therapy under the previous payment model was not driven by patient need but was in fact waste. While APTA contends that number is likely small, and notes CMS has not put forth any assumptions or calculations regarding overpayment under the previous model, it's

not entirely unrealistic to assume some percentage of the drop in utilization is the result of a decline in waste. However, the current methodology still results in a punitive payment adjustment for what CMS should view as a positive behavioral adjustment. Had PDGM not been implemented, this waste would have continued, and CMS would have continued to reimburse for it. APTA believes the amount of the drop in therapy utilization attributable to waste is small, as our anecdotal evidence from members mostly supports the theory that the drop in utilization is largely driven by the pandemic. However, CMS' failure to consider this potential driver of behavior is one flaw in its methodology.

While APTA expects that CMS' application and administration of the behavioral adjustments will more likely be addressed in the legislative and judicial avenues, APTA still has sizable concern that CMS is content to judge the appropriateness of this policy by its impact on utilization and payments alone. We agree with the agency that something needs to be done about inappropriate utilization amongst HHAs, but we disagree with the agency's strategy to curtail it. Further, CMS has minimized the impact of this policy on patient outcomes as it relates to the mix and number of services. The agency's home health analyses over the last three years fail to adequately address the impact of its policy on patient outcomes, and it has not undertaken companion efforts to determine which, if any, HHAs neglected to provide appropriate levels of care to their patients, despite the fact that **therapy utilization has now dropped over 18% between 2019 and 2022.**

It is alarming that CMS is neither taking action to understand why utilization has been so significantly reduced, nor determining whether beneficiaries are receiving safe and appropriate care. A near-20% drop in a single type of service is a potentially serious and dangerous change in patient access to care, and the casual approach CMS has taken since the PDGM implementation to seek a more nuanced understanding of these changes is concerning. We remind CMS that it understood PDGM could result in reductions in utilization, and the agency responded to stakeholder concerns in the 2020 rule, stating:

> We reiterate that we expect the provision of services to be made to best meet the patient's care needs and in accordance with the home health CoPs at § 484.60 […]. **Therefore, we do not expect HHAs to under-supply care or services; reduce the number of visits in response to payment; or inappropriately discharge a patient receiving Medicare home health services as these would be violations of the CoPs and could also subject HHAs to program integrity measures.** (84 FR 60495)

CMS knows that the CoPs, like any rule or regulation, are only as effective as the program integrity efforts that buttress it. CMS has clear evidence that visits have been reduced, and while some of that was largely anticipated by stakeholders, the agency cannot be satisfied that a near-20% reduction in therapy services was entirely the result of therapy thresholds being removed, or genuinely believe that the entirety of the reduction is tied to actual clinical needs of patients. The behavioral adjustment and the removal of therapy thresholds are acknowledgments that legislators and regulators believe HHAs make utilization decisions to maximize payment — thus, it is unclear why CMS would believe that HHAs would immediately provide the appropriate level of therapy after the change, and not make changes to their financial benefit to stabilize their margins when cuts are levied against them regardless of their behavior. This is at best naïve, and at worst willfully ignorant.

Since CMS attributes all behavioral changes over the past three years to the PDGM implementation with respect to payment, it would follow that CMS would interpret the drop in utilization in accordance with the CoPs, or in the same manner as overutilization, especially since anecdotal evidence from HHA-employed clinicians supports that many HHAs have affirmatively reduced therapy services in response to the cuts. We would at least expect CMS to be consistent in its assumptions: **If the reduction in utilization is**

egregious enough to warrant payment adjustments it should also warrant data collection and program integrity measures. If there's potential overutilization, CMS is obligated to protect the trust fund; similarly, when there's underutilization, CMS' responsibility is to protect its beneficiaries; however, the latter has not received commensurate attention.

Further, there is a reasonable argument that underutilization of therapy has its own impact on spending. MedPAC home health data has indicated that as we move closer to post-COVID-19 data, therapy services have been distinctly increasing for efficient providers:

MedPAC Analysis of Therapy Visit Share Per Episode, 2015-21 (Efficient Providers vs. All Other Providers)

	2015	2016	2017	2018	2019	2020	2021
Efficient	45%	43%	45%	No Data	51%	46%	49%
All Other	41%	44%	44%	No Data	50%	45%	45%
Differential	+4%	-1%	+1%	N/A	+1%	+1%	+4%

CMS should not have to be urged to explore this trend more thoroughly; it is in the agency's best interest to understand why therapy services at HHAs are provided at a lower clip than their efficient counterparts. Through quantitative and qualitative analyses, APTA believes CMS can shed light on the appropriateness of the current case mix in the average HHA. And to our original point, if increased therapy visits tend to reduce the number of hospitalizations and promote better rates of successful discharges to the community, and can do so with a higher patient severity case-mix, (as efficient providers do, according to MedPAC's data) CMS should focus on ensuring a clinically appropriate number of therapy services are provided.

For instance, MACs could perform targeted medical necessity audits on HHAs that saw the steepest therapy declines, and the threat of these measures could help normalize the level of therapy provided across HHAs. CMS must use caution to ensure that these reviews are specifically targeted to HHAs who are underperforming — otherwise, it risks creating a similarly inequitable scenario wherein all HHAs are punished with the administrative burden of a review when the behavior of a select subset of HHAs is in question. Such action would in fact help the agency see the true causes of various behavioral changes HHAs exhibited. As the workforce data shows, into 2023 HHAs have and continue to face staffing shortages in the industry. At times, HHAs were forced to reduce services because there simply was not enough workforce available, either due to high turnover or staff illness. HHAs in this instance were forced to do the best they could with what they had, spreading their available workforce across all patients so that at least every patient received some care. APTA has also heard of HHAs laying off therapists at the onset of PDGM in anticipation of cutting back services. CMS cannot treat these two types of HHAs the same. It is shortsighted for the agency to remain content that utilization decreased without understanding why, and we urge CMS to take serious efforts to explore the issues described above.

Removal of OASIS Item M2200 "Therapy Needs"

In light of our concerns detailed above, we urge CMS to maintain OASIS item M2200 "therapy needs" despite its proposal to remove the item. APTA has made clear that it has significant concerns about the

limited analyses on the clinical need for therapy services, and these limitations are borne in large part due to not having enough date mechanisms to monitor therapy utilization.

In the proposed rule, CMS notes that the item is “no longer used in the calculation of quality measures already adopted in the HH QRP, nor [is it] being used currently for previously established purposes unrelated to the HH QRP, including payment, survey, the HH VBP Model or care planning.” We believe the measure should be maintained for potential non-QRP related monitoring around payment. Given the significantly lower utilization of therapy services, being able to compare “therapy needs” with the number of therapy visits provided could offer insight into the actions that some HHAs have taken, since the item identifies the “total number of planned therapy visits” and is based on the plan of care, not the number of visits that are actually provided. Thus, it can paint a more comprehensive picture of clinical need versus services rendered.

FY 2025 and FY 2026 Quality Reporting Program Proposals

Addition of the Discharge Function Measure (FY 2025)

Beginning in FY 2025, CMS proposes removing the current Application of Functional Assessment/Care Plan measure from the HH QRP because the measure is both topped out (meeting conditions for measure removal factor one) and the Discharge Function Score, or DC Function measure, is more strongly associated with desired functional outcomes. In its stead, CMS proposes to add the DC Function measure beginning in FY 2025. The DC Function measure would use data collected through OASIS to measure the percentage of home health patients who meet or exceed their expected function score, which would be calculated by risk-adjusting the reported observed discharge scores, as detailed in the accompanying technical report. Further, CMS would also require home health measure performance to be displayed publicly on Care Compare. The agency believes that the DC Function measure is the most appropriate means to measure functional status that can reliably distinguish performance among providers in the OASIS.

Public display requirements mean that not only will CMS quality payment be premised on measure performance, but health care consumers will use this measure as an indicator of clinical efficacy. Of course, this reflects not only on the institution but also on its clinicians, including physical therapists, and their work. APTA supports the addition of the DC Function measure, but we encourage CMS to continually reevaluate this important measure; it is imperative that both CMS and its beneficiaries understand the value of skilled therapy in maintaining or improving function through assessment and intervention. Still, we agree with CMS that the DC Function measure is a significant improvement in evaluating whether therapy professionals are improving patient outcomes by providing interventions that improve or maintain levels of function.

However, we remind CMS that physical therapists and their colleagues in the home health setting will be judged under this measure largely based on the expected function risk adjustment, which accounts for a variety of factors that are crucial in accurately measuring functional improvement or maintenance. These factors, which include primary diagnosis group, prior function, cognitive function, and others, should theoretically provide for more accurate comparison in assessing functional improvement from therapeutic rehabilitation by providing more meaningful distinctions between patients’ abilities to improve function. The DC Function measure also has the potential to demonstrate the value of maintenance therapy when it is appropriate based on the patient's presentation.

Regardless of these benefits, we request that CMS exercise caution since the DC Function measure is only as strong as its risk adjustment is accurate. We have concerns, detailed later in our responses on potential measure gaps, that the data sources for certain aspects of the risk adjustment methodology, such as cognitive function, are flawed and should be closely monitored. We will continue to provide the agency with feedback as stakeholders, and we ask CMS to monitor the appropriateness of risk adjustment for the expected discharge score in practice and ensure that it accurately reflects reasonable expectations of improvement for patients.

Addition of the DC Function Measure in the HH QRP and Responses to the RFI on Cognitive Measures

In the CY 2024 proposed rule, CMS requests information on approaches to filling existing measurement gaps through the inclusion of several types of measures. CMS specifically seeks comment on the potential inclusion of cognitive function measures, including existing measures that could be used in the HH QRP, the overall feasibility of measuring improvement of cognitive function during HH stays (which average around 56 days), and other information on clinical conditions and interventions. APTA fully supports the introduction of cognitive measures for future HH QRP measure sets, which would provide additional context for HH efficacy given the inseparability of function and cognition in patient improvement. However, we encourage CMS to approach measurement cautiously for several reasons.

Most notably, CMS asks whether there are measures that could be developed using standardized patient assessment data on cognitive function collected through the Brief Interview for Mental Status, or BIMS, and Confusion Assessment Method, which are collected as part of OASIS. However, clinicians overwhelmingly indicate that the BIMS test is not an appropriate or effective data source for measuring or risk-adjusting for patient cognition or communication, particularly in the HHA setting. Home health clinicians and administrators highlighted concerns over the limited utility of BIMS for certain risk factors, such as communication and cognitive impairment. Notably, in practice, the BIMS test is best conducted by speech-language pathologists, though many HHAs do not have staffing to support this since every patient must receive the BIMS. Though other clinicians can and do conduct and score BIMS, this can create significant variance in the reliability of scoring and may create issues in the overall risk adjustment, as failure to capture accurate data on a patient's cognitive or communicative function plays a significant role in assessing impairment and potential for improvement. Further, the BIMS tool also lacks physician buy-in due to these perceived issues, and thus education to non-SLP staff can suffer; this means that existing variation between clinical interviewers is unlikely to be resolved in many settings. We encourage CMS to pursue alternative data sources for cognitive function measures, its risk-adjustment methodology, and future data collection through OASIS. CMS should also ensure that risk-adjustment factors based on this standardized data are similarly reconsidered. Ultimately, quality measurement and risk adjustment can be significantly improved by ensuring the source data is a well collected and understood representation of cognitive function. More accurate and in-depth assessment would provide better input for risk adjustment in cognitive and communicative impairment, and thus offer better quality measurement and better representation of an HHA and its clinicians' efficacy.

Conclusion

APTA thanks CMS for the opportunity to comment on the CY 2024 Home Health PPS proposed rule. Should you have any questions regarding our comments, please contact Andrew Amari, JD, specialist, health policy and payment, at andrewamari@apta.org or 703-706-8547; or Kate W. Gilliard, JD, director, health policy and payment, at kategilliard@apta.org or 703-706-8549.

Sincerely,

Roger Herr PT, MPA
President