August 24, 2020

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements Proposed Rule [CMS-1730-P; RIN: 0938-AU06]

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) Steering Committee appreciate the opportunity to comment on the Proposed Rule entitled, *Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements* (the Proposed Rule). This letter focuses on the Centers for Medicare and Medicaid Services' (CMS) implementation of the Patient-Driven Groupings Model (PDGM) and its impact on access to therapy in the home health setting, as well as the proposed telehealth provisions in the rule.

CPR is a coalition of more than 50 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. CPR is comprised of organizations that represent patients – as well as the clinicians who serve them – who are frequently in need of the rehabilitation care provided by Home Health Agencies (HHAs) and other settings of post-acute care.

Overview

The Proposed Rule includes technical and payment policy updates to the home health Prospective Payment System (PPS) and home health Quality Reporting Program. We do not offer comment on these proposed policies at this time. CMS also proposes to make permanent the telehealth flexibilities provided in the first COVID-19 Interim Final Rule with Comment Period, which expands the authority for HHAs to utilize telecommunications technologies in providing care to beneficiaries, as long as the use of such technology is outlined in the plan of

care, tied to a specific treatment outcome goal, and is not used to substitute for an in-person visit as ordered on the plan of care.

Permanent Expansion of Telehealth in the Home Health Payment System

On March 30, CMS issued an Interim Final Rule providing flexibilities to health care providers to address the COVID-19 pandemic. Among other provisions, the rule permitted home health agencies to provide services during the declared public health emergency to beneficiaries via telecommunications technology within the 30-day period of care, so long as these services were part of the patient's plan of care and do not replaced needed in-person visits as ordered on the plan of care. Under the FY 2021 Proposed Rule, CMS would make these changes permanent beginning January 1, 2021. CMS reiterates that HHAs should continue to provide in-person visits for any services that cannot be appropriately performed via telehealth and that access to telecommunications technology must be inclusive for people with disabilities. Finally, CMS states that HHAs cannot discriminate against any individual who is unable or unwilling to receive home health services via telehealth.

CPR recognizes that the expansion of telehealth has been a crucial element of the health care system's response to the pandemic, especially as vulnerable beneficiaries are encouraged to remain socially distant and avoid unnecessary in-person interaction. We support the provisions in the proposed rule to expand home health beneficiaries' access to telehealth without impeding their ability to receive in-person services. These guardrails are crucial to protect beneficiaries.

As CMS continues to explore avenues to permanently expand telehealth past the current public health emergency, we urge the agency to ensure that beneficiaries are not inadvertently harmed by increasing reliance on virtual services at the expense of in-person care. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions are in need of the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is critical that beneficiaries receiving post-acute care in particular are able to access the most appropriate care in the most appropriate settings. We understand that many patients nationwide have benefited from the expansion of telehealth and may expect to continue to be able to receive virtual care after the pandemic has subsided. However, the proliferation of telehealth must not come at the expense of in-person care. New regulations expanding telehealth must ensure that telehealth is utilized when clinically appropriate and that beneficiaries who need in-person care do not face additional barriers to access as a result of telehealth adoption. We encourage CMS to actively solicit and appropriately consider feedback from clinicians and beneficiaries, including organizations advocating for patients, when developing further telehealth policy that protects access to care.

Concerns with the Patient-Driven Groupings Model

CPR continues to be concerned with the observed and ongoing impact of the Patient-Driven Groupings Model (PDGM) implemented in the home health PPS effective January 1, 2020. CMS finalized this model with the intent of categorizing patients into "meaningful" payment categories (Home Health Resource Groups or "HHRGs") based on clinical and other characteristics to assign case-mix variables and associated payments. CMS has stated that the

intention of the PDGM was to better align payments with patient care needs and "ensure that clinically complex and ill beneficiaries have adequate access to home health care."

However, we have long held concerns regarding the PDGM structure and its impact on beneficiaries. Under the PDGM, CMS makes assumptions about provider behavior that could occur as a result of the new case-mix adjustment factors and the implementation of the 30-day unit of payment. As outlined in the CY 2020 rule, these behavioral assumptions result in significant decreases in payment to home health providers while being formulated without robust, evidence-based data. In our comments on the CY 2020 Proposed Rule, we aired these concerns, specifically citing the potential for home health agencies to reduce their operations or leave certain markets altogether.

Troubling Indicators Though Early PDGM Implementation

The PDGM has been in effect for less than a year, and most that time has been under the extenuating circumstances of the COVID-19 pandemic. Additionally, CMS has not yet published sufficient data to fully understand the impact of the new model on patients' ability to access therapy in the home health setting. However, there are a number of troubling indicators based on reports from organizations representing patients and therapists that suggest the PDGM is driving a decrease in access to rehabilitation care at home. While CMS has clarified that the PDGM (along with the Patient-Driven Payment Model implemented in the Skilled Nursing Facility PPS) does not impact Medicare coverage of home health and SNF services, reports from the field have thus far suggested that the models have already served to impede access to therapy for patients who need skilled care.

As reported by all of the major rehabilitation therapy associations, in the months leading up to and soon after the implementation of the PDGM, HHAs across the country began to eliminate positions and drastically reduce hours for employed therapists due to the payment changes inherent in the PDGM. Organizations representing therapists have also received reports from their members that remaining therapists have been directed to decrease the therapy minutes provided and that certain patients have been rejected or terminated due to their categorization under the new HHRGs. These reports are troubling and may indicate that the new model is driving decisions based on financial considerations, rather than patient care needs. CPR continues to be particularly concerned about the provision of maintenance therapy, which is covered by Medicare as affirmed under the *Jimmo v. Sebelius* class action settlement but is often at risk of being cut or eliminated entirely. "Maintenance" therapy assists a patient to maintain or prevent deterioration of their functional status, as opposed to improving their functional abilities.

More Data is Needed to Understand Impact on Patients

As outlined above, the data thus far is largely anecdotal but it is clearly concerning. In order to truly assess the impact of the PDGM on patients, robust data from CMS is critical. **We urge the agency to expedite the collection and reporting of data on therapy utilization, characteristics of patients receiving therapy, patient outcomes, and other information on the PDGM implementation as soon as possible.** With the significant change in reimbursement that the PDGM system represents, we strongly believe that the agency should report a broader

range of data to ensure that stakeholders and patient advocates are sufficiently able to understand potential barriers to accessing rehabilitation therapies inherent in the new system.

Additionally, we urge CMS to report this data at least quarterly, rather than annually, to ensure that patients who may face decreased access to therapy do not have to wait a full year or more to address these issues. Transparent and detailed data reporting will allow stakeholders in the rehabilitation and patient advocacy community to work with CMS to develop improvements to the system to properly serve beneficiaries and allow the reimbursement system to provide the skilled rehabilitative care they need.

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We greatly appreciate your consideration of our comments on the CY 2021 Home Health PPS Proposed Rule. Should you have any further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Steering Committee of the Coalition to Preserve Rehabilitation

Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Falling Forward Foundation
National Multiple Sclerosis Society
United Spinal Association